Trust Board

Minutes of a meeting of the Board of Directors held at 9.30 am on Wednesday 24th April 2019, in Room 3, Education Centre, Queen Elizabeth Hospital

Gateshead Health NHS Foundation Trust

Present:	
Mrs JEA Hickey	Chairman
Mr A Beeby	Medical Director
Mrs J Bilcliff	Group Director of Finance
Dr R Bonnington	Non-Executive Director
Mr S Bowron	Non-Executive Director
Mr P Hopkinson	Non-Executive Director
Mr M Laing	Acting Executive Director of Medicine and Community Services
Dr H Lloyd	Director of Nursing, Midwifery and Quality
Mr J Maddison	Acting Chief Executive
Mr J Robinson	Non-Executive Director
Mr M Robson	Non-Executive Director
Mr D Shilton	Non-Executive Director
Mrs S Watson	Director of Strategy and Transformation
In Attendance:	
Mrs D Atkinson	Trust Secretary
Mr N Halford	Deputy Medical Director
Mr R Wigham	Head of Communications and Marketing
Mrs J Williamson	Membership Co-ordinator
Governors and Members of the Public:	
Reverend J Gill	Public Governor
Mrs G Henderson	Public Governor
Mrs K Tanriverdi	Public Governor
Apologies:	
Mrs C Coyne	Director of Clinical Support and Screening Services
Cllr M Gannon	Non-Executive Director

Agenda Item	Discussion and Action Points	Action By
19/59	**CHAIRMAN'S BUSINESS:** Mrs JEA Hickey, Chairman, welcomed the Trust Governors and a member of the public to the meeting. She requested that Board members present report any revisions to their declared interests or any declaration of interest in the items on the agenda.	

<table>
<tr><th>Agenda Item</th><th>Discussion and Action Points</th><th>Action By</th></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td>19/60</td><td><u>MINUTES OF THE PREVIOUS MEETING:</u>

The minutes of the meeting of the Board of Directors held on Wednesday 27th March 2019 were approved as a correct record, subject to minor amendments.</td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td>19/61</td><td><u>MATTERS ARISING FROM THE MINUTES:</u>

The Board Action Plan was updated accordingly to reflect matters arising from the minutes.</td><td></td></tr>
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<tr><td>19/62</td><td><u>ANNUAL DECLARATIONS OF INTEREST:</u>

Mrs D Atkinson, Trust Secretary, presented the Declaration of Board Members' Interests and the Fit and Proper Persons Declaration.

All Board members have satisfactorily completed the Fit and Proper Persons Declaration and the declared interests are shown below:

<table>
<tr><th>Name</th><th>Position</th><th>Interest</th><th>Interest of Spouse</th><th>Category</th></tr>
<tr><td>Mr Lewis Atkinson</td><td>Deputy Director</td><td>Labour Networks Ltd</td><td>None</td><td>A</td></tr>
<tr><td>Mr Andrew Beeby</td><td>Medical Director</td><td>Director of Medicolegal reporting firm (Private company).</td><td>Rebecca Beeby – (Director of same company)</td><td>A</td></tr>
<tr><td>Mrs J Bilcliff</td><td>Group Director of Finance</td><td>None</td><td>None</td><td></td></tr>
<tr><td>Mr N Black</td><td>Chief Digital Officer</td><td>Director of NHS Healthcall (NHS Partnership between six NHS Trusts)</td><td>None</td><td>F</td></tr>
<tr><td>Dr Ruth Bonnington</td><td>Non-Executive Director</td><td>General Practitioner in Gateshead</td><td>None</td><td>B</td></tr>
<tr><td>Mr Shaun Bowron</td><td>Non-Executive Director</td><td>Non-Executive Director of QE Facilities</td><td>None</td><td>A</td></tr>
<tr><td>Mrs Claire Coyne</td><td>Executive Director</td><td>Director North East Transformation System Ltd</td><td>None</td><td>A</td></tr>
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Agenda Item	Discussion and Action Points					Action By
	Cllr Martin Gannon	Non-Executive Director	Newcastle Airport Local Authority Holding Company Limited Leader of Gateshead Council	None None	A F	
	Mr N Halford	Deputy Medical Director	None	None		
	Mrs Julia Hickey	Chairman	Trustee and Audit Chair of NHS Confederation and Management Committee Member of SVP which manages two local approved premises	None	D D	
	Mr Paul Hopkinson	Non-Executive Director	Partner PL Law LLP Trustee – FACT – Fighting All Cancers Together	Partner PL Law LLP	B D	
	Mr Michael Laing	Associate Director	Northern Housing Consortium	None	E	
	Mrs Hilary Lloyd	Director	None	None		
	Mr John Maddison	Director	None	None		
	Ms Karen O'Brien	Deputy Director	None	None		
	Mr John Robinson	Non-Executive Director	Non-Executive Director of QE Facilities	None	A	
	Mr Mike Robson	Non-Executive Director	Vice-President St Oswald's Hospice	None	E	
	Mr David Shilton	Non-Executive Director	Director Meadow Lodge Care Ltd Director Holistic Care Provision Ltd Member Meadow Lodge Homecare Services LLP	None	A A B	
	Mrs Susan Watson	Director	Trustee - Friends of Friarage Hospital	None	D	
	Mrs Atkinson noted that Deputy Directors are now also included in the declaration as they occasionally represent Executive Directors at Board. She confirmed that the annual check had also been carried out which included a check against the disqualified director records. Following discussion, it was: **RESOLVED:** i) to approve the declared interests and Fit and					

Agenda Item	Discussion and Action Points	Action By
	Proper Persons Declaration ii) to note the next full routine review of the declaration of Board members interests will take place in April 2020	
19/63	**PERFORMANCE REPORT:** Mrs S Watson, Director of Strategy and Transformation, provided an update on performance against national and local targets, giving assurance about the Trust's performance in the light of national requirements and local changes. She drew attention to the paper, agenda item 7, and stated that the report had been discussed in detail at the Finance and Performance Committee the previous day. Mrs Watson reported that the A&E performance has continued to be challenging to the end of the year, with the standard again not being met in March 2019. She noted that NHS Improvement is not unduly concerned with this, and the Trust remains in the top 20 performing Trusts in March 2019. She added that there are concerns regarding the performance in April 2019, so work is being undertaken with operational teams on this. She added that the 62 cancer target was not met in March, which is the second consecutive month that this has not been achieved. She noted that this may trigger NHS Improvement follow-up but the Trust is satisfied that this is within normal control limits. The current data for April shows an improved performance. Mrs Watson reported that the RTT target was met March 2019 (this had been flagged as "at risk"), however work still needs to be undertaken to recover the lost work over the period from issues in CSSD. She noted that the Mental Health metrics are not yet finalised, however the targets are expected to be met at the end of March 2019. She highlighted the key workforce metrics, noting a slight improvement in the Trust's sickness absence levels, however work continues in this area Mrs Watson reported that core training continues to be sustained at an improved level. With regard to appraisals, there has been little improvement in the compliance and this currently stands at 85%. Work is still ongoing and this target continues to be	

Agenda Item	Discussion and Action Points	Action By
	challenging. There is a need to understand whether appraisals have been carried out but have yet to be recorded, as feedback from some wards has identified this as an issue. Mrs Watson concluded her report by stating that overall the year-end report is pleasing given the pressures over the year. She congratulated the clinical teams and staff for their excellent performance. Mr P Hopkinson, Non-Executive Director, queried how staff turnover is measured. Mrs S Watson, Director of Strategy and Transformation, stated the definition of staff turnover is based on staff leaving the Trust, excluding any internal moves. She added that the turnover is calculated on a rolling 12 months period, and uses the WTE staff in post. The industry norm is between 10% and 15%. Following further discussion, it was: **RESOLVED:** to receive the report as assurance against the management of governance indicators in the Single Oversight Framework and local supporting measures of performance management	
19/64	**NURSE STAFFING EXCEPTION REPORT:** Dr H Lloyd, Director of Nursing, Midwifery and Quality, provided assurance to the Board that staffing establishments are being met on a shift-by-shift basis. The report includes details of the number of actual staff on duty, compared with the planned staffing level, the reason for any gaps and the actions being taken to address these gaps. The report provides information for March 2019. She stated that overall the report remains stable, with continued good staffing levels on a ward by ward and shift by shift basis. She noted that the average fill rate for days was slightly reduced at 85%; however nights continue to be stable. Dr Lloyd reported on changes to national requirements that mean Trusts will only have to publish CHPPD, not % fill rates. Mrs JEA Hickey, Chairman, commented, that the percentage fill rates are measured against a planned level where as Care Hours Per Patient Day (CHPPD) is not measured against a planned level. She added that the Board of Directors has always reflected the uncertainty in how to judge the Care Hours Per Patient Day	

Agenda Item	Discussion and Action Points	Action By
	(CHPPD) figure, and she queried the proposed change. Mrs Hickey also queried if the fill percentages can continue to be monitored for the Board, but stated this could be an onerous task if not required. Dr H Lloyd, Director of Nursing, Midwifery and Quality, stated that the reporting of percentages is well embedded and gives assurance to the Board of Directors and she would intend to continue monitoring and reporting these measures. She added that she is part of a regional group looking at this and the Trust is also looking at changing reports format, so there is work in progress in this area. She noted that the exception report flags anything less than 75%, and highlighted the reported reasons which included high fill rates for Nursing Assistant days and nights due to multiple patients requiring one-to-one enhanced care during March 2019. Dr Lloyd reported that a full review on the fill rates is due to begin soon, so the report may change some of the planned figures. Mr S Bowron, Non-Executive Director, stated that the report seems to show that the Paediatrics department is overstaffed as this is reported as 53 hours of care per patient per day overall. Dr H Lloyd, Director of Nursing, Midwifery and Quality, stated that this relates to the model of care. The department is set up as a POD so patients in that POD may change several times over the day. Mrs S Watson, Director of Strategy and Transformation, reported that, during discussions at a recent Human Resources Committee meeting, an issue was raised regarding an item on the risk register from the Medical Business Unit regarding staffing levels. Dr H Lloyd, Director of Nursing, Midwifery and Quality, stated that the information does not flow directly into the nurse staffing report. She stated that the Medical Business Unit is currently experiencing difficulty recruiting into care of the elderly posts, and this is compensated by moving staff over to cover shifts. Dr H Lloyd, Director of Nursing, Midwifery and Quality, stated that this issue was also picked up at the Quality Governance Committee, however the risk actions had not yet been updated. She added that she asked for it to be corrected to come to the Board meeting. Dr Lloyd also highlighted that the Trust's Nursing Associates have	

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	now qualified and some of those will now be going into Care of the Elderly wards. After further discussion, it was: **RESOLVED:** to receive the report for assurance	
19/65	**HEALTHCARE ASSOCIATED INFECTIONS:** Dr H Lloyd, Director of Nursing, Midwifery and Quality and Joint Director of Infection, Prevention and Control (DIPC), updated the Board on the current performance of HCAI in the Trust throughout 2018/19. She informed the Board that the Trust continues to perform well against the indicators. She drew attention to the report, agenda item 9, which gave an executive summary. She stated that the Trust had reported two episodes of hospital-onset and four community-onset MRSA, and continues to report a zero rate at the end of Q4. Dr Lloyd stated that the Trust has reported 20 cases of hospital-onset CDI samples; however 17 of the hospital-onset cases were upheld at appeal and therefore the Trust reports three positive samples against the quality premium, with 75 community-onset cases reported. She stated that the Trust's MSSA reporting remains low, with 17 hospital-onset cases and 45 community-onset cases. Dr Lloyd stated that NHS Improvement has changed the requirement from a 50% reduction to a 25% reduction in gram negative blood stream infections across the whole health economy. Dr Lloyd reported that the Trust has experienced 11 periods of increased incidence to Q4, with none reported in February or March 2019. The Trust has reported 351 positive samples of hospitalised Influenza A samples, with no reports of Influenza B. Mrs JEA Hickey, Chairman, queried to what extent community staff are working with primary care colleagues on community-onset C.Diff cases. Dr R Bonnington, Non-Executive Director, stated that primary care organisations have their own targets, however patients taking	

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	antibiotics are at higher risk of developing C.Diff and there are targets to reduce the prescribing of antibiotics. There is an arising issue, for example, if an elderly frail person is suffering from diarrhoea and needs to be prescribed antibiotics. She added that pathology staff do carry out work with community staff, and the infection control team will be in contact with care homes if there are identified cases. After further discussion, it was: **RESOLVED:** to receive the report for assurance	
19/66	**INTEGRATED QUALITY AND LEARNING REPORT:** Dr H Lloyd, Director of Nursing, Midwifery and Quality, provided assurance to the Board of Directors on the Trust's quality and safety performance to March 2019. Dr Lloyd drew attention to the paper, agenda item 15, highlighting that common cause variation is present in many of the key metrics and noting that she would therefore focus on the other areas. She informed the Board of a Never Event incident which occurred in March 2019, where a mid-line was put into the wrong patient in PIU. She noted that work has been carried out with the staff in PIU in terms of positive patient identification. She stated, however, that staff decided to keep the mid-line in as it was felt that the patient could benefit from this. Mr A Beeby, Medical Director, added that there was no harm to the patient and the Never Event actually gave an unintended positive outcome. Dr H Lloyd, Director of Nursing, Midwifery and Quality, reported that an investigation was undertaken following the attempted suicide by strangulation of a patient, using the ties of a hospital gown, whilst attending the ECC. Following this a mental health triage tool has been developed which will assist staff with risk assessing patients in A&E. In addition, ligature cutters are now available on every trolley and the Trust is looking at gowns with Velcro fastenings rather than ties. Mrs JEA Hickey, Chairman, asked if the ligature cutters are safely stored. Dr H Lloyd, Director of Nursing, Midwifery and Quality, added that the cutters are held securely on the resus station in a red box that would need breaking to gain access.	

Agenda Item	Discussion and Action Points	Action By
	Dr Lloyd reported that the Trust's Emergency C-section Rate was 21.5% in March 2019, displaying common cause variation. However, it is to be noted that the Emergency C-sections were carried out appropriately. She reported that the Trust continues to receive good results from the Friends and Family Test, with 97.8% of patients in March 2019 who would recommend the Trust's services to friends and family. She noted that the number of compliments reduced slightly in March 2019; however this could be due to staff not recording appropriately. Complaints remain stable with 29 formal complaints received in the month. Dr Lloyd reported that a 15 Steps Challenge took place on Ward 27. The visit was very positive with no recommendations arising. She stated that the CQUIN schemes are progressing well, and noted that the Single Oversight Framework report is showing as red for C Diff, however this is an anomaly. Mr J Robinson, Non-Executive Director, asked for clarification on a moderate harm medication error. Dr H Lloyd, Director of Nursing, Midwifery and Quality, stated that a moderate harm medication error is where a patient requires additional care or an extra stay in hospital. This would only be for a short period of time. Mrs JEA Hickey, Chairman, commented that it would be helpful for the Board to have further commentary if there are any deaths with a Hogan score in the 4, 5 or 6 category in a month, especially if the Board is not receiving a quarterly mortality report in that month. After further discussion, it was: **RESOLVED:** to receive the report for assurance	
19/67	**QUARTERLY MORTALITY REPORT:** Mr A Beeby, Medical Director, presented the quarterly mortality report for assurance. He reported that the Trust's SHMI score continues to be within the expected range at 1.04. He added that the Trust's monthly HSMR scores have remained within the expected range, however a sequence of rates above 100 has been reported for 17 consecutive	

Agenda Item	Discussion and Action Points	Action By
	months and the Trust commissioning a piece of work with NEQOS to undertake some analysis to help identify the cause of the increase. He noted that the findings of the report have now been received and will be presented in the next quarterly update, adding that the results have not demonstrated any concern and largely relate to coding issues. Mr Beeby informed the Board that work has been carried out around the CuSum Alerts, and case note review indicates that the majority of cases are identified as definitely not preventable, where this was not the case these cases have been reviewed further by the Trust's Mortality Council and learning and actions identified. He added that the Trust is now able to understand themes from this and it has been found that the GP notification of death form is not always completed. He reported that one patient death was recorded with a Hogan score of 4, however most deaths were not preventable. Mr J Robinson, Non-Executive Director, asked for further information on the reported palliative care deaths. Mr A Beeby, Medical Director, stated that a statistical model is used and deaths reported as palliative care have to have had input from someone who is palliative care trained. He stated that, for example, if there are no palliative care trained nurses on a respiratory ward then any palliative care deaths cannot be reported correctly. He added that he will be able to provide further details on this and other issues as part of the next regular mortality report, following analysis of the review work report. Mrs JEA Hickey, Chairman, asked if the work being undertaken to identify any outliers is finding any areas for concern, and if so what is being done to address these. She stated that the technicalities should also be showing up in other Trusts. Mr A Beeby, Medical Director, stated that there is no issue for the Trust around having too many deaths. The issues relate to end of life planning, earlier conversations between staff and patients, and ensuring the notification of death is reported to GPs. He added that these are quality aspects but are not showing that the Trust's mortality rate is too high. After further discussion, it was: **RESOLVED:** to receive the report for assurance	

Agenda Item	Discussion and Action Points	Action By
19/68	**FINANCE AND ACTIVITY REPORT:** Mrs J Bilcliff, Group Director of Finance, provided the Board with a summary performance against plan for activity, income and expenditure as at March 2019 (Month 12) for the Group (inclusive of Trust and QE Facilities, excluding Charitable Funds). She drew attention to the paper, agenda item 12, informing the Board that the key metrics are detailed in the report. Mrs Bilcliff explained that the Trust deficit of £15.4m, excluding PSF, is in line with the revised forecast other than the additional waste contract costs of £0.2m. She stated that since the paper was produced, NHS Improvement has allocated the year-end PSF and the Trust will receive £2.8m in July 2019. There are still pressures due to CSSD but the effect has been minimised as this is a block contract. She reported that the Trust's cash position at year-end was just under £9m which was more than anticipated. She noted that this includes around £4m of creditors which are due to be paid in April and May 2019. She highlighted the key financial metrics and explained that use of resources is an overall 3 at Month 12. Mrs Bilcliff stated that the Audit Committee recently held a workshop to go through the figures in depth and the risks in that position. This workshop highlighted that the main risk is a change in RICS guidance which relates to asset valuations which the Trust has not recognised in the figures currently. This could be a point of discussion with the auditors; however it is thought that this risk is minimal. Mr M Robson, Non-Executive Director, queried if the risks identified moving towards the end of year have been resolved. Mrs J Bilcliff, Group Director of Finance, stated that one of the risks related to the challenge from HMRC towards the application of the Trust's capital goods scheme. This was paid but not reflected in the bottom line position, as the Trust was advised that this was low risk. The tribunal hearing found in the Trust's favour so c£60ok will be repaid. Mrs Bilcliff confirmed that the issue relating to the pay award has also been addressed. She drew attention to table 11 included in the paper, agenda item	

Agenda Item	Discussion and Action Points	Action By
	12. She reported that the non-pay run rate in the previous financial year declined in the last month, however this year it has risen quite steeply at the year end. She noted that this can vary significantly in Month 12 with year-end adjustments and this year this is impacted by the £2.6m asset impairment. Mrs Bilcliff noted that the underlying non-pay run-rate has been stable over the last six months of the financial year. Mrs JEA Hickey, Chairman, stated that, regardless of the Trust not hitting the initial plan, it has been a tremendous achievement to meet the reforecast. She gave congratulations to the Finance team and the full organisation. After further discussion, it was: **RESOLVED:** to receive the report for assurance	
19/69	**ASSURANCE FROM BOARD COMMITTEES:** **i) Quality Governance Committee** Mr D Shilton, Non-Executive Director and Chairman of the Quality Governance Committee, provided an update from the Committee meeting held on 17th April 2019. He reported that the Committee received clarification around the CNST incentive scheme for maternity, noting that the Trust will achieve nine out of the 10 schemes by August 2019. An action plan is in place to achieve all 10, but nine of out 10 will be achieved by the specified date. Mr Shilton noted that good assurance was received on a number of issues, including the National Inpatient Survey results which showed the Trust's positive performance. He reported that the update around the unannounced CQC inspection has not been rated as this is still in progress. Mr Shilton commented that the Committee noted good progress on the CQC ECC action plan. He reported that an update was received on Seven Day Working, noting that this is no longer required to be reported on and the Trust is moving to a Board assurance method going forward. Mr Shilton concluded his update by stating that the Committee received an update on the Getting It Right First	

Agenda Item	Discussion and Action Points	Action By
	Time (GIRFT) and heard that the Trust is engaged in a number of programmes. This was therefore rated green. **ii) Finance and Performance Committee** Mrs JEA Hickey, Chairman, provided an update from the Finance and Performance Committee meetings held on 26th March 2019 and 23rd April 2019. She reminded the Board that the March assurance report was covered verbally at the last Board of Directors' meeting. Mrs Hickey noted that there were no changes made to the ratings but the Committee did identify that Month 12 assurance levels were no longer split between year-to-date and forecast. She stated that the Committee reviewed the BAF and were happy with the adjustments made. The Committee received a summary of the annual committee self-assessment and agreed that there are no significant actions. It was noted that there is no annual report from the Committee to the Board, but it was felt this was not necessary as monthly reports are presented. Mrs Hickey stated that this is consistent among committees, the only exception being the Audit Committee. Mr D Shilton, Non-Executive Director, commented that there is no suggestion from the Quality Governance Committee that an annual report would be beneficial. Dr H Lloyd, Director of Nursing, Midwifery and Quality, stated that the Quality Account summarises the key areas plus there are other relevant annual reports relating to safeguarding etc. She stated that an annual Committee report would be duplicating information. Mr J Robinson, Non-Executive Director, stated that the Human Resources Committee has a similar view, as assurance reports are presented to each Board of Directors' meeting, with an annual overview presentation given to the Council of Governors' summarising what has been presented to the Board of Directors'. Mrs JEA Hickey, Chairman, concluded her update by reporting that the Committee approved terms of reference with minor changes. This will be presented to the Board of	

Agenda Item	Discussion and Action Points	Action By
	Directors' meeting in June 2019 with the suite of other Committee Terms of Reference. **iii) Human Resources Committee** Mr J Robinson, Non-Executive Director and Chairman of the HR Committee, provided an update from the Committee meeting held on 9th April 2019. He reported that the Committee reviewed the Learning Culture stand of the People Strategy, noting that good progress is being made. One element with work still outstanding is the review and redesign of the Trust's induction arrangements, however this will be enacted in 2019/20. Mr Robinson stated that the Committee received an overview on the Freedom to Speak Up Guardian cases received in the quarter and how the issues are being handled. He stated that a report was received on the Gender Pay Gap 2018, with the Committee noting the report was published by the deadline in March 2019. Actions have been incorporated into the People Strategy Work Plan for 2019/20. The Committee received reasonable assurance on the Equality Delivery System, with the need identified for Equality Objective 1 to be led by the Quality Governance Committee.	
19/70	**QUALITY ACCOUNT/REPORT 2018/19 PROGRESS REPORT:** Dr H Lloyd, Director of Nursing, Midwifery and Quality, provided the Board with a progress report on the production of the Quality Account 2018/19. She stated that the report provides an update, by exception, of the Trust's performance against the 2018/19 priorities and local and national indicators. This provides the Board with assurance that good progress is being made. Dr Lloyd highlighted the key points. She reported that with regards to Priority 3, a query has been raised on the continuity of care on maternity as the figure is a percentage and is not based on absolute numbers. She stated that	

Agenda Item	Discussion and Action Points	Action By
	she will check that this is reviewed. She added that the Badger system was introduced from 1st March 2019, and not all bookings have therefore been recorded on the system. Dr Lloyd stated that Priority 5 refers to patient experience and continuing with public involvement. She noted that the original monitoring tool was found to contain too many questions to be asked. This will be reviewed and the Trust will be looking to develop a process to collect this information from patients. She reported that the Trust participated in 89% of clinical audits in the year and highlighted that the Trust has significantly improved PROMS results relating to hip and knee. The Trust is performing well against the pressure damage indicator; however a slight increase has been reported. Further work will be carried out in 2019/20. Dr Lloyd agreed to distribute the full draft of the Quality Account to the Board of Directors for information and comment. After further discussion, it was: **RESOLVED:** to receive the report for assurance	
19/71	**QUESTIONS FROM GOVERNORS IN ATTENDANCE:** There were no questions from governors in attendance.	
19/72	**ANY OTHER BUSINESS:** Mr J Maddison, Acting Chief Executive, informed the Board that the meeting would be his last public Board of Directors' meeting before he retires from the Trust. Mrs JEA Hickey, Chairman, expressed her thanks to Mr Maddison during his time as Group Director of Finance and more recently as Acting Chief Executive role, and for his support over the last five years. Mr J Maddison, Acting Chief Executive, thanked colleagues for the opportunity and the privilege of working at the Trust for the last five years. He added that his time at the Trust had been on the whole enjoyable and occasionally challenging, but very rewarding and gave his thanks for the support received.	

Agenda Item	Discussion and Action Points	Action By
19/73	**DATE AND TIME OF NEXT MEETING:** **RESOLVED:** that the next meeting of the Board of Directors will be held at 9.30am on Wednesday 26th June 2019 in Room 3, Education Centre, Queen Elizabeth Hospital	
19/74	**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	

Gateshead Health
NHS Foundation Trust

Actions from Board of Directors' Meetings – Part I

Date of Meeting	Minute Reference	Action	Lead	Complete
24/04/2019	19/67	To provide further detail on the palliative care element of recording deaths as part of the regular mortality report	AB	

Trust Board

Gateshead Health NHS Foundation Trust

Report Cover Sheet

Agenda Item: 7

Date of Meeting:	26 June 2019			
Report Title:	Premises Assurance Model Annual Report			
Purpose of Report:	To provide the Board with an update on the NHS Premises Assurance Model tool and the results for 2017/2018.			
	Decision: ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
Trust Goals that the report relates to: (Including reference to any specific risk)	**Goal 7** We will deliver value for money and help ensure the local health and care system is sustainable and well led.			
Recommendations: (Action required by Board of Directors)	To receive the report for assurance.			
Financial Implications:	To receive assurance that the estate and facilities are effectively and efficiently managed.			
Risk Management Implications:	To provide assurance on the risks associated with estates and facilities management as set out in the associated risks in the risk register.			
Human Resource Implications:	Minimal			
Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)	**Objective 1** All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers.			
Author:	Miss S Needham, Sustainability, Waste and PAM Manager			
Presented by:	Mr P Harding, Managing Director, QEF			

GATESHEAD HEALTH NHS FOUNDATION TRUST
Premises Assurance Model (PAM) Annual Report

1. Introduction

This paper provides the Board with an update on any assurances against compliance with the NHS Premises Assurance Model (PAM) toolkit from QE Facilities. The paper also provides the results achieved for the year 2018-2019 along with an action plan to address any identified gaps.

The PAM toolkit permits QE Facilities managers to assess the condition of built assets, provide premises assurance to the Trust's management boards and assure patients, commissioners and regulators that robust systems are in place to assure that the premises and associated services are safe. It also has the ability to provide a consistent basis to measure compliance against legislation and guidance, across the whole NHS and prioritise investment decisions to raise standards in the most advantageous way.

Since its launch the toolkit has developed and changed multiple times influenced through several key reports and proposals to reflect a holistic approach to the management of estates and facilities services reflecting changes in policy, strategy, regulations and technology.

The 2016 PAM toolkit was prepared against the background of a rapidly developing policy and most importantly supports the NHS constitution right:

"You have the right to be cared for in a clean, safe, secure and suitable environment."

2. Overview

The toolkit allows NHS organisations to better understand the efficiency, effectiveness and level of safety within which Estates and Facilities are managed and how this links to patient experience. The PAM toolkit currently has one distinct part to achieve this, extensive self-assessment questions which look at the quality and safety compliance through self-assessment evaluation requiring the need for supporting evidence.

Previous PAM toolkits included a metrics element that had drawn upon information from ERIC and other sources; however this has been super seeded by Dashboards developed as part of the Efficiency and Productivity Programme to improve management of the estate.

2.1 Self-Assessment Questions

The self-assessment questions are broken down into the following key domains:

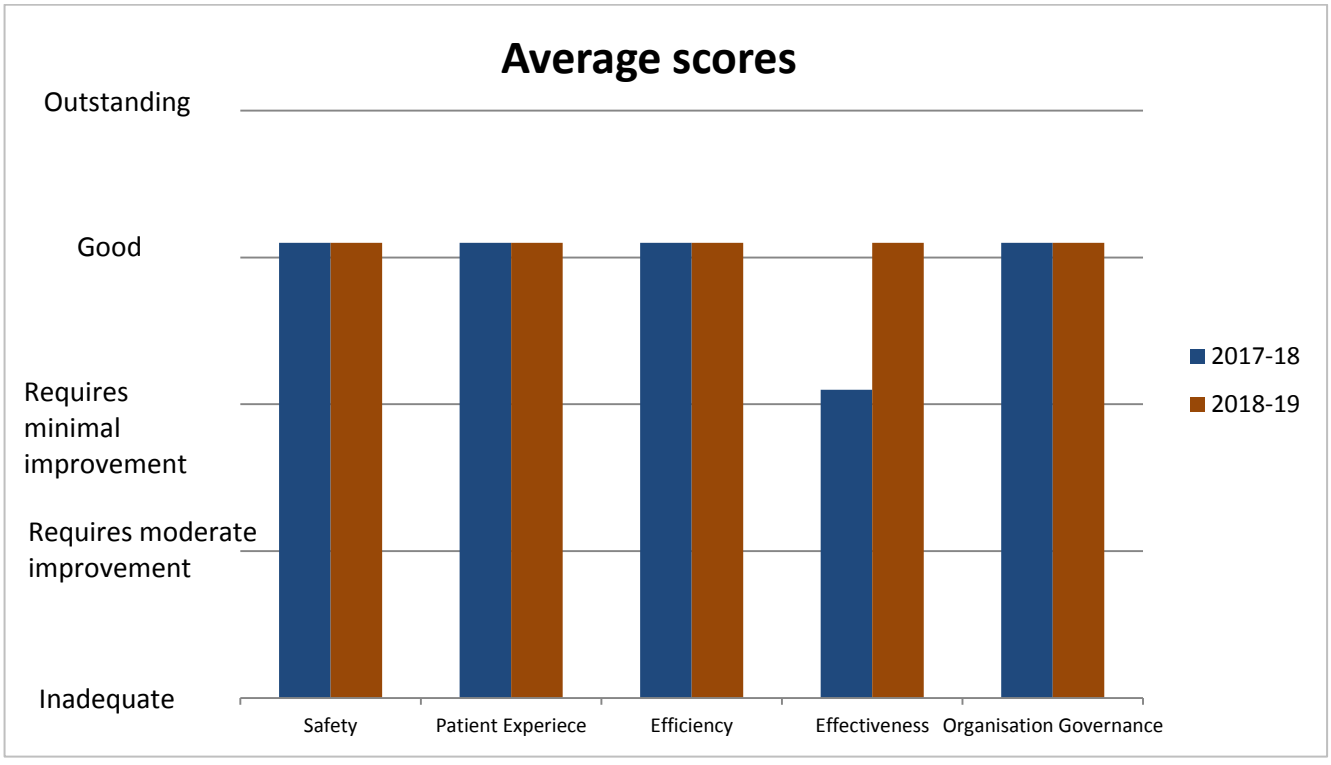
- Patient Experience
- Safety Hard
- Safety Soft
- Efficiency
- Effectiveness
- Governance

Each domain contains a variety of questions covering a range of topics and services across estates and facilities. Each individual question is compliance rated after considering the level and quality of supporting evidence. The ratings are;

- Outstanding
- Good
- Requires minimal improvement
- Requires moderate improvement
- Inadequate
- Not Applicable

3. PAM Outcomes 2018-19

The self-assessment questions (SAQ's) in the PAM toolkit relating to 2018-19 were completed over a period of 3 months. Across the five domains (both soft and hard safety are combined), as outlined above, QE Facilities scores an average rating of 'good' in regards to assurance in all areas. Overall this provides a good level of assurance to the Trust, however there are still individual specific areas for improvement that have been ascertained from individual questions rated less than good within each domain and are shown in Appendix I and are detailed within the attached action plan (Appendix II).



Please note that as there have been no alterations to the Pam toolkit therefore we can once again demonstrate comparable data from 2017/18 to 2018/19 as detailed in the above graph. However if future changes occur these sets of data may no longer be comparable going forward.

3.1 Safety Hard FM

The safety hard FM domain is identified as a key area to ascertain significant assurance as an organisation, ensuring the standard of the estate and facilities services are maintained to a high standard preventing and minimising risk to any service users including patients and staff. QE Facilities has scored a rating of good in all of the areas, except one which requires minimal improvement regarding ensuring estates and facilities services are safe and suitable when the organisation is not directly responsible for providing these services, actions realting to this can be found in the action plan (Appendix II). This is a slight drop from last year when every area was rated as good. This provides substantial assurance to the Trust that the estates and facilities services QE Facilities provide are to a high standard of safety and the actions previously identified have been implemented. (See Appendix I Chart 1)

3.2 Safety Soft FM

Along with the safety hard domain the safety soft domain is also identified as a key area to ascertain significant assurance as an organisation, once again ensuring the standard of services are maintained to a high standard preventing and minimising risk to any service users including patients and staff. QE Facilities has scored a rating of good in all areas, since work has been done to improve decontamination over the last 12 months in particular the relocation of the department. Overall this provides a high level assurance to the Trust that these elements of QE Facilities services are to a high standard of safety. (See Appendix I Chart 2)

3.3 Effectiveness

The effectiveness domain identifies whether the design of our estates and facilities are suitable, sustainable and effective in the delivery of health outcomes. QE Facilities scored an average rating of good with one area identified as requiring minimal improvement; the Estate Strategy (see action plan, Appendix II). Within this specific area one questioned was identified as inadequate and several others as requiring moderate improvement, these all relate to the Estate Strategy particularly regarding costed action plans due to the need to formally risk assess and cost current gaps in the Estate Strategy; these are highlighted as key actions with the action plan (Appendix II). Overall this can provide a substantial assurance to the Trust that the services that QE Facilities provide are effective for purpose and where work is needed to be undertaken actions are in place to improve. (See Appendix I Chart 3).

3.4 Efficiency

The efficiency domain provides assurance that space, activity, income and operational costs of the estates and facilities provide value for money, and are economically sustainable and meet clinical and organisational requirements. QE Facilities scored an average rating of good in all areas providing a high level of assurance to the Trust that the services that QE Facilities provide are value for money whilst meeting requirements. (See Appendix I Chart 4).

3.5 Patient Experience

The patient experience domain identifies assurance that the organisation ensures that patient experience is an integral part of service provision and is reflected in the way in which services are delivered. QE Facilities scored an average rating of good and can provide a high level of assurance to the Trust that the

services that QE Facilities provide ensure patient experience is an integral part of service provision. (See Appendix I Chart 5).

3.6 Governance

The governance domain identifies assurance on strategic leadership and effective scrutiny of the organisations estates and facilities operations. As well as how the other four Domains are managed as part of the internal governance of the organisation. QE Facilities scored an average rating of good and can provide a high level of assurance to the Trust that the outcomes of the Domains are reported to both the Trust Board and QE Facilities Board and embedded in internal governance and assurance processes to ensure actions are taken where required. (See Appendix I Chart 6)

4. Conclusion

This report highlights that by using the PAM toolkit the Trust has an effective way to provide assurance and compliance with the statutory requirements and good practice guidelines which inform the delivery of Estates and Facilities services across all six domains. In addition the tool kit permits the identification and coordination of improvements through a monitored risk assessed action plan. As the tool kit is no longer a new concept to QE Facilities the requirement to work to the principles of demonstrating assurance is one which is embedded into everyday practice.

Whilst the overall average rated score across all of the domains was good it should be definitely be considered that there are specific areas across the board that did score lower and require improvement; actions have been identified as a priority to improve going forward over the next year. On the other hand it should also be recognised that specific areas rated higher as well; in particular our work as QE Facilities to provide a well-managed approach to performance management of our estates and facilities operations, whereby key performance indicators are set, reviewed and often stretched as a result of our continual improving performance.

It is still anticipated that the current PAM tool kit will be developed by the Department of Health (DoH) as policies and regulations change, along with indications that PAM may become an online system in future.

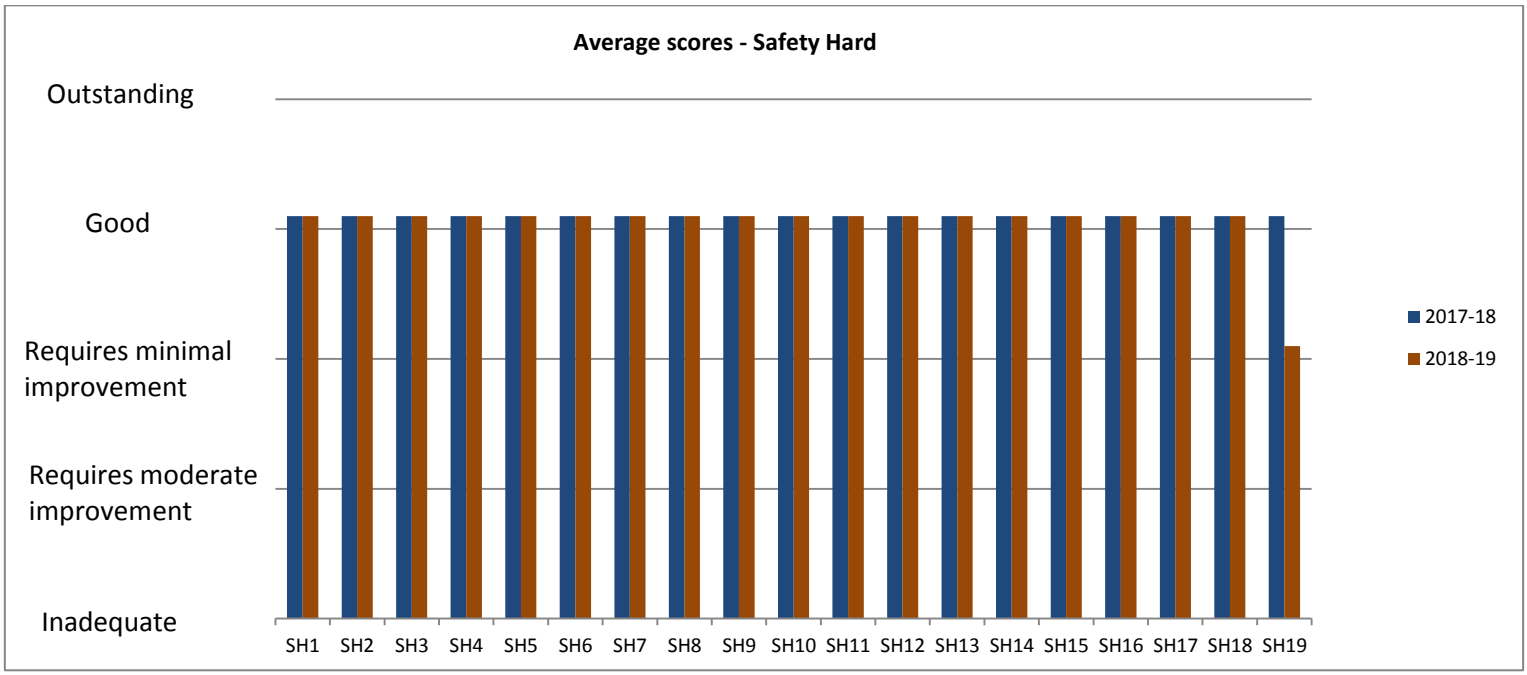
5. Recommendations

The board is asked to receive this report for information and assurance.

Mr P Harding
QE Facilities Managing Director

Appendix I

Chart 1 – Overview Safety Hard Scores



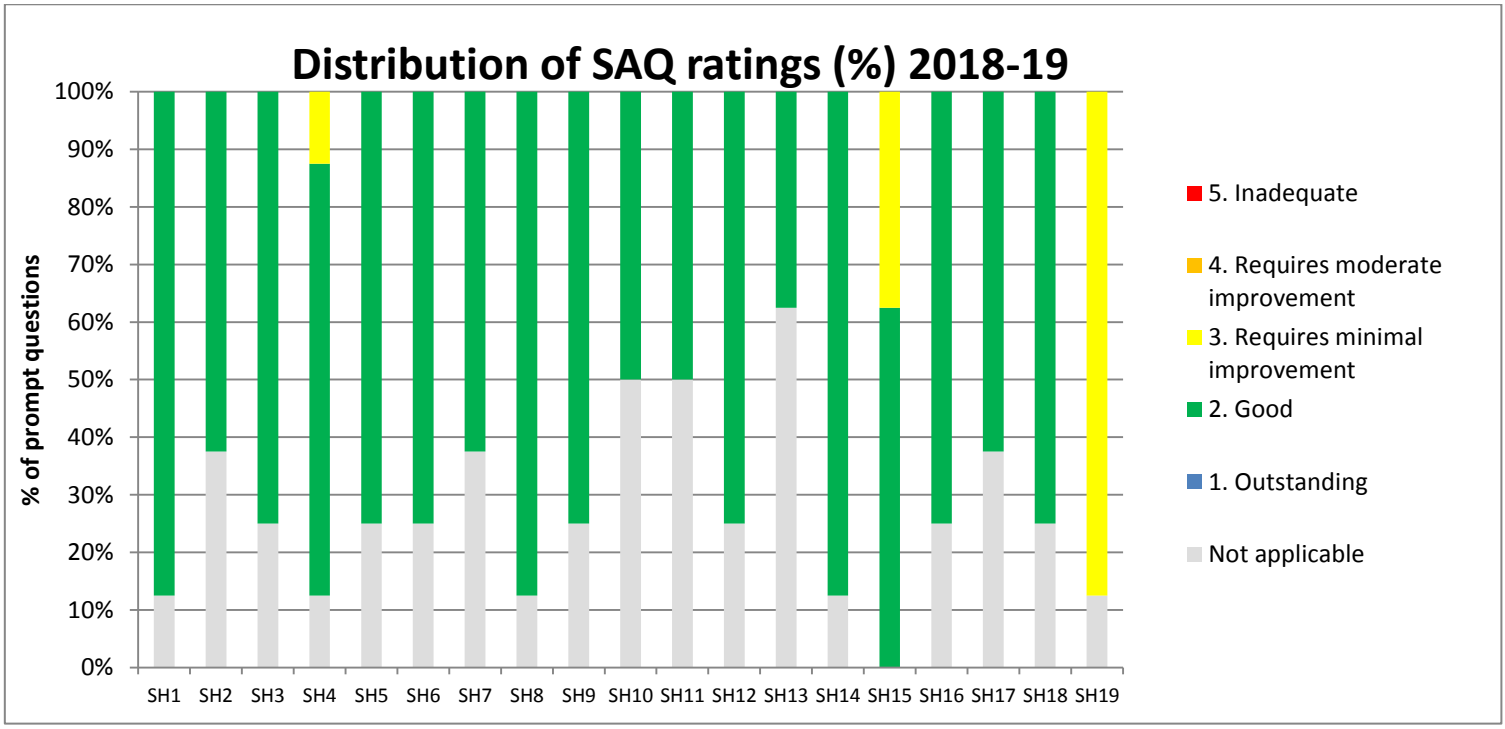
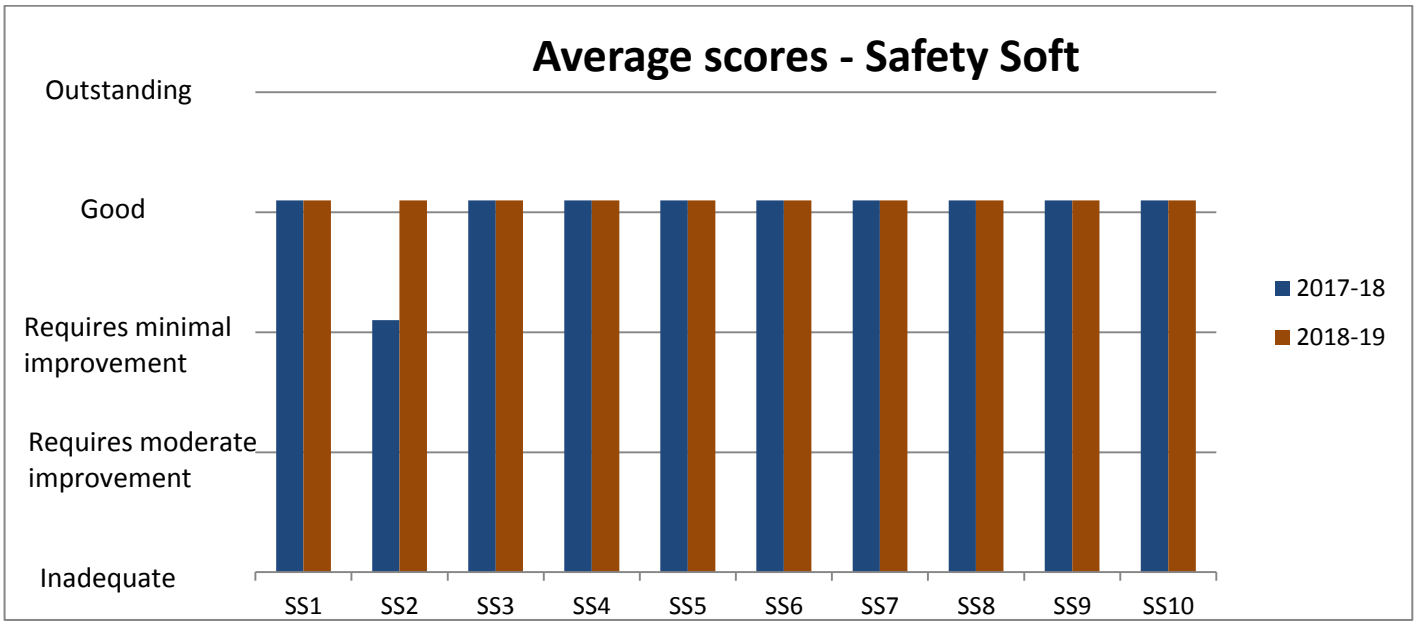


Chart 2 – Overview Safety Soft Score



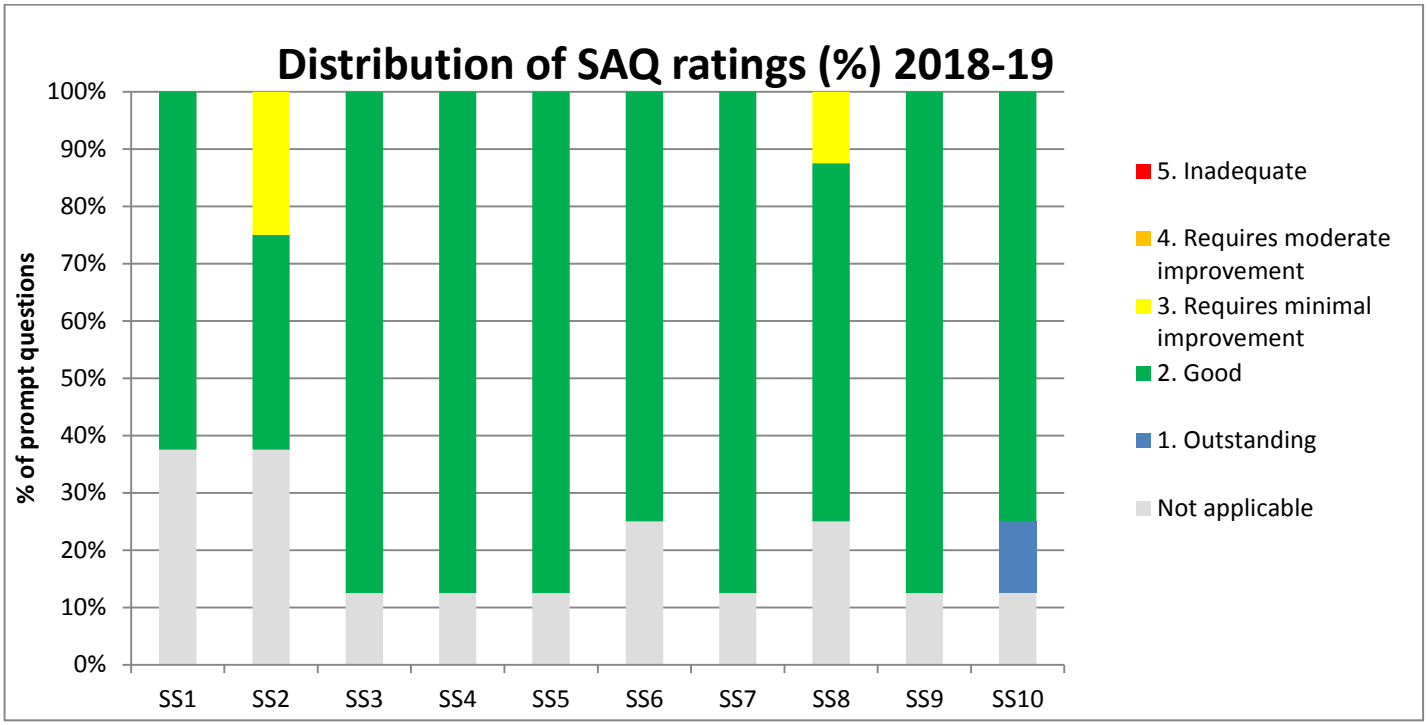
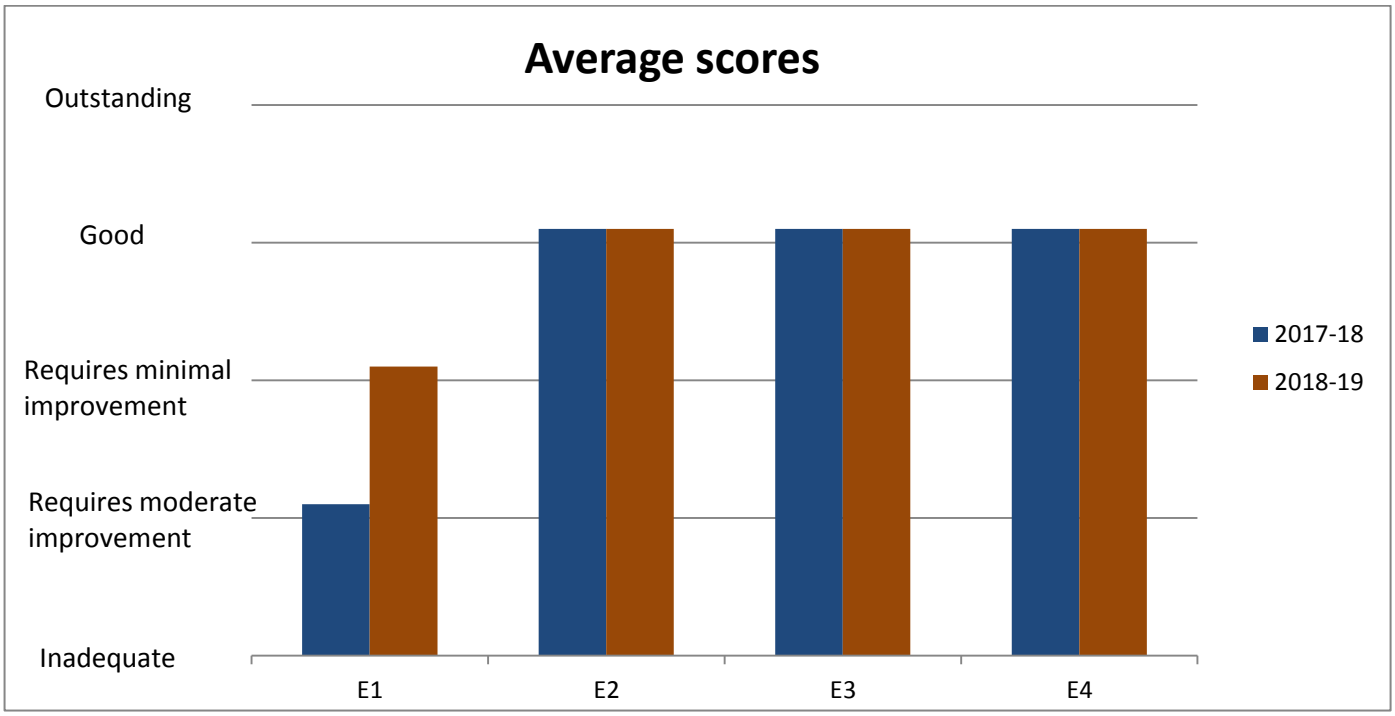


Chart 3 - Overview Effectiveness Scores



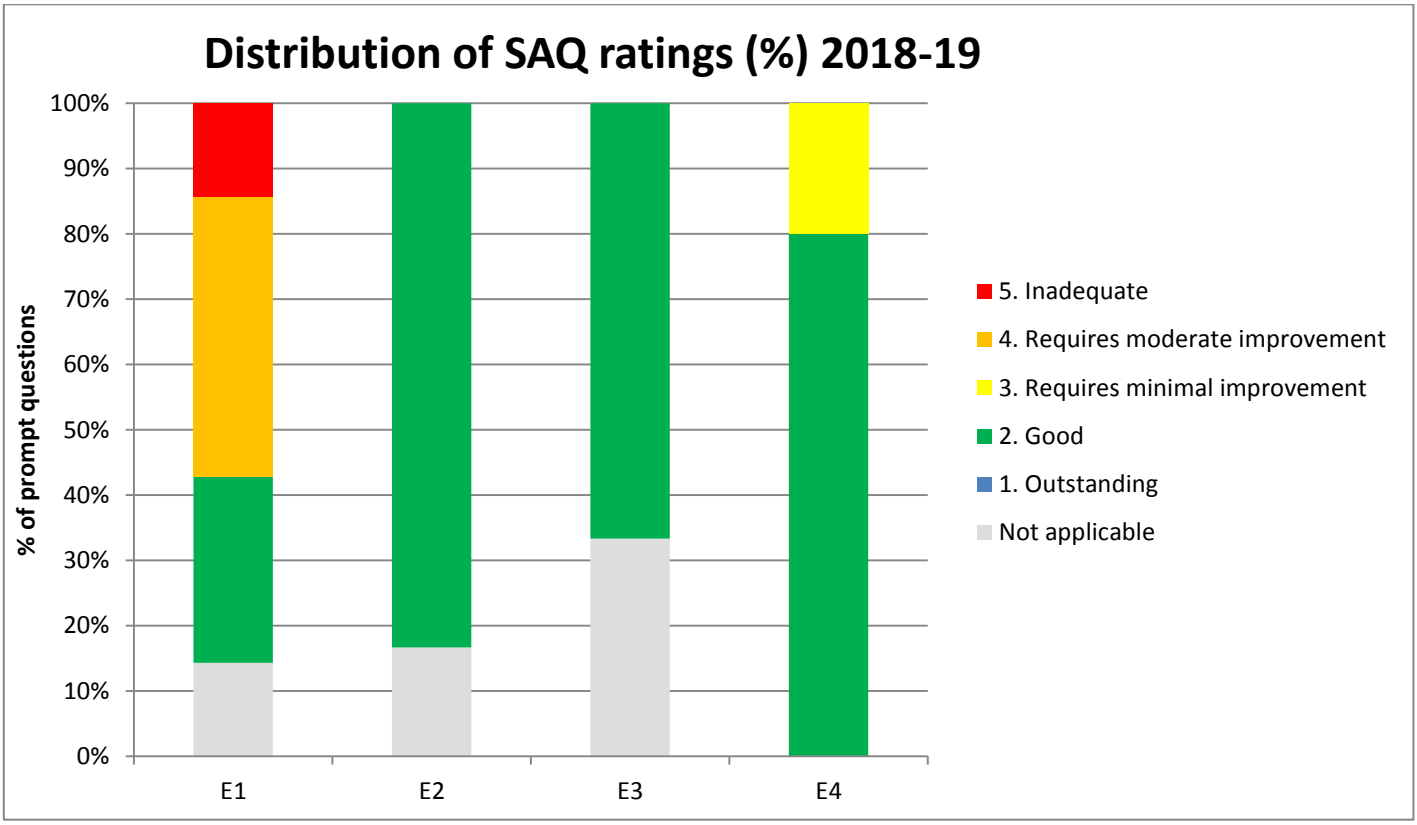
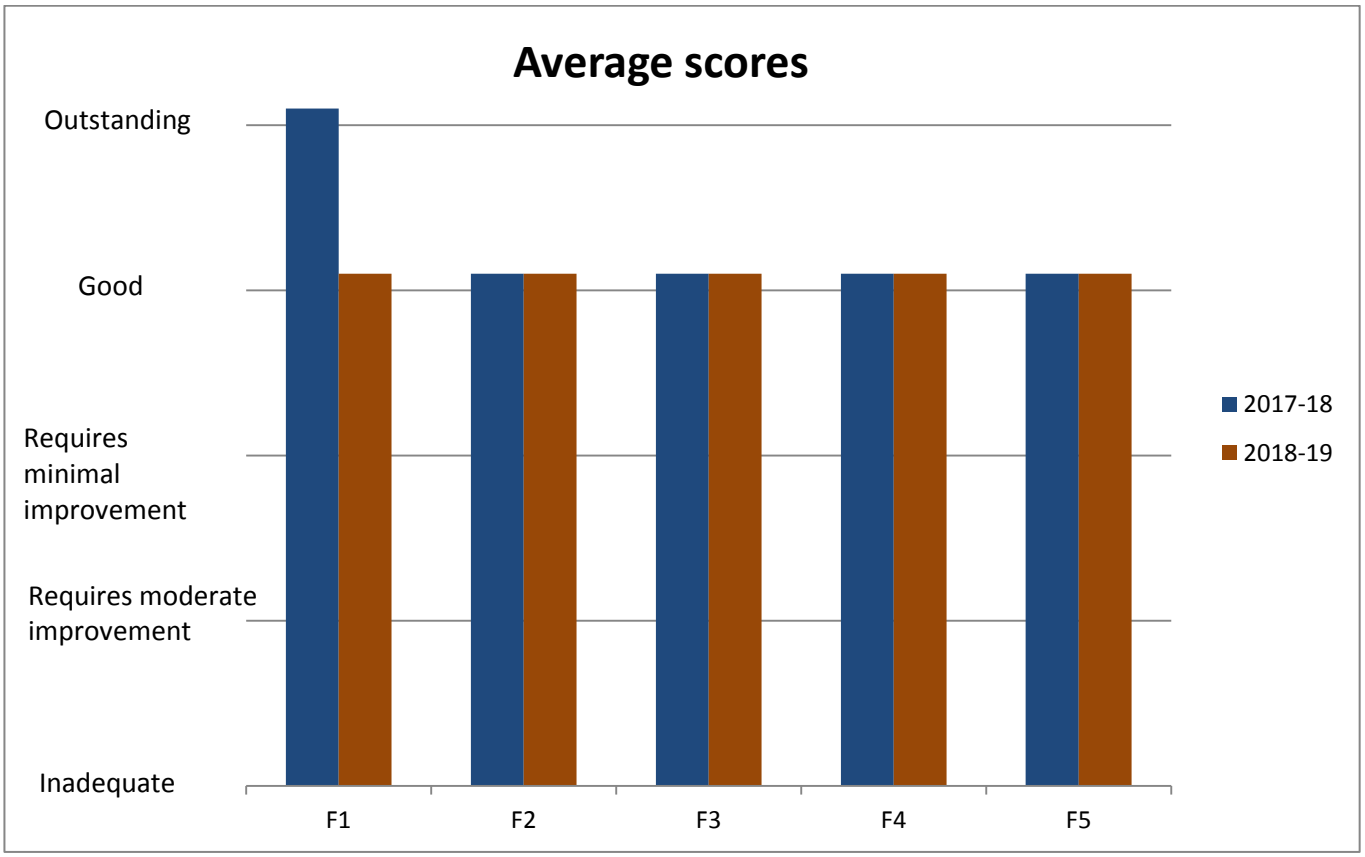


Chart 4 – Overview Efficiency Scores



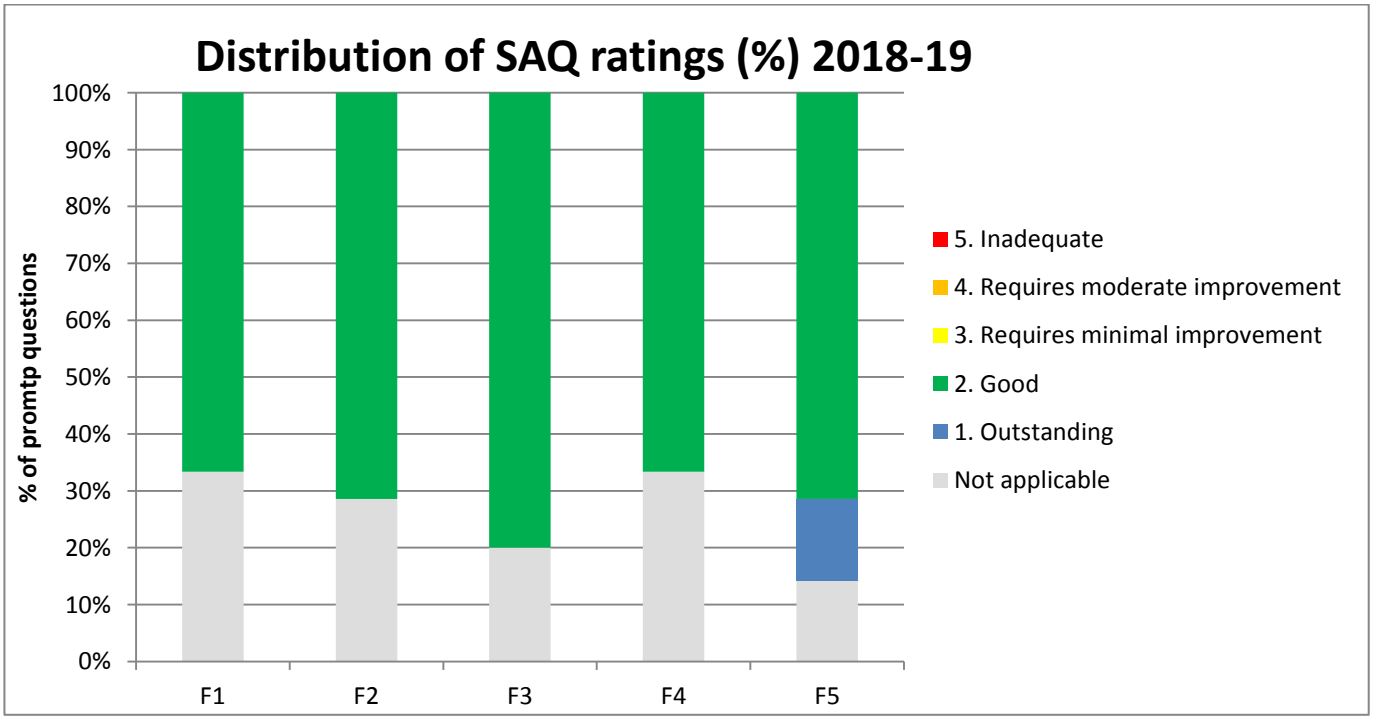
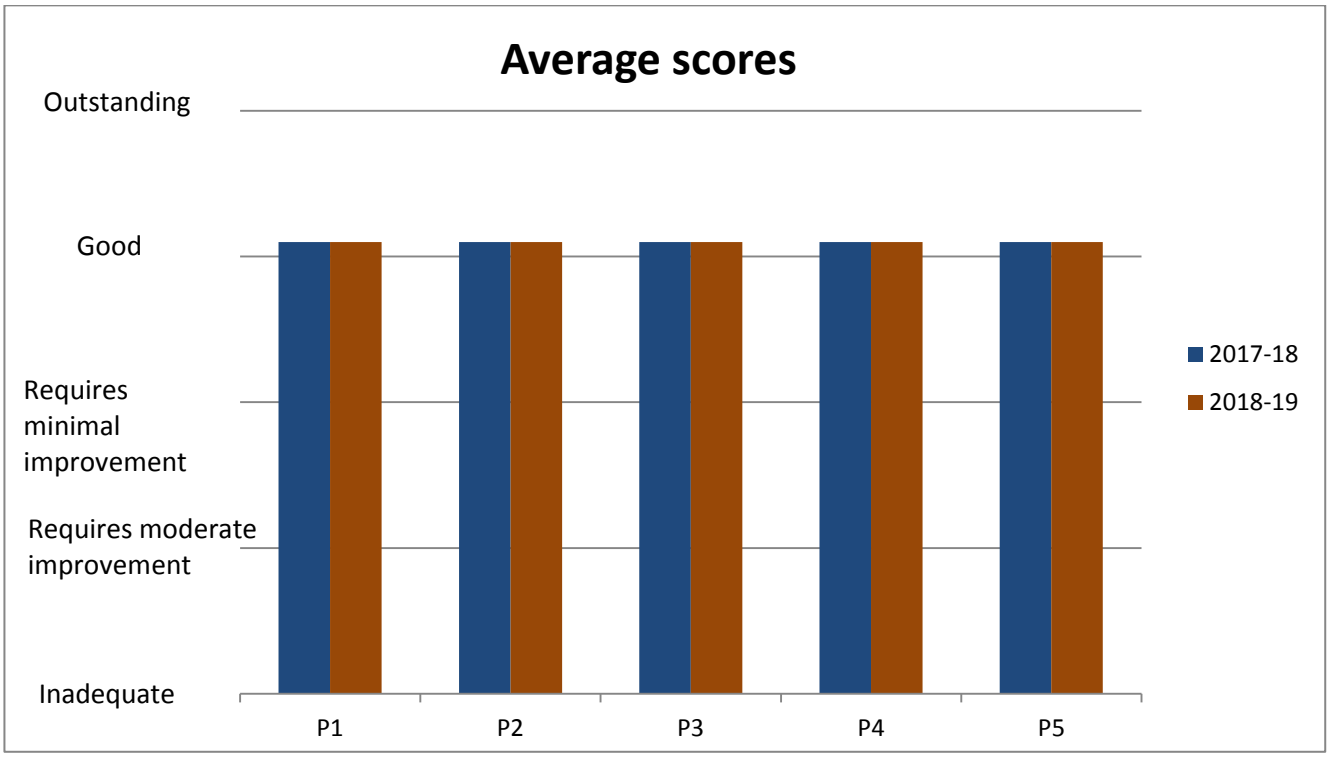


Chart 5 – Overview Patient Experience Scores



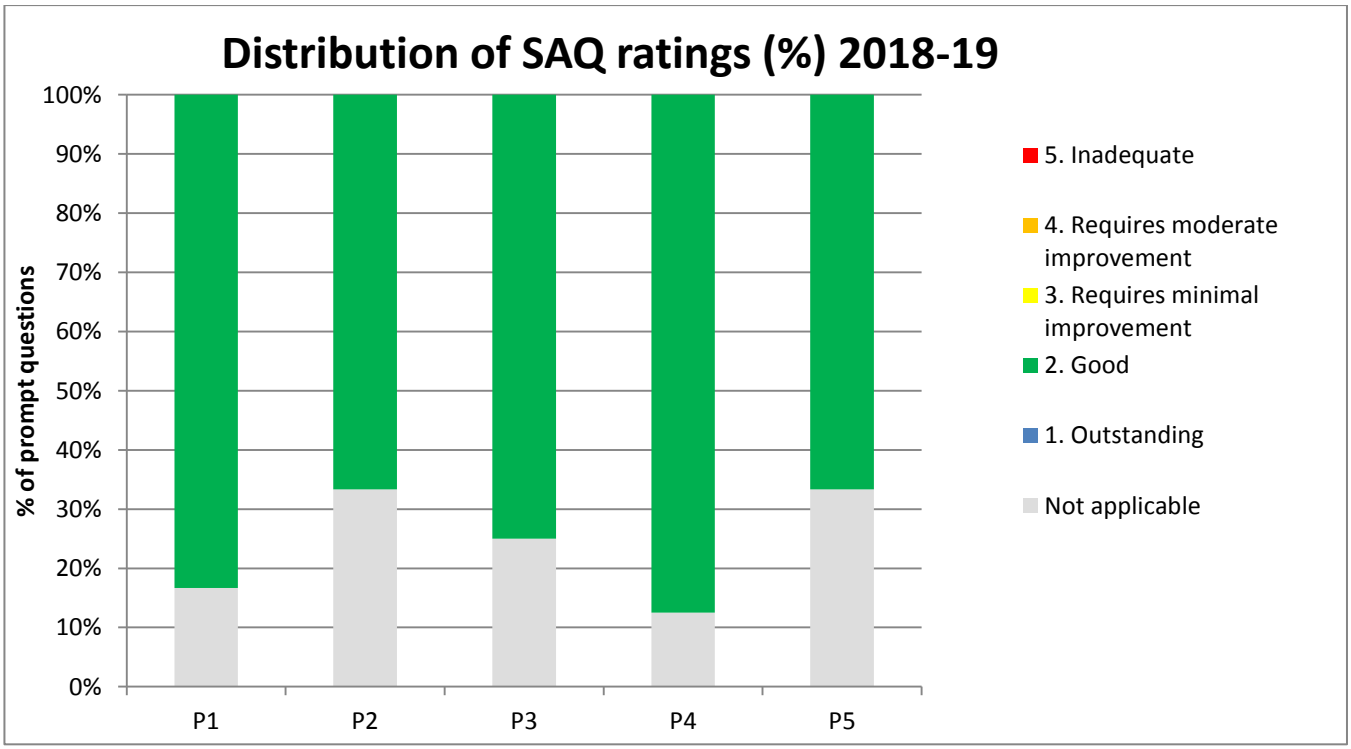
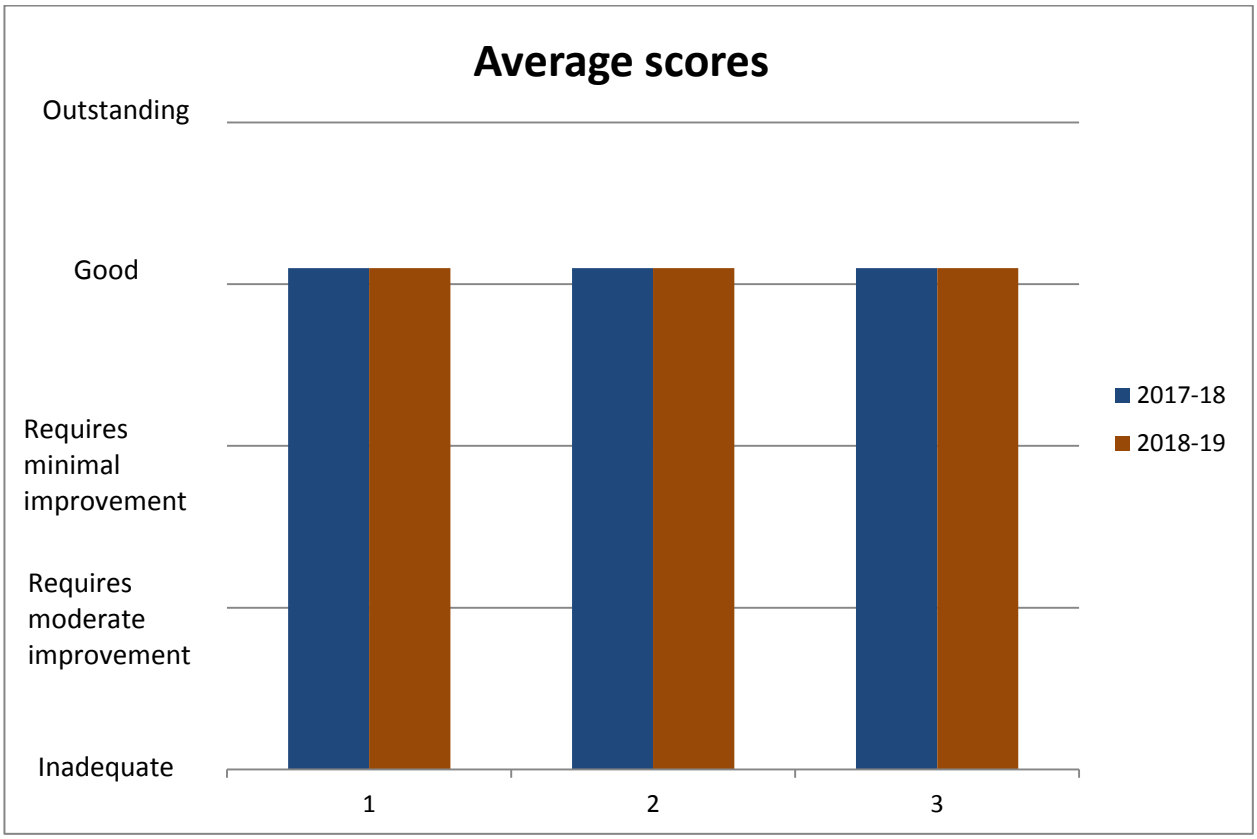
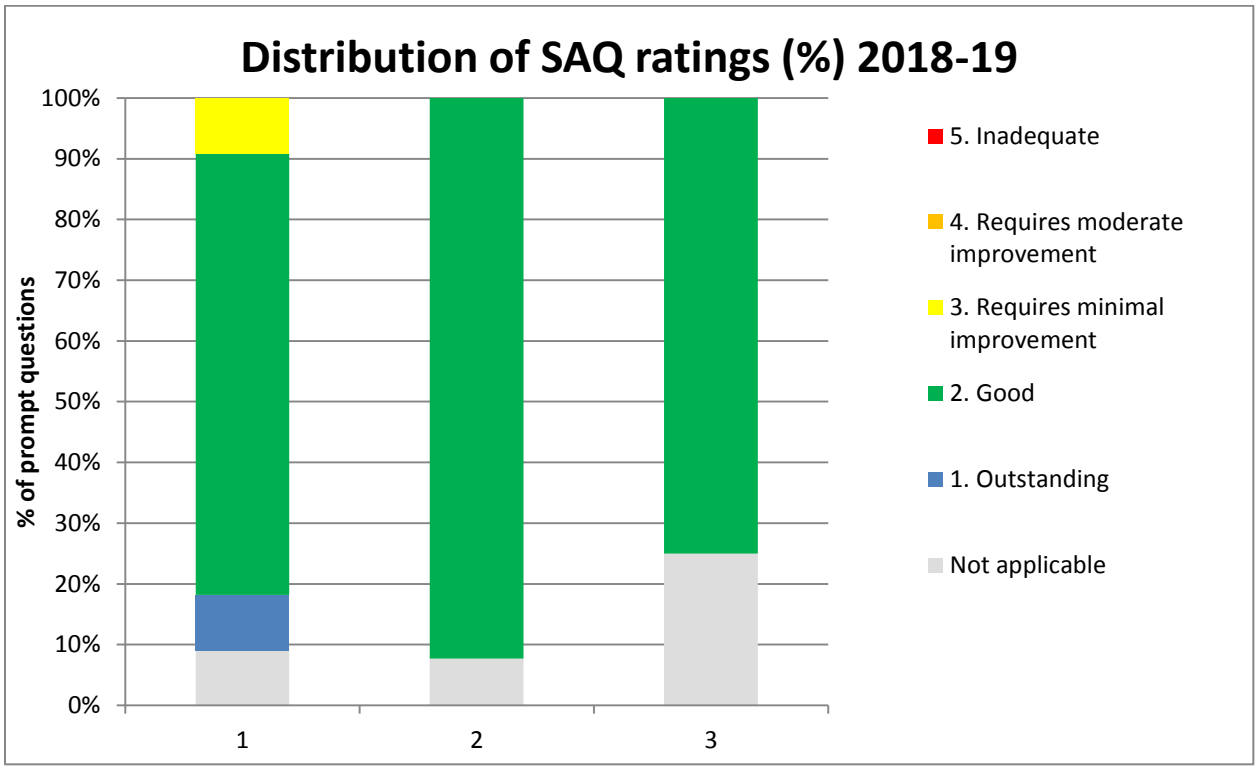


Chart 6 – Overview Governance Scores





Appendix II - Action Plan

ID	Domain	SAQ	Prompt Question	Date action identified	Action	Responsible officer	Risk Score C x L	Target date
1	Safety Hard	6	6.5	2018	Risk identified and business case written by QEF regarding the Trust's requirement of medical gas training for Nurses. This action sits with the Trust to be decided and implemented.	Trust Representative	4 x 3 = 12	Ongoing
4	Safety Hard	16	16.8	April 2019	The Trust should consider replacing its decontamination tent circa £15,000 as advised by QEF.	Trust Representative	2 x 2 = 4	Advised Recommendation
5	Safety Soft	2	2.8	April 2019	There is currently a Decontamination business case approved which is being progressed. A separate project team is in place to manage the implementation of this project.	Head of Medical Devices	2 x 2 = 4	Ongoing
6	Safety Soft	3		April 2019	Monitor and review the healthcare waste situation regionally and nationally, and when we can retender the contract. All healthcare waste tenders are currently on hold for 12 months.	Sustainability, Waste & PAM Manager	3 x 3 = 9	Ongoing
7	Safety Soft	8	8.7	April 2019	Pest Control Policy needs to be reviewed in light of internal moves to Domestic Services.	Head of Facilities	1 x 2 = 2	September 2019
8	Patient Experience	4	4.8	April 2019	There is a large six phase catering action plan approved and in progress to develop staff, choices along with the overall operation of the business.	Facilities Manager – Catering	2 x 2 = 4	September 2019
9	Patient Experience	5	5.8	April 2019	Install contract with AMPR to enhance enforcement and reduce consumables and maintenance costs	Facilities Manager - Security	1 x 2 = 2	2019- 2020
10	Effectiveness & Governance	1	E1.2 E1.3 E1.4 G1.1	April 2019	Trust Service Strategy is now out of date and subject to review, reflecting emergency plans through integrated care systems. Estates Strategy will need to be revised to reflect agreed service strategy. Trust Service Strategy currently being updated. Estate Strategy to be developed to be developed within six months of Service Strategy being published	Managing Director (QE Facilities)	4 x 3 = 12	September 2019
11	Effectiveness	1	1.7	April 2019	Formally risk assess and cost current gaps in approved Estates Strategy relating to Emergency Service Strategy and shortfall in funding.	Managing Director (QE Facilities)	4 x 3 = 12	September 2019
12	Effectiveness	4	4.4	April 2019	Governance over the Sustainable Development Management Plan has previously sat with QE Facilities; however the plan belongs with the Trust and requires a Sustainability Lead on	Head of Facilities & Sustainability, Waste & PAM	3 x 3 = 9	August 2019

ID	Domain	SAQ	Prompt Question	Date action identified	Action	Responsible officer	Risk Score C x L	Target date
					the Trust Board of Directors. This governance arrangement is still in the process of changing over back to the Trust as a result the membership and Terms of Reference of the Sustainability Group require reviewing.	Manager		
13	Governance	1	1.7	April 2019	Need to develop improved system to record and verify ERIC data in line with financial ledger.	Director of Finance (QEF)	3 x 2	October 2019

Trust Board

Gateshead Health NHS Foundation Trust

Report Cover Sheet

Agenda Item: 8

Date of Meeting:	26 June 2019			
Report Title:	Sustainable Development Management Plan			
Purpose of Report:	To set out the framework for the Trust to achieve the requirements under the NHS Carbon Reduction Strategy 2009.			
	Decision: ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
Trust Goals that the report relates to: (Including reference to any specific risk)	**Goal 7** We will deliver value for money and help ensure the local health and care system is sustainable and well led.			
Recommendations: (Action required by Board of Directors)	To receive the report for assurance.			
Financial Implications:	To note the financial savings achieved.			
Risk Management Implications:	To ensure compliance with national policy.			
Human Resource Implications:	To ensure staff are aware and take part in the sustainability agenda			
Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)	**Objective 1** All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers.			
Author:	Sarah Needham, Sustainability, Waste and PAM Manager			
Presented by:	Peter Harding, Managing Director, QEF			

GATESHEAD HEALTH NHS FOUNDATION TRUST

Sustainable Development Management Plan – May 2019

This is the sixth Annual Report setting out the Trust's Sustainable Development Management Plan.

This plan sets the framework for the Trust to achieve the requirements under the NHS Carbon Reduction Strategy 2009.

This management plan has also contributed significant financial savings which have fed into the Trust's Cost Reduction Programme.

The report outlines the framework adopted by the Trust in responding to the 'sustainability agenda', setting out the key achievements made to date together with the proposed actions identified for the coming year.

Recommendation

The Board is asked to endorse the Sustainable Development Management Plan.

Sustainable Development Management Plan

May 2019

Gateshead Health NHS Foundation Trust

Contents

1.0 Executive Summary

Since 2012 Gateshead NHS Foundation Trust has implemented a Sustainable Development Management Plan (SDMP) which has embedded the importance of the Trust reducing its carbon footprint. The SDMP was introduced as a requirement under the NHS Carbon Reduction Strategy (2009) enforcing the need for NHS organisations to take action towards reducing carbon emissions and embed sustainability within polices and culture.

In 2014 this developed into Sustainable Development Strategy for the NHS, Public Health and Social Care System 2014 – 2020. The strategy encompasses the whole of the health care system, taking on a far broader view of sustainable development. The 8 modules include the following topics:

- Leadership, Engagement and Workforce Development
- Carbon Hotspots
- Commissioning and Procurement
- Sustainable Clinical and Care Models
- Healthy, Sustainable and Resilient Communities.
- An Integrated Metrics Approach
- Innovation, Technology and R&D
- Creating Social Value

It is particularly important for the NHS to embrace sustainable development across the healthcare system as 21 million tonnes of greenhouse gases, representing 3.2% of the UK's total emissions, are emitted each year. Under the Climate Change Act 2008 every NHS organisation is required to reduce carbon emissions, here at Gateshead Health NHS Foundation Trust we've already met the first target of 10% reduction by 2015 (based on the 2007 baseline figures). The next targets we are striving towards are 34% reduction by 2020 followed by 50% by 2025 and 80% by 2050.

The trust recognises it consumes significant quantities of energy, fuel and water, produces large volumes of waste and spends a vast amount on procuring materials and equipment to deliver the high quality healthcare services available to patients. This SDMP will develop upon previous plans and help establish and embed the importance of sustainability across all aspects of healthcare whilst maintaining high quality patient care.

2.0 Introduction

The global consensus for prompt and co-ordinated action to address the effects of climate change and the sustainable management of finite resources has provoked action by organisations and governments.

Climate change is one of the greatest threats to our health and well-being. It has the potential to result in human suffering or loss of life due to extreme weather events, spread of infectious diseases, food and water shortages and an increased burden of disease.

As a nation the UK government has introduced numerous national drivers aimed at improving energy efficiency and reducing carbon emissions as part of a strategy to achieve a sustainable environment and meet global climate change targets.

2.1 What is Sustainable Development?

The Government describes sustainable development as ensuring 'the basic needs and quality of life for everyone are met, now and future generations' (Securing the Future, 2005) and within this document five guiding principles are described:

- Ensuring a strong, healthy and just society
- Living within environmental limits
- Achieving a sustainable economy
- Promoting good governance
- Using sound science responsibly

The principles above present a broader concept of sustainability in comparison to the often misconception of financial affordability.

2.2 Why is Sustainable Development important in the NHS?

The case for sustainable development in healthcare is clear as improving sustainability can help improve the health and well-being of staff and the local community and help achieve cost reductions ensuring finances can be spent at the frontline. In regards to the long term future will be beneficial in reducing waste and inappropriate demand whilst ensuring effective use of products and services.

- Reducing Carbon Dioxide Emissions in the UK

The Climate Change Act 2008, set targets to reduce carbon dioxide emissions by 80% by 2050, all public sector organisations including the NHS have a responsibility to put plans in place to meet this target. The NHS is one of the largest employers in the world with 1.7m employees and the largest public sector contributor to climate change in Europe, therefore it has a significant potential to reduce the UK's emissions.

- Business Case

There is a strong business case in reducing environmental impacts whilst maintain a high level of patient care as resources become more expensive; particularly finite resources as they are becoming increasingly expensive to access, and with landfill tax increasing and taxation on CO2 emissions. Through reducing the Trusts CO2 emissions via consumption of energy for example, significant financial savings can be made and re invested into frontline care.

- Mitigate the negative impact of climate change upon health

As previously stated climate change is a recognised threat against our health and well-being with the World Health Organisation (WHO) estimating 150,000 deaths are caused annually as a result of climate change, and between 2030 and 2050 this is set to rise to 250,000 additional deaths per year. Then if you consider household air pollution currently causes some 4.3 million deaths per year, and ambient air pollution, which causes about 3 million deaths every year; including 64,000 early deaths in the UK. Air pollution is said to cause more deaths than smoking. Swift action is needed to prevent this number rising from hunger, water shortages, increased spread of disease and coastal flooding. The NHS has a major role to play on a national and international level.

- Leading example in the public sector

The NHS is the world's largest publicly funded health service and the UK's largest employer therefore it has the duty to embed sustainable development, operating ethically and economically. Healthcare must be delivered safely and cost effectively whilst recognising the potential negative environmental impacts. It has the potential to have great influence and power over the public, partners and suppliers through its buying power and provision of products and services.

3.0 Sustainability at Gateshead

3.1 Sustainability in Context

Gateshead Health NHS Foundation Trust provides a range of hospital and community services across the Gateshead region, with the primary site being the Queen Elizabeth Hospital (QEH). The QEH provides a full range of hospital services for inpatients, out patients and day cases as well as a pathology laboratory and breast screening programme that services the Sunderland and South Tyneside areas. The Trust employs approximately 4,500 staff and delivers services to over 450,000 people annually.

It has previously been recognised that sustainable development issues can help the Trust make financial savings; however the Trust needs to continue to build on it SDMP approved by the Board to regulate and monitor how our actions are helping to embed sustainability.

3.2 Organisational Roles and Responsibilities

Ensuring that sustainable development is embedded into the organisation requires all stakeholders to be aware of how it is incorporated into their roles. To facilitate effective management of the plan, which is required by the NHS Standard Contract (Service Condition 18) the following roles and responsibilities have been designated between the Trust and QE Facilities:

- *Chief Executive*
  The Chief Executive has overall responsibility for the delivery of the plan.

- *Director with responsibility for sustainability*
  There is currently no designated Director at Board level within the Trust responsible for sustainable development and the delivery of the SDMP.

- *Responsible Persons*
  Key Officers have been designated for lead roles to be responsible for the day to day implementation of the plan as follows:

  - Head of Facilities (QE Facilities) – Travel & Logistics
  - Head of Estates (QE Facilities) – Asset Management & Utilities, Capital Projects and Green Space & Bio Diversity
  - Procurement & MES Manager (QE Facilities) – Sustainable Use of Resources
  - Head of Human Resources – Our People
  - Sustainability, Waste & PAM Manager (QE Facilities) – Sustainable Use of Resources
  - Health, Safety and Resilience Manager – Adaption
  - Facilities Manager Security (QE Facilities) – Sustainable Use of Resources
  - Trust Board Level Lead Director on Sustainable Development (TBC) – Sustainable Care Models and Corporate Approach

- *External Advisors*
  External advisors will be appointed when further or specialist information is required.

- Sustainability Group
  The sustainability group co-ordinates and proactively manages the Sustainable Development Management Plan.

- Green Champions
  The network of green champions across the Trust will help engage staff to respond to policies.

- Trust Staff
  All staff will be expected to respond to trust policies on the environment and sustainability and comply with identified practices and procedures.

3.3 Partnerships

To ensure the success of the Sustainable Development Management Plan it is important that strong effective partnership working must be developed. These partnerships will include government bodies, including the Department of Health and other regional public sector bodies. It is also vital that as a Trust we work closely with other NHS organisations particularly in the local region to enable development of cross sectional strategies that lead to regional change. Private companies' regional and national who we source supplies and services from are key partners in developing, influencing and ensuring a sustainable future for the Trust and the NHS as a whole.

3.4 Sustainable Development Assessment Tool

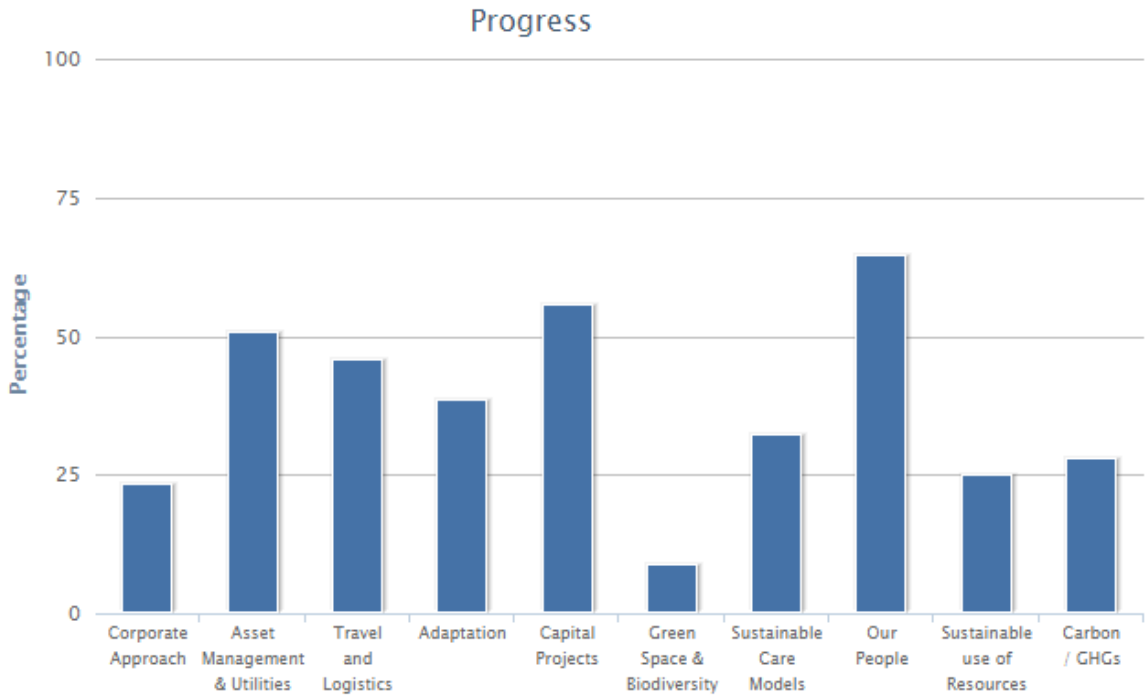
The Sustainable Development Assessment Tool (SDAT) has been developed to replace the previous Good Corporate Citizenship Assessment Model (GCC), not only have numerous improvements been made but the tool is also more functional and helps reduce time burdens.

Overall the tool was designed to help identify the focus of the sustainable development management plan whilst allowing the Trust to bench mark progress year on year by evaluating sustainability across the board in financial, social and environmental terms. The tool also allows the Trust to identify and evidence how it is supporting progress against the UN Sustainable Development Goals.

The online based tool consists of 10 main areas allowing easy identification of how the organisation is progressing; this is up from the 8 previous areas of the GCC model. Within the 10 areas are almost three hundred statements with different cross cutting themes all relating to a sustainable development goal. As a result of the significant changes and extensive detail including different levels of response in comparison to the previous GCC

tool there is no possibility to be able to compare the two results together. However going forward if the SDAT continues in its current format comparisons will be possible in future years allowing a clear visualization of progress against the action plan.

Figure 1: Approximate Average Percentage Score for each of the 10 areas of the Sustainable Development Assessment Tool



4.0 Current Achievements

The Trust has achieved the first Climate Change Act target of reducing our emissions by 10% (based on the 2007 baseline) in 2011 ahead of the 2015 deadline. However this won't mean we will stop trying to reduce it further as we look towards the next target of 34% by 2020. Prior to further actions being implemented it is important that we reflect upon what we've achieved in the ten key areas of the SDAT, so we can identify future areas of focus using the tool.

1. Corporate Approach
2. Asset Management & Utilities
3. Travel & Logistics
4. Adaptation
5. Capital Projects
6. Green Space & Bio Diversity
7. Sustainable Care Models
8. Our People
9. Sustainable Use of Resources
10. Carbon/ GHG's

4.1 Corporate Approach

Gateshead Health's values and vision are an integral part of the organisation in regards to everything we do and who we are. Underpinning these values are a set of value based behaviours, both these behaviours and values reflect the organisations commitment to sustainability both socially and financially.

Throughout the last few years the Trust has seen several changes with the creation of QE Facilities providing estates and facilities services for the Trust as a result the Trust's board lead on sustainability was due to change, however restructuring resulted in a no designated board level appointed lead. As a result this lack of leadership over the past year has weakened and slowed progress in regards to sustainable development across the Trust, through lack of engagement and participation particularly around the Sustainability Group. The Sustainability Group has ceased to meet over the last twelve months as there has been no leadership, input or participation from the Trust.

The SDMP though continues to be updated annually, using the Sustainable Development Assessment Tool as its basis and going forward it will be monitored through the Sustainability Group who will start to meet quarterly again once a designated lead has been appointed The group will then feed information up through any relevant committees as the Trust requires. Six monthly updates on progress of the plan can also be provided to the board for additional assurance if required.

The Trusts' Annual Report contains a significant section on sustainability and for the second year in row the 2017-18 report was even recognised by the Sustainable Development Unit with HFMA and NHS Improvement for its excellence in sustainability reporting. They review all trust and commissioner published sustainability reports against the published criteria to identify leading practice in transparency in reporting progress across social, economic and environmental sustainability.

Increasingly they are looking for evidence of how health organisations are thinking beyond their walls to how they use their influence as employers, estates and procurers in supporting the wider determinants of health and prevention in communities in line with the principals of the UN Sustainable Development Goals. Society, the environment and economy are critical life support systems.

4.2 Asset Management & Utilities

QE Facilities provides the management service of all the utilities and are continually looking for the latest innovations to help improve efficiency and reduce emissions. There is a real commitment to this in the Estates Strategy and as a result over the years numerous achievements have been made in reducing the Trust's carbon footprint. These achievements include the installation of two bio diesel combined heat and power (CHP) systems at the QE site which each have the capacity to generate up to 280kw/hour of heat and around 280kw/hour of electricity. The units are "load tracking" which means they only generate enough electricity to supply the areas they feed. The CHPs have continued to help power and heat the Hospital over the last year with around 3,000,000 KWs of energy provided in to our buildings over the year at zero carbon. With the help of this ongoing work we're projecting to reduce our carbon emissions by around 800 tonnes or circa 10% over the previous year. Both CHP's also generate a financial income anticipated to be in the region of £200,000 this year from Renewable Obligation Certificates (ROC) sales and it is also anticipated future ROC sales will be circa £300,000 per annum for the next 10 years. This confirms they are great assets not only for reducing energy costs, emissions and reliance on the national grid but for also generating an income which can be invested back into the Trust. Looking forward there is potential of installing a third CHP on site in the future which would go further in reducing emissions.

Alongside this in recent years a successful Energy Reduction Strategy has provided numerous successful and effective measures that include, boiler economisers, removal of old pipework replaced with high efficiency systems, installation of LED lighting both internally and externally and lighting controls. These measures along with others have not only seen financial efficiencies but reductions in emissions as well.

Energy and water consumption is reported annually via ERIC (Estates Return Information Collective) and regularly monitored by QE Facilities as they continually look at new innovative low carbon technologies that may improve usage and carbon performance. This is evident when it comes to large capital schemes such as the Emergency Care Centre (ECC) and Pathology laboratory that were built to meet the required BREEAM Standards.

There is also a great understanding that alongside these technologies and measures a collaborative partnership is required with staff, patients and visitors to engage them in changing their behaviours to help reduce energy and water use both within the Trust and at home as well. It is these behaviour changes that will not only have a significant impact on the Trusts carbon emissions but that of the wider community as well, resulting in financial savings and potentially reducing those in fuel poverty through advice and direction on where to get support.

4.3 Travel & Logistics

The Trust's Green Travel Plan has been active since 2001 and a number of measures have been implemented over the last 17 years to encourage the use of the more sustainable forms of transport in regards to both business travel and travel to and from work. This has resulted in the Trust achieving Bronze, Silver, Gold and Platinum Accreditation Awards with Go Smarter.

The work undertaken has continuously been focused on results from travel surveys undertaken through the years, as we look to accommodate the requirements of users across the Trust in a variety of roles.

Figure 2 details the fluctuation in the methods used by staff travel to and from work from 2001 to 2016, as you can see there have been significant changes in some areas. Unfortunately we are currently undertaking the latest travel survey and do not have the results ready to compare with previous years progress.

Mode of Transport	**% of respondents 2001**	**% of respondents 2006**	**% of respondents 2010**	**% of respondents 2013/14**	**% of respondents 2016**
Car Driver (alone)	71.0%	71.9%	72%	67.6%	61.8%
Car Share (as driver)	9%	7.2%	5.0%	6.7%	7.9%
Car Share (as passenger)		0.9%	2.0%	4.0%	4.0%
Bus	11.0%	11.5%	7.0%	8.7%	10.3%
Walk	6.0%	4.7%	7.0%	6.0%	8.4%
Metro & Bus	2.0%	2.8%	4.0%	2.8%	3.9%

Bicycle (non-electric)	0.1%	0.8%	2.0%	2.3%	0.3%
Bicycle (electric/motorised)					0.8%
Motorcycle	0.1%	0.3%	0.0%	0.2%	0.4%
Taxi	0.0%	0.0%	0.0%	1.6%	0.3%
Work From Home	0.0%	0.0%	0.0%	0.1%	0.0%
Other	-	-	-	-	2.1%

Here are a few of the measures that have been implemented:

- Showers and changing facilities available to staff in the Emergency Care Centre.
- Cycle lockers and stands for staff and public use totalling 34 long stay spaces and 17 short stay spaces.
- Refurbishment of existing cycle lockers to help improve usability and security.
- Salary sacrifice scheme for staff to purchase bikes and network travel tickets covering bus and metros if required.
- Participation of numerous events including Cycle to Work Day, Bike Week Walk to Work day and National Walking Month Pedometer Challenge.
- Information and appropriate links are available on both the internet and intranet for both staff and visitors to access, which are updated when required covering cycling, public transport and walking. Staff are also provided with information via welcome packs, induction and ongoing communications.
- A travel information point in the Main Entrance provides real time information to be displayed of local bus services including a map of the nearby bus stops.
- Improved lighting within the site including upgrading to LED along with continual improvements to footpaths and crossing facilities.
- Car sharing scheme available to staff to receive a 66% discount for car sharing 50% or more of their journeys to and from work.
- Pricing tariff encourages use of Park and Ride and low emission vehicles as staff are now partly charged based on the emissions of the vehicle alongside tighter specifications to park on site.
- Electric Cars and low emission vehicles available on salary sacrifice with electric car charging points are available at several locations on site at the QE, with ongoing plans to implement more across both the QE and Bensham.
- Video conferencing and teleconferencing facilities available to staff.

Future actions have to reflect the continual changes particularly in regards to the mode and the distance travelled along with looking at feedback from the latest ongoing staff and patient/visitor travel surveys as to what would encourage staff to use alternative options the Travel plan target aims to reduce the number of car drivers to and 60% by 2022.

In regards to business travel staff are encouraged to walk, cycle or use public transport and can claim mileage rates or any costs (i.e. bus fares) as expenses, trains can also be booked

for longer journeys through the travel co-ordinator. Car usage for business is discouraged with pool cars and shuttle bus services available to staff through QE Facilities Transport department which utilises a range of low emission vehicles including hybrid and electric.

Even with all these measures and future actions we are looking to undertake to reduce car usage and improve air quality it is understood there will still be a need for some staff to use cars. This is particularly around the access to patients in the community along with other sites including Trinity Square Health Centre and services in Newcastle to be able to undertake their role for the organisation. The Local Authority's consultation on air quality and proposed clean air zone plans will impact how services are designed and delivered and the way staff are able to undertake their day to day business. There may also be implications for the way patients and carers are able to access our services both here in Gateshead and in Newcastle. There will need to be wider action from the North East Combined Authority around access to public transport to aid the Trust in any impact this may cause.

Despite the funding coming to an end for the Go Smarter to Work programme the Business Network continues on some basis through newsletters and occasional meetings or relevant conferences via the North East Combined Authority.

In regards to logistics with suppliers work has been undertaken with Laundry services to ensure only bulk activity occurs minimising the number of journeys required within the service provided.

4.4 Adaptation

It is widely recognised that climate change impacts weather systems creating extremes of weather systems which have the potential to result in human suffering or loss of life for a multitude of reasons. As a Trust we accept that our emissions and carbon footprint has a role to play, which is why we are continually looking to reduce our impact on the environment along with ensuring that we are resilient and prepared for any potential circumstances to be able to provide and maintain a high level of patient care. However we have to recognise, adapt and plan for potential staff or supply shortages a long with an increase in patient activity with the development of a comprehensive adaptation plan, which is to be developed.

Over the last few years the adverse weather plan has been utilised and put into effect several times ensuring patients are kept cool and hydrated for example, alongside regular training tests of the Major Incident Plan, utilising the major incident coordination centre. There is currently work ongoing to review the hot weather plan and use of fans due to recent alerts relating to potential risks around infection control.

From an Estates perspective there is ongoing work to reduce the Trust's reliance on the national grid as two bio diesel CHP's (combined heat and power units) have been installed to heat and power several parts of the QE Hospital. These in turn also significantly reduce our carbon emissions as well, however it is noted that these do require and rely on fuel to be delivered although this is sourced locally.

4.5 Capital Projects

Although there have been few large capital projects due to financial constraints across the Trust in the last year, the relocation of CSSD scheme included a heat recover system built in to the ventilation plant along with LED lighting throughout & the Cragside refurbishment also includes an extensive LED lighting scheme with reduced night lighting to all corridor areas. This follows last year's creation of the PIU/Ambulatory Care facility where by energy systems were upgraded and all the lighting replaced for LED. Alongside this smaller work has been undertaken to change the lights in all public areas to LED on site at both the QE and Bensham. In the past the Pathology Centre of Excellence and the Emergency Care Centre (ECC) have provided opportunities to be innovative in the way in which the buildings operate as well as designed as they went for BREEAM ratings. One key feature of the ECC was the introduction of a bio fuel CHP, which as seen above in. The development of the ECC also created green spaces, particularly at the front of the building but also at the rear and roof area as well improving the biodiversity of the area.

When large capital developments occur there is careful consideration about the design of the development ensuring numerous parties are involved from the planning stages including staff and the local community to ensure it meets everyone's needs. This not only accounts for the current needs and demands but also the potential flexibility of the space for future uses or developments taking into account the whole life cycle of both the building itself and any internal equipment etc.

4.6 Green Space & Bio Diversity

Across each of the Trust sites, there is limited green space, and unfortunately over recent years this has decreased to some extent with regards to on site developments which have occurred. However with the remaining green space is well managed and maintained, with careful consideration taken regarding biodiversity. There are several garden areas that have been developed for different patient groups to enjoy as part of their treatment or recovery along with several areas staff can enjoy as well and staff are continually looking for ways to improve patient access to these areas to improve patient health.

4.7 Sustainable Care Models

As a Trust we understand the importance of using sustainable care models and the benefits they can bring in regards to not only financially and clinically but also socially and environmentally as well. The trust works with local partners both NHS organisations and others to ensure a holistic approach to patient care is undertaken.

The development of the ECC allowed for us to improve patient flow by bringing together numerous services including accident and emergency, GP services and walk in centre. For patients this means they will be assessed quicker and if they require further tests, treatments or admission this can occur in the one location as part of a stream lined process, improving both patient care but privacy and dignity as well.

However moving forward other wards and departments are looking at how they can improve patient flow and reduce delayed discharged, through Rapid Process Improvement Workshops which are part of the Just Try It….SAFER Programme that aims to empower staff across the Trust to help make improvement to achieve proactive, timely and safe transfers of care. The programme has led to appointment of discharge co-ordinators, enabling the discharge process to start earlier helping both the patient and their future care but also improving patient flow within the hospital.

4.8 Our People

As one of the largest employers in the area the Trust takes great pride and care of its staff ensuring that their opinions are valued and acted upon through annual staff surveys whilst ensuring health and well-being is a priority within the Trust. It was highlighted that although many services are provided to staff, they are not co-ordinated under one umbrella so the SALS (Staff Advice and Liaison Service) was developed to make it easier for staff to access them. The annual Pedometer Challenge continues to be a great success encouraging staff to get active through healthy team competition, linking nicely with active travel and promotion of local gym facilities.

Supporting this work is an ongoing action plan, steered by the Health and Well-being Steering Group who continually look at improving the access staff have to a range of health and well-being and support services and schemes both within and external to the organisation depending on the needs. A few of the key focus points over the last year include stress and mental health and the RCN ‘Rest, Rehydrate and Refuel’ Campaign. The rehydration aspect relates well to the impact of climate change with the increase extreme weather events and the impact this has not only upon the community and patients but staff who have to work in through those conditions.

Since 2007 the Trust has implemented a smoke free policy across all its sites, which is applied to both staff and visitors which aids smoking cessation whilst reducing the risk of non-smokers. The Trust also offers support services to staff to encourage smoking cessation and supports national campaigns on the matter.

Within the community the Trust supports local schools offering work experience to students in a variety of departments, and apprenticeships in numerous roles providing and supporting their training needs with the potential to lead into future careers in other roles within the organisation.

Staff and the community are encouraged to engage with issues around sustainability, with training and information provided at induction, participation in national events and communication through the internet and intranet sites QE Weekly and Green News. Staff are also encouraged to become 'Green Champions' within their ward or department and are supported with information and knowledge to feedback to staff and implement changes within their work areas.

4.9 Sustainable Use of Resources

The Trust is committed to reducing waste outputs and working towards a zero to landfill approach in regards to waste, working not only with our waste contractors but with procurement as well to reduce waste volumes from the initial outset. Along with reducing waste there is also a real emphasis on reuse as well, with departments encouraged to utilise the available and wanted items sections on the intranet for materials/items they may no longer require but could be used elsewhere. Supporting this there are communications regarding how staff can minimise waste at home and the money they could potentially save along with potential environmental benefits.

There has also been work undertaken to improve segregation of waste including the introduction of offensive waste and increasing recycling rates along with reducing the volume of heavy plastic used in packaging waste, switching to bio bins instead of plastic drums in numerous areas. The recent waste contingency situation has put even greater pressure on the Trust to improve segregation further and review alternative containers or waste streams for particular items as we see costs increase and tighter regulation from the Environment Agency.

Despite all this work it is likely that as patient numbers and activity increases particularly over certain periods in the year where additional wards are utilised further the volume of waste is likely to increase to some degree.

Catering across the hospital is focused more than ever on producing and supplying healthier choices ensuring that not only patients receive the nutritional and hydration required for

their needs and promote healthy eating to both staff and patients, but they also consider the sustainable procurement of these choices.

Since the Food and Drink Strategy was approved in 2015 catering have ensured foods are brought from the NHS Framework agreement, which is a step towards ensuring that government buying standards are met. The latest CQINN targets aimed towards reducing sugary drinks and foods high in fat, sugar and salt has reduced the sale of sugary drinks and now water and 'zero calorie' drinks account for all sales. Patient feedback is also a key focus to help improve the service, and these are clearly working as from this year's annual PLACE report a score of 93.3% was achieved in regards to food.

Currently a review is underway of the provision of catering provided by QE Facilities to staff and visitors at its restaurant facilities, allowing an opportunity to improve the holistic process from where food is sourced, how it is packaged and how it could be disposed of.

In regards to chemical use across the organisation there is a system in place to ensure the COSHH regulations are met, with staff training undertaken to ensure they follow these guidelines and use the correct amount for the required job. There is always a drive to reduce use of chemicals and look at alternative products on the market where possible.

4.10 Carbon/ GHG's

Overall the Trust has great ambitions to reduce its carbon emissions as it recognises the impact on the local community and on a national level, this plan will set out targets in numerous areas of activity across the organisation in order to achieve this. From the few achievements listed above to the continual work on daily basis the Trust has already come so far in significantly reducing our emissions in line with national targets set in the Climate Change Act 2008; but with greater collaborative working across the organisation these achievements will be even greater.

The Trust works closely with its partners particularly QE Facilities in ensuring that relevant data is captured, monitored and benchmarked, along with ensuring building stock and capital projects are continual utilising new innovative technologies and pushing the boundaries in regards to carbon. However as we move forward it is key the organisation must further establish its links with other providers, contracts to help progress the journey and reduce emissions further. There are already great links between the Trust and local community particularly with schools and local colleges and universities, and those staff that work out and about in the community, but as we look forward we need to analyse and see how we could make better use of these contacts to improve sustainability in the wider area.

The Trust's visions and values have always underpinned financial and social sustainability but as we move forward we must integrate them along with environmental factors, as we

strive to become a leader amongst the local community on sustainability. As one of the largest employers in the region it is the Trust's duty to look at every aspect of the organisation and work to improve our carbon emissions, but also provide the tools for staff, patients and visitors to take with them to the wider community. This may include further education and information on waste minimisation, energy usage, active travel and the impacts of climate change on human health; whilst working to support the local infrastructure to help enable these developments and opportunities. Looking forward a greater ownership from the Trust at board level down to its employees needs to be developed and actively participate across sustainable development within the organisation.

In particular regards to active and sustainable travel, we as an organisation understand the potential influence over staff and visitors and therefore we look to provide the facilities and make information available for both staff and visitors to make the choice supported by policies alongside. There is information available at the main reception on public transport routes; there are cycle lockers or shelters located close to entrances and electric charging points around site to name a few all this is supported with tough policies and restrictions on those eligible for car parking and charges based upon the emissions of your vehicle.

QE Facilities understands that there is a great need for sustainable procurement and commissioning to help reduce our CO2 emissions and that as an organisation work needs to improve on identifying hot spot areas within procurement and develop ways to mitigate the risks. There is a fantastic opportunity to partner and work with other local NHS organisations and NHS Supply Chain to develop strategies for both ourselves and suppliers to reduce the carbon impacts of the goods and services they provide. As waste tonnages slowly increase due to pressures and growth of the Trust we need to place a wider emphasis on re-use across the organisation and externally other than the Estates and Facilities departments and items for auction. There are networks available to procure and trade items for free that either ourselves or other organisations or NHS Trusts no longer require, that we could tap into which could generate considerable savings financially and environmentally.

5.0 Trust Targets 2014-2020

5.1 Overall Objectives of SDMP

The introduction of the 'Sustainable, Resilient, Healthy People & Places; A Sustainable Development Strategy for the NHS, Public Health and Social Care System' in 2014 broadens the role of the SDMP encompassing areas previously not depicted in the Carbon Reduction Strategy 2009.

The key goals and visions include:

1. A healthier environment.
2. Communities and services are ready and resilient for changing times and climates.
3. Every opportunity contributes to healthy lives, healthy communities and healthy environments.

The delivery of these goals is supported through a number of modules and accompanying guidance notes covering the following areas:

- Leadership, Engagement and Development
- Sustainable and Clinical Care Models
- Healthy, Sustainability and Resilient Communities
- Carbon Hotspots
- Commissioning and Procurement
- Creating Social Value
- An Integrated Approach to Metrics
- Innovation, Technology and R&D

These areas cover a wide ground to ensure we encompass wider aspects of sustainability along with obvious factors like carbon. As a result it helps develop means of reducing emissions on a wider basis particularly with clinical care models and resilient communities ensuring that current and future targets are met along with helping to positively influence the wider local community.

Both the Trust and QE Facilities understand the need to maintain our sustainable development efforts to ensure maximum success of meeting future targets and set a precedent for others.

Our Key Objectives for the SDMP

1. Reduce the Trust's absolute carbon footprint by 34% by 2020.
2. Achieve a score of 60% in the Sustainable Development Assessment Tool by 2020.
3. Achieve zero waste to landfill by 2020.
4. Introduce and establish a sustainability evaluation into the procurement process by the end of 2018/19.

5.2 Monitoring Progress

The following section contains an action plan setting out how the targets above will be achieved in the timeframe, along with roles and responsibilities for individual staff. It also contains a small number of additional qualitative objectives. The action plan is structured in accordance with the Sustainable Development Assessment Tool and lists actions under the following sections.

1. Corporate Approach
2. Asset Management & Utilities
3. Travel & Logistics
4. Adaptation
5. Capital Projects
6. Green Space & Biodiversity
7. Sustainable Care Models
8. Our People
9. Sustainable Use of Resources
10. Carbon/ GHG's

The Trust will regularly monitor the delivery of the actions in the SDMP and its progress against the Sustainable Development Assessment Tool, where results will be published annually. The Sustainability Group will meet regularly to review progress against the action plan and identify opportunities for further improvement wherever possible. Carbon emissions will be reported as part of the annual Estates Return Information Collection (ERIC) return.

Progress with the SDMP will be reported to the board annually upon its review and updated where necessary particularly in regards to new guidance and documentation.

6.0 SDMP Action Plan

6.1 Corporate Approach

The Trust recognises the impact it has on the environment and is committed to improving social, financial and environmental sustainable development across the organisation and local community.	
Lead	Board Level Director for the Trust
Overall Objective	To be a leading example organisation in sustainable development.
SDMP Target	To reduce absolute CO2 emissions by 34% by 2020, against the 2007 baseline.

Action Plan

Action	Target Date
Engage with staff, patients, visitors and local stake holders on issues of sustainable development policy.	November 2019
Implement a sustainable development and social value policies to support the plan.	December 2019
Develop a communications plan around the promotion of sustainable development to staff, including awareness of policies and procedures mentioned above.	February 2020
Introduce a standing section on sustainability on all board papers.	September 2019
Introduce sustainable development and social value as material considerations in all business cases.	October 2019
Develop and maintain a network of sustainability champions across the Trust, providing regular training and information.	Ongoing
Recommence the Sustainability Group ensuring a coordinated approach from across the Trust.	June 2019
Commit to increasing our spend with SME's and social enterprises.	September 2019
Appoint an internal sustainable procurement and social value lead.	September 2019
Develop a process/ awareness programme ensuring that decision makers, procurement and budget holders fully understand their roles and responsibilities of the Social Value Act.	October 2019
Develop a process and awareness raising programme ensuring that procurement understand and maximise the benefits of whole life costing and circular economy.	October 2019
Implement sustainability and social value commitments in existing procurement policy frameworks.	February 2020
Develop a process to seek ideas from the wider public on how to improve our environmental and sustainability performance.	August 2019

6.2 *Asset Management & Utilities*

The Trust recognises the impact its assets and utilities have upon the carbon footprint, as these can account for a significant proportion of our overall emissions.	
Lead	Anthony Pratt – Head of Estates (QE Facilities)
Overall Objective	To reduce our energy and water consumption across the Trust.
SDMP Target	Reduce our carbon emissions through reducing demand on energy and water, using green technology where possible.

Action Plan

Action	Target Date
Ensure sustainability commitments are a key feature in the Estates Strategy.	September 2019
Develop a sustainable buildings action plan and communicate it clearly to staff and key partners e.g. NHS Property Services.	October 2019
Investigate potential to implement sub meter readings for electricity to help better understand the demand and management.	August 2019
Regularly assess space utilisation across our estate to maximise the value of the estate.	Ongoing
Continue to communicate with staff their role in conserving energy and water at work managing usage and reporting leaks and faults. Whilst also providing information and tips to help them in the home as well.	Ongoing
Introduce energy and water consumption evaluations in whole life costing during the procurement of relevant goods and services.	September 2019
Assess if the carbon benefits are additional when buying green energy.	When required.
Work with any onsite contractors/suppliers to ensure they also reduce our water and energy usage where relevant.	Ongoing
Continue to offer energy advice and warm home support to patients, users, carers and the local community to improve their health and well-being.	Ongoing

6.3 *Travel & Logistics*

The Trust recognises that sustainable travel requires staff, service users and suppliers to actively be encouraged to participate and provide the necessary infrastructure and polices for this to occur.	
Lead	Andy Colwell – Head of Facilities (QE Facilities) Sarah Needham – Sustainability, Waste & PAM Manager (QE Facilities)
Overall Objective	To encourage staff to utilise sustainable forms of transport for both commuting and business travel, whilst working with suppliers to look at their travel emissions.
SDMP Target	To reduce CO2 emissions associated with travel and transport.

Action Plan

Action	Target Date
Calculate the carbon footprint of all business travel and patient transport services.	August 2019
Develop a business travel/ travel policy that supports sustainable business travel through a travel hierarchy and is communicated to staff.	October 2019
Set a carbon reduction target in relation to business mileage emissions aligned to the Climate Change Act 2020 target.	October 2019
Continually measure carbon emissions from travel and transport to be able to demonstrate a continual reduction.	Ongoing from August 19.
Work with the Local Council on the consultation around air pollution and the potential impacts it may cause the Trust and its service provision.	Ongoing
Continue to advertise and promote electric charging points on site and gradually increase the number available to both staff and visitors on all sites.	Ongoing
Continue to promote the technologies and methods available to reduce travel e.g. teleconferencing and provide training when necessary.	Ongoing
When collecting business mileage data segregate into different directorates or departments to allow trend reports and implement measure actions.	August 2019
Continue to promote and communicate the green travel plan to staff, patients, users/clients, visitors, suppliers and the local community.	Ongoing
Continue to promote and encourage staff with incentives to use methods of active travel.	Ongoing

6.4 Adaptation

Despite this SDMP setting out actions to mitigate climate change through reducing emissions and embedding sustainability, the Trust must recognise that this will not protect us from the predicted effects of climate change. Possible effects include heat waves, flooding and harsher winters all of which impact upon the services provided by the Trust to the local community. It is vital the Trust is able to adapt in these circumstances to deal with a higher influx of patients yet still maintain a high quality level of care.	
Trust Leads	Peter Weatherburn – Health, Safety & Resilience Manager
Overall Objective	To ensure that climate change adaptation is effectively incorporated into the Trusts business continuity, emergency planning and risk assessment procedures. The design and operation of the Estate must adequately cater for the potential effects of climate change.
SDMP Target	To develop an adaptation plan that takes account of all climate change adaptation requirements for GHNFT.

Action Plan:

Action	Target Date
Add the risks of climate change to the Trust Risk Register.	September 2019
Develop a climate change risk assessment to highlight risks of continuity and supply; this is to be renewed annually.	November 2019
Develop an Adaptation Plan for the Trust which is to go to the board for approval which should be informed by a Trust climate change risk assessment and involve representatives from across the Trust to ensure a co-ordinated and integrated plan.	January 2020
Develop and update protocols aligned to national heatwave plans, cold weather plans, and flood plans.	Ongoing
Assess the climate change risks to prioritise the development of actions/interventions.	Ongoing
Undertake an assessment of flood risk for our estate, access routes and supporting infrastructure and workforce based on current and future projected climate conditions.	November 2019
Assess the financial implications of climate change to our organisation and the cost of doing nothing and communicate to the board.	January 2020
Provide training to staff relevant to their role to ensure they understand their roles and responsibilities in relation to adaptation planning.	Ongoing

6.5 Capital Projects

The Trust understands the need to reduce CO2 emissions when developing or refurbishing new buildings to ensure it has a minimal impact at the time and going forward.	
Trust Leads	Antony Pratt – Head of Estates (QE Facilities)
Overall Objective	To reduce CO2 emissions as part of all capital projects across our estate.
SDMP Target	To reduce absolute CO2 emissions by 34% by 2020, against the 2007 baseline.

Action Plans

Action	Target Date
Develop a sustainable capital projects plan/process to ensure all potential opportunities in new builds and major refurbishments are leverage for sustainable benefit.	As required
Set clear sustainability aims and objectives that are scaled and applied to all capital projects and project refurbishment.	As required
Monitor and report on the in-use performance of new building and refurbishment projects to ensure they meet our design objectives.	Ongoing
Train capital project staff in how they can develop sustainable outcomes within their roles.	January 2020
Continue to apply whole life costing in the design and construction of refurbishment projects to ensure that health and sustainable development objectives are prioritised throughout the design process.	Ongoing
Continue to ensure that design briefs invite or ask for low carbon/environmental impact proposals and solutions from suppliers and partners.	Ongoing
Ensure resource efficiency including recycled/reused materials and low embodied carbon products is embedded into the design specification for all new builds and major refurbishments.	As required
Ensure social value outcomes including engagement of local small businesses, local labour, certified considerate construction and local skills development; are embedded into the design specification for new builds and major refurbishments.	As required
Continue to utilise the views of staff, patients and the local community in regards to design processes and Estates Strategy.	Ongoing
Continue to share examples of best practice with other healthcare organisations of the lessons learnt and key success points in regards to successful sustainable, low embodied carbon and well-being capital projects.	Ongoing

6.6 Green Space & Biodiversity

The Trust understands the benefits of accessible green space and increased biodiversity has upon the local environment but also the potential health benefits for both staff and the local community.	
Trust Leads	Anthony Pratt – Head of Estates (QE Facilities)
Overall Objective	Improve and maximise the extent, use, accessibility of green spaces on site for staff, visitors patients and the local community; whilst increasing biodiversity
SDMP Target	Review, improve and try and maximise the green spaces available to both staff and patients.

Action Plans:

Action	Target Date
Assess the impacts of the provision of our services on local bio diversity and implement and put in place any required mitigating measures to reduce these impacts.	November 2019
Assess the health, safety and cleanliness and accessibility of our green spaces with input from users, to ensure areas are safe and pleasant to use.	Ongoing
Develop a Green Space/Bio-diversity Strategy and or action plan which is to be approved by the board.	December 2019
Communicate bio diversity strategy to staff, patients and stakeholders.	January 2020
Report to the board on the quality and accessibility of our green spaces and biodiversity, emphasising the value of green space in health environments.	December 2019
Actively work to maintain and enhance biodiversity on our estates.	Ongoing
Work with local greenspace and biodiversity partners to improve biodiversity on the estate.	Ongoing
Ensure any plans to maintain and enhance green space and biodiversity are publically available and easy to understand.	As required
Ensure catering and food contracts demonstrate their sustainability credentials by exceeding government guidelines.	Ongoing
Collect and process food waste, green waste and other organic matter for composting either on or off site.	December 2019
Continue to minimise demand for all timber and paper products and ensure that they at least meet government guidelines.	Ongoing
Engage with staff and patients in food growing and local sustainable food sourcing.	Ongoing
Continue to promote the health benefits of green space to our staff, patients and local community.	Ongoing

6.7 Sustainable Care Models

The Trust understands the importance of sustainable care models in regards to wider approach to sustainability and the benefits this could have on the health of patients and local community.	
Trust Leads	Board Level Director for the Trust
Overall Objective	To ensure that sustainability forms part of the culture that transforms health care delivery.
SDMP Target	To reduce CO2 emissions associated with approach to healthcare provision.

Action Plan:

Action	Target Date
Continue to embed the principle of getting it right first time (GIRFT) and have a system approach for the best use of all resources.	Ongoing
Continue to ensure the NHS Constitution approach to sustainability is reflected in the values of quality within the organisation.	Ongoing
Continue to embed prevention in the development of all our care models both internally and externally to address the wider determinants of health and causes of illness.	Ongoing
Link sustainability as a dimension of quality with other dimensions of quality when we design/deliver/commission care models such as fairness, inequalities and social justice.	As required
Train the board on sustainable care models in particular how they are developed and deployed.	March 2020
Quantify the direct financial co benefits of some of our emerging and more sustainable care models.	March 2020
Quantify the wider economic benefits of some of our emerging and more sustainable care models.	March 2020
Quantify the health co benefits of some of our emerging and more sustainable care models.	March 2020
Quantify the wider social co benefits of some of our emerging and more sustainable care models.	March 2020
Calculate the carbon impact of specific care models to help identify the most impactful areas or hotspots to minimise the environmental impact.	March 2020
Ensure training particularly induction refers to holistically sustainable care models.	March 2020
Routinely and formally report on progress in regards to developing holistically sustainable care models to the board and publically.	March 2020
Actively engage staff in service design, asking staff to place themselves as the patient, so that the care models we provide are realistic and appropriate.	March 2020

6.8 Our People

The Trusts workforce is key to sustainable development across the organisation as it is their training and behaviours that will impact	
Trust Leads	Rebekah Coombes – Head of HR
Overall Objective	To ensure that sustainable development objectives are reflected through the workforce, promoting social value across the organisation.
SDMP Target	Engage staff in sustainability objectives and the impact they can have on sustainable development within and outside of the Trust.

Action Plan:

Action	Target Date
Ensure the Trust Modern Slavery Statement is publically available.	September 2019
Analyse the training needs of our workforce and produce talent maps to identify potential to upskill staff and to support succession planning.	Ongoing
Continue to develop an action plan that promotes and supports health choices in all parts of the workplace including off site.	Ongoing
Continue to promote sustainability plans at Induction training.	Ongoing
Include sustainability as part of staff annual appraisals and it links to organisational policy.	January 2020
Continue to improve processes and support which aims to improve the health of the workforce.	Ongoing
Continue to offer flexible working, support schemes and initiatives for all staff dependent on their specific needs.	Ongoing
Engage staff to be part of the sustainability journey through an engaging and co-ordinated approach that staff can identify and contribute to.	Ongoing
Agree a training and awareness raising programme focussing on increasing knowledge and understanding of sustainability and social value amongst our staff.	October 2019
Staff are expected to demonstrate sustainable behaviours in practice throughout their role and this is reflected in all staff personal development objectives.	March 2020
Continue to demonstrate a commitment to participate in national sustainability campaigns and encourage staff to be involved.	Ongoing
Develop an active communications strategy to raise awareness about sustainability at entry level to the organisation.	September 2019
Request access to our suppliers approaches to equality and diversity and where appropriate we ask prospective suppliers to confirm that they comply with the Modern Slavery Act.	As required
Develop schemes to help long term unemployed people into work.	March 2020

6.9 Sustainable Use of Resources

The Trust recognises that sustainable use of resources is a key factor when trying to reduce carbon emissions across the organisation from procurement through to disposal.	
Trust Leads	Sarah Needham – Sustainability, Waste & PAM Manager (QEF) Ruth Green – Facilities Manager (Catering & Hotel Services) (QEF) Mick Lloyd – Procurement & MES Manager (QEF)
Overall Objective	Continual reduction of waste across the organisation and reduction of emissions through the food and procurement supply chain.
SDMP Target	Ensure the Trust sends zero waste to landfill by 2020.

Action Plan:

Action	Target Date
Develop a resource and waste minimisation action plan to apply the waste minimisation hierarchy.	August 2019
Review potential initiatives to reduce overall material use in the products we purchase across the organisation.	Ongoing
Set targets to increase to increase the amount of healthy and sustainable food choices including from catering services as well as on sale to staff, patients and public in vending machines and retail outlets located within the estate.	October 2019
Develop and set waste minimisation targets for individual key areas e.g. procurement, pharmacy etc.	December 2019
Track and monitor food miles, consumption patterns and disposal of food and drink products for staff and patients.	September 2019
Work with our supply chain to maximise repair and reuse of durable goods across the organisation (e.g. furniture, building materials, IT, walking aids etc.)	September 2019
Review catering contracts to include a requirement to maximise the use of fresh and seasonal food to minimise the transportation needs.	As required
Continue to collaborate and engage with other local procurers to share best practice of sustainable use of resources and maximise opportunities.	Ongoing
Work with external stakeholders to encourage greater provision of healthier and sustainable food choices more widely in the local area.	October 2019
Promote access to sustainable products to our staff and patients e.g. hosting a local products marketplace or promoting local farmers markets.	August 2019
Continue to engage and support staff on minimising waste and expense at home including food waste.	Ongoing
Communicate the benefits of sustainable products and services to our employees, to encourage staff to maximise similar benefits at home.	Ongoing

6.10 Carbon/GHG's

Adopting a more sustainable operating and working practices makes good business sense as carbon becomes an increasingly expensive consequence of traditional operations. From a business case perspective any opportunity that arises to reduce carbon emissions and waste can often deliver significant financial reward.	
Trust Leads	All
Overall Objective	To reduce the Trust's organisational carbon impact and become a low carbon organisation.
SDMP Target	To reduce absolute CO2 emissions by 34% by 2020, against the 2007 baseline.

Action Plan:

Action	Target Date
Annually measure our carbon impact including core emissions such as energy, water, waste, anaesthetic gases and business travel. Analysing trends overtime to validate performance and ensure lessons are learnt.	March 2020
Report our carbon emissions and trend data to staff, patients and the public annually.	March 2020
Develop a specific carbon reduction programme approved by the board and supported financially.	March 2020
Utilise the SDU Securing Healthy Returns Tool to identify and maximise carbon reduction opportunities in all estates investments.	As required
Continue to communicate to staff and patients the value we place on being a low carbon organisation due to the adverse effects of climate change on human health.	Ongoing
Estimate the carbon emissions of our procurement to identify areas for targeted action.	November 2019
Identify the products and services that we source that have a big contribution to our overall carbon footprint.	December 2019
Invite and encourage our providers and suppliers to disclose/share their organisation wide carbon impact and encourage/ support them to reduce these.	As required
Continue to consistently encourage staff and patients to consider and reduce the carbon emissions and climate change impacts of high impact activity.	Ongoing
Continue and develop partnerships with other local agencies and third sector organisations to contribute to the delivery of area wide carbon reduction strategies and plans.	Ongoing

Trust Board

Gateshead Health NHS Foundation Trust

Report Cover Sheet

Agenda Item: 9

Date of Meeting:	Wednesday 26th June 2019			
Report Title:	Trust Performance Report			
Purpose of Report:	To provide an overview on performance against national and local operational performance and workforce targets, ensuring the Board receives assurance about the Trust's performance.			
	Decision: ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
Trust Goals that the report relates to: (Including reference to any specific risk)	**Goal 3** In all locations and settings of delivery, our patients will experience excellent, timely and seamless care that meets their individual needs. **Goal 6** We will have an engaged and motivated workforce living the values and behaviours of the organisation, and who are responsive and adaptive to the changing needs of our environment. **Goal 7** We will deliver value for money and help ensure the local health and care system is sustainable and well led.			
Recommendations: (Action required by Board of Directors)	The Board is asked to note the performance of the Trust, and the continued focus on improving performance against the 4 hour urgent & emergency care standard, and on staff appraisal rates.			
Financial Implications:	This report contains performance information on sickness absence which is a cost to the organisation.			
Risk Management Implications:	The Trust is reporting one operational support need (Urgent & Emergency Care 4 hour performance) under the SOF as at 31st May 2019. This has been discussed with NHSI who are currently satisfied with the Trust's actions to improve performance, considering its performance in context of others in the region/country.			
Human Resource Implications:	Appraisals continue to be a priority for improvement in all departments and this has been discussed at HR Committee. Appraisals are occurring every month (concurrently as other staff expire) in line with the values and behaviours based process. Sickness absence remains under control, albeit above our desired target. All absences are being managed appropriately with individuals			

	whilst the Health and Wellbeing steering group continue to evaluate and introduce services/initiatives to support physical and mental wellbeing of staff.
Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)	**Objective 1** All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers. **Objective 2** The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance between working life and personal commitments.
Author:	Lewis Atkinson, Deputy Director of Strategy and Transformation
Presented by:	Susan Watson, Director of Strategy and Transformation

1. Single Oversight Framework:

The scorecard below reflects the Trust performance against the operational metrics described in the Single Oversight Framework and if there are any potential support needs. As at 31st May 2019, the Trust is reporting one area of potential support need under the operational performance theme of the SOF – A&E performance.

2019/20 Trust Performance Dashboard
NHS Improvement - Single Oversight Framework

NHS Gateshead Health NHS Foundation Trust

Category	Performance Indicator Information		PSF Trajectory	2018/19	2018/19 Performance Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Standard 2019/20	Trigger for Potential Support Need:- (2 consecutive months of non delivery of standard/PSF trajectory)*
Operational	Incomplete RTT Pathways - Waiting < 18 weeks		N	92.6%	91.7%	92.7%											92.2%	92%	
	Maximum Waiting Time 4 hours in A&E		Y	94.0%	92.2%	92.7%											92.5%	95%	
	62 day wait for 1st definitive treatments		N	83.6%	89.3%	77.0%											82.2%	85%	
	62 day wait for treatment (screening patients)		N	92.8%	95.2%	97.1%											96.1%	90%	
	Maximum 6-week wait for diagnostic procedures		N	99.5%	99.7%	99.7%											99.7%	99%	
	Dementia assessment and referral: the number and proportion of patients aged 75 and over admitted as an emergency for more than 72 hours:	Find	N	88.6%	90.4%												90.4%	90%	
		Assess		98.5%	100%												100%	90%	
		Refer		89.3%	100%												100%	90%	

Dashboard Key:

	Performance is below the required threshold		Indicative performance is below the required threshold
	Performance is above the required threshold		Indicative performance is above the required threshold

2. Workforce metrics

Workforce metrics

No.	Performance Indicator	Target	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
1	Trust sickness absence rate (12 month rolling rate)	4.00%	4.76%	4.77%	4.74%	4.66%	4.65%	4.62%	4.65%	4.58%	4.67%	4.56%	4.53%	4.54%	4.54%
2	Core training compliance (12 month rolling rate)	85%	84.00%	84.44%	85.01%	85.47%	84.69%	83.22%	86.22%	87.20%	87.77%	88.40%	88.51%	88.01%	88.22%
3	Appraisal compliance (12 month rolling rate)	85%	69.00%	67.11%	70.00%	71.00%	72.00%	72.01%	70.14%	71.42%	71.20%	72.53%	75.06%	74.11%	72.28%
4	Staff turnover rate		11.82%	12.08%	12.56%	11.91%	12.59%	12.65%	12.54%	12.20%	12.52%	12.47%	13.23%	12.74%	12.82%

Business Unit / Directorate			Chief Executive	Clinical Support & Screening	Community Services	Finance	IT & Information	Medicine & Elderly	Nursing & Midwifery	Strategy & Transformation	Surgical Services
5	Sickness	4.00%	2.51%	3.77%	5.41%	1.92%	4.09%	5.09%	5.63%	2.99%	4.64%
6	Appraisal	85%	89.29%	80.37%	75.89%	91.43%	87.10%	60.00%	82.81%	89.69%	67.47%
7	Turnover	TBC	14.20%	11.57%	10.93%	25.86%	10.25%	14.52%	8.72%	17.36%	13.25%

Key: Confirmed performance on or above target | Confirmed performance progress towards target | Confirmed performance below target

Business Unit:	Equality, Diversity and Human Rights	Fire Safety	Heath, Safety and Welfare	Infection Preventon and Control Lvl 1 and 2	Information Governance	Moving and Handling Lvl 1 and 2	NHS Conflict Resolution	Preventing Radicalisation Lvl 1 & 2 and 3, 4 & 5	Resuscitation All Levels	Safeguarding Adults Lvl 1 and 2	Safeguarding Children Lvl 1, 2 and 3
Chief Executive	96.43%	78.57%	96.43%	92.86%	92.86%	100.00%	92.86%	100.00%	50.00%	96.43%	96.43%
Clinical Support & Screening	98.59%	83.73%	98.59%	93.17%	86.24%	91.23%	91.97%	96.83%	77.18%	98.47%	97.66%
Community Services	98.35%	70.21%	98.35%	74.70%	78.96%	82.20%	92.20%	93.30%	79.24%	98.54%	92.93%
Finance & Information	99.14%	89.22%	99.14%	100.00%	93.97%	95.61%	94.83%	99.53%		100.00%	99.12%
Medicine & Elderly	94.42%	74.01%	93.81%	75.98%	75.23%	68.63%	86.80%	87.62%	60.51%	94.47%	80.39%
Nursing & Midwifery	99.24%	88.64%	99.24%	93.08%	91.67%	90.77%	96.97%	98.43%	86.21%	100.00%	96.38%
Strategy and Transformation	100.00%	90.32%	100.00%	100.00%	91.40%	97.85%	96.77%	98.89%	90.00%	98.89%	98.91%
Surgical Services	94.45%	74.04%	95.20%	77.64%	75.63%	74.16%	89.46%	90.96%	70.09%	94.41%	77.28%

Trust Board

Gateshead Health NHS Foundation Trust

Report Cover Sheet

Agenda Item:10

Date of Meeting:	Wednesday 26th June 2019			
Report Title:	Emergency Preparedness, Resilience and Response (EPRR) Group Annual Report			
Purpose of Report:	To provide the Board with an update on the changes within the NHS for Emergency Preparedness, Resilience and Response (EPRR) and the programme of work currently being addressed by the Trust's EPRR Group			
	Decision: ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
Trust Goals that the report relates to: (Including reference to any specific risk)	**Goal 1** Working with partners, we will manage and improve the health of the population of Gateshead, promoting wellbeing and preventing the occurrence and progression of ill-health wherever possible. **Goal 2** All the services we deliver will be good or outstanding when assessed against being safe, effective, caring, responsive, and well-led. **Goal 3** In all locations and settings of delivery, our patients will experience excellent, timely and seamless care that meets their individual needs. **Goal 4** All our services will have a high safety culture in which openness, fairness, accountability and learning from high levels of incident reporting and mortality reviews is the norm. **Goal 5** All our services will be effective: we will reduce unwarranted variation, ensure our practice is consistent with recognised best practice 7 days a week, and improve outcomes for patients. **Goal 6** We will have an engaged and motivated workforce living the values and behaviours of the organisation, and who are responsive and adaptive to the changing needs of our environment.			
Recommendations: (Action required by Board of Directors)	The Board is asked to receive this Emergency Preparedness, Resilience and Response Group Annual Report for information and assurance			
Financial Implications:	In - direct costs of releasing staff to attend training as part of the EPRR has not been costed.			

Risk Management Implications:	The achievement of the EPRR core standards ensures that business continuity (BCP) and emergency plans are in place to reduce risk to patients and staff in the event of a requirement to respond to incidents and emergencies, as identified in EPRR framework.
Human Resource Implications:	HR implications relate to the training of key staff and the participation in staff in EPRR and BCP exercises.
Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)	**Objective 1** All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers. **Objective 2** The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance between working life and personal commitments. **Objective 3** Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve.
Author:	Peter Weatherburn, Health, Safety and Resilience Manager
Presented by:	Claire Coyne, Executive Director, Clinical support and screening, Accountable Emergency Officer

GATESHEAD HEALTH NHS FOUNDATION TRUST

Emergency Planning Response and Recovery (EPRR) Committee
Annual Report

1. Introduction

This paper provides the Board with an update on the programme of work currently being addressed by the Emergency Preparedness, Resilience and Response (EPRR) committee. The work undertaken provides assurance to the Board and ensures that the Trust is able to competently discharge its Emergency Preparedness, Resilience and Response (EPRR) responsibilities.

In particular, the group is responsible for the regular review of emergency plans including the Trusts Major Incident Plan and ensuring the implementation of national and regional guidance on all aspects of EPRR.

2. NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) Framework

As part of the national EPRR assurance process for 2018/19, a self-assessment against the EPRR core standards is performed to demonstrate that as a provider of NHS funded care we consider EPRR (including business continuity) as a systematic and continuous process and have procedures and processes in place for updating and maintaining plans.

The Trust submitted the EPRR core standards self-assessment in September 2018.

The outcome of our self-assessment indicated that the Trust was "**Substantially Compliant**" the results against the following applicable standards were achieved:

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non-compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	14	13	1	0
Command and control	2	1	1	0
Training and exercising	3	1	2	0
Response	7	7	0	0
Warning and informing	3	3	0	0
Cooperation	4	4	0	0
Business Continuity	9	9	0	0
CBRN	14	14	0	0
Total	64	60	4	0

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non-compliant
Incident Coordination Centres	4	4	0	0
Command structures	4	2	2	0
Total	8	6	2	0

The annual assurance "Deep-Dive" this year from NHS England focussed on "Command and Control" which did not contribute to the overall EPRR assurance rating and was reported separately, as seen in the table above there were 8 areas covered in this section.

Incident Co-ordination Centre:

- Communication and I.T. equipment
- Resilience
- Equipment Testing
- Functions

Command structures:

- Resilience
- Stakeholder interaction
- Decision making processes
- Recovery planning

The outcome of the process is the production of an action plan which is progressed through the EPRR committee.

3. Incident Plan reviews

Policies and plans that have been reviewed and approved by the EPRR committee include:

- SOP-QE-BCM0 - Business Continuity Planning Policy
- SOP-QE-BCP-C - Corporate Business Continuity Management Response Plan
- SOP-QE-EPRR-01 - Emergency Preparedness, Resilience and Response (EPRR) Policy
- SOP-QE-EPRR-04 - Major Incident Plan
- SOP-QE-EPRR-06 – Hospital Evacuation Plan

3.1 Major Incident Plan

There has been a full review of the Major Incident Plan with additional contact information relating to fire arms, ballistics, radiation, burns and plastics.

The publication of the Kerslake report, which was a review of Emergency response plans following the Manchester bombing , contained guidance for acute hospitals to consider in response to mass casualty incidents. This has been reviewed and included in Action cards.

3.2 Hazardous Materials (HAZMAT) and Chemical, Biological, Radiological and Nuclear (CBRN)

Our systems for CBRN have been considered and a number of additions added to support our approach, specifically in relation to how we manage self-presenting patients during chemical incidents (see training section 6).

Despite the introduction of the Initial Operational Response (IOR) and the focus on dry decontamination for powders and dust rather than wet (other than for caustic incidents). We still maintain our readiness to support other contaminants with wet decontamination using the inflatable tent and we continue to test the tent on a 6 monthly basis. Whilst still functional the age and condition of the inflatable tent will need to be considered in line with the existing risk management process for EPRR, this issue is on the risk register.

The Trust stock consists of 15 Powered Respirator Protective Suits (PRPS), with 12 PRPS being the minimum number to be held and whilst the introduction of IOR and dry decontamination reduces the likelihood of this equipment being required we are still required to maintain stocks.
In the event of a prolonged incident involving the use of this equipment then mutual aid would be invoked to request additional equipment or support.

3.3 Waste Contractor

New arrangements with regard to the collection of waste heave been implemented following a change in the Contractor of the National Contract.

4. Flu Campaign

This flu vaccination campaign for 2018/19 has been successful, with the trust achieving an uptake of **80%** of frontline staff vaccinated across the trust.

5. Business Continuity Planning (BCP)

5.1 Progress to date

Work has been progressing into 2019 on the key services identified within the Business Continuity Strategy. Business Continuity progress is measured against a set of key performance indicators (KPIs). The following scores have been achieved thus far and relate to the areas and departments listed in phases 1 2 & 3

Element	Percentage Complete			
	2015	**2016**	**2017**	**2018**
Business Impact Analysis	92%	95%	96%	100%
Business Continuity Plans (BCP) Complete	77%	90%	96%	100%
BCP Training	69%	86%	96%	100%
BCP Exercise (plans)	7%	57%	50%	50%
Overall % BCMS	**61%**	**88.2%**	**86.7%**	**87.5%**

The lower percentage for BCP exercising is to be expected as it is the last element to be undertaken in relation to BCP management and although some of the plans have not been tested in a "staged incident" i.e. PowerPoint scenarios, they are tested regularly in everyday working lives through incidents such as I.T. upgrades/time-out situations, staffing levels, utility failures etc..

An audit of the business continuity management system was carried out by AuditOne in November 2018 the objective of the internal audit was to evaluate the design and test the application of key controls in respect of business continuity.

The conclusion of the audit was:

"Governance, risk management and control arrangements provide **"a good level of assurance"** and the risks identified are managed effectively. A high level of compliance with the control framework was found to be taking place. Minor remedial action is required."

An action plan has been drawn up to address the 5 issues raised in the audit, 3 of which were Medium and 2 Low.

5.2 Community Services

Work has continued with community services teams and BCPs have been developed to ensure that Business Continuity and other specific plans are in place. Areas covered in the plans include:

- Escalation
- Lone working
- Adverse weather
- Buildings access/egress, damage etc.

- Security
- Flood
- I.T. Failures
- Transport Issues
- Staffing Issues
- Single points of failure

5.3 Business Continuity Incidents

Maintaining Business Continuity Plans (BCPs) is of critical importance to sustain our key services. A number of incidents have been recorded where Business Continuity Plans have been considered or implemented. The Trust BCPs are tested on a regular basis in the day to day running of the organisation

There has been an emerging trend during 2018/19 for incidents involving utilities such as power and water supplies and for IT systems to fail or have downtime for upgrades etc. Another factor that has had an impact recently has been the adverse weather (The Beast from the East 2018), where BCPs have been implemented especially around staffing and patient flow issues. It is important that we are able to capture learning from these events both as a preventative measure and for sharing learning from the response of our staff. One learning point from the adverse weather last year was the 4X4 service provided by the volunteer organisation 4X4 Response North East which was extremely beneficial in transporting staff to and from work, as a result we now have formal agreement with this group for any future disruption. The EPRR committee will be considering the approach to capture this type of learning during its work plan for 2019.

6. Training and Exercises

6.1 Training Feedback

The EPRR team have implemented a new audit tool to measure feedback from EPRR exercises including Business Continuity Exercises. The feedback tool establishes if the training was successful, relevant and records comments and suggestions for improvement and additional earning. The feedback is presented at the EPRR committee.

6.2 Regional Exercise Pelican 1 April 2018

This regional exercise was undertaken to test the Trust's and supporting organisation's response to a mass casualty incident. Issues/areas that were included but were not restricted to were staff availability, surge capacity, bed availability, discharge, working with partners e.g. Local authority (LA), NEAS, adjoining Trusts.

Feedback from the exercise overall was positive and quite comprehensive, with a number of learning points raised the two main points were communication and further training. Staff suggested the need to exercise plans, procedures with as much staff involvement as possible.

6.3 Regional Exercise Pelican 2 September 2018

This second regional exercise was similar to Pelican 1 with the aims and objectives being to test response from health and social care providers to mass casualty incident.
Feedback from Pelican 2 participants was similar to the feedback from Pelican 1 highlighting communication and further training requirements, also the circulating of the learning points and the involvement of other staff not involved in Pelican 1&2 so they are aware of the major incident plan, action cards etc.

There is another exercise planned for April 2019 Pelican 3 this will be a full Emergo exercise involving all partnership organisations, there is also going to be a coroner's inquest following this exercise where the decision makers will be interviewed.

6.4 Operational Pressures Escalation Levels Framework (OPEL) – November 2018

NHS E have first developed the Operational Pressures Escalation Levels Framework (OPEL) in 2016 this was published again in December 2018, with the idea that a single national system will bring consistency to local approached, improve management of system-wide escalation, encourage wider co-operation, and make regional and national oversight more effective and less burdensome. All directors and SLMs on call attended an awareness training session on how OPEL would affect staff and the Trust these topics below were explained:

- Opel checklist
- Opel triggers and command centre
- Roles and responsibilities of on-call structure
- Site Huddle attendance requirements

6.5 Hospital Major Incident Medical Management and Support (HMIMMS) – August 2018

This was a 2 day training course for staff who may be involved in the consequences of a major incident and the effect on the Trust. The course consisted of lectures from a team of experts, discussions and table-top exercises involving the attendees. Topics included:

- Definitive care phase
- Specialist services/regional response, Public Health Incidents
- Protracted large geographical incidents CBRN
- Recovery following an incident
- Discussions around HMIMMS in the hospital setting
- Structured approach to the hospital response to major incidents
- Planning for Major Incidents
- Triage & Communication workshops

The staff feedback from this course was that it had been very beneficial; there are plans to organise further sessions this year.

6.6 Major Incident Loggist Training April & July 2018

Following 2 internal training courses the Trust the Trust now has 6 Major Incident loggists these staff are to be used during an incident so that the Trust has contemporaneous records of actions and decisions taken.

6.7 Self-presenting Patients following CBRN Incidents June 2018

The receptionists for A&E at QEH and Blaydon received training on CBRN incidents and self-presenting patients this consisted of showing them the Initial Operating Response (IOR) DVD and talking through the Standard Operating Procedure (SOP) with them so they understood the actions to take in this type of scenario.

7. Recommendation

The Board is asked to receive this EPRR Annual Report for information and assurance.

Trust Board

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 11

Date of Meeting:	**26th June 2019**			
Report Title:	**Healthcare Associated Infection (HCAI) Performance Report**			
Purpose of Report:	To update and advise the Trust Board on the current performance of HCAI mandatory reporting for Gateshead Health NHS Foundation Trust throughout the 2019 – 20 period.			
	Decision: ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
Trust Goals that the report relates to: (Including reference to any specific risk)	**Goal 1** Working with partners, we will manage and improve the health of the population of Gateshead, promoting wellbeing and preventing the occurrence and progression of ill-health wherever possible. **Goal 2** All the services we deliver will be good or outstanding when assessed against being safe, effective, caring, responsive, and well-led. **Goal 3** In all locations and settings of delivery, our patients will experience excellent, timely and seamless care that meets their individual needs.			
Recommendations: (Action required by Board of Directors)	To note the Trust performance on mandatory HCAI reporting and other infection prevention activity as required.			
Financial Implications:	**Yes** - HCAI and treatment is costly across the whole healthcare economy, delays discharge and increases length of hospital stay. Financial sanctions may also be applied by NHS England and Commissioners.			
Risk Management Implications:	**Yes** - HCAI has implications for the whole healthcare economy. The expertise, advice and support of the IPC team are crucial in ensuring that the risk and spread of infection is minimised.			
Human Resource Implications:	**Yes –** organisational culture and behaviours, engagement, responsibility and ownership required across the whole healthcare economy.			
Trust Diversity & Inclusion Objective that the report relates to: (*including reference to any specific implications and actions*)	**Objective 1** All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers.			
Author:	**Louise Caisley** - Head of Infection Prevention and Control			
Presented by:	**Andy Beeby** - Medical Director Joint Director of Infection Prevention and Control (DIPC)			

1.0 EXECUTIVE SUMMARY

With regard to patient safety and quality the Trust adopts the national aspiration of attaining a zero tolerance approach to all avoidable infections including MRSA blood stream infections.

The Trust has reported zero (0) Community/Hospital-onset samples of MRSA BSI to date with a zero (0) rate per 100k bed days.

NHS Improvement has **changed** the CDI reporting algorithm for the financial year 2019/20:

- *adding* a prior healthcare exposure element for community onset cases
- *reducing* the number of days to apportion hospital-onset cases from three (3) to two (2)

and cases will be assigned as

- **hospital onset healthcare associated**: cases detected in the hospital two or more days following admission
- **community onset healthcare associated**: cases that occur in the community where the patient has been an inpatient in the Trust in the previous 4 weeks.
- **community onset indeterminate association**: cases that occur in the community where the patient has been an inpatient in the Trust in the previous 12 weeks but not the most recent 4 weeks.
- **community onset community associated**: cases that occur in the community where the patient has not been an inpatient in the Trust in the previous 12 weeks

The Trust CDI objective for 2019/20 is forty (40) set against **healthcare associated** samples and an annual rate of 23.6 per 100k bed days.

To date the Trust has reported to date:

- Four (4) **healthcare associated** CDI samples.
    - Two (2) Healthcare associated cases were successfully upheld at appeal therefore the Trust reports zero (0) cases against the quality premium.
- Four (4) Indeterminate association /Community associated samples to date.

The Trust continues to report one of the lowest Meticillin sensitive *Staphylococcus aureus* (MSSA) BSI in the North East region reporting zero (0) Hospital-onset MSSA cases and a rate of 0.0 and zero (0) Community-onset samples.

With regard to Gram negative BSI:

- *Escherichia coli* (*E.coli*): The Trust reports eight (8) Hospital-onset samples with a rate of 4.5 and twenty four (24) Community-onset samples to date.
- *Pseudomonas aeruginosa*: The Trust reports two (2) Hospital-onset samples with a rate of 1.1 and five (5) Community-onset samples to date.
- *Klebsiella spp*: The Trust reports zero (0) Hospital-onset samples with a zero rate and seven (7) Community-onset samples to date.

There have been no reported periods of increased incidence to date however all areas continue to be actively monitored.

The Trust reported 7 positive Influenza samples from April 2019 to June 2019. Six (6) Influenza A and one (1) Influenza B.

2.0 MANDATORY HCAI SURVEILLANCE

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

With regard to patient safety and quality the Trust adopts the national aspiration of attaining a zero tolerance approach to all avoidable infections including MRSA blood stream infections (BSI). All positive Community-onset MRSA samples are attributed to the Newcastle and Gateshead Clinical Commissioning Group (CCG).

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

A. *Table 1* - Acute Trust Data	Q1			Q2			Q3			Q4		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Hospital-onset MRSA BSI	0	0										
Cumulative YTD	0											
2018/19 data = **2/0**	0	0	0	0	0	0	0	2	0	0	0	0

Table 1 - Community Data	Q1			Q2			Q3			Q4		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Community-onset *MRSA* BSI	0	0										
Cumulative YTD	0											
2018/19 data = **3/0**	0	0	1	0	1	0	0	0	0	0	0	0

Chart 1 demonstrates the total number of attributed MRSA BSI data per Foundation Trust/CCG across the North East.

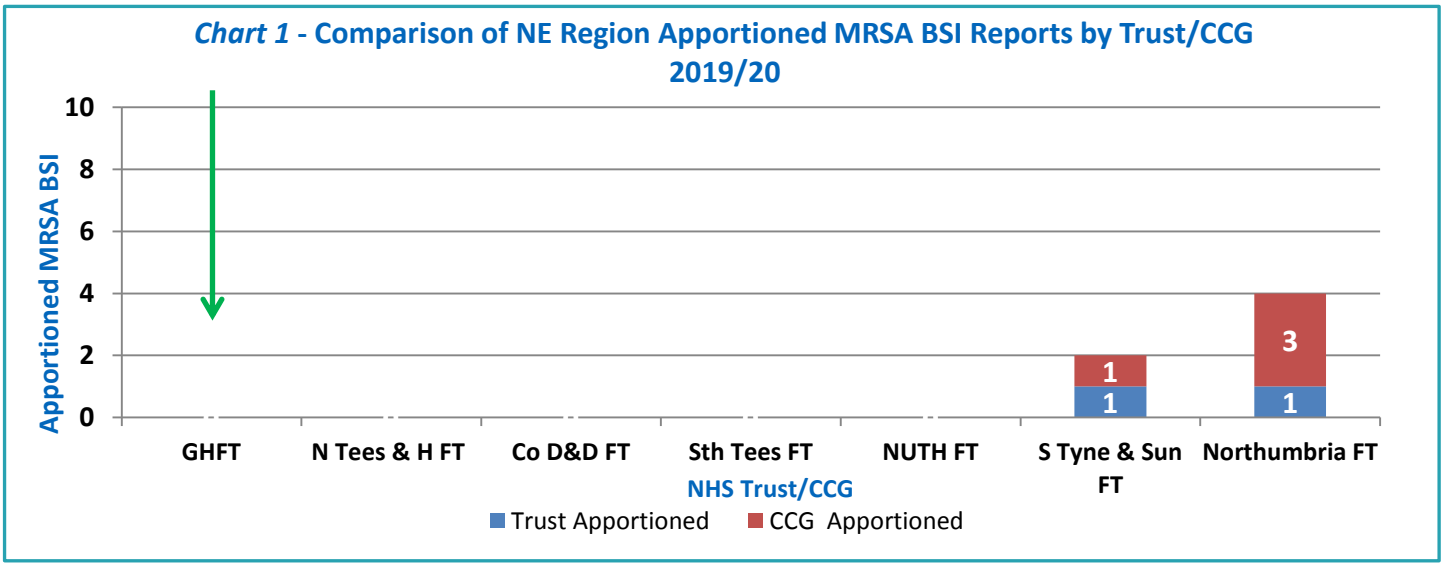
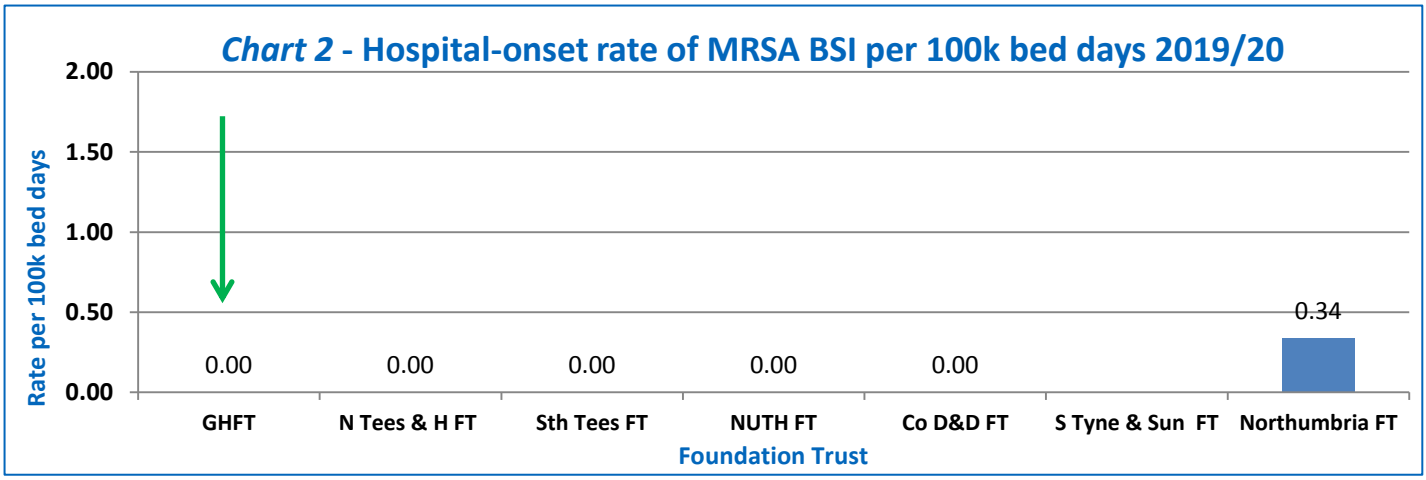


Chart 2 demonstrates the rate of MRSA BSI acquisition per 100k bed days per Foundation Trust/CCG across the North East to date with Gateshead Health FT continuing to maintain the national aspiration.



Currently no rates available for newly formed South Tyneside and Sunderland NHS Foundation Trust

2.2 *Clostridium difficile* Infection (CDI)

Clostridium difficile infection (CDI) is an unpleasant, and potentially severe or fatal infection that occurs mainly in elderly and other vulnerable patient groups, especially those who have been exposed to antibiotic treatment. Reduction of CDI continues to present a key challenge to patient safety across the Trust.

The Trust CDI objective for 2019/20 is forty (40) set against **healthcare associated** samples and an annual rate of 23.6 per 100k bed days.

To date the Trust has reported to date:

- Four (4) **healthcare associated** CDI samples.
    - Two (2) Healthcare associated cases were successfully upheld at appeal therefore the Trust reports zero (0) cases against the quality premium.
- Four (4) indeterminate association/community associated samples to date.

Table 2 - documents the total number of **healthcare associated** CDI toxin positive samples and total number of indeterminate association/community associated

Table 2 - Acute Trust Data	Q1			Q2			Q3			Q4		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Healthcare associated CDI	2	2										
Cumulative YTD (objective 40)	**4**											
Actual following appeal by month	0	0										
Cumulative YTD following appeal	**0**											
Table 2 - Community Data	Q1			Q2			Q3			Q4		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Indeterminate/Community-onset CDI	2	2										
Cumulative YTD	**4**											

Chart 3 demonstrates the Trust position against its Healthcare associated cumulative objective to date with four (4) cases reported against the Trust objective.

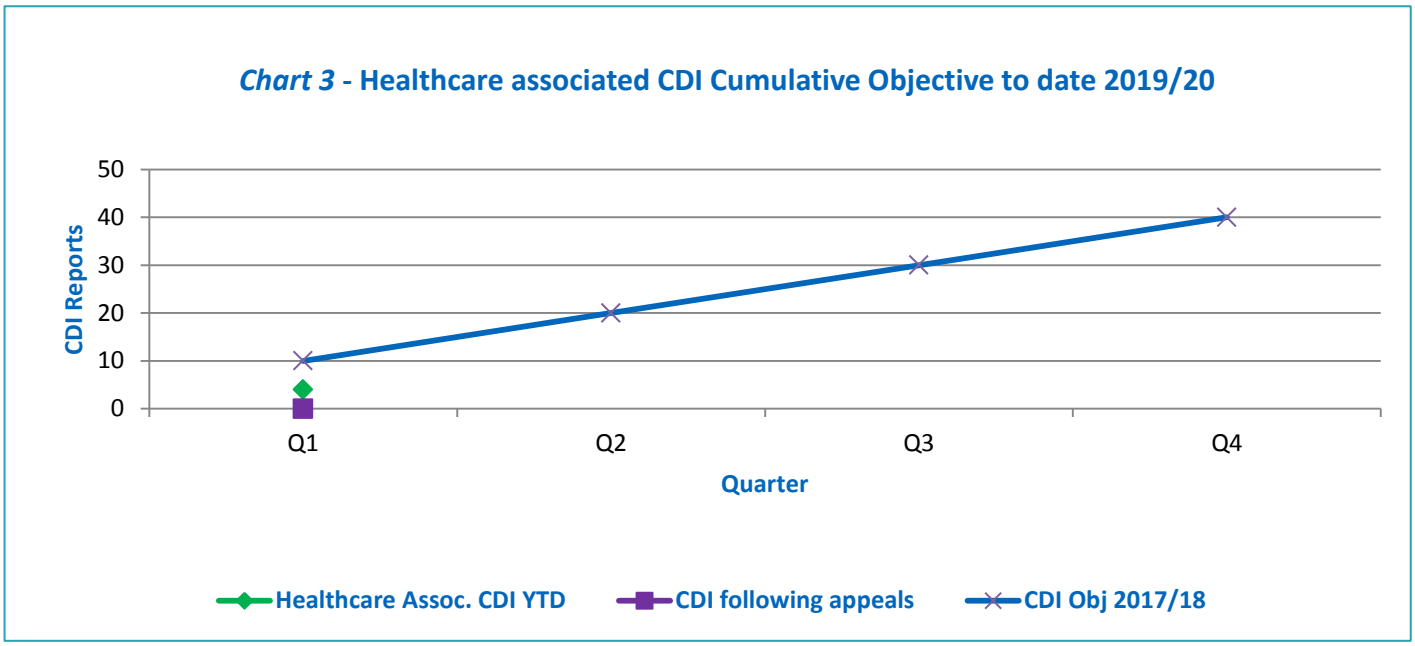
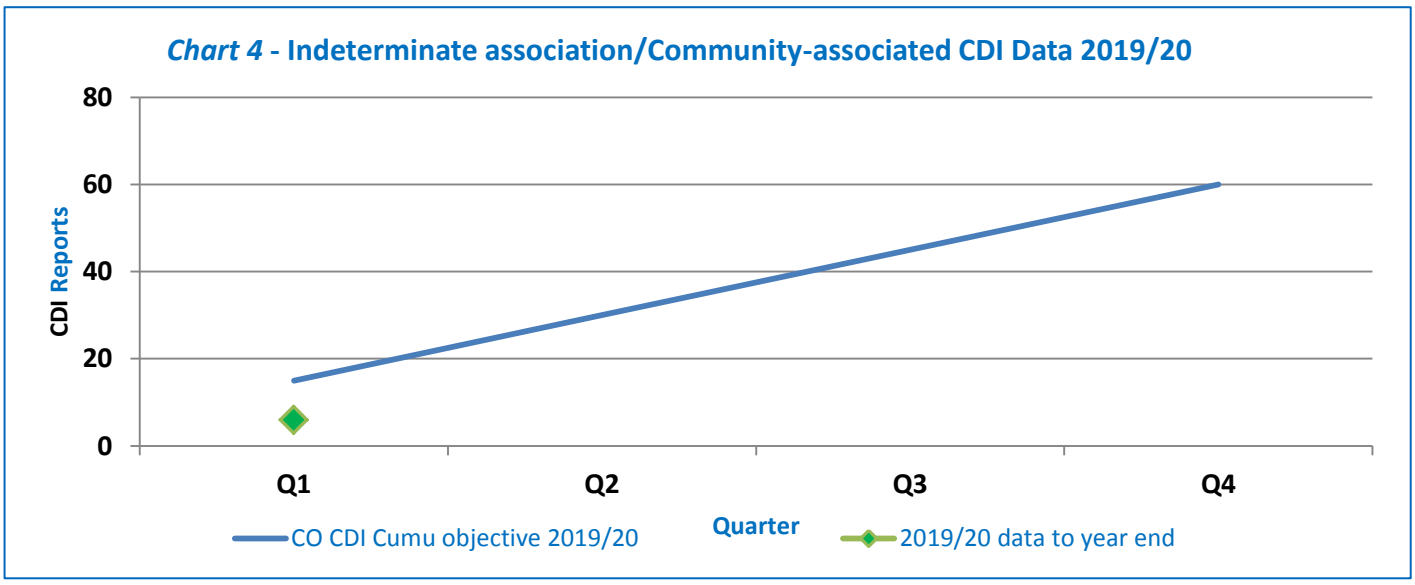


Chart 4 demonstrates indeterminate association/community onset CDI position reporting four (4) samples to date.



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

Reporting of MSSA BSI is a mandatory requirement and collated nationally by PHE for all Trusts however there are no established national improvement objectives to benchmark against.

In terms of improving patient safety and continuous development a 10% internal performance improvement has been applied for 2019/20.

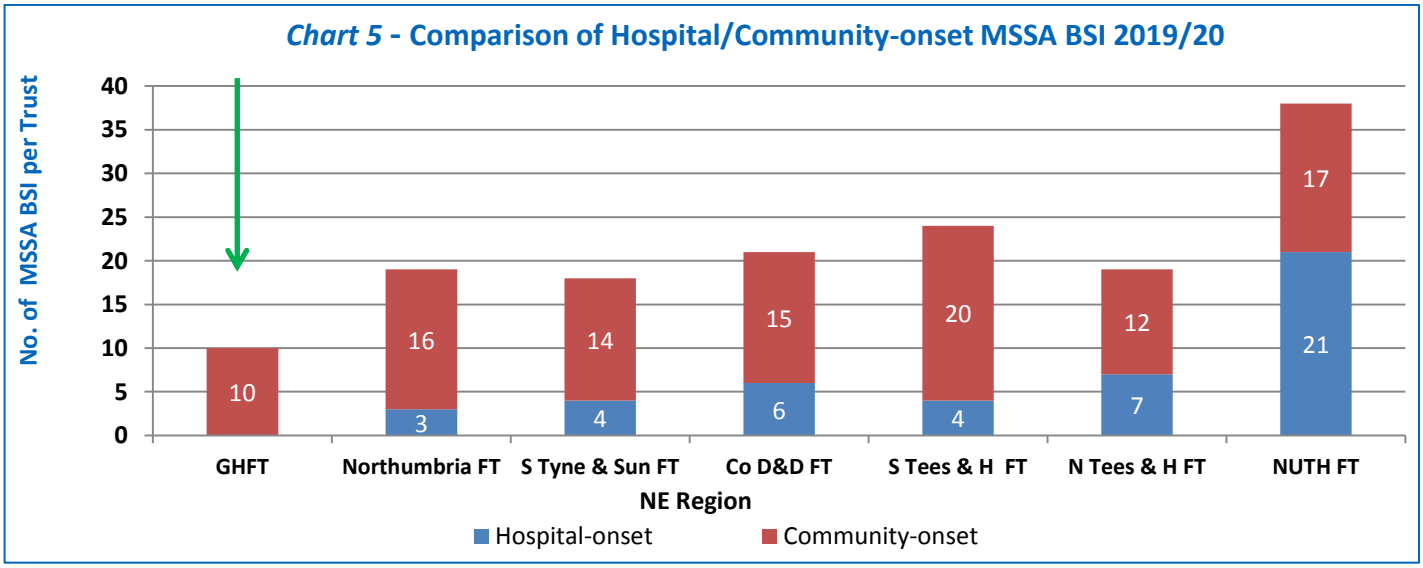
Table 3 indicates the number of apportioned MSSA BSI against 2018/19 as a comparison and reports zero (0) Hospital-onset samples and ten (10) Community-onset samples to date.

***Table 3* - Acute Trust Data**	Q1			Q2			Q3			Q4		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Hospital-onset *MSSA* BSI	0	0										
YTD	0											
2018/19 Actual = 17	0	1	0	2	2	2	1	2	2	4	0	1

***Table 3* - Community Data**	Q1			Q2			Q3			Q4		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Community-onset *MSSA* BSI	7	3										
YTD	10											
2018/19 Actual = **45**	2	4	4	4	5	0	5	4	9	2	2	5

Chart 5 provides a comparison of the total number of reported Community/Hospital-onset MSSA BSI by Foundation Trust in the NE region to date.

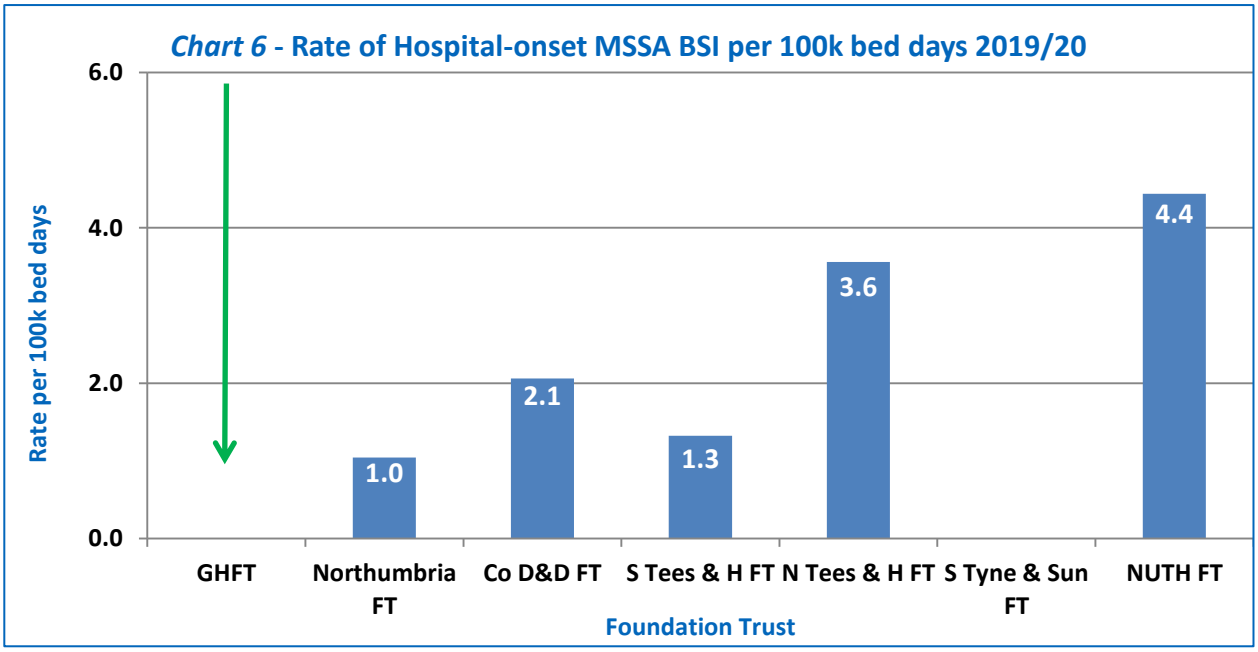
Gateshead Health FT continues to remain one of the lowest reporting Foundation Trusts despite a rise against 2018/19.



The chart is ordered by Hospital-onset samples

Chart 6 demonstrates the rate of MSSA BSI acquisition per 100k bed days per Foundation Trust/CCG across the North East.

Gateshead Health FT continues to remain one of the lowest reporting Foundation Trusts with a Hospital-onset rate of zero (0) per 100k bed days.



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

A national ambition to reduce healthcare associated GNBSI by 50% by March 2021 was introduced from April 2017 across the whole health care economy in England. The objective has since been reviewed under the Governments 5 year Antimicrobial Strategy and has now advised a 25% reduction of E.coli by 2020/21 and the full 50% reduction by 2023/24.

This ambition continues to present a challenge for secondary care providers and an even greater challenge for the primary and social care economy.

The following data representing *E. coli*, *Klebsiella* species and *Pseudomonas aeruginosa* blood stream infections (BSI) demonstrate that the main proportion of BSI occur within the primary and social care environment. A joint action plan has been formulated with Newcastle Gateshead CCG and is being reviewed for 2019/20.

3.1 *Escherichia coli* BSI (E. coli)

The Trust aims for an annual ≥10% performance improvement in line with the current national ambition reporting eight (8) Hospital-onset samples and twenty four (24) Community-onset *E.coli* BSI samples to date as indicated in *table 4*.

Table 4 **- Acute Trust Data**	**Q1**			**Q2**			**Q3**			**Q4**		
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Hospital-onset *E-coli* BSI	**3**	**5**										
YTD 10% objective = **40**	**8**											
2018/19 Actual =**44**	**3**	**4**	**3**	**3**	**4**	**7**	**3**	**2**	**5**	**3**		

Table 4 **- Community Data**	**Q1**			**Q2**			**Q3**			**Q4**		
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Community-onset *E-coli* BSI	**14**	**10**										
YTD 10% objective = **206**	**24**											
2018/19 Actual =**229**	**20**	**22**	**21**	**20**	**21**	**22**	**17**	**19**	**11**			

Chart 7 demonstrates' the total count of Trust *E. coli* BSI data to date in comparison to other Trusts across the NE region representing actual patient infections.

Chart 7 **- Comparison of Hospital/Comunity onset E.coli BSI reports per NE Trust 2019/20**

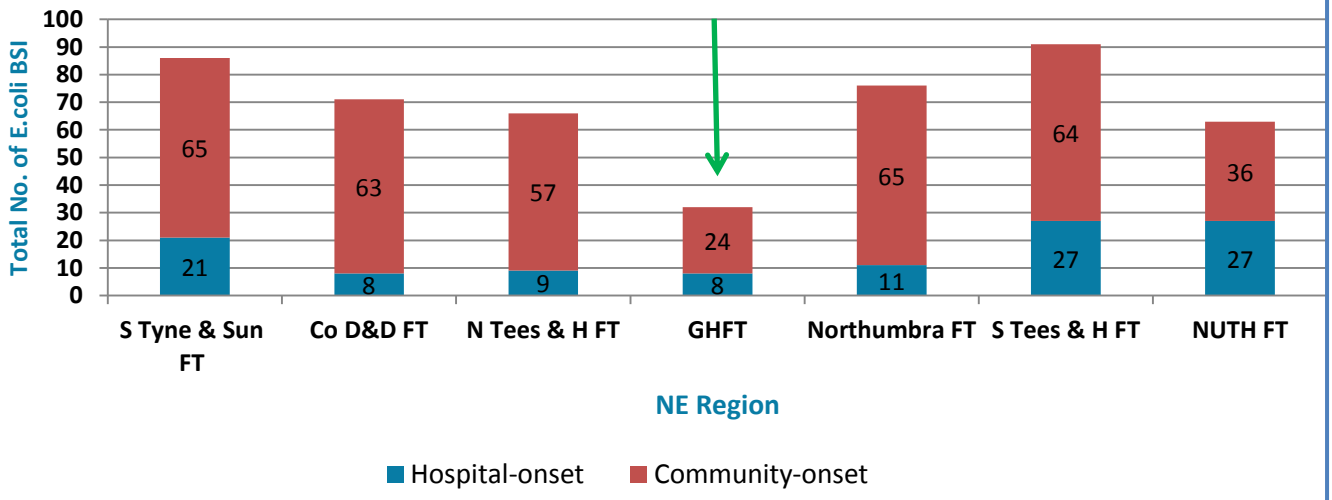
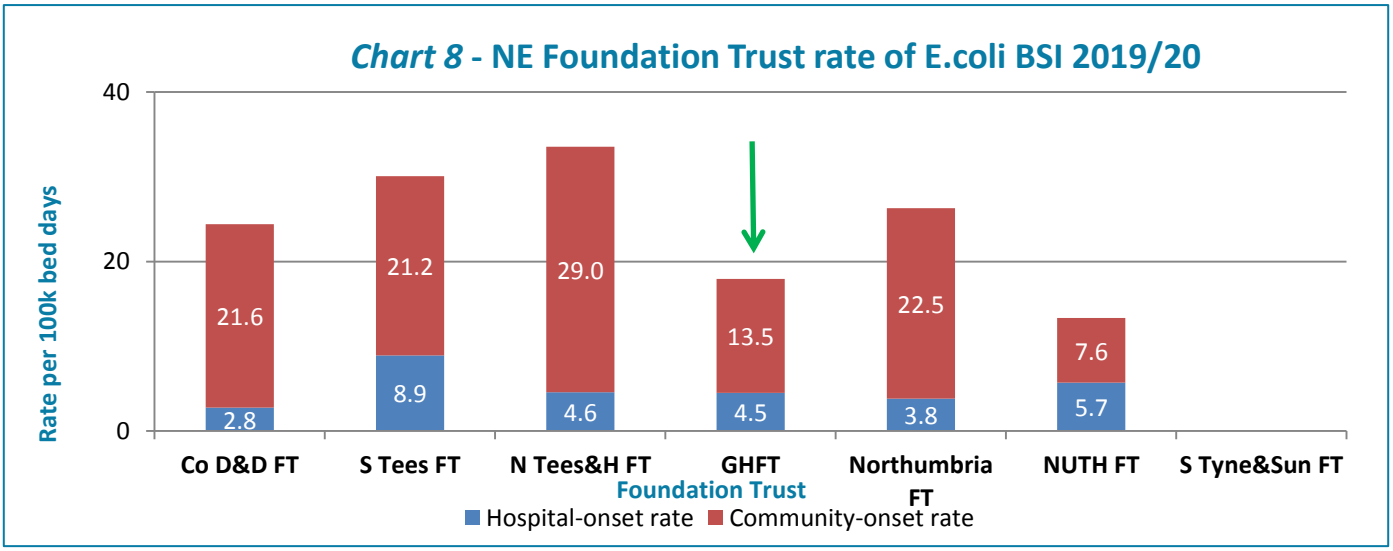


Chart 8 demonstrates a comparison of the total North East region FT *E. coli* BSI rate per 100k bed days to date for Community/Hospital Onset.

The Trust reports a Hospital-onset rate of 4.5 per 100k bed days. Primary care and Community-onset rates continue as a challenging GNBSI area for improvement.



3.2 *Pseudomonas aeruginosa* BSI

Pseudomonas aeruginosa is a common opportunistic Gram-negative pathogen often found in soil and ground water. It rarely affects healthy individuals however can cause a wide range of infections, particularly in those with a weakened immune system.

In hospitals, the organism can contaminate devices that are left inside the body, such as respiratory equipment and urinary catheters. *P. aeruginosa* is also resistant to many commonly-used antibiotics.

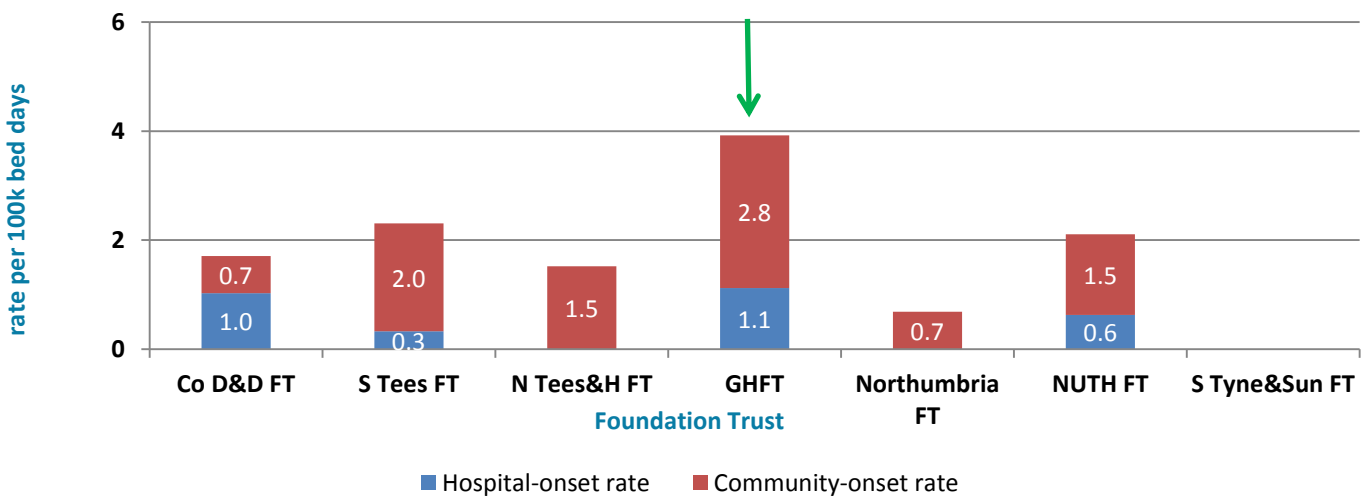
The Trust reports two (2) Hospital-onset and five (5) Community-onset *P. aeruginosa* BSI samples to date as indicated in *table 5*.

Table 5 - Acute Trust Data	Q1			Q2			Q3			Q4		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Hospital-onset (HO) *P. aeruginosa BSI*	2	0										
YTD	2											
HO *P. aeruginosa BSI 2018/19 = 5*	1	0	0	1	0	0	0	1	0	1	1	0

Table 5 - Community Data	Q1			Q2			Q3			Q4		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Community-onset (CO) *P. aeruginosa* BSI	4	1										
YTD	5											
CO *P. aeruginosa* BSI 2018/19 = 15	0	1	0	3	0	2	0	2	3			

Chart 9 demonstrates the Community/Hospital-onset rates of all reported *P. aeruginosa* BSI with Gateshead Health reporting a Hospital-onset rate of 1.1 per 100k bed days.

***Chart 9* - NE Foundation Trusts rate of *Pseudomonas aeruginosa* BSI 2019/20**



3.3 *Klebsiella species* BSI

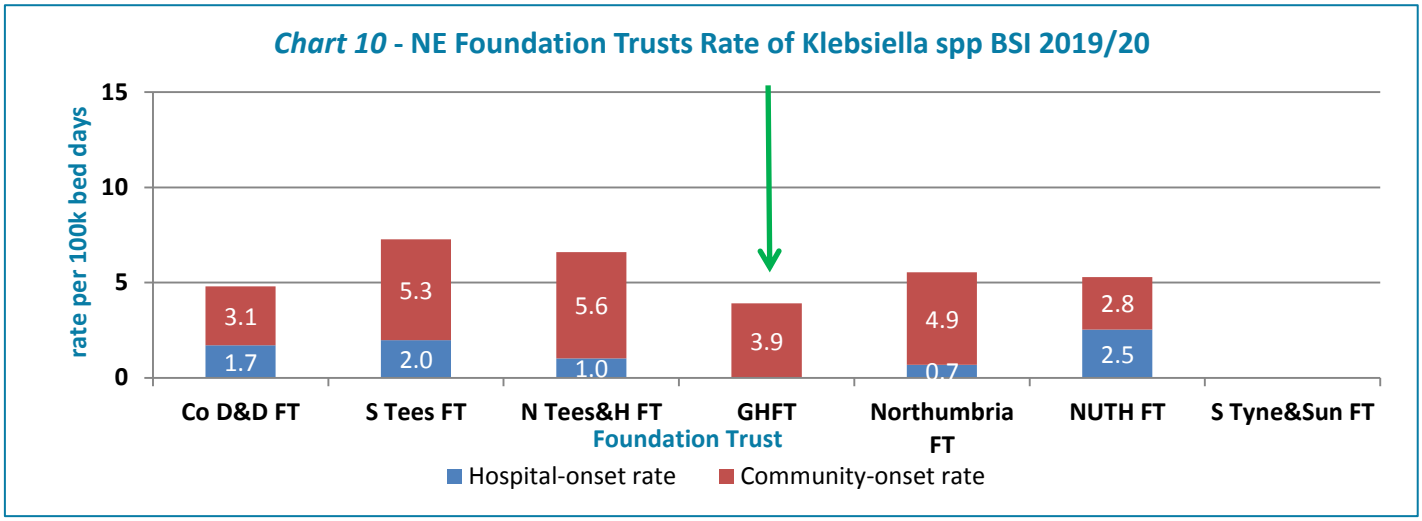
Klebsiella species are a type of bacteria that are found ubiquitously in the environment and also in the human intestinal tract and are commonly associated with a range of HCAI. In healthcare settings, *Klebsiella* infections are seen in vulnerable, immunocompromised and unwell patients who have other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

The Trust reports zero (0) Hospital-onset and seven (7) Community-onset *Klebsiella* BSI samples to date as indicated in *table 6*.

***Table 6* - Acute Trust Data**	Q1			Q2			Q3			Q4		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Hospital-onset (HO) *Klebsiella spp. BSI*	0	0										
YTD	0											
HO *Klebsiella spp. BSI 2018/19 = 16*	0	1	2	0	0	3	1	1	1	2	4	2

***Table 6* - Community Data**	Q1			Q2			Q3			Q4		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Community-onset (CO) *Klebsiella spp.* BSI	5	2										
YTD	7											
CO *Klebsiella spp.* BSI 2018/19 = 39	4	2	4	3	4	3	2	6	4			

Chart 10 demonstrates the current Community/Hospital-onset rate of all reported *Klebsiella spp.* BSI with the Trust reporting a Hospital-onset rate of zero (0) per 100k bed days and a community-onset rate of 4.5.



4.0 PERIODS OF INCREASED INCIDENCE (PII) AND OUTBREAKS

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

The Trust has experienced zero (0) PII to date. There have been no further identified PII however all areas continue to be actively monitored. *Table 7* indicates the number of PII by month against 2018/19.

Table 7 **- Outbreaks & Periods of Increased Incidence (PII)**	**Q1**			**Q2**			**Q3**			**Q4**		
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
2019/20	**0**	**0**										
YTD	**0**											
2018/19 Actual = 11	**1**	**6**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**3**	**0**	**0**

5.0 INFLUENZA ACTIVITY

Through April and May 2019 the Trust has reported 7 positive Influenza samples.
Six (6) Influenza A and one (1) Influenza B.

The Infection Prevention and Control Team and Consultant Clinical Microbiologists provide advice, guidance and daily monitoring with regard to patient flow and bed management to ensure patient and staff safety remains a top priority.

Louise Caisley
Head of Infection Prevention and Control

Trust Board

Gateshead Health NHS Foundation Trust

Report Cover Sheet

Agenda Item: 12

Date of Meeting:	26 June 2019			
Report Title:	Nurse Staffing Exception Report			
Purpose of Report:	Provide assurance to the Board that staffing establishments are being met month by month			
	Decision: ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
Trust Goals that the report relates to: (Including reference to any specific risk)	**Goal 2** All the services we deliver will be good or outstanding when assessed against being safe, effective, caring, responsive, and well-led **Goal 3** In all locations and settings of delivery, our patients will experience excellent, timely and seamless care that meets their individual needs **Goal 5** All our services will be effective: we will reduce unwarranted variation, ensure our practice is consistent with recognised best practice 7 days a week, and improve outcomes for patients			
Recommendations: (Action required by Board of Directors)	The Board are asked to receive the report for assurance			
Financial Implications:	Costs associated with nurse bank to provide cover for maternity and sickness			
Risk Management Implications:	Areas of potential risk have been mitigated against through the implementation of robust staffing plans and ongoing monitoring of staffing levels across the organisation			
Human Resource Implications:	Nurse recruitment continues to be a challenge; however the Trust is being proactive and innovative in terms of recruitment solutions			
Diversity and Inclusion Implications:	**Objective 3** Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve			
Author:	Yvonne Evans Deputy Director of Nursing, Midwifery &Quality Gareth Armstrong, Chief Matron Surgery			
Presented by:	Hilary Lloyd, Direct of Nursing, Midwifery & Quality			

Gateshead Health NHS Foundation Trust

Nursing and Midwifery Staffing Exception Report

April – May 2019

1. Introduction

This report is to provide assurance to the Board that staffing establishments are being met on a shift-to-shift basis. The Board will receive monthly updates on workforce information, including the number of actual staff on duty during the previous month, compared to the planned staffing level, the reasons for any gaps and the actions being taken to address these. Following the Lord Carter Cole report, it was recommended that all trusts start to report on care hours per patient per day (CHPPD) this is to provide a single consistent way of recording and reporting deployment of staff working on inpatient wards/units. It is calculated by adding the hours of registered nurses to the hours of support workers and dividing the total by every 24 hours of inpatient admissions. This report provides information for April and May 2019.

2. Staffing

The actual ward staffing against the budgeted establishments for April and May are presented in Tables 1a and 1b: Whole Trust wards staffing and Tables 2a and 2b: Ward by ward staffing in this report. In addition the Trust has published this information on our website for the public, and provided a link from NHS Choices to this information.

Table 1a: Whole Trust wards staffing April 2019

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 (%)**
86.1%	117.4%	97.2%	122.5%

Table 1b: Whole Trust wards staffing May 2019

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 (%)**
85.8%	116.6%	98.1%	117.0%

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

Appendix 1

Illustrates the Trusts staffing fill rates over the past 12 months by Qualified days, Nursing Assistant days, Qualified nights and Nursing Assistant nights.

Table 2a: Ward by Ward staffing April 2019

	Day		Night		Care Hours Per Patient Per Day (CHPPD)			
Ward	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Cumulative patient count over the month**	**Registered midwives / nurses**	**Care Staff**	**Overall**
Cragside Court	69.4%	132.5%	85.1%	100.4%	383	3.9	5.6	9.4
CCD	83.7%	89.9%	95.1%	82.1%	280	28.6	3.9	32.5
EAU	110.9%	158.1%	95.7%	124.5%	1233	5.3	3.0	8.4
Maternity	72.8%	87.5%	93.6%	90.2%	298	15.4	6.8	22.2
Paediatrics	81.3%	106.5%	107.8%	-	59	46.9	12.1	59.0
SCBU	83.6%	83.6%	105.0%	103.3%	89	18.1	6.0	24.1
St Bede's	99.1%	116.0%	98.3%	111.4%	244	6.3	5.8	12.1
Sunniside	111.4%	95.2%	102.2%	111.6%	316	5.5	4.6	10.0
Ward 1	87.7%	101.4%	100.0%	105.5%	667	2.7	3.1	5.8
Ward 11	79.6%	109.9%	105.4%	151.8%	801	2.5	3.4	5.9
Ward 12	89.1%	104.8%	105.7%	96.8%	625	3.5	3.1	6.6

	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 14	109.6%	107.4%	110.1%	112.9%	767	3.4	3.8	7.2
Ward 21	99.2%	88.5%	101.7%	105.9%	431	4.1	2.8	6.9
Ward 22	94.4%	138.3%	76.7%	136.5%	856	2.5	3.5	6.0
Ward 23	74.3%	175.8%	104.7%	253.7%	687	2.4	6.8	9.2
Ward 24	80.2%	119.3%	102.7%	156.7%	838	2.4	3.4	5.8
Ward 25	64.9%	137.6%	100.0%	143.2%	862	2.0	3.5	5.5
Ward 26	73.5%	93.3%	100.4%	102.1%	679	2.8	3.3	6.1
Ward 27	80.8%	84.5%	102.1%	103.7%	719	2.8	2.8	5.7
Ward 4	85.4%	146.1%	104.1%	119.8%	879	2.9	3.7	6.6
Ward 6	111.6%	126.8%	101.5%	80.5%	670	2.2	3.4	5.6
Ward 8	95.8%	110.2%	70.4%	209.5%	584	4.6	2.8	7.4
Ward 9	73.3%	131.2%	101.1%	115.0%	1017	2.7	3.3	6.1

Table 2b: Ward by Ward staffing May 2019

	Day		Night		Care Hours Per Patient Per Day (CHPPD)			
Ward	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Cumulative patient count over the month**	**Registered midwives / nurses**	**Care Staff**	**Overall**
Cragside Court	70.1%	113.2%	81.9%	140.0%	412	3.7	5.4	9.1
CCD	79.2%	95.4%	95.3%	95.9%	307	26.0	4.0	30.0
EAU	109.4%	172.5%	90.7%	136.0%	1289	5.1	3.3	8.4
Maternity	74.8%	95.2%	86.7%	87.5%	357	13.1	6.5	19.6
Paediatrics	91.0%	119.8%	170.6%	-	73	48.3	11.4	59.7
SCBU	70.9%	117.0%	100.4%	96.8%	83	17.9	7.4	25.3
St Bede's	101.8%	105.4%	100.0%	106.5%	250	6.5	5.4	11.9
Sunniside	110.2%	85.9%	104.6%	110.8%	409	4.4	3.4	7.7
Ward 1	84.7%	92.5%	103.3%	96.8%	700	2.6	2.8	5.4
Ward 11	74.0%	110.0%	103.4%	105.1%	840	2.4	3.0	5.3
Ward 12	87.5%	112.7%	104.8%	102.8%	683	3.3	3.1	6.4

	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 14	100.5%	110.2%	106.6%	101.8%	813	3.1	3.6	6.7
Ward 21	98.7%	87.6%	101.8%	100.6%	434	4.2	2.8	7.1
Ward 22	74.1%	144.1%	100.0%	128.9%	864	2.3	3.6	5.9
Ward 23	82.2%	139.7%	96.2%	212.4%	700	2.5	5.6	8.1
Ward 24	85.3%	108.8%	108.5%	132.6%	860	2.6	3.1	5.7
Ward 25	69.3%	127.1%	93.3%	154.2%	894	2.1	3.4	5.4
Ward 26	75.1%	90.7%	101.7%	95.6%	683	2.9	3.4	6.3
Ward 27	74.9%	104.6%	102.1%	101.8%	795	2.5	3.1	5.6
Ward 4	74.2%	142.1%	106.2%	120.7%	941	2.5	3.5	6.1
Ward 6	178.1%	176.1%	102.2%	58.8%	520	4.0	5.3	9.3
Ward 8	98.9%	97.9%	69.8%	206.1%	621	4.6	2.5	7.1
Ward 9	78.3%	119.2%	101.1%	108.8%	1059	2.8	3.0	5.9

3. Exceptions:

The Board will be advised of those wards where staffing capacity and capability frequently falls short of what is planned, the reasons why, any impact on quality and the actions taken to address gaps in staffing. In terms of exception reporting, we will report to the Board if the safe planned staffing drops below 75% or above 125%.

The exceptions to report are as below:

April 2019			May 2019	
Qualified Nurse Days	**%**		**Qualified Nurse Days**	**%**
Cragside Court	69.4%		Cragside Court	70.1%
Maternity	72.8%		Maternity	74.8%
Ward 23	74.3%		SCBU	70.9%
Ward 25	64.9%		Ward 11	74.0%
L1 PSSC	73.50%		Ward 22	74.1%
Ward 9	73.3%		Ward 25	69.3%
			L2 PSSC	74.9%
			Ward 4	74.2%
			Ward 6	178.1%
Nursing Assistant Days	**%**		**Nursing Assistant Days**	**%**
Cragside	132.5%		EAU	172.5%
EAU	158.1%		Ward 22	144.1%
Ward 22	138.3%		Ward 23	139.7%
Ward 23	175.8%		Ward 25	127.1%
Ward 25	137.6%		Ward 4	142.1%
Ward 4	146.1%		Ward 6	176.1%
Ward 6	126.8%			
Ward 9	131.2%			
Qualified Nurse Nights	**%**		**Qualified Nurse Nights**	**%**
Ward 8	70.4%		Paediatrics	170.6%
			Ward 8	69.8%
Nursing Assistant Nights	**%**		**Nursing Assistant Nights**	**%**
Ward 11	151.8%		Cragside Court	140.0%
Ward 22	136.5%		EAU	136.0%
Ward 23	253.7%		Ward 22	128.9%
Ward 24	156.7%		Ward 23	212.4%
Ward 25	143.2%		Ward 24	132.6%
Ward 8	209.5%		Ward 25	154.2%
			Ward 6	58.8%
			Ward 8	206.1%

Qualified Nurses

The following areas had low fill rate on day shift in April and May due to vacancies, sickness/absence and maternity leave; Cragside court, Maternity, SCBU, Wards 4, 6, 23, 11, 25, L2 PSSC and Ward 9.
Ward 8's fill rates for April and May remains low on night shift due to rostering practices on the unit, with the third qualified nurse often backfilled by Nursing Assistants.
Paediatrics qualified fill rate for night shift is high due to the newly recruited advanced practitioners who work on the medical rota but are still part of the nursing establishment. Work is being undertaken to ensure that these shifts will be linked to the appropriate rota for the next report.
All areas which have shown shortfalls are monitored on a shift by shift basis by the Ward Manager and Matron responsible the ward to ensure safe staffing numbers are maintained.

Nursing Assistants

Fill rates for Nursing Assistant days in April and May remain high for EAU, Cragside Court, Wards 4, 9, 6, 23, 24 and 25 due to back filling for qualified vacancies, maternity leave and long term sickness absence. Wards 8,11, 22, 23, 24 and 25 have also needed to roster additional Nursing Assistants on night shifts to maintain patient safety and provide enhanced care.

4. Care Hours Per Patient Day (CHPPD)

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

- Patient acuity and dependency
- Patients required enhanced care and support
- Bed occupancy (activity)

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

5. Monitoring Nurse Staffing via Datix

The Trust has in place a process for reporting and monitoring any concerns regarding nurse staffing levels. This is via the Datix incident reporting system. A report is generated on a monthly basis and 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. It is also helpful in identifying trends and organisational learning. There have been no reportable nurse staffing resource Datix's submitted in April or May 2019

6. Governance

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

7. Conclusion

This paper provides an exception report for nursing and midwifery staffing in April and May 2019.

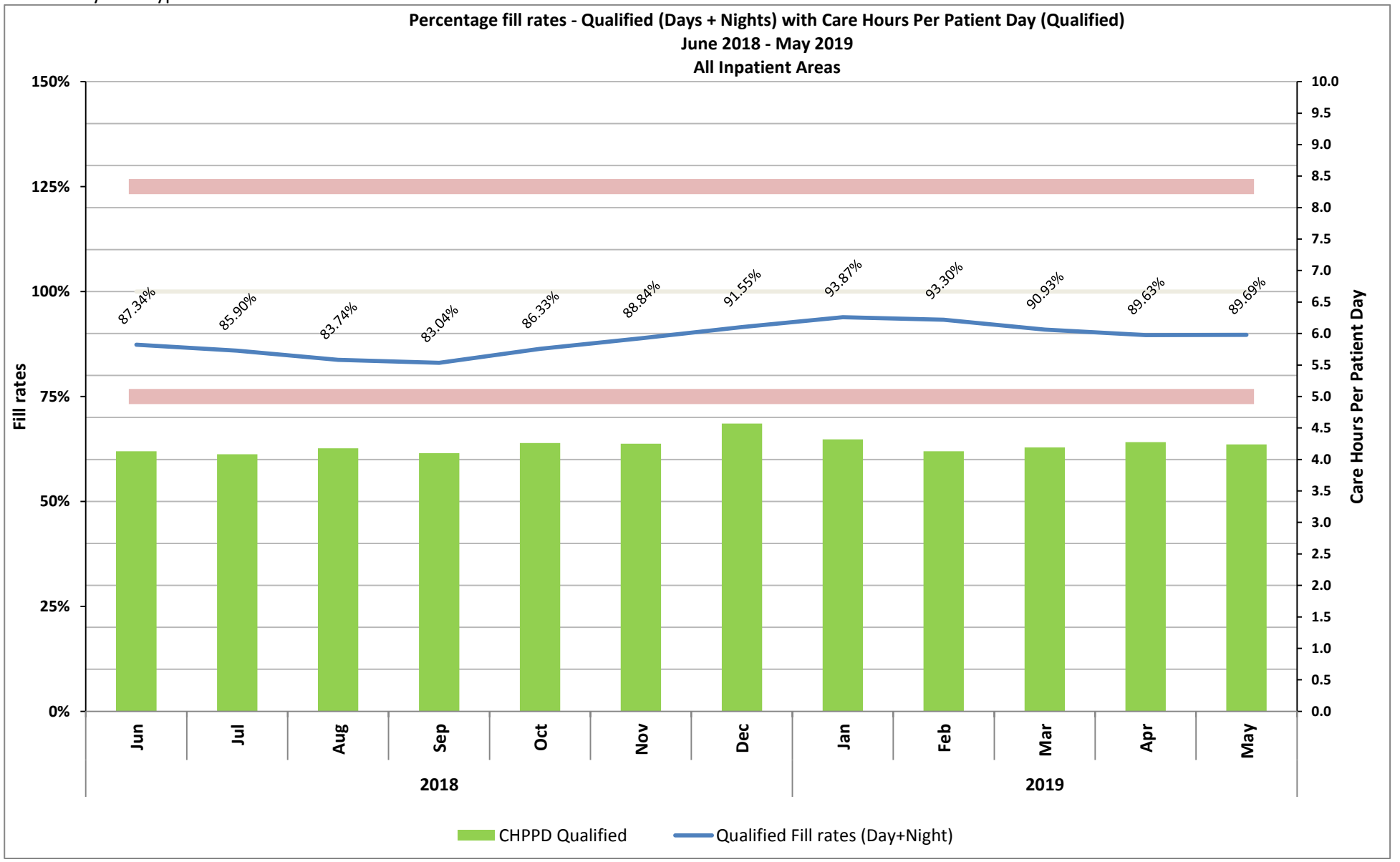
8. Recommendations

The Board is asked to receive this report for assurance.

Avril Lowery, Deputy Director of Nursing, Midwifery and Quality
Gareth Armstrong, Chief Matron, Surgery

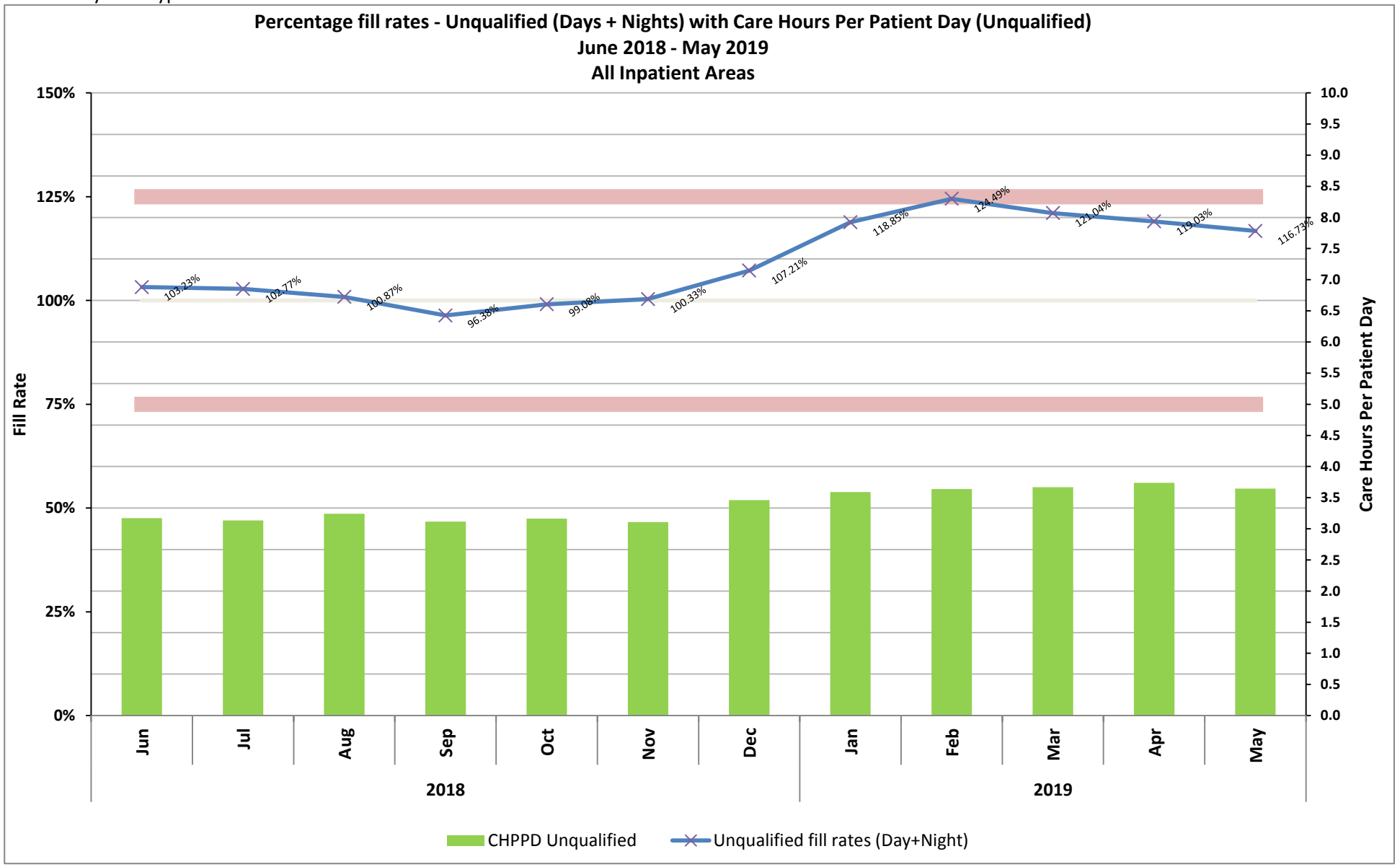
Appendix 1

Fill rates by shift type



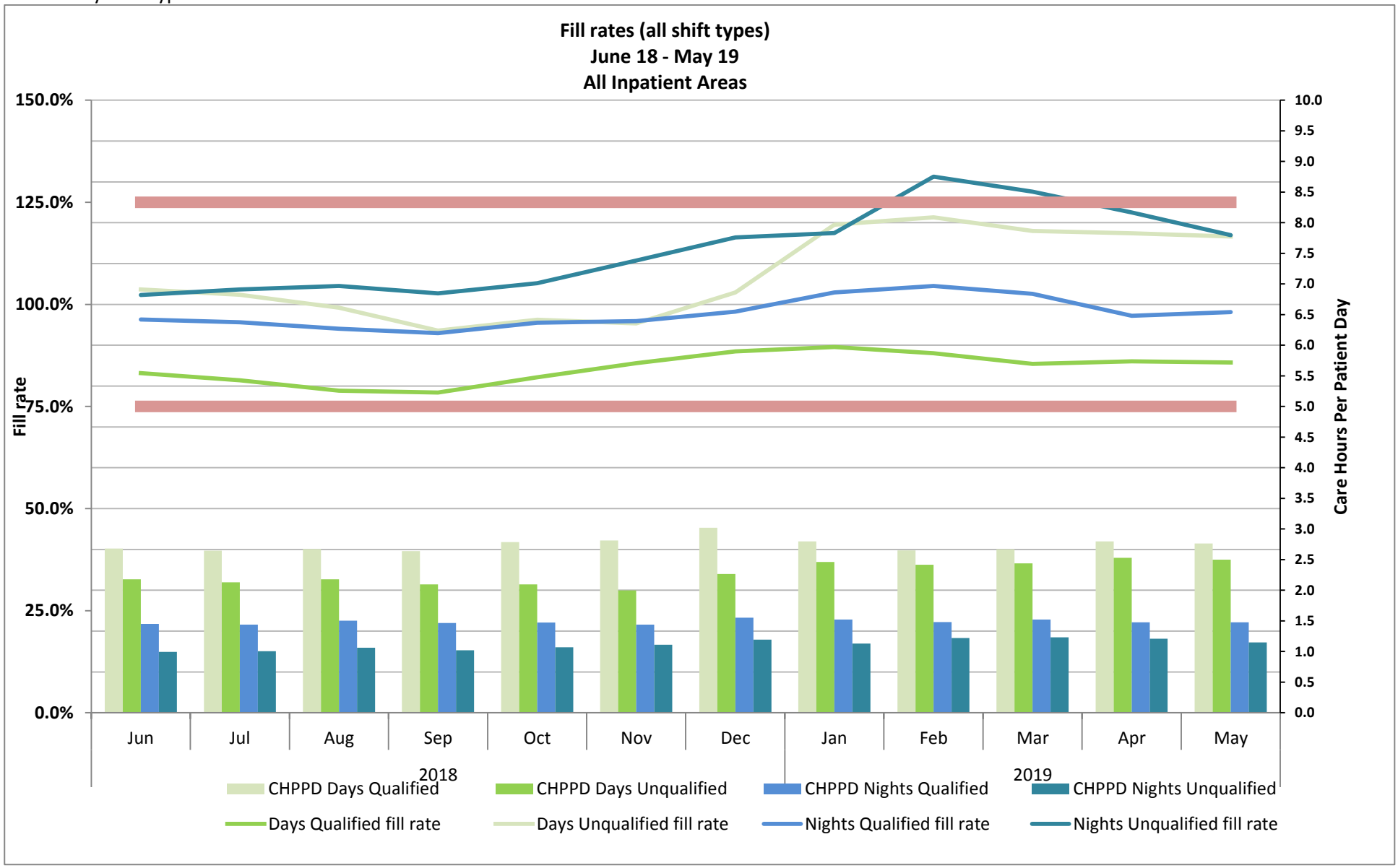
Appendix 1

Fill rates by shift type



Appendix 1

Fill rates by shift type



Appendix 1

Fill rates by shift type

Fill rates (all shift types)
June 18 – May 19
All inpatient areas

	Days Qualified fill rate	Days Unqualified fill rate	Nights Qualified fill rate	Nights Unqualified fill rate	CHPPD Days Qualified	CHPPD Days Unqualified	CHPPD Nights Qualified	CHPPD Nights Unqualified
Jun 2018	83.2%	103.7%	96.30%	102.3%	2.68	2.18	1.45	0.99
Jul 2018	81.4%	102.4%	95.60%	103.6%	2.65	2.13	1.44	1.00
Aug 2018	78.9%	99.2%	94.06%	104.5%	2.67	2.18	1.50	1.06
Sep 2018	78.4%	93.6%	92.94%	102.7%	2.64	2.10	1.46	1.02
Oct 2018	82.1%	96.2%	95.54%	105.2%	2.79	2.10	1.47	1.07
Nov 2018	85.6%	95.3%	95.90%	110.7%	2.81	2.00	1.44	1.11
Dec 2018	88.5%	102.9%	98.20%	116.4%	3.02	2.19	1.55	1.16
Jan 2019	89.6%	119.5%	102.90%	117.5%	2.80	2.46	1.52	1.13
Feb 2019	88.0%	121.3%	104.50%	131.3%	2.65	2.42	1.48	1.22
Mar 2019	85.4%	118.0%	102.57%	127.6%	2.67	2.44	1.52	1.23
Apr 2019	86.1%	117.4%	97.23%	122.5%	2.80	2.53	1.48	1.21
May 2019	85.8%	116.6%	98.12%	117.0%	2.76	2.50	1.48	1.15

Trust Board

Gateshead Health NHS Foundation Trust

Report Cover Sheet

Agenda Item: 13

Date of Meeting:	Wednesday 26th June 2019			
Report Title:	Integrated Quality and Learning Report			
Purpose of Report:	To provide assurance to the Board on the Trusts quality and safety performance in the last 18 months to May 2019.			
	Decision: ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☒
Trust Goals that the report relates to: (Including reference to any specific risk)	**Goal 3** In all locations and settings of delivery, our patients will experience excellent, timely and seamless care that meets their individual needs. **Goal 4** All our services will have a high safety culture in which openness, fairness, accountability and learning from high levels of incident reporting and mortality reviews is the norm.			
Recommendations: (Action required by Board of Directors)	To receive for information on the Trusts key quality and safety indicators			
Financial Implications:	Financial sanctions may be applied by NHS England and commissioners in relation to Health Care Associated Infection (HCAI)			
Risk Management Implications:	The indicators contained relate to the quality of patient care. Risks are associated with any areas of poor performance of these indicators.			
Human Resource Implications:	None			
Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)	**Objective 1** All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers.			
Author:	Andrew Ward – Senior Information Analyst			
Presented by:	Kate Jones – Head of Risk and Patient Safety Carolyn Harper - Assistant Director of Clinical Quality			

Integrated Quality and Learning Report
May 2019

Gateshead Health
NHS Foundation Trust

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

Integrated Quality and Learning Report

Introduction and about SPC

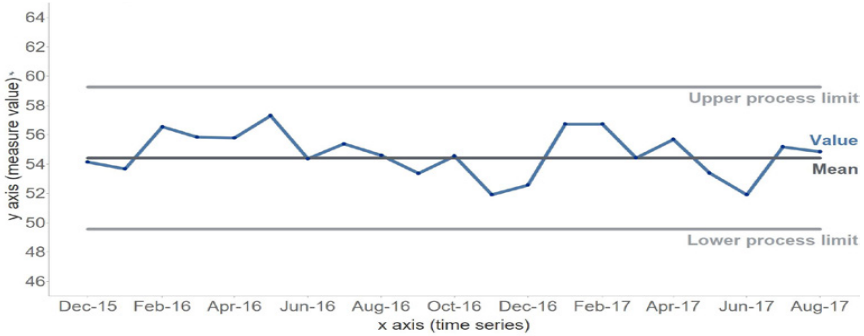
Gateshead Health NHS Foundation Trust

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

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

Statistical process control (SPC) chart

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



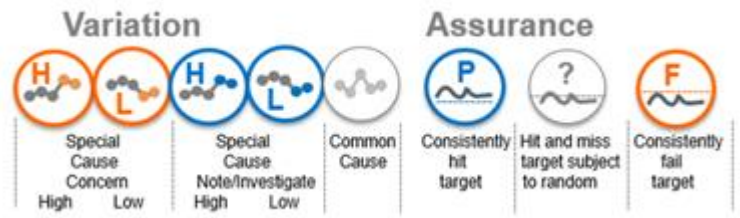
The reference lines are:

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

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

Key

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



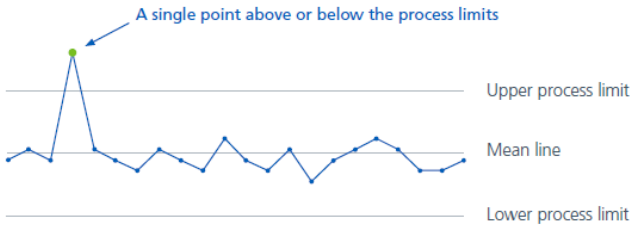
Integrated Quality and Learning Report

more about SPC

Gateshead Health NHS Foundation Trust

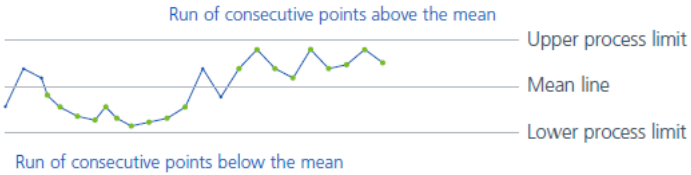
A single point outside the control limits

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



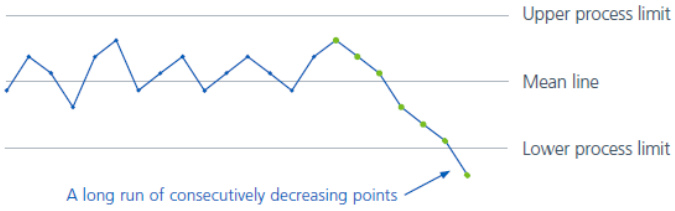
Consecutive points above or below the mean line

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



Six consecutive points increasing or decreasing

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



Integrated Quality and Learning Report

Included this month

Gateshead Health NHS Foundation Trust

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

Safe	**5-17**	• Medication Errors • Health-Care Associated Infections • Falls • Pressure damage	• Safety Thermometer • Never Events • Serious Incidents (SIs) • Patient Safety Incidents • Emergency C-Section Rate • VTE Risk Assessment
Effective	**18-22**	• HSMR • SHMI • Crude Mortality • Learning From Deaths	
Caring	**23-24**	• Friends and Family Test • Mixed-Sex Accommodation Breaches	
Responsive	**25**	• Compliments • Informal Complaints • Formal Complaints	
Well-led	**26-28**	• 15 Steps Challenge • CQUIN 2018-2019 • CQUIN 2019-2020 • NHS Smokefree Survey	
	29-30	• Single Oversight Framework	

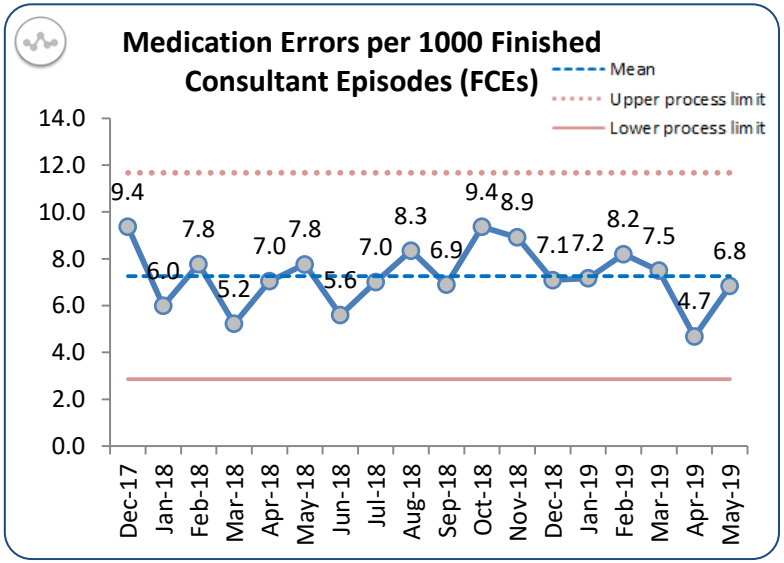
Integrated Quality and Learning Report

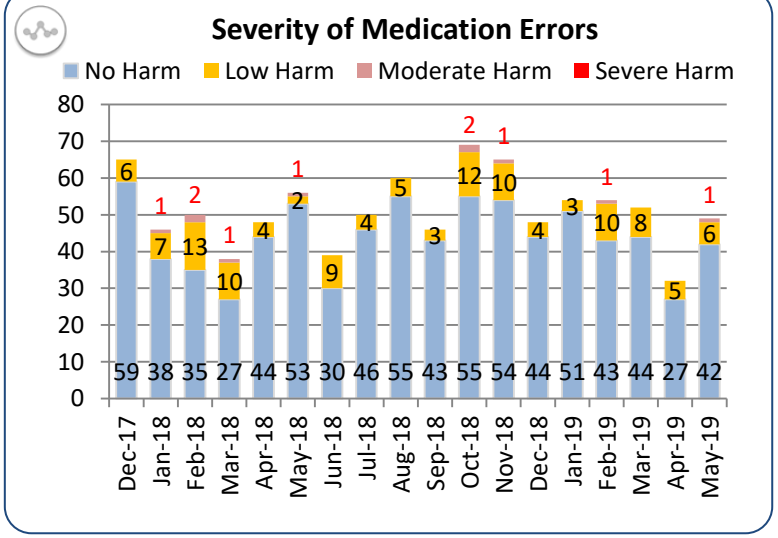
Medication Reporting

Safe

Gateshead Health NHS Foundation Trust

Datix Software for Patient Safety





Medication Errors

- A total of 49 medication errors were reported in May 2019.
- There was 1 moderate harm error.
- Common cause variation is observed in the medication error rate over the last 18 months.

Integrated Quality and Learning Report

Safe

Healthcare Associated Infections

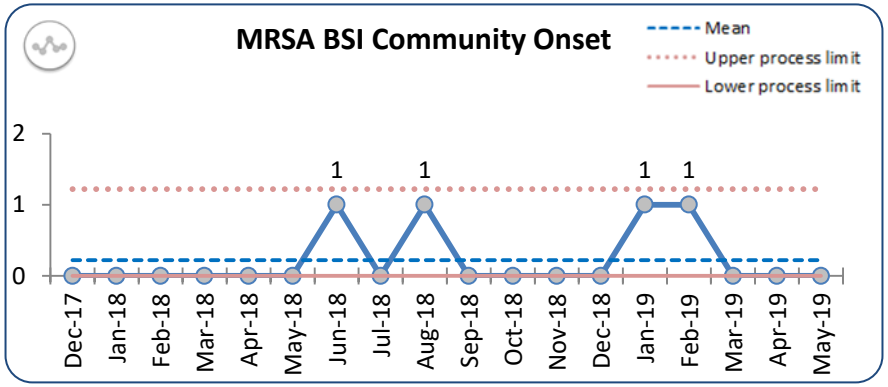
Gateshead Health NHS Foundation Trust

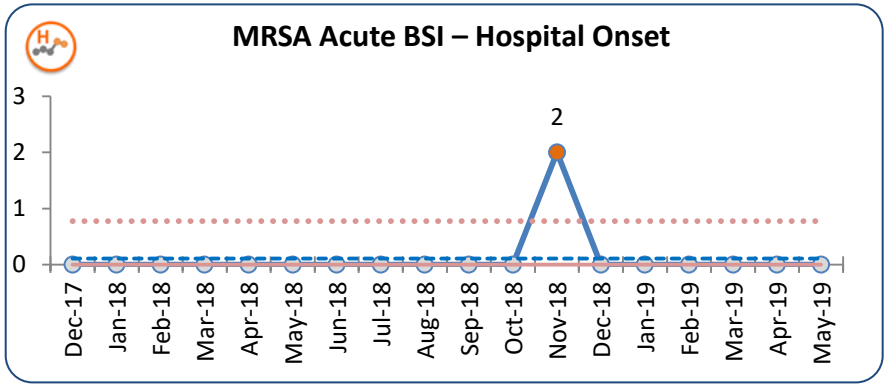
The national ambition to reduce healthcare associated Gram Negative Blood Stream Infections (GNBSI) by 50% by March 2021 has been revised due to the continued rise in incidence. The ambition has been reviewed within the AMR action plan to continue to halve healthcare associated GNBSI, delivering a 25% reduction by 2021-2022 with the full 50% by 2023-2024.

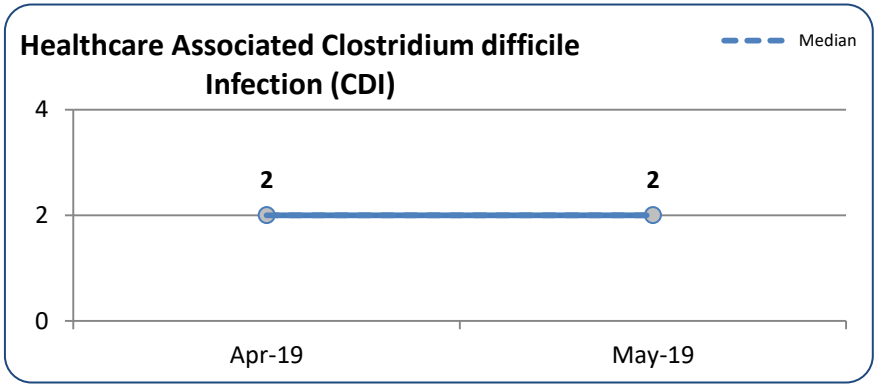
The hospital objective for *Clostridium difficile* infection is now set against two categories of infection.

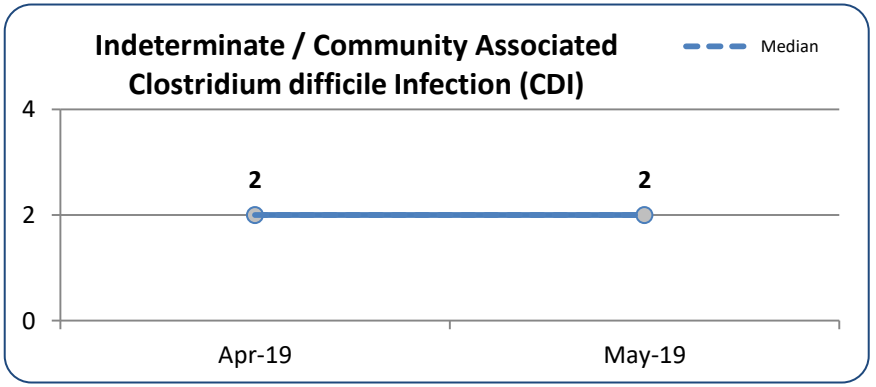
Hospital-onset healthcare associated – cases that are detected following day two of admission, when the day of admission is day one.
Community-onset healthcare associated – cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust in the previous four weeks

The Trust objective for 2019/20 has been identified at 40 cases and a rate of 23.6. The data presented in this report reflects the new data collection settings







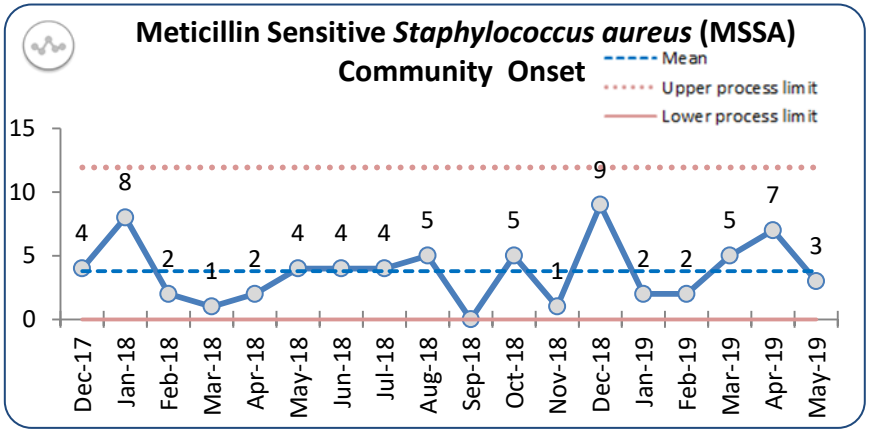


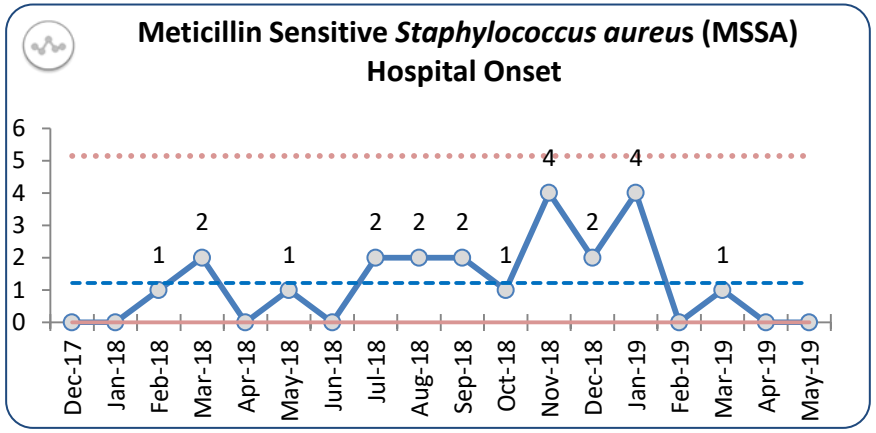
Integrated Quality and Learning Report

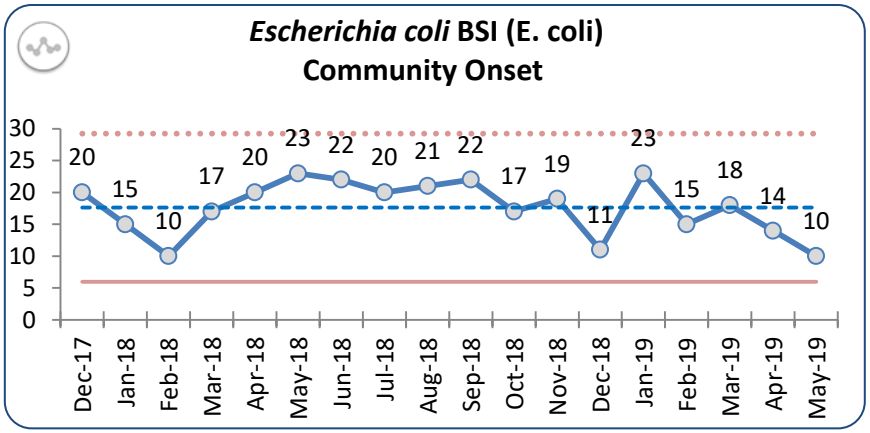
Healthcare Associated Infections

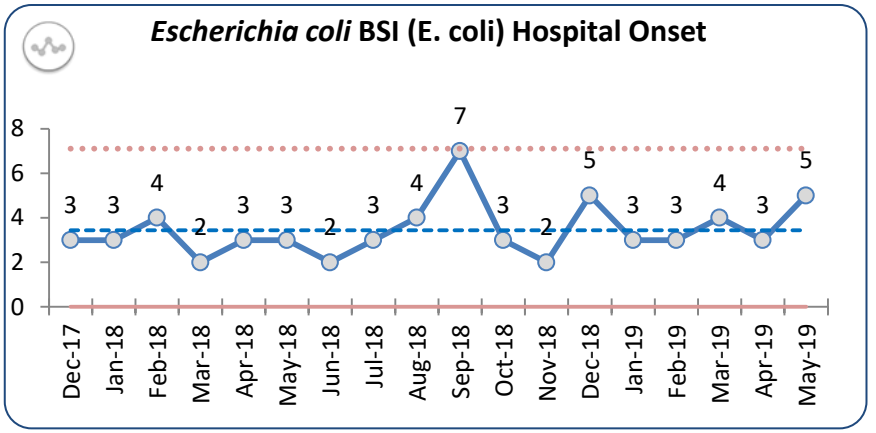
Gateshead Health NHS Foundation Trust

Safe







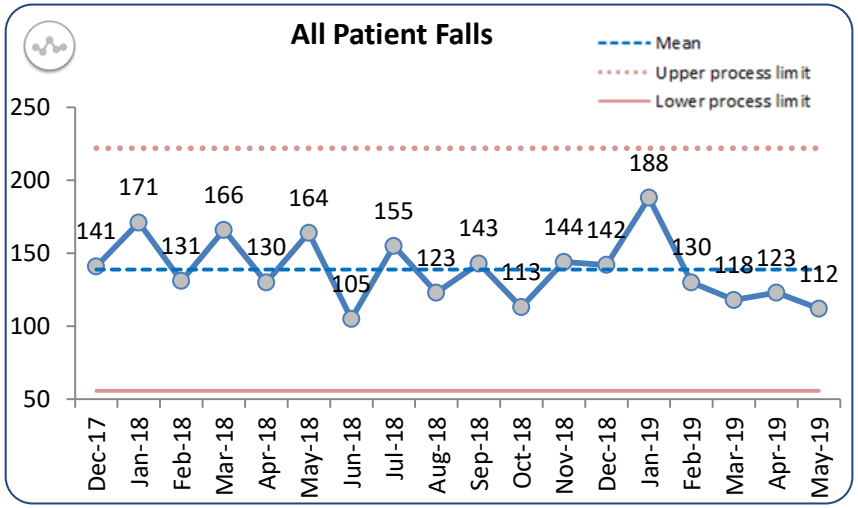


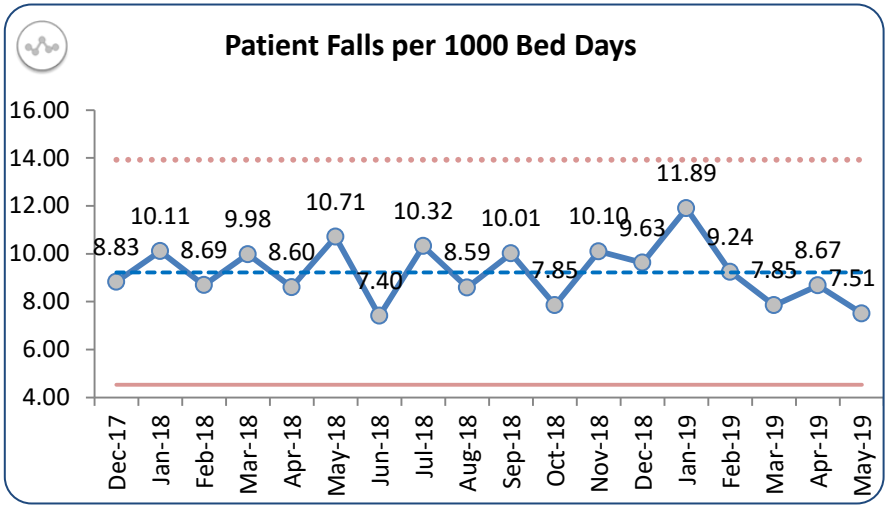
The Trust continues to promote infection prevention as a key element of its quality improvement approach and is committed to ensuring that appropriate resources are allocated for patient and staff safety.

Integrated Quality and Learning Report

Falls

Safe





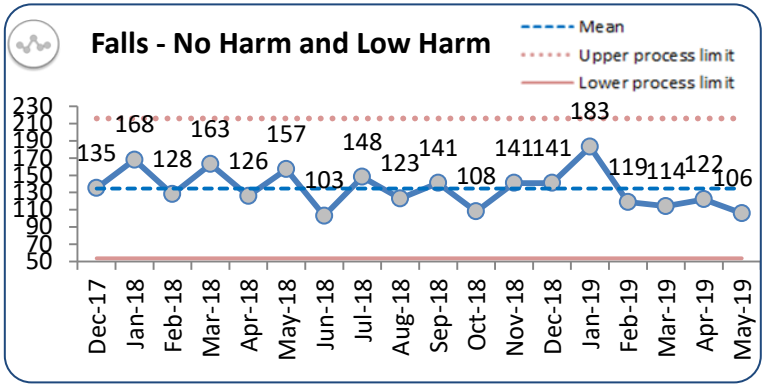
Patient Falls

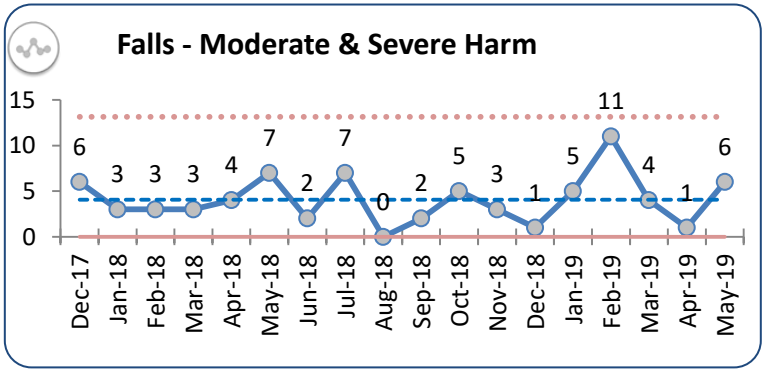
- May 2019 - 112 falls reported .
- 87 No Harm; 19 Low harm, 4 Moderate; 2 Severe.
- Common cause variation is observed in the number of falls and rate of falls per 1,000 bed days.

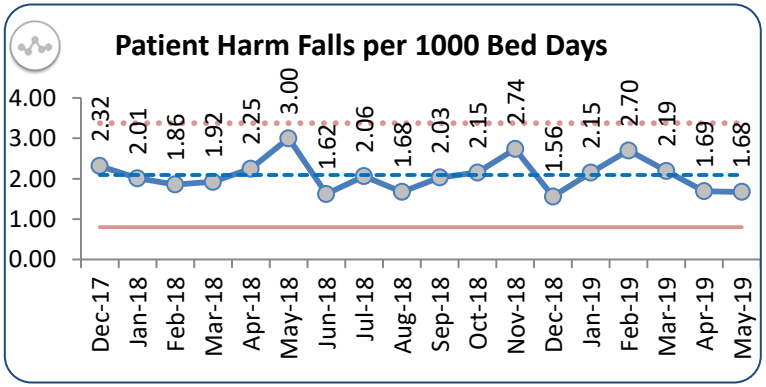
Integrated Quality and Learning Report

Falls

Safe







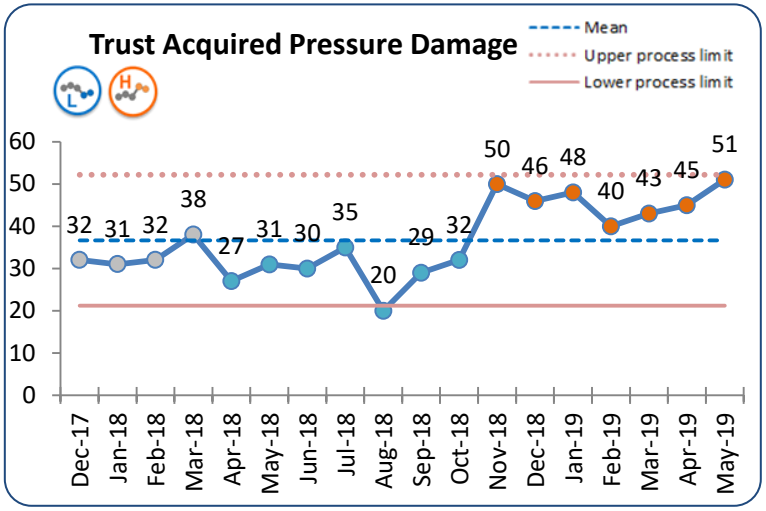
Patient Falls

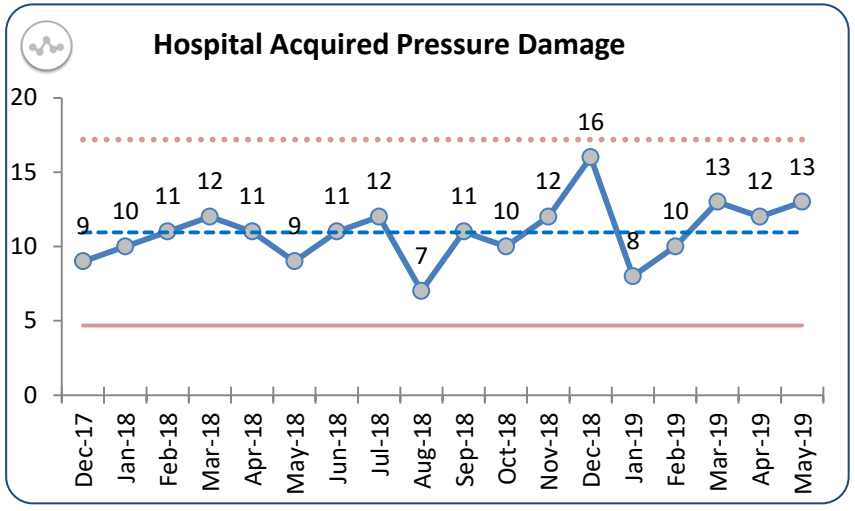
This has been identified as an area for improvement as outlined in our QI Strategy. A Falls collaborative has been developed and has identified 5 wards within the Trust to commence improvement with the introduction of several interventions e.g. engagement with patients and families, enhanced care monitoring and working with activities co-ordinator. Early data suggests improvements of reduction of falls in some areas. Feedback on this work will be reported to the August meeting in the form of a presentation and paper.

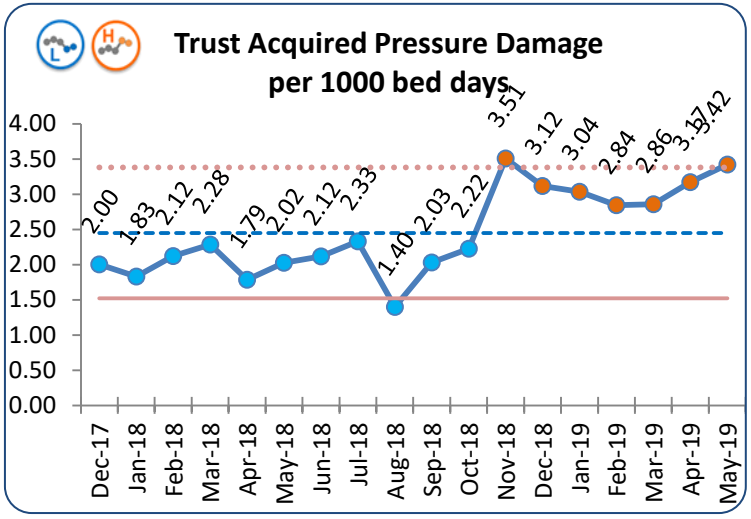
Integrated Quality and Learning Report

Trust & Hospital Acquired Pressure Damage

Safe







Trust Acquired Pressure Damage
(Category 2 and above including deterioration, unstageable and deep tissue injuries)
Please note that these figures include pressure damage acquired in both acute and community settings whilst under the care of the Trust.

- 51 incidents of Trust acquired pressure damage were reported in May 2019.
  - 13 incidents observed in an acute setting (11 x category 2 pressure damage, 1 x unstageable, 1 x Deep Tissue Injury during trust care (Low Harm)
  - 38 incidents observed in a community setting during Trust care (24 x category 2, 1 x deterioration to category 2, 1 x category 3, 1 x deterioration to category 3, 9 x unstageable damage during trust care, 2 x deep tissue injury)
- Special cause variation (high) is identified in Trust acquired pressure damage with 7 points above the mean from November 2018.
- Special cause variation (Low) is observed prior to November 2018.

Pressure Damage has been identified as an area for improvement as outlined in our QI Strategy. A pressure damage collaborative has been developed to look at system wide improvements. Feedback on this work will be reported to the September meeting in the form of a presentation and paper.

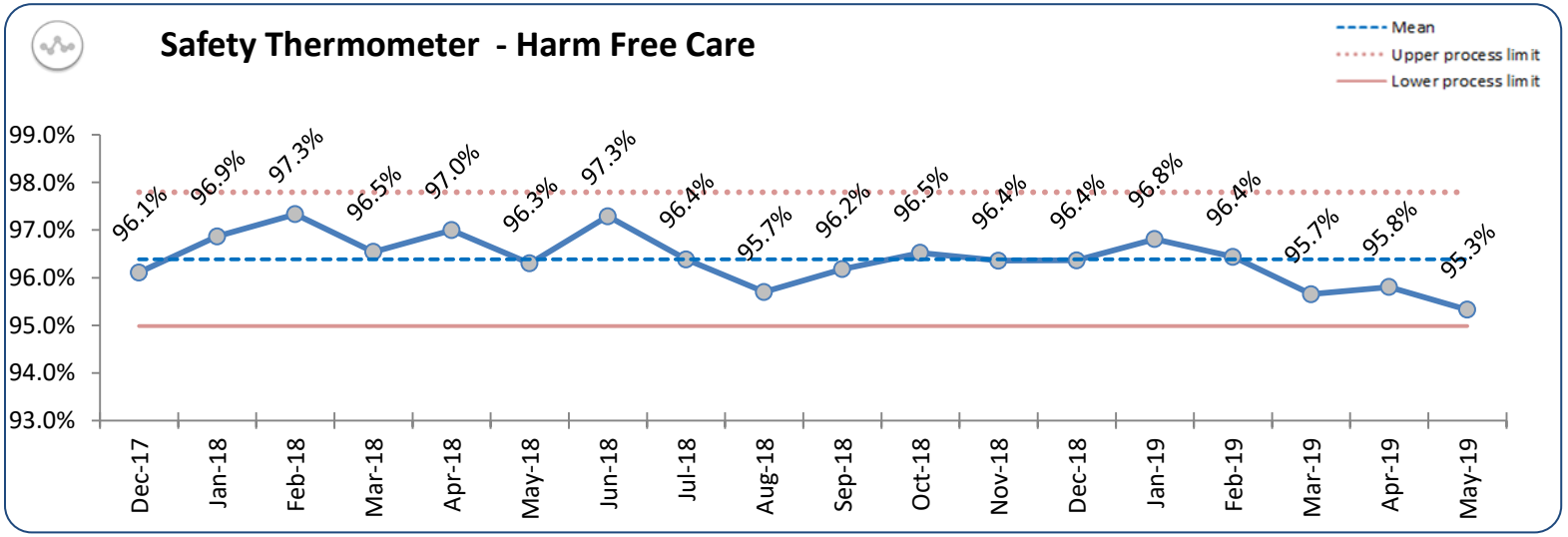
Integrated Quality and Learning Report

Safety Thermometer – Harm Free Care

Safe

The Safety Thermometer is a measurement tool for improvement that focuses on the four most commonly occurring harms in healthcare: pressure ulcers, falls, UTI (in patients with a catheter) and VTEs.

Data is collected through a point of care survey on a single day each month on 100% of patients across all NHS Trusts. This enables wards, teams and organisations to: understand the burden of particular harms at their organisation, measure improvement over time and connect frontline teams to the issues of harm, enabling immediate improvements to patient care.



Safety Thermometer – Harm Free Care

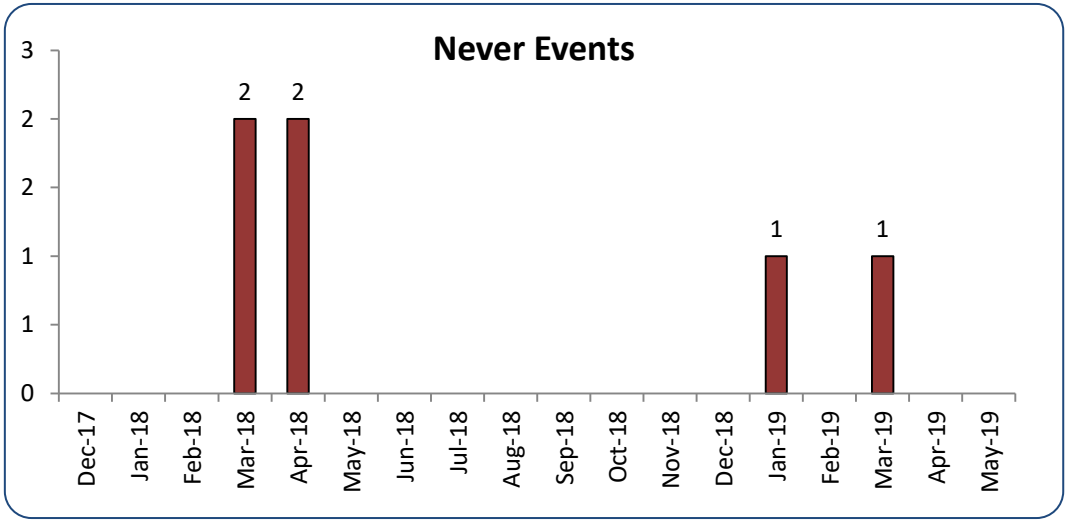
- The Trust continues to demonstrate harm free care in excess of 95%.
- Common cause variation in harm free care observed.
- 12 new harms were identified during the May survey of 685 patients.
    - 3 Pressure damage.
    - 6 Falls with harm. (Definition in the Safety Thermometer is all harm, low and above)
    - 3 Catheter and UTI.
    - 0 VTEs.

Integrated Quality and Learning Report

Never Events

Safe

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



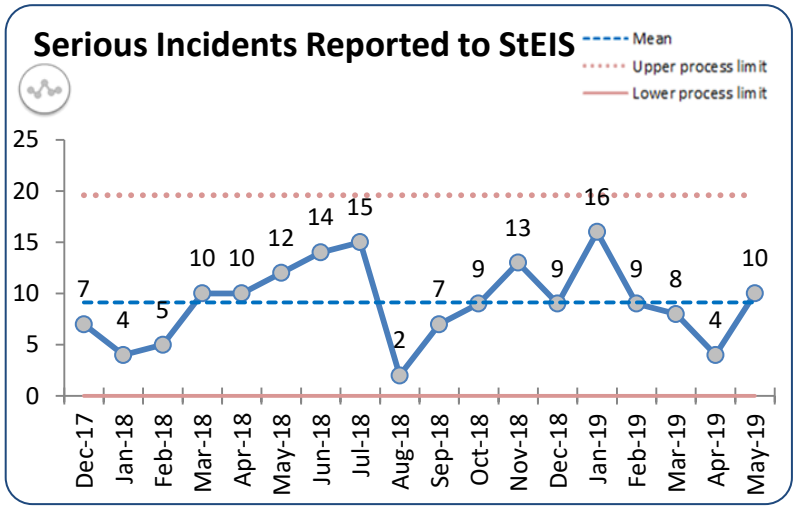
Never Events

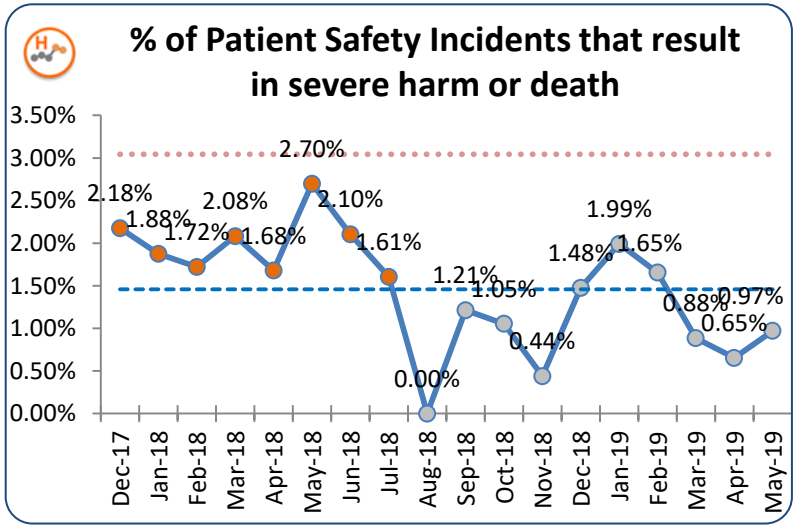
- March 2019 - Wrong Patient for treatment/procedure (Low Harm)
- January 2019 - Incorrect Site for Surgery (Low Harm)
- March 2018 - Two historical events reported 1)wrong implant/prosthesis. (relating to 2011 and 2016).
- April 2018, Two historical events reported 1)wrong implant/prosthesis - August 2015 and March 2017.

Integrated Quality and Learning Report

Serious Incidents

Safe





A review of the Serious Incident process was undertaken in March 2018 outcomes from this review introduced a new panel structure to ensure appropriate consideration to all information received.

Serious Incidents Reported to StEIS

10 incidents were reported in May 2019:

- 3 x Diagnosis – delay / failure
- 2x treatment / procedure – delay /failure
- 2 x fall on same level – cause unknown
- 1 x Complications during surgery or procedure
- 1 x shoulder dystocia
- 1 x Apgar score <5 at 5 minutes

Special cause variation concern is identified Dec-17 to Jun-18 in the % of patient safety incidents that result in severe harm or death. (High) this relates to 100 incidents mainly comprising community acquired category 4 pressure damage (67) and falls (17).

Integrated Quality and Learning Report

Learning From Serious Incidents

Gateshead Health NHS Foundation Trust

Safe

Learning from Serious Incidents

Recent Inquest – Regulation 28 Report

Recent Inquest – Regulation 28 Report

The Coroner's Regulation 28 Report (also known as a 'Prevention of Future Deaths Report') sets out the concerns and requests that action should be taken. A recent report was received from the Coroner following an Inquest into the death of a neonate after a shoulder dystocia.

The Coroner stated that this was an avoidable neonatal death following a shoulder dystocia, and outlined several areas for learning for the Trust e.g. policy review.

The learning and practice changes introduced are summarised as follows:

- Community midwives' glucose tolerance test pathology system - ALERT now appears on screen asking "Is the patient pregnant?", this requires answer from team to enable correct test interpretation.
- Trust guideline for the management of women who measure large for gestational age implemented.
- Trust water birth guideline has been updated to support the midwives to perform an up to date clinical risk assessment prior to the mother entering the pool.

Integrated Quality and Learning Report

Learning From Serious Incidents

Gateshead Health NHS Foundation Trust

Safe

Learning from Serious Incidents

April 2019 - Serious Incident Review Panel
This incident was investigated using the Human Factors model: the focus of this type of investigation is to understand 'how?' and 'why?' an incident has occurred rather than the 'who?

Never Event – wrong site surgery:

Two male patients with the same first name attending Ambulatory Care Centre (ACC) : **Patient 1** required intravenous antibiotics via midline catheter. **Patient 2** also attended ACC to receive intravenous antibiotics.
No staff on duty during shift trained to site a midline catheter, the Acute Response Team (ART) were contacted to undertake the procedure. Contact made via Vocera. Subsequent attendance to ward to carry out intervention ART spoke to different member of staff. Both patient 1 & 2 had occupied same cubicle/bed.

Identified issues;
- Up to date communication between a) ward staff and b) external staff (ART)
- Referral process to the ART Team was not sufficiently robust at the time of the incident.
- Positive patient identification failure
- Adequate staff training in midline insertion, necessitating referral to ART.

Learning/implemented actions:
- LocSSIPs developed in one clinical area - there may be other areas undertaking the same procedure but are unaware of the LocSSIP.
- The LocSSIP is to be amended to include space for the batch number sticker and be incorporated into policy for insertion of midlines.
- The LocSSIP will be added to the VIGON midline packs on ACC and will be checked as part of the morning walk around.
- Trust wide awareness raising is required regarding current LocSSIPs.
- Review of staff training in area for midline insertion – increased number of staff will undertake this.
- Positive Patient Identification (PPI) Trust wide awareness raising is required regarding the importance of PPI.
- Update referral process to ART team.

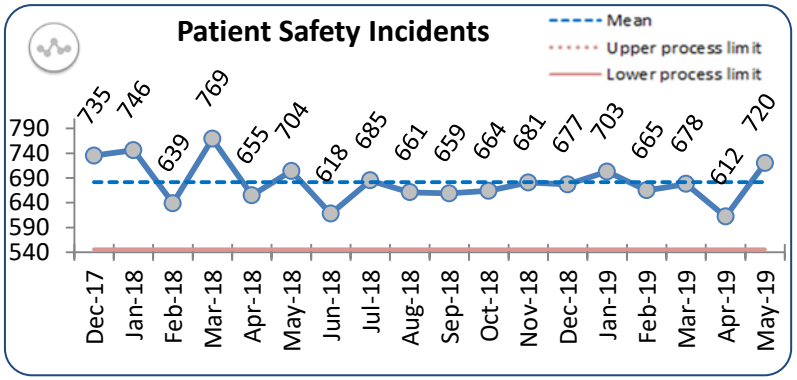
Integrated Quality and Learning Report

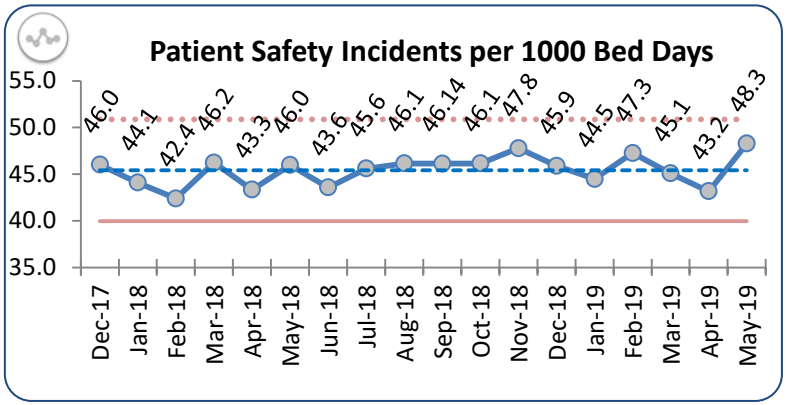
Patient Safety Incidents

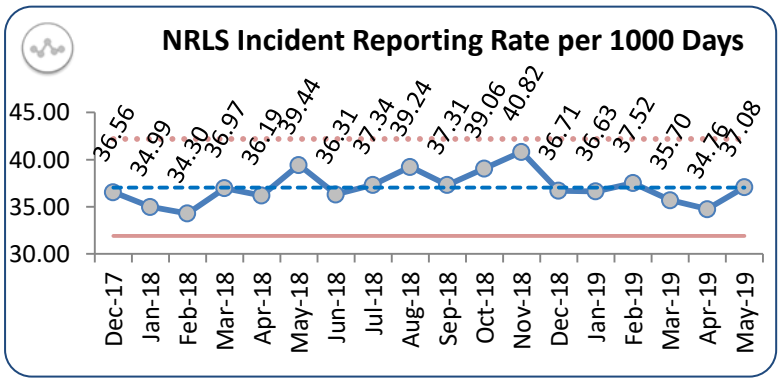
Gateshead Health NHS Foundation Trust

Datix Software for Patient Safety

Safe







Patient Safety Culture

The NRLS (National Reporting & Learning System) incident reported rate was 37.08 incidents per 1000 bed days in May 2019.

All staff should be assured that reporting incidents is a positive process. The purpose of reporting is to ensure processes and practices are being adhered to, embed a just culture and to ensure best possible outcomes for patients.

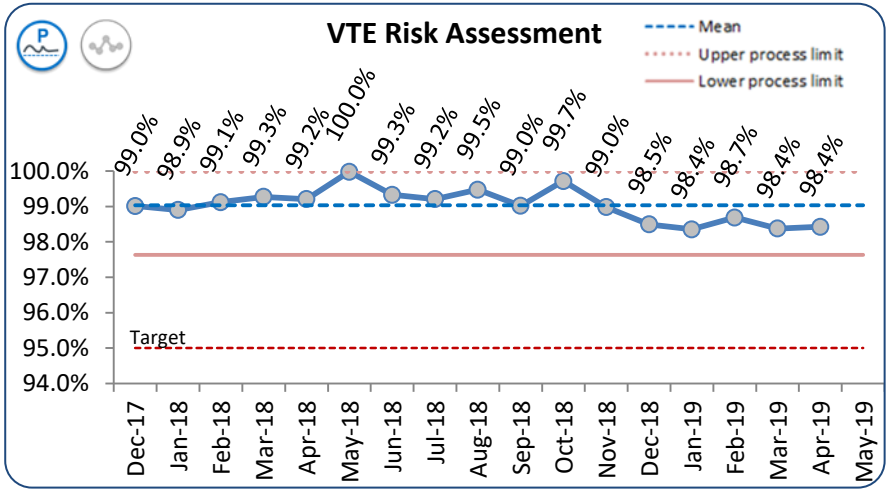
Patient Safety Incidents

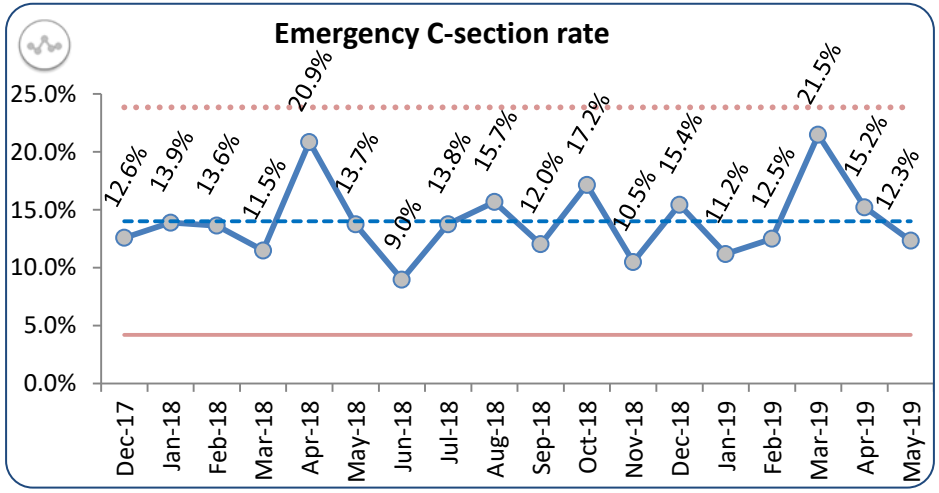
- 720 patient safety incidents were reported in May 2019
- The top 5 incident types are listed below:
    - Pressure damage (239)
    - Patient Falls (112)
    - Delay / failure to treat / monitor (44)
    - Medication (49)
    - Medical Devices / Equipment (40)
    - Maternity / foetal / neonatal (40)

Integrated Quality and Learning Report

Safe – Other Incidents

Safe





VTE Risk Assessment

The 95% target achieved.

- Common cause variation displayed.
- *May 2019 figure not yet available.

Emergency Caesarean-section rate

- May 2019 - 12.3% displays common cause variation.

Integrated Quality and Learning Report

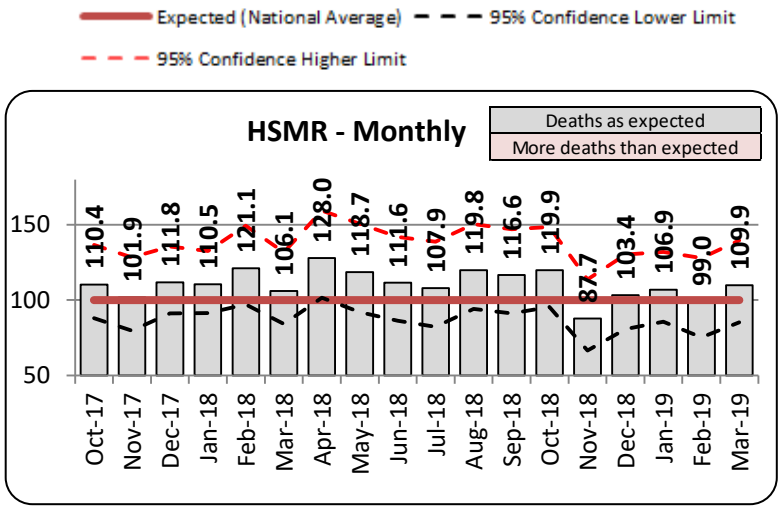
Gateshead Health NHS Foundation Trust

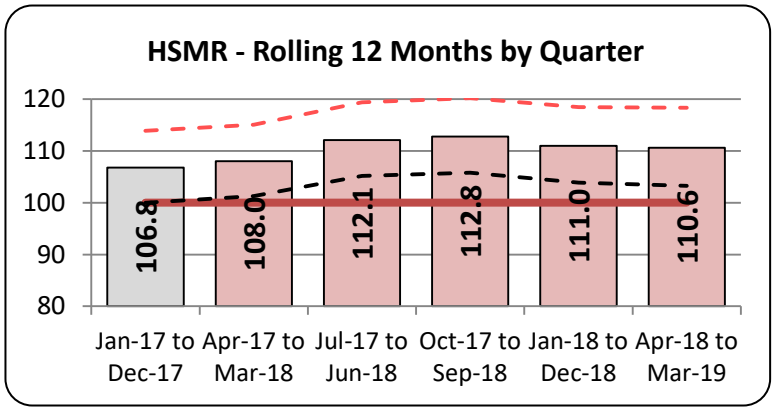
Effective

Mortality Indicators – HSMR

Hospital Standardised Mortality Ratio (HSMR)

This is an indicator of healthcare quality that measures whether the number of deaths in hospital is higher or lower than you would expect given the characteristics of the patients treated there. Like all statistical indicators it is not perfect, but can be both a measure of safe, high-quality care and a warning sign that things are going wrong. A score of 100 means that the number of deaths is similar to what you would expect. A higher score means more deaths; a lower score, fewer.





HSMR - HSMR data is available to March 2019.

- Individual monthly HSMR figures demonstrate deaths were within the expected range.
- The HSMR covering the 12 month period April 2018 to March 2019 (110.6) identifies that the Trust has more deaths than expected deaths when compared to trusts nationally, taking into account the trust case mix.
- The HSMR without adjusting for palliative care coding is 105.1

- The Trust contacted the North East Quality Observatory Service (NEQOS) to undertake some analysis of the Trusts high HSMR. The key findings were:

1. The high 'HSMR' at the Trust is largely explained by the low Palliative Care coding.
2. Mortality review and the Serious Incidents process has only identified a small number of cases involving harm in 2018
3. Analysis highlights the winter peak for Dec 2017 / Jan 2018 which was seen across the NE and England.
4. Looking at the deaths by diagnosis group doesn't reveal any problems with Pneumonia, Sepsis and COPD; it may be that there is some room for improvement in the coding for Primary diagnosis.
5. High mortality for lung cancer is common to most of the NE. Proximity to Newcastle probably reduces spells but not deaths in Gateshead.

No specific cause for the high HSMR, or concern about quality of care, has been identified

Integrated Quality and Learning Report

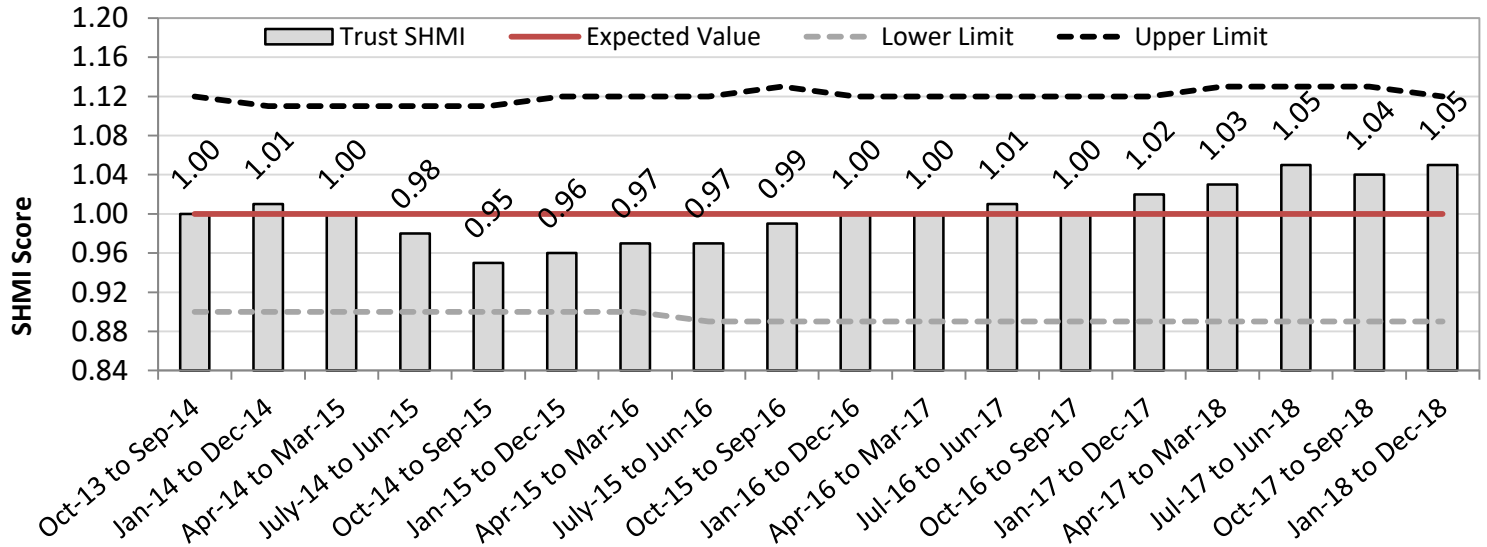
Effective

SHMI

The SHMI is the ratio between the actual number of patients who die following hospitalisation (either within hospital or within 30 days of discharge) and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. A score of 1 means that the number of deaths is similar to what you would expect. A higher score means more deaths; a lower score, fewer.

The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at trust level across the NHS in England using a standard and transparent methodology. It is produced and published quarterly as a National Statistic by NHS Digital. The most recent national data available covers the January 2018 to December 2018.

Gateshead Health NHS Foundation Trust - SHMI scores



- Currently the Trust is performing with the number of deaths as expected. Current Period January 2018 to December 2018.
- SHMI = 1.05
- Number of deaths observed 1,485
- Number of deaths expected by SHMI calculation 1,413

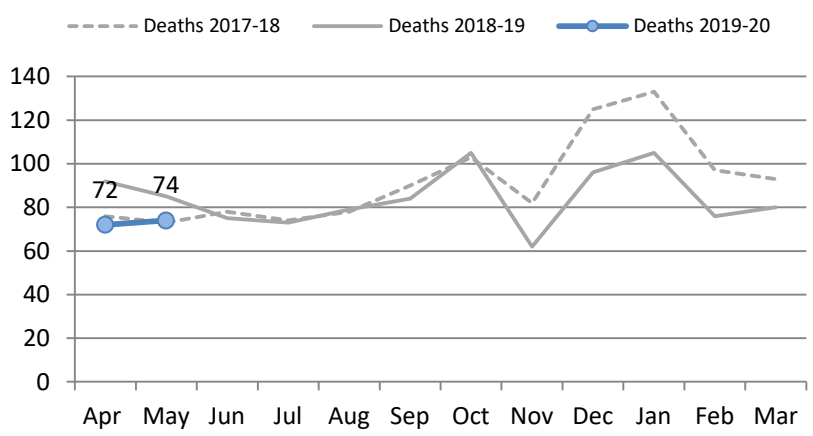
Integrated Quality and Learning Report

Crude Mortality

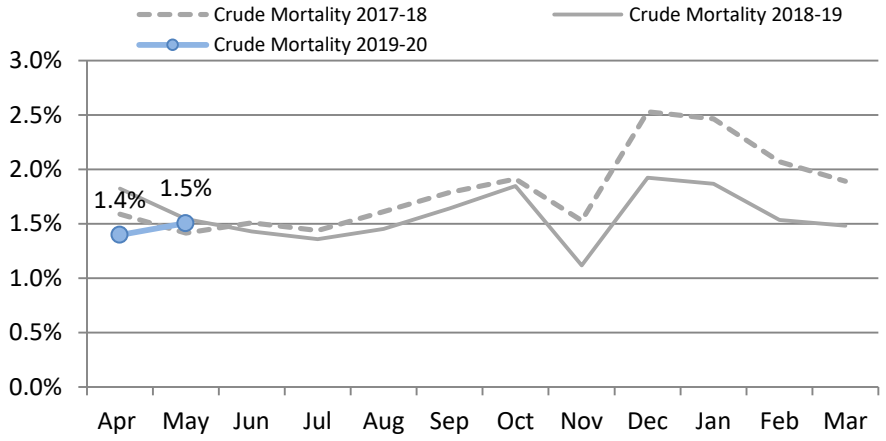
Gateshead Health NHS Foundation Trust

Effective

Inpatient Deaths



Inpatient Crude Mortality



Mortality

- 74 inpatient deaths were observed in May 2019 compared to 73 in May 2018
- The crude mortality for May 2019 is 1.5%.

Integrated Quality and Learning Report

Learning From Deaths

Gateshead Health NHS Foundation Trust

Effective

Trust Mortality Review Compliance

During the period 1st May 2018 to the 30th April 2019 , 824 (79.3%) deaths have been reviewed with 1 death being identified as potentially avoidable (Hogan preventability score of score 4)

Deaths in scope	Deaths reviewed	GP Notification
1039	824	840

Hogan 1 - Definitely Not Preventable	Hogan 2 - Slight Evidence of Preventability	Hogan 3 - Possibly Preventable (Less than 50:50)	Hogan 4 - Possibly preventable (more than 50:50)	Hogan 5 - Strong Evidence Preventable	Hogan 6 - Definitely Preventable
812	9	2	1	0	0

Potentially avoidable deaths
1

NCEPOD Score 1 Good Practice	NCEPOD Score 2 Room for improvement - Clinical Care	NCEPOD Score 3 Room for Improvement - Organisational Care	NCEPOD Score 4 Room for Improvement Clinical and Organisational Care	NCEPOD Score 5 Less Than Satisfactory	NCEPOD score 6 Insufficient data	No Score Allocated
666	32	105	14	2	4	2

Integrated Quality and Learning Report

Learning From Deaths

Gateshead Health NHS Foundation Trust

Effective

Learning from deaths – Themes October 2018 to March 2019

Mortality reviews for deaths between October 2018 to March 2019 have been recently analysed.

Good Care , Good Practice, and Good communication with families featured strongly however missing or incorrect GP notification of death, and poor documentation feature strongly as learning themes.

Medway training sessions have been arranged in June and have been advertised in the QE Weekly and are will be shared through the medical directors bulletin.

Integrated Quality and Learning Report

Caring

The NHS Friends and Family Test

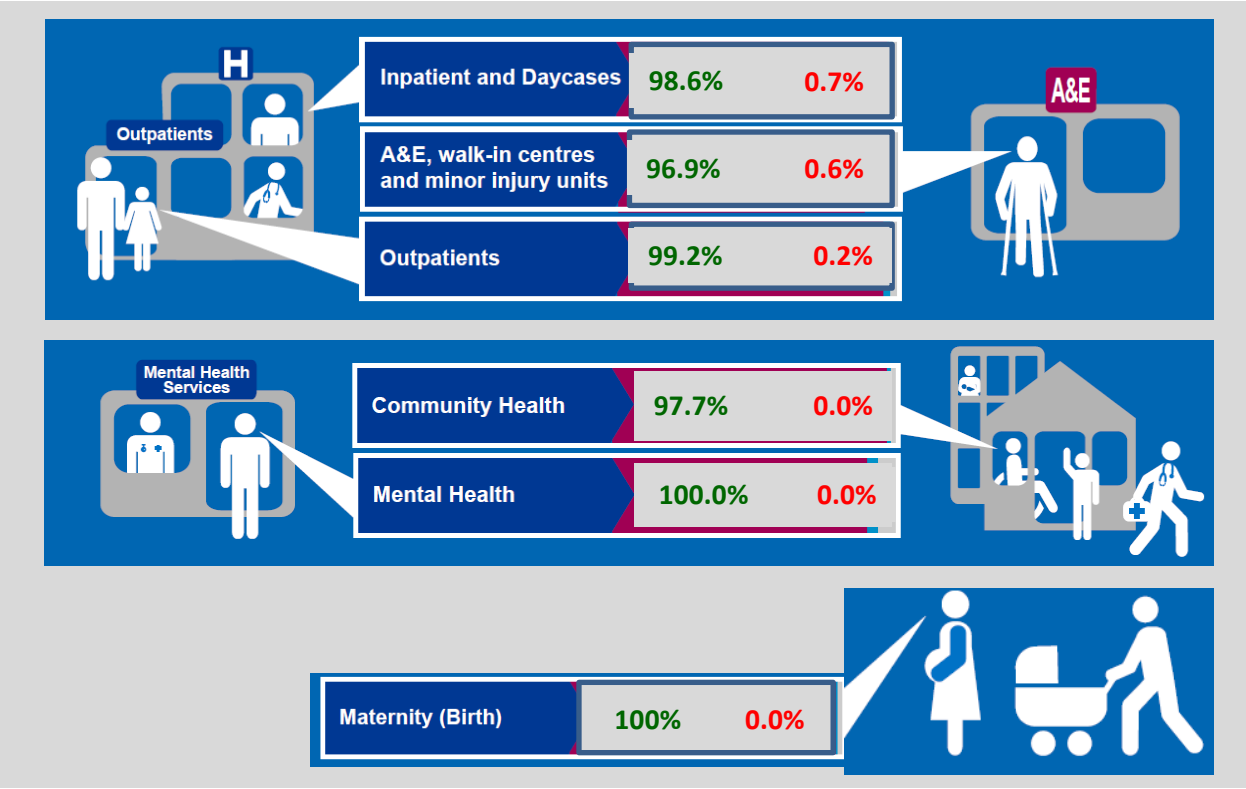
See how we did in May 2019

NHS
Gateshead Health
NHS Foundation Trust

The Friends & Family Test

In May 2019 the Trust received 3,742 responses. 97.8% of patients would recommend the services to friends and family.

The following numbers show the proportion of people that would recommend or not recommend these services to a friend or family member if they needed similar care or treatment.



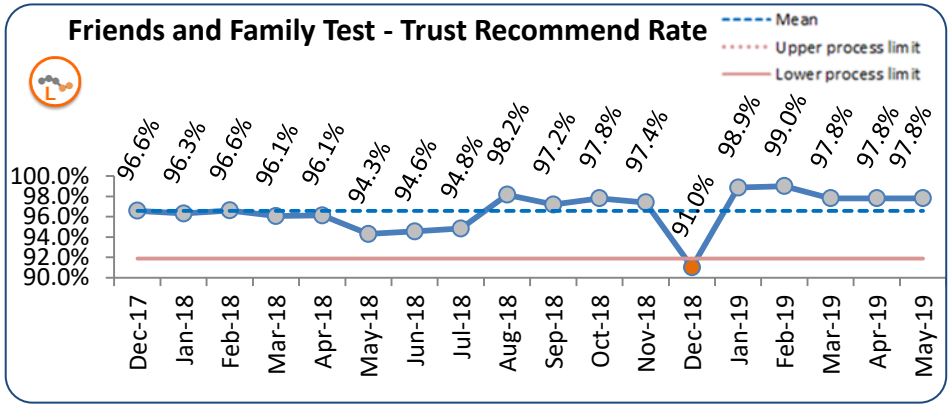
Key
Green - % Recommend
Red - % Not Recommend

Integrated Quality and Learning Report

Gateshead Health NHS Foundation Trust

Caring

NHS Friends and Family Test- Trust Recommend Rate



F&FT Trust Recommend Rate

- The friends and family test recommend rate for May was 97.8%.
- Special cause variation (low) was identified in December. Investigation identified that this appears to be attributable to a relatively high volume of 'Neither Likely nor Unlikely' (239 of 1742) recommend responses received in A&E .

	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Inpatient and Day cases	97.6%	98.4%	98.1%	97.8%	98.5%	98.4%	98.0%	98.4%	99.2%	98.4%	98.3%	99.2%	98.6%	99.1%	99.1%	99.2%	98.5%	98.6%
A&E, walk in centres, and minor injuries unit	94.9%	94.1%	94.3%	91.8%	94.5%	89.5%	91.1%	90.9%	96.9%	95.7%	96.9%	95.3%	85.2%	99.4%	99.0%	96.8%	96.8%	96.9%
Outpatients	99.4%	100.0%	99.3%	97.6%	97.3%	95.6%	96.7%	97.4%	97.9%	97.2%	98.6%	98.4%	97.4%	96.7%	98.8%	98.7%	98.7%	99.2%
Community Health	97.8%	98.0%	98.0%	100.0%	96.8%	97.5%	97.2%	98.9%	100.0%	98.0%	99.4%	98.3%	98.5%	96.8%	98.7%	98.5%	98.1%	97.7%
Mental Health	98.2%	97.9%	97.8%	100.0%	100.0%	100.0%	97.5%	94.6%	96.7%	100.0%	100.0%	100.0%	100.0%	99.2%	98.9%	100.0%	100.0%	100.0%
Maternity (Birth)	98.6%	100.0%	98.3%	98.1%	100.0%	96.0%	100.0%	100.0%	98.5%	96.7%	98.6%	100.0%	97.7%	97.8%	100.0%	100.0%	100.0%	100.0%
Trust	96.6%	96.3%	96.6%	96.1%	96.1%	94.3%	94.6%	94.8%	98.2%	97.2%	97.8%	97.4%	91.0%	98.9%	99.0%	97.8%	97.8%	97.8%

Mixed Sex Accommodation (MSA) Breaches

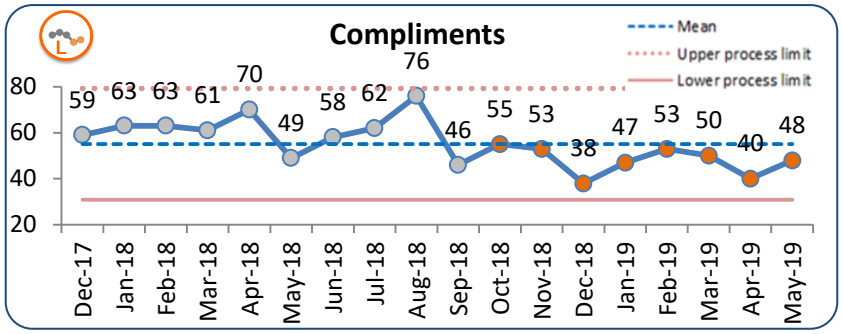
Mixed-sex Accommodation Breaches

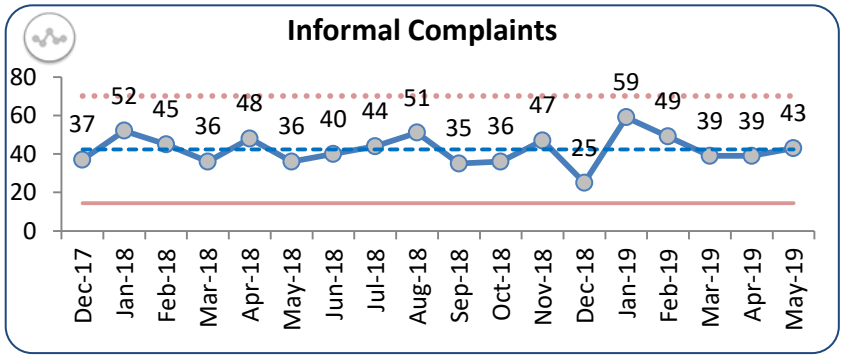
The Trust continues to report zero mixed sex accommodation breaches since Nov 2017.

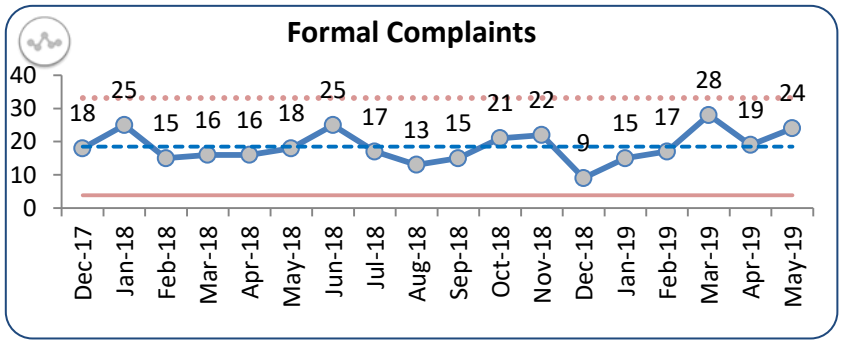
Integrated Quality and Learning Report

Complaints Management

Responsive







Compliments

- 48 compliments were reported in May 2019.
- Special cause variation is identified with fewer compliments being recorded monthly over the last nine months.
- Staff are reminded to record compliments on the Datix system.

Informal complaints

- 43 Informal complaints were received in May 2019.
- Informal complaints remain stable and display common cause variation.

Formal Complaints

- 24 formal complaints were received in May 2019.
- Common cause variation is displayed.

- The themes identified in complaints were:
  - Clinical Treatment – Surgical Group (3)
  - Clinical Treatment - Obstetrics & Gynaecology (1)
  - Values and Behaviours (Staff) (2)
  - Clinical Treatment – Accident and Emergency (4)
  - Communications (6)
  - Appointments including delays & cancellations (1)
  - Clinical Treatment - General Medical Group (4)
  - Facilities (1)
  - Privacy, Dignity & wellbeing (including patients' property & expenses)(1)
  - Clinical Treatment - Paediatric Group (1)

- The areas where formal complaints were received were: Emergency Care (6) General Surgery (3) Trauma & Orthopaedics (2) Planned Care (2) Gynae-Oncology (2) Facilities (1)Paediatrics (1) Obstetrics (1) Cardiology (1) Hospital to Home (1) Stroke(1) Rheumatology (1) Screening Services (1) Respiratory (1)

Integrated Quality and Learning Report

15 Steps Challenge

Gateshead Health NHS Foundation Trust

Well-led

15 Steps Challenge
Ward & Departments visited in May 2019:
Ward 23 and Urology

Welcoming	Safe	Caring and Involving	Well organised and calm
Is the area welcoming? What is the atmosphere like? What are the interactions between staff and patients like? Is there visible information useful information for staff?	Does the ward appear to think safety is important? What tells you about the quality of care here? How are medicines managed on the ward? What have I noticed that builds my confidence? What makes me less confident?	How have staff made you feel? What can I understand about patient experience on this ward? How is dignity and privacy being respected? How are staff interacting with patients? Is good team working in place?	Is the area welcoming? What is the atmosphere like? What are the interactions between staff and patients like? Is there visible information useful information for staff?
Positive • Friendly reception staff • Pleasant smell • Delirium scrabble board • Clear signage • Clear corridors • Calm waiting area • Water fountain with cups and juice **Recommended** • Consider duplication of information on both sides of the ward • No reception/booking in area • Signage to ring bell and take a seat would easily be missed	**Positive** • Clean area • Visible drinks in reach of patients • Protected meal times displayed **Recommended** • Consider duplication of safety and fire notices on both sides of the ward	**Positive** • Great interactions between staff and patients and the team were introduced to patients • Nice conversation between doctor and patient • Curtains drawn for privacy and dignity • Patient information on display and easily accessible **Recommended** • It wasn't clear how the clinic operated • Information board identifying the staff on duty incorrect • Toilets were not signposted	**Positive** • There was an overall feeling of calm. • Clean and clutter free • Electronic board in use • Storage cupboard organised, clean and tidy • Television and clock within the waiting area • Calm atmosphere with gentle music playing • Good information and signage **Recommended** • Limited space for wheelchair users within entry and waiting areas

Integrated Quality and Learning Report

CQUIN 2018-2019

Gateshead Health NHS Foundation Trust

Well-led

CQUIN stands for commissioning for quality and innovation. The system was introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of patient care.

2018-19 CQUIN Performance

- In Q4 the majority of CQUIN schemes fully achieved and year end performance was submitted to the CCG. The Trust is currently forecasting achieving around 87% of the CQUIN requirements and is awaiting a reconciliation statement from the CCG to confirm achievement.
- Specialised CQUIN - The Trust has fully achieved for all of the Specialised CQUIN schemes

The details of the **2019-20 CQUIN** schemes were recently published www.england.nhs.uk/nhs-standard-contract/cquin/cquin-19-20

Leads have been identified for each CQUIN and regular meetings have been setup to review requirements and implement these CQUIN schemes.

CCG1: Antimicrobial Resistance

CCG2: Staff Flu Vaccinations (80% uptake of flu vaccinations by frontline clinical staff))

CCG3: Alcohol and Tobacco

CCG7: Three high impact actions to prevent Hospital Falls

CCG11: Same Day Emergency Care

Integrated Quality and Learning Report

Smokefree NHS Survey

Gateshead Health NHS Foundation Trust

Well-led

The Trust recently participated in the national smokefree NHS survey.

The Trust scored 6/7 and is rated as GREEN.

This means that the trust is considered to have demonstrated positive steps towards comprehensive smokefree status, defined as:
- Every frontline professional discussing smoking with their patients
- Stop smoking support offered on site or referral to local services
- No smoking anywhere in NHS buildings or grounds

Public Health England advised 'We are pleased to see trusts scoring highly in this survey. This gives assurances that trusts are in a good place to continue developing their policies and practice further.'

The Long Term Plan includes the commitment: "*By 2023/24, all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services.*" Participating in programmes such as the national "Screening and brief advice for tobacco and alcohol use in inpatient settings CQUIN" shows a commitment to treating tobacco dependency. We are aware that trusts will be carefully reviewing their CQUIN activity to date to ensure that they can continually improve the quality and scope of the offer to their patients.

QE patients who smoke and want to quit now have access to a new Smoking Cessation Service, which is a behavioural change text message service that is designed to give daily 'nudges' of motivation and advice that can give them the support they need when they need it.

The smoking cessation service was developed by the Trust's Global Digital Exemplar (GDE) team and launched in January 2019. Since its launch 3 months ago, over 500 patients have accepted support to stop smoking and have benefited from daily support via their mobile phones.

Integrated Quality and Learning Report

Single Oversight Framework

Gateshead Health NHS Foundation Trust

Model Hospital

The report below is the most recent Single Oversight Framework - Quality of Care report for the Trust produced by NHS Improvement - Model Hospital

Report Date: 10th June 2019

Single Oversight Framework	Data Period		Trust Value	Performance Band Description	Peer median	National median
Single Oversight Framework segment	Mar-19		1 - Maximum Autonomy			
CQC Inspection Ratings (Latest at reporting date)						
CQC Inspection Rating: Overall	30/04/2019		Good			
CQC Inspection Rating: Caring	30/04/2019		Outstanding			
CQC Inspection Rating: Effective	30/04/2019		Good			
CQC Inspection Rating: Responsive	30/04/2019		Good			
CQC Inspection Rating: Safe	30/04/2019		Good			
CQC Inspection Rating: Well-Led	30/04/2019		Good			
Friends and Family Test scores						
Staff Friends and Family Test % Recommended - Care	Q2 2018/19		89.3%	In quartile 4 - Highest 25%	82.7%	80.0%
A&E Scores from Friends and Family Test - % positive	Mar-19		96.8%	In quartile 4 - Highest 25%	89.4%	87.7%
Inpatient Scores from Friends and Family Test - % positive	Mar-19		99.2%	In quartile 4 - Highest 25%	97.6%	96.1%
Maternity Scores from Friends and Family Test -question 2 Birth % positive	Mar-19		100.0%	In quartile 3 - Mid-High 25%	99.6%	98.8%
Organisational Health						
CQC Inpatient Survey	Sep-17		8.5	In quartile 4 - Highest 25%	8.2	8.1
Caring						
Written Complaints Rate	31/12/2018		13.42	In quartile 1 - Lowest 25%	16.73	25.49
Safe						
Central Alerting System - Patient Safety Alerts not completed by deadline	Oct-17		2	In quartile 3 - Mid-High 25%	1	1
Never events	30/06/2018		2	In quartile 3 - Mid-High 25%	2	1
Emergency c-section rate	Feb-19		12.23%	In quartile 1 - Lowest 25%	15.51%	16.57%
VTE Risk Assessment	Q3 2018/19		99.10%	In quartile 4 - Highest 25%	96.08%	95.95%
Clostridium Difficile - infection rate	To Feb 2019		12.76	In quartile 3 - Mid-High 25%	11.62	11.52
MRSA bacteraemias	To Feb 2019		1.11	In quartile 3 - Mid-High 25%	0.52	0.60
Potential under-reporting of patient safety incidents	31/05/2018		36.89	In quartile 2 - Mid-Low 25%	42.87	N/A
Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI)	Feb-19		150	In quartile 4 - Highest 25%	137	128
Meticillin-sensitive staphylococcus aureus (MSSA) rates to quality indicators	Feb-19		10	In quartile 3 - Mid-High 25%	10	9
Safe					**Peer median**	**Benchmark value**
Clostridium Difficile - variance from plan	Feb-19		1.0	Below the benchmark	0.0	0.0
Effective					**Peer median**	**Benchmark value**
Summary Hospital Mortality Indicator (SHMI)	31/07/2018		1.04	Above the benchmark	N/A	0

Integrated Quality and Learning Report

Single Oversight Framework

Gateshead Health NHS Foundation Trust

Model Hospital

The Model Hospital uses colour to indicate a trust's performance relative to a national median or other benchmark. Different colours represent quartiles of the national data set or your trust's position on a red-amber-green scale. For some metrics a relatively low value, putting the trust into Quartile 1, would indicate a weak performance, but for other metrics a low value can indicate a strong performance. The colour coding helps you understand whether low values should be interpreted as weak or strong.

Green	Either • Lowest quartile, where low represents best productivity • Highest quartile, where high represents best productivity • Performance better than benchmark, in a chart using a red-amber-green scale
Amber/green	Either • Mid-low quartile, where low represents best productivity • Mid-high quartile, where high represents best productivity
Amber/red	Either • Mid-high quartile, where low represents best productivity • Mid-low quartile, where high represents best productivity
Amber	Performance approaching benchmark, in a chart using a red-amber-green scale
Red	Either • Highest quartile, where low represents best productivity • Lowest quartile, where high represents best productivity • Performance below benchmark, in a chart using a red-amber-green scale
Blue	We have not judged whether a high or low quartile is more desirable.

Trust Board

Gateshead Health NHS Foundation Trust

Report Cover Sheet

Agenda Item: 14

Date of Meeting:	Wednesday 26th June 2019			
Report Title:	Consolidated Finance Report			
Purpose of Report:	To provide a summary of performance as at 31st May (Month 2) for the Group (inclusive of Trust and QE Facilities, excluding Charitable Funds).			
	Decision: ☐	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☐
Corporate Objectives report relates to: (Including reference to any specific risk)	**Goal 7** We will deliver value for money and help ensure the local health and care system is sustainable and well led.			
Recommendations: (Action required by Board of Directors)	The Board is asked to note the reported financial performance for Month 2 2019/20.			
Financial Implications:	As included in the report			
Risk Management Implications:	As included in the report			
Human Resource Implications:	None			
Equality and Diversity Implications:	**Objective 3** Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve.			
Author:	Mrs Jacqueline Bilcliff, Group Director of Finance			
Presented by:	Mrs Jacqueline Bilcliff, Group Director of Finance			

Executive Summary

The purpose of this report is to inform the Board of Directors of the financial and contract performance position of the Group for the period to 31st May 2019.

Summary

The operational plan is based on achieving a balanced position in line with the required control total set by NHSI. In order to achieve this position a CRP of £8.996m has been set along with an expectation £4.0m of system support and centralised funding in the form of PSF/ FRF / MRET funding of £6.512m.

At month 2 the Trust has delivered the phased control total with the position slightly ahead of plan, primarily due to the receipt of a tax refund from HMRC and downward pressure on bank spend.

Recommendation

The Board are asked to note the financial position and financial performance for month 2 of 2019/20 and the key assumptions made. In particular the Board are asked to note the risks to achieving the plan and agreed control total and the increasingly difficult financial challenge both in year and in terms of ongoing financial sustainability.

Key financial performance indicators

Finance KPIs	Plan	Actual	Difference
Performance against control total (including PSF)	**(2,403)**	**(2,118)**	**285**
Performance against control total (excluding PSF)	**(3,123)**	**(2,838)**	**285**
CRP achieved	**100%**	**177%**	**77%**
Capital spend	**1,245**	**551**	**(694)**
Cash position	**3,798**	**11,349**	**7,551**
Liquidity days	**(9.69)**	**(10.21)**	**(0.52)**

Key financial metrics

Metric	Month 2 Plan	Month 2 Actual
Use of Resources		3
Capital Service Cover	4	4
Liquidity Ratio	3	3
I&E Margin Rating	4	4
I&E Margin Variance From Plan rating		1
Agency metric	1	2

Key risks

The 2019-20 risk table is included below:

Risks	Mitigations	Residual concerns	Rating
Assumed System Support of £4m	The principles of system working have been discussed and agreed between partners. The issues have also been raised and discussed with NHSI	No firm guarantee that the ICP can support the Trust to this level. Impact of this would see the CRP increase to c4.7%	
Non Delivery of CRP / efficiency programme savings	Business units being supported by KPO and finance. FRSB, financial control meetings and new accountability framework with supporting escalation process established	Achievement and transaction will be a challenge which will remain throughout the year	
Vascular and Maternity developments	Resultant loss of income for vascular has been factored into the plan	Patient flows may not materialise as expected for both services	
Changes in RICS guidance	Dicsussions undertaken with auditors, audit risk is low but potential c£1m pressure on plan. Lookikng to extend asset lives on equipment to mitigate this		
Cash Position	Active cash management. Management of creditors. Positive relationships with commissioners. Distressed Financing in place	Dependent upon delivery of CRP, achievement of control total and receipt of PSF/ MRET/FRF funding	

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

As at 31st May the Group is reporting an operational deficit (excluding PSF) of £2.838m for the period. This is against a planned deficit of £3.123m, a positive variance £0.284m. Within this total operating income is behind plan by £0.392m and total operating expenses are better than plan by £0.695m, there are further negative non-operating adjustments of £0.048m.

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

Section 2 - Income Analysis (see appendix 2)

The reported income position as at May is an under recovery against plan of £0.392m. This comprises an under recovery of £0.389m for operating income from patient care activities and an under recovery of £0.003m against other operating income.

Operating income from patient care activities by Commissioner is detailed in **Table 3** and reports a year to date over performance against income targets of £0.018m for CCG Commissioners and £0.329m under performance for NHS England which relates to the possible clawback of funding from commissioners arising from a delay in the commencement of the new faecal immunochemical screening test.

For commissioners on a block contract actual performance against contract values is detailed in **Table 4** and results in a favourable adjustment of £0.767m to balance to agreed contract values. This is based on April actual activity and May planned activity.

Performance against planned income targets by Point of Delivery is detailed in **Table 5** and includes actual activity for April and planned activity for May. As at the end of May the Trust is broadly on plan against its activity targets except for non-elective which is reporting 155 less spells compared to plan.

Detailed performance information will continue to be shared with Business Units in order to monitor and inform future capacity requirements.

Section 3 - Expenditure Analysis (see Appendix 3)

As at May operating expenses are better than plan by £0.284m. This is made up of a pay overspend of £1.370m and a non-pay underspend of £2.128m and depreciation and revaluation overspends of £0.152m, predominantly associated with the RICS revaluation. See **Tables 1 and 2.**

Tables 6, 7, 8, and 9 highlight the different pressures within the overspending employee position and the run rate for the component parts of the employee budgets; substantive staff, waiting list payments, agency and contract staff and bank. Run rate has increased this month by £0.054m. Pay continues to show pressure in all categories but has fallen back by comparison to April due to the one off lump sum payments in April for people on the top of grades.

The drivers of the staffing pressures include the continuation of the winter rehabilitation ward 6, bed pressures and the continuing need to employ medical agency staff within Stroke, Respiratory, Elderly Medicine, Paediatrics and Upper GI Surgery. Agency medical staffing continues to be a pressure but is at its lowest since before April 19. QEF's agency position is at its highest at £0.118m reflecting recruitment pressures for the Coventry contract. The Trust's position against the cap is over the ceiling by £0.006m with an amber flag.

Non Staff underspends are across a range of expenditure categories, most notably clinical supplies and services and other operating expenses. The main elements of other operating expenses includes a £0.380m credit associated with HMRC refunds for capital goods schemes as well as depressed expenditure on Non-Healthcare services from NHS FT's across a range of headings.

Section 4 - CRP performance (see appendix 4)

The Group CRP positon has been set at £8.896m in order to achieve the breakeven position set by NHSI. **Table 12** indicates the phasing of the programme which is weighted towards the back end of the year. As at month 2 the Trust has delivered £1.253m (177%) of its CRP target of £0.709m (**Table 13**). A one off gain of £0.378m in relation to an HMRC VAT appeal has significantly contributed to this positive transaction. The full year effect of this is £2.390m and plans are in place for another £1.459m of delivery which would account for 43% of the total target (**Table 15**).

It should be noted that the ability of the Trust to continue to deliver the levels of CRP required to maintain financial sustainability, without wider system change and support is the biggest financial concern and challenge for future years.

Section 5 - Cash and working balances (see appendix 5)

Cash at the beginning of the 2019/2020 financial year was £2.2m above plan at £8.1m due in the main to scheduled creditor payments in respect of the 2018/2019 financial year end. The cash position has been further strengthened by an advance of £2m by the Newcastle and Gateshead CCG, which is repayable within the current financial year and the successful capital goods scheme appeal with HMRC. The monthly payment of the Pathology contract to Roche has also yet to be made (£1.8m). Any deterioration in the I&E position and in securing CRP savings will have a significant impact and be a major risk to the cash position.

The cash level of £11.349m as at 30th April is equivalent to 15.1 days operating costs (12.5 days in April) and represents a £1.9m increase from 30th April. Cash is £7.6m above plan however contractual creditor payments as discussed above remain outstanding, with cash pressures expected in the calendar year.

A reduction of 0.52 days in liquidity against Plan in May (a reduction of 1.9 days against April) is driven by a marginal reduction in the working capital balance (£250k) together with a reduction in operating expenses before depreciation, amortisation and impairments (£833k). Current assets are £5.8m above plan due to cash reserves, offset by current liabilities being £5.9m above plan as a result of an adverse movement of £2m in deferred income due to the CCG advance and an increase in creditors in the period.

Debtors have reduced by £1m since 31st March 2019 and are £1.2m below plan.

Creditors have increased by £1.4m since 31st March 2019 and are £3.8m above Plan. Trade creditors have increased by £1.1m since March at £4.5m as at 31st May a £0.3m increase on April. Of the trade creditor balance there are no creditors currently authorised for payment and outstanding over 30 days.

Table 16 details.

Section 6 – Capital spend (see appendix 6)

The 2019/2020 capital programme was set at £7.1m at budget setting, however this has increased by £1m to £8.1m due to the successful HPV bid (£0.875m) and an additional £0.130m of PDC awarded in respect of I.T. Health Service Lead Investor (HSLI). The outline of the programme is included at Table 17 with the current spend to date which is behind the planned position, due to timing differences.

Section 7 – Summary

The Trust financial position is positive against plan as at month 2 and delivers the phased control total.

Jacqueline Bilcliff
Group Director of Finance
18th June 2019

Appendix 1 – Summary Income and Expenditure Position

Table 1 – summary financial position

May 2019/20

	GROUP POSITION			VARIANCE		
	Annual Budget	Budget to Date	Actual to Date	Variance (Actual - Budget)		Previous Month Variance
	£000's	£000's	£000's	£000's		£000's
Operating						
Total Operating Income From Patient Care activities	**(250,907.9)**	**(40,940.8)**	**(40,551.2)**	**389.5**		**170.4**
Total Other Operating Income	**(26,460.8)**	**(4,103.0)**	**(4,100.1)**	**2.8**		**172.6**
Total Operating Income	**(277,368.7)**	**(45,043.7)**	**(44,651.3)**	**392.4**		**343.0**
Total Employee Expenses	**177,066.9**	**29,623.1**	**30,993.2**	**1,370.2**		**863.7**
Operating Expenses included in EBITDA	**267,523.2**	**45,819.4**	**44,971.7**	**(847.7)**		**(1,260.4)**
Operating Expenses excluded from EBITDA	**5,448.3**	**908.5**	**1,060.9**	**152.4**		**(27.5)**
Total Operating Expenses	**272,971.5**	**46,727.9**	**46,032.6**	**(695.2)**		**(1,287.9)**
(Profit)/Loss from Operations	**(4,397.2)**	**1,684.1**	**1,381.3**	**(302.9)**		**(944.9)**
Non Operating						
Total Non-Operating Income	**(80.0)**	**(13.3)**	**(17.7)**	**(4.3)**		**(2.5)**
Total Non-Operating Expenses	**3,857.2**	**642.9**	**707.3**	**64.4**		**0.9**
Corporation Tax	620.0	103.3	91.7	**(11.7)**		**(5.8)**
(Surplus) / Deficit After Tax	**(0.0)**	**2,417.0**	**2,162.5**	**(254.5)**		**(952.3)**
(Surplus) / Deficit After Tax from Continuing Operation	**(0.0)**	**2,417.0**	**2,162.5**	**(254.5)**		**(952.3)**
Remove capital donations / grants I&E impact	(80.0)	(14.0)	(44.2)	(30.2)		(16.9)
Adjusted Financial Performance (Surplus) / Deficit	**(80.0)**	**2,403.0**	**2,118.3**	**(284.7)**		**(969.2)**
PSF adjustment	6,512.0	719.7	720.0	0.4		0.0
Adjusted Financial Performance (Surplus) / Deficit excluding PSF	**6,432.0**	**3,122.7**	**2,838.3**	**(284.4)**		**(969.2)**

Table 2 – detailed financial position

STATEMENT OF COMPREHENSIVE INCOME
May 2019/20

Red >100k over Amber <> (£50k) - £99.99k Green <(£50.1k)	GROUP POSITION			VARIANCE		
	Annual Budget	Budget 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	(249,439.8)	(40,696.1)	(40,353.5)	342.6		148.7
Income From Local Authority Care Contracts	(90.0)	(15.0)	(15.0)	-		-
Private Patient Revenue	(688.5)	(114.7)	(111.2)	3.5		(5.1)
Injury Cost Recovery	(689.6)	(114.9)	(69.5)	45.5		27.4
Other non-NHS clinical revenue	-	-	(2.0)	(2.0)		(0.6)
Total Operating Income From Patient Care activities	**(250,907.9)**	**(40,940.8)**	**(40,551.2)**	**389.5**		**170.4**
Other Operating Income						-
Education and Training Income	(6,420.1)	(1,070.9)	(1,087.2)	(16.3)		(11.6)
R&D Income	(506.8)	(84.5)	(114.9)	(30.4)		(10.4)
PSF Income	(6,512.0)	(719.7)	(720.0)	(0.4)		(0.0)
Other Income	(12,791.2)	(2,189.5)	(2,178.0)	11.5		175.5
Donations & Grants Received	(230.6)	(38.4)	-	38.4		19.2
Total Other Operating Income	**(26,460.8)**	**(4,103.0)**	**(4,100.1)**	**2.8**		**172.6**
Total Operating Income	**(277,368.7)**	**(45,043.7)**	**(44,651.3)**	**392.4**		**343.0**
Operating Expenses						
Employee Expenses - Substantive	176,215.0	29,430.4	29,707.9	277.5		371.8
Employee Expenses - Bank	21.1	21.1	500.5	479.4		261.1
Employee Expenses - Agency	78.3	43.6	612.4	568.9		203.2
Employee Expenses - Other	752.5	128.1	172.4	44.3		27.6
Total Employee Expenses	**177,066.9**	**29,623.1**	**30,993.2**	**1,370.2**		**863.7**
Purchase of Healthcare - NHS bodeis	5,387.1	897.8	909.4	11.6		14.7
Purchase of Healthcare - Non NHS bodies	1,079.9	180.0	276.5	96.5		37.8
NED's	170.4	28.4	29.7	1.3		0.7
Supplies & Services - Clinical	26,265.7	4,470.9	4,370.9	(100.0)		(304.9)
Supplies & Services - General	2,074.4	346.1	356.0	9.9		1.8
Drugs	7,547.8	2,956.5	2,933.9	(22.6)		(44.0)
Research & Development expenses	5.4	0.9	0.5	(0.4)		(0.3)
Education & Training expenses	1,580.1	264.8	237.2	(27.6)		(87.4)
Consultancy costs	366.7	61.1	85.8	24.7		(25.4)
Establishment expenses	4,187.0	709.8	705.7	(4.2)		48.5
Premises	12,797.3	2,129.5	2,259.0	129.5		(38.3)
Transport	293.7	53.6	117.9	64.3		19.6
Clinical Negligence	5,759.2	959.9	959.7	(0.2)		(0.1)
Operating Leases	-	-	-	-		-
Other Operating expenses	7,594.4	2,306.9	736.1	(1,570.7)		(1,463.6)
Cost Improvement Programme	(6,506.0)	830.1	-	(830.1)		(286.2)
Reserves	21,853.3	-	-	-		2.8
Operating Expenses included in EBITDA	**267,523.2**	**45,819.4**	**44,971.7**	**(847.7)**		**(1,260.4)**
Depreciation & Amortisation - Purchased / Constructed	5,037.7	839.4	1,032.1	192.7		94.5
Depreciation & Amortisation - Donated / Granted	310.6	52.4	44.2	(8.2)		(2.3)
Depreciation & Amortisation - Finance Leases	-	-	-	-		-
Impairment & Revaluation	100.0	16.7	(15.5)	(32.1)		(119.7)
Restructuring Costs	-	-	-	-		-
Operating Expenses excluded from EBITDA	**5,448.3**	**908.5**	**1,060.9**	**152.4**		**(27.5)**
Total Operating Expenses	**272,971.5**	**46,727.9**	**46,032.6**	**(695.2)**		**(1,287.9)**
(Profit)/Loss from Operations	**(4,397.2)**	**1,684.1**	**1,381.3**	**(302.9)**		**(944.9)**
Non Operating						
Non-Operating Income						
Finance Income	(80.0)	(13.3)	(17.7)	(4.3)		(2.5)
Total Non-Operating Income	**(80.0)**	**(13.3)**	**(17.7)**	**(4.3)**		**(2.5)**
Non-Operating Expenses						
Finance Costs	817.2	136.2	200.6	64.4		0.9
Gains / (Losses) on Disposal of Assests	-	-	-	-		-
PDC dividend expense	3,040.0	506.7	506.7	-		-
Total Finance Costs (for non-financial activities)	**3,857.2**	**642.9**	**707.3**	**64.4**		**0.9**
Other Non-Operating Expenses						-
Misc. Other Non-Operating expenses	-	-	-	-		-
Total Non-Operating Expenses	**3,857.2**	**642.9**	**707.3**	**64.4**		**0.9**
(Surplus) / Deficit Before Tax	**(620.0)**	**2,313.7**	**2,070.9**	**(242.8)**		**(946.5)**
Corporation Tax	620.0	103.3	91.7	(11.7)		(5.8)
(Surplus) / Deficit After Tax	**(0.0)**	**2,417.0**	**2,162.5**	**(254.5)**		**(952.3)**
(Surplus) / Deficit After Tax from Continuing Operations	**(0.0)**	**2,417.0**	**2,162.5**	**(254.5)**		**(952.3)**
Remove capital donations / grants I&E impact	(80.0)	(14.0)	(44.2)	(30.2)		(16.9)
Adjusted Financial Performance (Surplus) / Deficit	**(80.0)**	**2,403.0**	**2,118.3**	**(284.7)**		**(969.2)**
PSF adjustment	6,512.0	719.7	720.0	0.4		0.0
Adjusted Financial Performance (Surplus) / Deficit excluding PSF	**6,432.0**	**3,122.7**	**2,838.3**	**(284.4)**		**(969.2)**

Appendix 2 - Income Analysis

Table 3 – Operating income by commissioner

Table 3: Operating Income from Patient Care Activities by Commissioner as at May 2019

Red	**>100k over**
Amber	**<> (£50k) - £99.99k**
Green	**<(£50.1k)**

		Group Position				
Commissioner	**Contract Type**	**Annual Budget**	**Budget to Date**	**Actual**	**Variance (Actual Budget)**	**Previous Month Variance**
		£000's	£000's	£000's	£000's	£000's
NHS Newcastle Gateshead CCG	Acute - Block	(135,582.4)	(22,597.1)	(22,597.1)	0.0	0.0
NHS Newcastle Gateshead CCG	Community - Block	(20,319.3)	(3,386.5)	(3,386.5)	0.0	0.0
NHS Newcastle Gateshead CCG	AQP - Block	(1,052.1)	(175.4)	(175.3)	0.0	0.0
NHS Sunderland CCG	Acute - Block	(19,304.5)	(3,217.4)	(3,217.4)	0.0	0.0
NHS Sunderland CCG Breast Contract	Acute - Block	(891.9)	(148.7)	(148.7)	0.0	0.0
NHS South Tyneside CCG	Acute - Block	(9,175.0)	(1,529.2)	(1,529.2)	0.0	0.0
NHS South Tyneside CCG Obstetrics	Acute - Variable	(1,544.5)	(74.3)	(78.7)	(4.5)	0.0
NHS North Durham CCG	Acute - Block	(6,799.7)	(1,133.3)	(1,133.3)	0.0	0.0
NHS Northumberland CCG	Acute - Block	(1,433.5)	(238.9)	(238.9)	0.0	0.0
NHS Durham, Dales & Easington CCG	Acute - Block	(1,369.3)	(228.2)	(228.2)	0.0	0.0
NHS North Tyneside CCG	Acute - Block	(692.4)	(115.4)	(115.4)	0.0	0.0
NHS Cumbria	Acute - Variable	(640.7)	(106.8)	(134.0)	(27.2)	0.0
Other CCG's	Non Contract	(894.6)	(150.8)	(134.4)	16.3	5.9
Non English A&E	Non Contract	(26.6)	(2.6)	(5.0)	(2.4)	0.0
Overseas Visitors - Reciprocal	Non Contract	0.0	0.0	(1.1)	(1.1)	(1.1)
Other - System Support Monies	Other	(4,000.0)	0.0	0.0	0.0	0.0
Sub-Total Clinical Commissioning Groups		**(203,726.4)**	**(33,104.5)**	**(33,123.2)**	**(18.7)**	**4.8**
Specialised Commissioning Hub	Acute - Variable	(16,843.7)	(2,779.9)	(2,774.4)	5.5	0.0
North East & Cumbria Area Team	Screening - Block & Variable	(10,046.1)	(1,674.3)	(1,558.7)	115.7	47.9
Yorkshire & Humber Area Team	Screening - Block	(5,558.4)	(926.4)	(734.4)	192.0	96.0
Lancashire Area Team	Screening - Variable	(509.7)	(85.0)	(82.8)	2.1	0.0
NHS England (South West North)	Armed Forces - Variable	(41.4)	(6.8)	(4.1)	2.8	0.0
Cancer Drug Fund & HEP C Drugs	Non Contract	(1,018.6)	(169.8)	(158.7)	11.1	0.0
Sub- Total NHS England		**(34,018.0)**	**(5,642.2)**	**(5,313.1)**	**329.1**	**143.9**
County Durham & Darlington FT	Ante-Natal Pathway	(14.9)	(2.6)	(3.8)	(1.2)	0.0
South Tyneside & Sunderland NHS FT	Pathology & Ante Natal Pathway	(9,944.2)	(1,657.4)	(1,663.0)	(5.6)	0.0
Newcastle Hospitals FT	TIMS	(1,732.2)	(288.7)	(228.0)	60.7	0.0
South Tees Hospitals NHS Foundation Trust	Gynaecology SLA	0.0	0.0	(21.1)	(21.1)	0.0
Northumbria FT	Ante-Natal Pathway	(4.5)	(0.8)	(0.5)	0.3	0.0
Other FT's	Ante-Natal Pathway	0.0	0.0	0.0	0.0	0.0
Sub- Total Foundation Trusts		**(11,695.9)**	**(1,949.4)**	**(1,916.3)**	**33.1**	**0.0**
Local Authorities	Block	(90.0)	(15.0)	(15.0)	0.0	0.0
Private Patients	Non Contract	(688.5)	(114.7)	(111.8)	2.9	0.0
Overseas Visitors - Non Reciprocal	Non Contract	0.0	0.0	0.0	0.0	0.0
NHS Injury Cost Recovery Scheme	Non Contract	(689.6)	(114.9)	(69.5)	45.5	0.0
Other Non NHS Clinical Revenue	Non Contract	0.0	0.0	(2.4)	(2.4)	0.0
Sub-Total Other		**(1,468.1)**	**(244.7)**	**(198.7)**	**45.9**	**0.0**
Total Operating Income from Patient Care Activities		**(250,908.4)**	**(40,940.8)**	**(40,551.3)**	**389.5**	**148.7**

Table 4 – contract performance compared with the contracted position

Table 4: Contract Performance Block Contract as at May 2019

Commissioner	Contract Type	Budget to Date	Actual	Variance	Previous Month Variance	Movement In month
		£000's	£000's	£000's	£000's	£000's
NHS Newcastle Gateshead CCG	Acute - Block	(22,597,058)	(21,885,766)	(711,292)	0	(711,292)
NHS Newcastle Gateshead CCG	Community - Block	(3,386,542)	(3,386,542)	0	0	0
NHS Newcastle Gateshead CCG AQP Contract	AQP - Block	(175,345)	(177,892)	2,546	0	2,546
NHS Sunderland CCG	Acute - Block	(3,217,424)	(3,219,374)	1,950	0	1,950
NHS Sunderland CCG Breast Contract	Acute - Block	(148,657)	(159,148)	10,491	0	10,491
NHS South Tyneside CCG	Acute - Block	(1,529,166)	(1,516,200)	(12,966)	0	(12,966)
NHS North Durham CCG	Acute - Block	(1,133,288)	(1,088,720)	(44,568)	0	(44,568)
NHS Northumberland CCG	Acute - Block	(238,922)	(250,060)	11,138	0	11,138
NHS Durham, Dales & Easington CCG	Acute - Block	(228,209)	(193,702)	(34,507)	0	(34,507)
NHS North Tyneside CCG	Acute - Block	(115,394)	(126,078)	10,684	0	10,684
Total Block Contract Impact		**(32,770,006)**	**(32,003,482)**	**(766,524)**	**0**	**(766,524)**

Table 5 – contract performance by point of delivery

Table 5 : Contract Performance by Point of Delivery as at May 2019

	Group Position						Previous Month		Movement in Month	
Point of Delivery	Budget to Date	Actual	Variance	Budget	Actual	Variance	Variance	Variance	Variance	Variance
	£000's	£000's	£000's	Activity	Activity	Activity	£000's	Activity	£000's	Activity
Elective Long Stay	(2,828.7)	(2,693.6)	135.1	712	702	10	0.0	0	135.1	10
Elective Day Case	(2,673.7)	(2,584.6)	89.0	3791	3870	(78)	2.1	(1)	86.9	(77)
Elective Excess Bed Days	(38.1)	(39.1)	(1.1)	137	144	(7)	0.0	0	(1.1)	(7)
Non Elective	(9,468.6)	(9,036.8)	431.8	4717	4562	155	3.3	(2)	428.5	157
Non Elective Excess Bed Days	(124.6)	(175.5)	(50.9)	470	664	(194)	0.0	0	(50.9)	(194)
Outpatient First	(1,526.5)	(1,509.8)	16.8	8259	8341	(81)	0.0	0	16.8	(81)
Outpatient Follow Up	(1,780.0)	(1,743.4)	36.6	20763	21055	(291)	0.1	(2)	36.5	(289)
Accident & Emergency	(2,421.6)	(2,409.5)	12.0	21041	20600	442	0.3	(2)	11.7	444
High Cost Drugs	(2,062.0)	(2,178.3)	(116.3)	0	0	0	0.0	0	(116.3)	0
High Cost Devices	(72.4)	(67.8)	4.6	0	0	0	0.0	0	4.6	0
Chemotherapy Delivery	(218.8)	(225.0)	(6.2)	812	851	(39)	0.0	0	(6.2)	(39)
Other:										
- Bed Days	(2,450.6)	(2,430.0)	20.6	9693	9720	(28)	0.0	0	20.6	(28)
- Adult Critical Care	(1,202.1)	(1,141.8)	60.3	796	756	40	0.0	0	60.3	40
- SCBU	(164.9)	(125.1)	39.8	383	290	92	0.0	0	39.8	92
- Outpatient Imaging	(677.2)	(706.8)	(29.6)	8114	8354	(240)	0.1	(1)	(29.7)	(239)
- Maternity Pathways	(691.5)	(693.0)	(1.6)	640	730	(90)	0.0	0	(1.6)	(90)
- Ambulatory Care	(538.6)	(504.7)	33.9	1487	1390	96	0.0	0	33.9	96
- Outpatient Procedures	(308.1)	(334.6)	(26.5)	2295	2301	(5)	0.0	0	(26.5)	(5)
- Daycare	(243.6)	(242.4)	1.2	1416	1554	(138)	0.0	0	1.2	(138)
- Community	(3,404.9)	(3,403.2)	1.7	0	0	0	0.0	0	1.7	0
- Other	(7,814.7)	(7,354.8)	460.0	17806	18671	(865)	143.9	0	316.1	(865)
- Balance to Block Contract Adjustment	0.0	(766.5)	(766.5)	0	0	0	0.0	0	(766.5)	0
Private Patients	(114.7)	(111.8)	2.9	0	0	0	0.0	0	2.9	0
Overseas Visitors	0.0	(1.1)	(1.1)	0	0	0	0.0	0	(1.1)	0
Overseas Visitors - Non Reciprocal	0.0	0.0	0.0	0	0	0	0.0	0	0.0	0
NHS Injury Cost Recovery Scheme	(114.9)	(69.5)	45.5	0	0	0	0.0	0	45.5	0
Other Non NHS Clinical Revenue	0.0	(2.4)	(2.4)	0	0	0	0.0	0	(2.4)	0
Total Operating Income & Activity	**(40,940.8)**	**(40,551.3)**	**389.5**	**103331**	**104553**	**(1222)**	**149.8**	**(8)**	**239.68**	**(1,214)**

Appendix 3 – Expenditure analysis

Table 6 – Budgeted pay expenditure

STATEMENT OF COMPREHENSIVE INCOME
May 2019/20

		GROUP POSITION			VARIANCE		
Red	**>100k over**						
Amber	**<> (£50k) - £99.99k**	**Annual Budget**	**Budget to Date**	**Actual to Date**	**Variance (Actual - Budget)**		**Previous Month Variance**
Green	**<(£50.1k)**	**£000's**	**£000's**	**£000's**	**£000's**		**£000's**
	Operating Expenses						
	Employee Expenses - Substantive	176,215.0	29,430.4	29,707.9	277.5		371.8
	Employee Expenses - Bank	21.1	21.1	500.5	479.4		261.1
	Employee Expenses - Agency	78.3	43.6	612.4	568.9		203.2
	Employee Expenses - Other	752.5	128.1	172.4	44.3		27.6
Total Employee Expenses		**177,066.9**	**29,623.1**	**30,993.2**	**1,370.2**		**863.7**

Agency Position	
May-20	**Variance from Ceiling**
Month of	(10,136)
YTD	6,428

Table 7 – Substantive pay run rate (including WLIs)

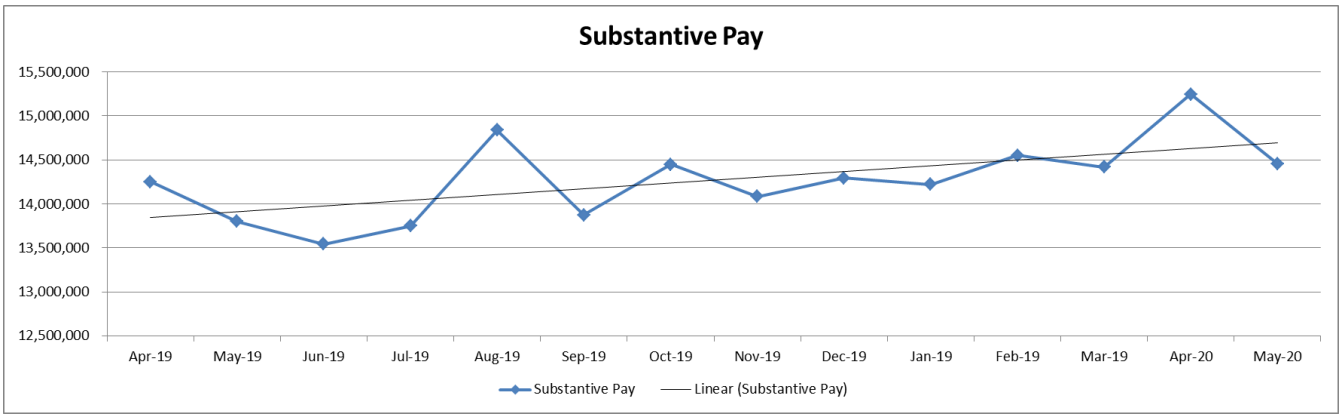


Table 8 – Non substantive pay run rate

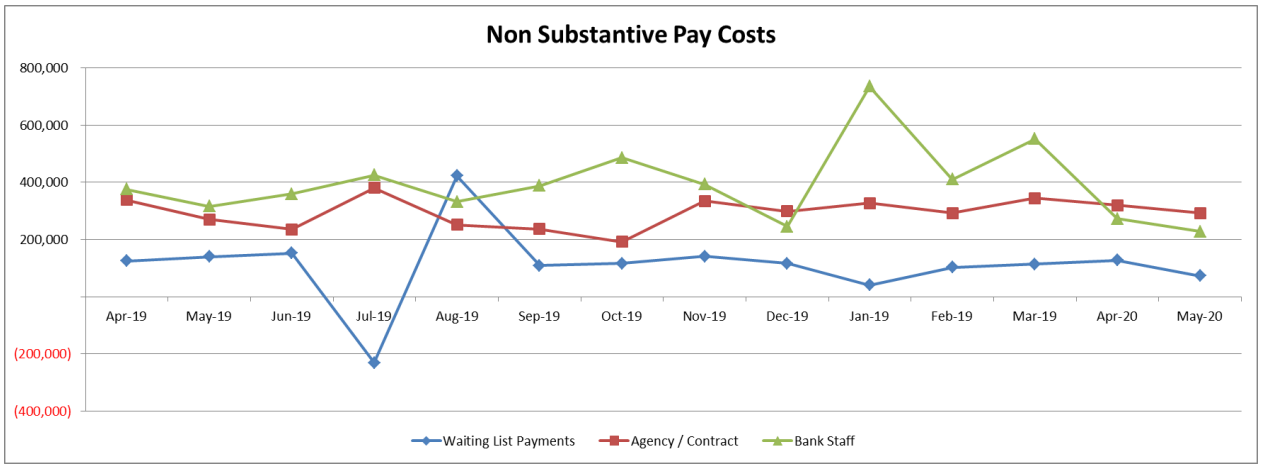
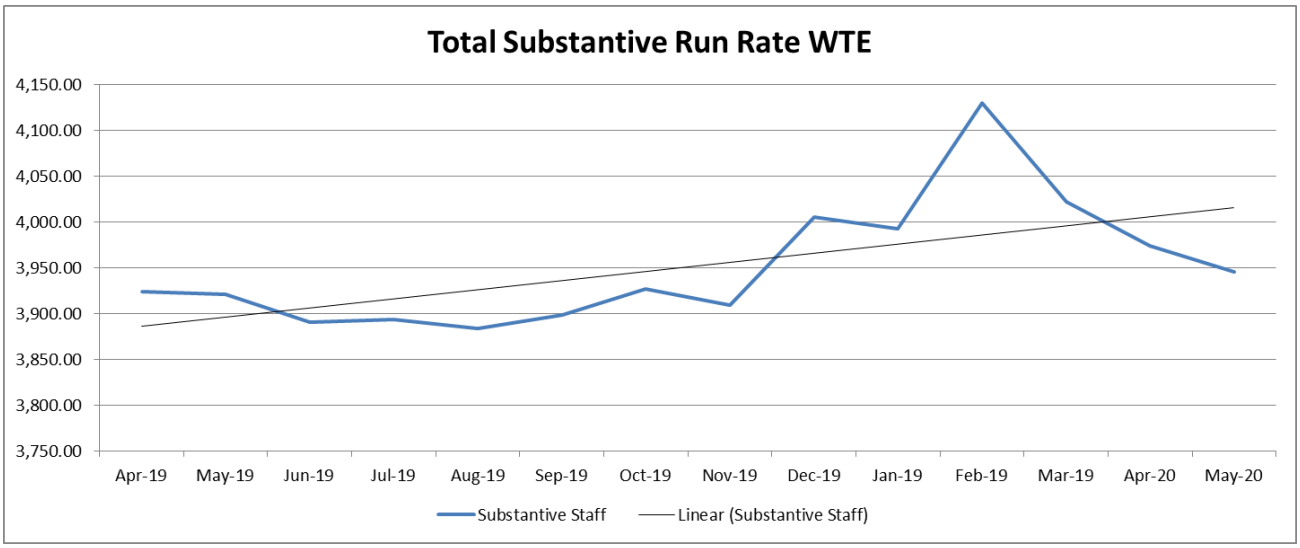


Table 9 – Whole Time Equivalent run rate



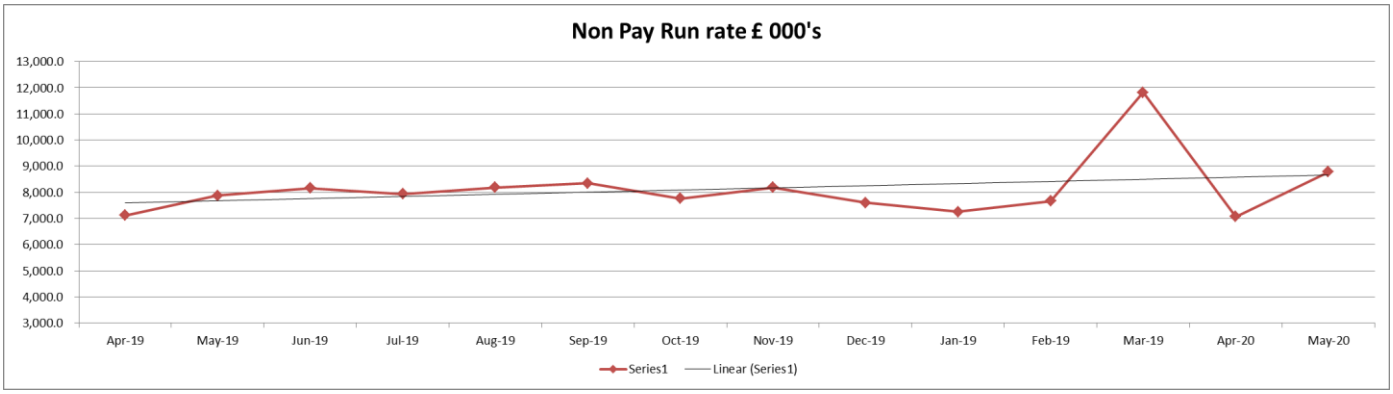
**Please note Jan19 – Mar 19 Skewed by weekly pay*

Table 10 – Budgeted non pay expenditure

STATEMENT OF COMPREHENSIVE INCOME
May 2019/20

		GROUP POSITION			VARIANCE		
Red	**>100k over**	**Annual Budget**	**Budget to Date**	**Actual to Date**	**Variance (Actual - Budget)**		**Previous Month Variance**
Amber	**<> (£50k) - £99.99k**						
Green	**<(£50.1k)**	**£000's**	**£000's**	**£000's**	**£000's**		**£000's**
	Purchase of Healthcare - NHS bodeis	5,387.1	897.8	909.4	11.6		14.7
	Purchase of Healthcare - Non NHS bodies	1,079.9	180.0	276.5	96.5		37.8
	NED's	170.4	28.4	29.7	1.3		0.7
	Supplies & Services - Clinical	26,265.7	4,470.9	4,370.9	(100.0)		(304.9)
	Supplies & Services - General	2,074.4	346.1	356.0	9.9		1.8
	Drugs	7,547.8	2,956.5	2,933.9	(22.6)		(44.0)
	Research & Development expenses	5.4	0.9	0.5	(0.4)		(0.3)
	Education & Training expenses	1,580.1	264.8	237.2	(27.6)		(87.4)
	Consultancy costs	366.7	61.1	85.8	24.7		(25.4)
	Establishment expenses	4,187.0	709.8	705.7	(4.2)		48.5
	Premises	12,797.3	2,129.5	2,259.0	129.5		(38.3)
	Transport	293.7	53.6	117.9	64.3		19.6
	Clinical Negligence	5,759.2	959.9	959.7	(0.2)		(0.1)
	Operating Leases	-	-	-	-		-
	Other Operating expenses	7,594.4	2,306.9	736.1	(1,570.7)		(1,463.6)
	Cost Improvement Programme	(6,506.0)	830.1	-	(830.1)		(286.2)
	Reserves	21,853.3	-	-	-		-
Non Pay Operating Expenses included in EBITDA		**90,456.4**	**16,196.3**	**13,978.5**	**(2,217.8)**		**(2,126.9)**

Table 11 – Non Pay Run rate



Appendix 4 – CRP performance

Table 12 – phasing of the full year CRP by type

NHSI Category Expenditure / Income	Q1 Plan	Q2 Plan	Q3 Plan	Q4 Plan	Total CRP Plan
Income (Other op income)	0.0	(139.0)	(159.0)	(502.0)	(800.0)
Income (Patient Care Activities)	0.0	(153.0)	(153.0)	(694.0)	(1,000.0)
Non pay	(595.0)	(926.0)	(1,155.0)	(1,210.0)	(3,886.0)
Pay (Skill mix)					0.0
Pay (WTE)	(480.0)	(640.0)	(720.0)	(1,370.0)	(3,210.0)
Grand Total	**(1,075.0)**	**(1,858.0)**	**(2,187.0)**	**(3,776.0)**	**(8,896.0)**

Table 13 – year to date phasing of the CRP and achievement by type

NHSI Category Expenditure / Income	CRP Plan YTD £000's	CRP Actual YTD £000's	CRP Variance YTD £000's
Income (Other operating income	0.0	(10.0)	(10.0)
Income (Patient Care Activities)	0.0	0.0	0.0
Non pay	(389.0)	(522.4)	(133.4)
Pay (Skill mix)	0.0	(113.7)	(113.7)
Pay (WTE reductions)	(320.0)	(606.9)	(286.9)
Grand Total	**(709.0)**	**(1,252.9)**	**(543.9)**

Percentage Achieved	**176.7%**

Table 14 – Achievement of CRP by business unit

Variance < 0
Variance > 0, < 50
Variance > 50

Division	CRP Plan £000's	Total 19/20 £000's	CRP Variance YTD £000's	% Achieved 19/20	Total Recurrent £000's	Variance Recurrent £000's
Chief Executive	(75.0)	(97.0)	(22.0)	129.3%	(97.0)	22.0
Clinical Support	(1,916.0)	(621.2)	1,294.8	32.4%	(82.6)	(1,833.4)
Community Services	(532.0)	(194.8)	337.2	36.6%	(65.8)	(466.2)
Estates & Facilities	(1,380.0)	0.0	1,380.0	0.0%	0.0	(1,380.0)
Finance	(65.3)	(52.4)	12.9	80.2%	(37.7)	(27.6)
IT & Information	(302.7)	(162.9)	139.8	53.8%	(86.4)	(216.3)
Medicine	(1,735.0)	(108.2)	1,626.8	6.2%	0.0	(1,735.0)
Nursing & Midwifery	(135.0)	(10.0)	125.0	7.4%	0.0	(135.0)
QEF	(662.0)	0.0	662.0	0.0%	0.0	(662.0)
Strategy & Transformation	(122.0)	(31.4)	90.6	25.8%	(31.4)	(90.6)
Surgical Services	(1,971.0)	(733.4)	1,237.6	37.2%	(206.2)	(1,764.8)
Trust Financing	0.0	(378.8)	(378.8)	0.0%	0.0	0.0
Total	**(8,896.0)**	**(2,390.0)**	**6,506.0**	**26.9%**	**(607.1)**	**(8,288.9)**

Table 15 – full year effect of identified CRPs and forecast

% Achieved >75%
% Achieved >50% <75%
% Achieved <50%

Division	RAG	Target	Actioned	Planned	Total Forecast	% Achieved	Recurrent
Chief Executive	Target	75.0			75.0		
	Green		(97.0)	0.0	(97.0)		
	Amber				0.0		
	Red				0.0		
Chief Executive Forecast Position		75.0	(97.0)	0.0	(22.0)	129%	(97.0)
Clinical Support	Target	1,916.0			1,916.0		
	Green		(621.2)	0.0	(621.2)		
	Amber		0.0	(5.0)	(5.0)		
	Red						
Clinical Support Forecast Position		1,916.0			1,289.8	33%	(82.6)
Community Services	Target	532.0			532.0		
	Green		(194.8)	(63.1)	(257.9)		
	Amber		0.0	(309.2)	(309.2)		
	Red		0.0	(355.9)	(355.9)		
Community Services Forecast Position		532.0	(194.8)	(728.2)	(391.0)	174%	(65.8)
Estates & Facilities	Target	1,380.0			1,380.0		
	Green				0.0		
	Amber		0.0	(64.6)	(64.6)		
	Red				0.0		
Estates & Facilities Forecast Position		1,380.0	0.0		1,315.4	5%	0.0
Finance	Target	65.3			65.3		
	Green		(52.4)	(4.5)	(56.9)		
	Amber		0.0	0.0	0.0		
	Red				0.0		
Finance & Information Forecast Position		65.3	(52.4)	(4.5)	8.4	87%	(37.7)
IT & Information	Target	302.7			302.7		
	Green		(162.9)	(284.6)	(447.5)		
	Amber				0.0		
	Red				0.0		
Finance & Information Forecast Position		302.7	(162.9)	(284.6)	(144.8)	148%	(86.4)
Medicine	Target	1,735.0			1,735.0		
	Green		(108.2)	0.0	(108.2)		
	Amber				0.0		
	Red		0.0	0.0	0.0		
Medicine Forecast Position		1,735.0		0.0	1,626.8	6%	0.0
Nursing & Midwifery	Target	135.0			135.0		
	Green		(10.0)	0.0	(10.0)		
	Amber				0.0		
	Red		0.0	(0.0)	(0.0)		
Nursing & Midwifery Forecast Position		135.0			125.0	7%	0.0
QEF	Target	662.0			662.0		
	Green				0.0		
	Amber				0.0		
	Red				0.0		
Nursing & Midwifery Forecast Position		662.0	0.0	0.0	662.0	0%	0.0
Strategy & Transformation	Target	122.0			122.0		
	Green		(31.4)	0.0	(31.4)		
	Amber				0.0		
	Red				0.0		
Strategy & Transformation Forecast Position		122.0		0.0	90.6	26%	(31.4)
Surgical Services	Target	1,971.0			1,971.0		
	Green		(733.4)	(371.6)	(1,104.9)		
	Amber				0.0		
	Red				0.0		
Surgical Services Forecast Position		1,971.0	(733.4)	(371.6)	866.1	56%	(206.2)
Trust Financing	Target	0.0			0.0		
	Green		(378.8)		(378.8)		
	Amber				0.0		
	Red				0.0		
Trust Financing Forecast Position		0.0	(378.8)	.0	(378.8)		0.0
Trust Forecast Position		8,896.0	(2,390.0)	(1,458.5)	5,047.5	43%	(607.1)

Appendix 5 – Cash and working balances

Table 16 – statement of financial position

Statement of Position - May 2019

	2019/2020 April 2019 Group	2019/2020 May 2019 Group	2019/2020 Variance - Prior Month	2019/2020 May 2019 QEF	2019/2020 May 2019 FT
	£000's	£000's	£000's	£000's	£000's
Assets					
Non-Current Assets					
Investments	80	80	0	80	16,824
Property, Plant and Equipment, Net	115,909	115,537	(372)	405	115,132
Trade and Other Receivables, Net	2,379	2,367	(12)	870	1,498
Finance Lease - Intragroup				45,094	0
Trade and Other Receivables - Intragroup Loan	0	0	0		23,618
Total Non Current Assets	118,368	117,985	(383)	46,449	157,073
Current Assets					
Inventories	3,002	3,130	128	1,834	1,296
Trade and Other Receivables - NHS	5,479	7,475	1,996	795	6,679
Trade and Other Receivables - Non NHS	5,309	3,010	(2,299)	569	2,441
Trade and Other Receivables - Intragroup	6,354	5,541	(813)	5,497	44
Trade and Other Receivables - Other	0	0	0		0
Prepayments	3,907	3,942	35	306	3,636
Cash and Cash Equivalents	9,397	11,348	1,951	3,865	7,484
Other Financial Assets - PDC Dividend	446	446	0	0	446
Accrued Income	523	788	265	557	230
Finance Lease - Intragroup				1,733	0
Trade and Other Receivables - Intragroup Loan					3,106
Total Current Assets	34,418	35,680	1,262	15,155	25,364
Liabilities					
Current Liabilites					
Deferred Income	4,298	4,292	(6)	233	4,059
Provisions	276	276	0	5	271
Current Tax Payables	3,886	3,558	(328)	341	3,217
Trade and Other Payables -Intragroup	6,354	5,541	(813)	44	5,497
Trade and Other Payables - NHS	1,489	1,078	(412)	786	292
Trade and Other Payables - Other	7,685	6,347	(1,338)	2,088	4,260
Trade and Other Payables - Capital	128	125	(3)	0	125
Other Financial Liabilities - Accruals	11,807	16,994	5,187	3,641	13,353
Other Financial Liabilities - Borrowings FTFF	1,356	1,356	0	0	1,356
Other Financial Liabilities - PDC Dividend	253	507	253	0	507
Other Financial Liabilities - Intragroup Borrowings	0	0		3,106	0
Finance Lease - Intragroup	0	0		0.000	1,733
Total Current Liabilities	37,533	40,074	2,541	10,244	34,668
NET CURRENT ASSETS (LIABILITIES)	(3,116)	(4,394)	(1,278)	4,911	(9,305)
Non-Current Liabilities					
Deferred Income	2,864	2,864	(0)	1,944	920
Provisions	2,886	2,894	9	0	2,894
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	23,618	0
Other Financial Liabilities - Borrowings FTFF	28,779	28,779	0	0	28,779
Finance Lease - Intragroup				0	45,094
Total Non-Current Liabilities	34,528	34,536	8	25,562	77,687
TOTAL ASSETS EMPLOYED	**80,724**	**79,054**	**(1,670)**	**25,798**	**70,081**
Tax Payers' and Others' Equity					
PDC	115,447	115,447	0	0	115,447
Taxpayers Equity	0	0	0	0	0
Share Capital	0	0	0	16,824	0
Retained Earnings (Accumulated Losses)	(44,564)	(46,234)	(1,670)	8,973	(55,207)
Other Reserves	0	0	0	0	0
Revaluation Reserve	9,743	9,743	0	0	9,743
Misc Reserve	99	99	0	0	99
TOTAL TAXPAYERS EQUITY	80,724	79,054	(1,670)	25,798	70,081
TOTAL ASSETS EMPLOYED	**80,724**	**79,054**	**(1,670)**	**25,798**	**70,081**

Appendix 6 – Capital programme delivery

Table 17 – detailed capital schemes

Scheme description	2019/20 Plan £000	Plan to month 2 £000	Actual to month 2 £000
IT GDE	3,700	1,033	474
Equipment Replacement	1,000	128	11
Backlog Maintenance	500	84	31
ECC Cladding	360	0	0
Maternity Scheme	862	0	0
Donated Assets	230	0	0
HPV	875	0	16
IT HSLI	130	0	0
Energy Conservation	100	0	13
H&S Disabled Access	100	0	6
Woodside	180	0	0
Safe Code & Dementia	50	0	0
	8,087	**1,245**	**551**

Trust Board

Gateshead Health NHS Foundation Trust

Report Cover Sheet

Agenda Item: 15

Date of Meeting:	Wednesday 26 June 2019			
Report Title:	Information Governance Assurance Report			
Purpose of Report:	To provide the board with a statement of assurance on Information Governance issues across the Trust			
	Decision: ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
Trust Goals that the report relates to: (Including reference to any specific risk)	**Goal 2** All the services we deliver will be good or outstanding when assessed against being safe, effective, caring, responsive, and well-led. **Goal 3** In all locations and settings of delivery, our patients will experience excellent, timely and seamless care that meets their individual needs. **Goal 7** We will deliver value for money and help ensure the local health and care system is sustainable and well led.			
Recommendations: (Action required by Board of Directors)				
Financial Implications:	None			
Risk Management Implications:	Compliance with confidentiality, data protection, information security, freedom of information, records management and data quality standards.			
Human Resource Implications:	None			
Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)	None			
Author:	Dianne Ridsdale, Information Governance Officer			
Presented by:	Nick Black, Chief Digital Information Officer and Senior Information Risk Officer			

Health Informatics Assurance Report – June 2019

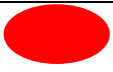
The operational informatics groups; Information Governance Assurance Group (IGAG) and Digital Optimisation and Transformation Group (DOTG) are required to provide assurance through the Finance and Performance Sub Committee. This report, together with the associated the group minutes; provides the assurance for the key areas of compliance for the Trust.

The minutes of the IGAG and DOTG; together with the SIRO Report are available to the Sub Committee.

Assurance Group	Assurance to F&P	Assurance level	Committee update	Next action	Timescale
Information Governance Assurance Group (IGAG)	Senior Information Risk Owner (SIRO) Report.		The SIRO Report is produced annually to document the work which has taken place on Information Governance compliance across the Trust. On track for IGAG on 19/3, then March Trust Board Accepted at March 2019 Trust Board	Complete Work plan for 2019/20 developed.	March 2019. March 2020
IGAG	Cyber Security.		Cyber Essentials Plus is a standard which has to be achieved by all Trusts by 2021. A Cyber Security Project has been established which will address these requirements. Any additional actions will also be identified and managed through the Information Governance Assurance Group. Cyber Essentials Certification complete August 2018. The Trust has commissioned a partner (IT Health) to support Cyber Essentials Plus accreditation. Trust Board training from GCHQ - March 2019 Work progressing on Cyber Essentials Plus, GHNT on track to achieve accreditation by Oct 2019.	Monitor in year progress against the internal target of 31st Oct.	National requirement to deliver Cyber Essentials Plus Certification by June 2021. Oct 2019
IGAG	Data Security and Protection Toolkit		Feb 2019 - Internal Audit review completed, some outstanding areas but on track to complete and submit by 31 March. Toolkit submitted at the end of March – with action plan to address: 1. Percentage of Staff Successfully Completing the Level 1 Data Security Awareness training. – 31st May – 95.06% 2. All system administrators have signed an agreement which holds them accountable to the highest standards of use. – 18th June.	Complete Work plan for 2019/20 developed.	Baseline submission - October 31st 2019. Final submission – 31st March 2020

IGAG	Information Asset Register/Data Flow Maps.		July 18 - A short term six month project commenced to ensure that the Trust has an Information Asset Register and full set of Data Flow Maps. In addition the completion of a systems register has also been incorporated into this project. Currently Information Asset Registers and Data Flow Maps are over 90% complete. On track to achieve this requirement. - Completed	Complete	31st March Information Asset Registers and Data Flow Maps - Complete.
IGAG	Information Governance Training.		There is a national requirement that 95% of all staff will have completed Information Governance training annually for the new toolkit. Currently the Trust is at 85% however CMT has committed to achieving 95% for IG training by the 8 March 2019. Weekly individual emails targeted reminding staff and managers to do their training, weekly progress tracking at CMT. Agreement for all staff to complete IG training between 1st Apr and 30th Nov.	Monitor in year progress against the internal target of 30th Nov.	Ongoing. Nov 2019
Digital Optimisation and Transformation Group	Delivery against Funding Agreement		Informatics Strategy reviewed by CMT, roll out being planned – Apr 19 Funding assurance milestone achieved – 31 May. Deployments underway on SAN, Nervecentre, Pharmacy, Doc Store, Clinical Noting. Full Trust wide communications plan being implemented. Business cases for next round of projects being developed, questions around timelines and budget allocations being clarified. Consideration of a Change Control to ensure GDE milestone assurance requirements can be met.	For information.	6 monthly funding milestones Bimonthly Programme Board meetings

Assurance Key

	Level of Assurance
	Assured – there are no gaps in assurance and no issues of concern
	Partially assured – there are gaps in assurance but we are assured appropriate action plans are in place to address these
	Not assured – there are significant gaps in assurance and we are not assured as to the adequacy of current action plans

Trust Board

Gateshead Health NHS Foundation Trust

Report Cover Sheet

Agenda Item: 16

Date of Meeting:	Wednesday 26th June 2019			
Report Title:	Summary of Assurances and Items for Escalation from Board Committees			
Purpose of Report:	To receive the assurance reports from the following meetings: (i) Quality Governance Committee • 15 May 2019 • 19 June 2019 (verbal) (ii) Finance and Performance Committee • 28 May 2019 • 25 June 2019 (verbal) (iii) Audit Committee • 16 May 2019 (iv) HR Committee • 11 June 2019			
	Decision: ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
Trust Goals that the report relates to: (Including reference to any specific risk)				
Recommendations: (Action required by Board of Directors)	To receive the reports for assurance.			
Financial Implications:				
Risk Management Implications:				
Human Resource Implications:				
Equality and Diversity Implications:				
Author:				
Presented by:				

ASSURANCE REPORT
Quality Governance Committee – 15 May 2019

Gateshead Health NHS Foundation Trust

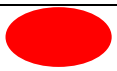
The Quality Governance Committee has fulfilled its role and functions as defined within its terms of reference.

The reports received by the Quality Governance Committee and level of assurance are set out below.

ISSUES TO BE RAISED TO BOARD	ASSURANCE LEVEL	COMMITTEE UPDATE	NEXT ACTION	TIMESCALE
BAF		Active review of BAF at all Board Committees.		
Quality Improvement Strategy 2019-2021		This strategy will be official launched at the Annual Nursing Conference on 21 May 2019.		
Integrated Quality and Learning Report	 	Amber assurance for pressure damage received due to high reporting figures needing to be reviewed. Green assurance received for overall report. Noted the majority of CQUIN achieved at year end.		
Research and Development Council Update		Good assurance received. Noted the Trust is part of the Northern Research Alliance with Dr Lloyd as Executive lead.		
CQC Mental Health Update		The Committee noted The challenge faced to address the requirements of the EMSA guidance in the context of the Trust's financial positon and existing capital commitments.		
Duty of Candour Update Q4		Good assurance received. The committee acknowledge the significant amount of work being undertaken around duty of candour. The Committee noted that all DoC letters have final sign off from Executive Director for the service.		

ISSUES TO BE RAISED TO BOARD	ASSURANCE LEVEL	COMMITTEE UPDATE	NEXT ACTION	TIMESCALE
SI Framework Compliance Update Q4		Good progress achieved, however amber assurance received due to the pressure damages and slowness of reporting.		
Health and Safety Annual Report		Good assurance received. Noted that the membership of the terms of reference would be reviewed.		

Assurance Key

	Level of Assurance
	Assured – there are no gaps in assurance
	Partially assured – there are gaps in assurance but we are assured appropriate action plans are in place to address these
	Not assured – there are significant gaps in assurance and we are not assured as to the adequacy of current action plans

ASSURANCE REPORT
Finance and Performance Committee – 28 May 2019

Gateshead Health NHS Foundation Trust

The Finance and Performance Committee has fulfilled its role and functions as defined within its terms of reference.

The reports received by the Finance and Performance Committee and level of assurance are set out below.

ISSUES TO BE RAISED TO BOARD	ASSURANCE LEVEL	COMMITTEE UPDATE	NEXT ACTION	TIMESCALE
Financial Performance – Finance & Activity Report		Year to Date: The Committee received and discussed the Month 1 Finance and Activity report which shows the Trust on plan.		Monthly review of progress through the Committee
		Forecast: Risks remain around achievement of full year forecast.		Monthly review of progress through the Committee
Financial Performance – Finance & Sustainability Programme		Year to Date: The Committee received and discussed the Month 1 Finance and Sustainability Programme report, which shows performance on plan.		Monthly review of progress through the Committee
		Forecast: Risks remain around achievement of full year CRP plans.		Monthly review of progress through the Committee
Performance report – NHSI Governance Rating Impact		Year to Date: The Committee received and discussed month 1 Performance Report. The Committee noted that the A&E and RTT targets were not met in April and remain at risk.		Monthly review of progress through the Committee

ISSUES TO BE RAISED TO BOARD	ASSURANCE LEVEL	COMMITTEE UPDATE	NEXT ACTION	TIMESCALE
Board Assurance Framework (BAF)		The Committee discussed and agreed updates to assurance at quarter 4.		

Assurance Key

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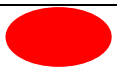	Not assured – there are significant gaps in assurance and we are not assured as to the adequacy of current action plans

ASSURANCE REPORT
Audit Committee – 16 May 2019

Gateshead Health NHS Foundation Trust

The Audit Committee has fulfilled its role and functions as defined within its terms of reference.

The issues to be raised to the Board are set out below

ISSUES TO BE RAISED TO BOARD	ASSURANCE LEVEL	COMMITTEE UPDATE	NEXT ACTION	TIMESCALE
Going Concern Letter		The Committee received the Going Concern Letter and recommended to Trust Board.	Final report to Trust Board.	May Extraordinary Board
Annual Governance Statement 2018/19		The Committee received the statement and amendments were agreed.	Final amended report to Trust Board.	May Extraordinary Board
Group Accounts 2018/19		The Committee received the Group Accounts and minor amendments were agreed.	Final amended accounts to Trust Board.	May Extraordinary Board
Quality Accounts 2018/19		The Committee received the Quality Accounts and were assured of the process.	Final report to Trust Board.	May Extraordinary Board
Internal Audit <u>Gateshead Health FT</u> Progress Report		The Committee received the report and noted that good progress has been made although there are still outstanding audits from 2018/19. It was agreed to receive an update to the Legal Services action for assurance at the next Committee.		July 2019
Final Head of Audit Opinion		The Committee received the report and noted that there has been an improvement in the follow up position from 18/19.		
<u>QE Facilities</u> Progress Report		The Committee received the report and a request for the security management work to be deferred was agreed with an update at the next Committee. A discussion took place around the Cardea system which was implemented earlier in the year.		July 2019
Final Assurance Statement		The Committee received the statement and were assured of the actions in place.		

ISSUES TO BE RAISED TO BOARD	ASSURANCE LEVEL	COMMITTEE UPDATE	NEXT ACTION	TIMESCALE
Operational Plan (Gateshead Health FT and QE Facilities)		The Committee received the Group Operation Plan and it was agreed for AuditOne to look at the layout of the report, the number of days planned and the carry over from 2018/19.		
External Audit ISA 260 Results Report Assurance on Quality Report	 	The Committee received the comprehensive update on the Annual Accounts ISA 260 report. The Committee received an update on the draft assurance on Quality Report. The key findings are outlined and we are still waiting for consistency checks.	Final version to QGC.	May Extraordinary Board

Assurance Key

	Level of Assurance
	Assured – there are no gaps in assurance
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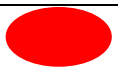	Not assured – there are significant gaps in assurance and we are not assured as to the adequacy of current action plans

ASSURANCE REPORT
Human Resources Committee – 11 June 2019

Gateshead Health NHS Foundation Trust

The Human Resources Committee has fulfilled its role and functions as defined within its terms of reference.

The reports received by the Human Resources Committee and level of assurance are set out below.

ISSUES TO BE RAISED TO BOARD	ASSURANCE LEVEL	COMMITTEE UPDATE	NEXT ACTION	TIMESCALE
People Strategy – Reward & Recognition		The Committee conducted a deep-dive into the Reward & Recognition strand of the People Strategy. Positive activity was noted over the last 12 months in relation to implementing ESR self-service, You're a Star/Star Awards, and commencement of HealthRoster roll-out, in addition to successful implementation of national pay changes. This is supported by positive assurance in staff survey questions in relation to staff involvement and recognition for good work. Discussion took place about the emerging challenges in relation to taxation and the NHS pension scheme which is being worked through by the Executive team.	Continue with people strategy work plan for 2019/20.	2019/20
HR Policies: • Managing Performance • Probation • Retirement		The Performance and Probation were new policies introduced in 2016 therefore a full review was undertaken with minor amendments. The Retirement policy was updated to reflect current practices.	Policies to be launched within the organisation.	Jun-19
Workforce Metrics		The Committee discussed all the workforce metrics, with a significant focus on the corporate and Business Unit actions in relation to sickness for reasons of mental health. The sustained improvement in core training compliance was noted however significant concern was expressed about the deteriorating position of appraisal completions.	All Business Units/Directorates to have a detailed plan in relation to completion of appraisals to rectify the current underperformance – and to deliver against plan.	By 1-July-19
Business Unit/Directorate Staff Survey Action Plans		The Committee received revised action plans from Community, Surgery, Medicine, Clinical Support and Corporate Nursing. They were amended and/or updated following the 2018 results where necessary.	Some specific areas of action identified within Business Units/Directorates.	Jun-Sept 2019

ISSUES TO BE RAISED TO BOARD	ASSURANCE LEVEL	COMMITTEE UPDATE	NEXT ACTION	TIMESCALE
Nurse Staffing Report		The Committee received this report for the first time to seek assurance that activities were underway to provide the correct level of nursing supply (not to scrutinise quality at a point in time which currently Trust Board receives). Further assurance was required in relation to other areas outside of inpatient wards, and to capture the recruitment and retention activities.	Revised report to be received at the next meeting.	Aug-19
Medical Appraisal and Revalidation Annual Report and Audit		The Committee approved for the annual submission to be made to NHS England, and signed off by the Medical Director (Responsible Officer) in relation to our processes and outputs in relation to the appraisals/ revalidation of medical staff.	Report and audit to be submitted to NHS England.	30-Jun-19
Trade Union Facility Time		The Committee received the 2018/19 Trade Union Facility Time report which is now a legal requirement outlining the number of trade union representatives in the organisation, the cost and percentage of time spent.	No further action.	
Guardian of Safe Working Quarter 4 report		The Committee received the Quarter 4 report and noted the exceptions are remaining static and only arising when a vacancy on a particular ward occurs.	No further action.	
Audit: • Equality Delivery System 2		The Committee received the final audit report and noted minor management actions.	None	
Workforce Risks		The Committee received all current open risks categorised as 'workforce' across the Trust and triangulated these with other papers/reports.	No further action.	

Assurance Key

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	Assured – there are no gaps in assurance
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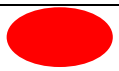	Not assured – there are significant gaps in assurance and we are not assured as to the adequacy of current action plans

Trust Board

Gateshead Health NHS Foundation Trust

Report Cover Sheet

Agenda Item: 17

Date of Meeting:	Wednesday 26th June 2019			
Report Title:	NHS Adult Inpatients Survey 2018			
Purpose of Report:	To provide the Trust Board with the results from the NHS Adult Inpatients Survey 2018.			
	Decision: ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
Corporate Objectives report relates to: (Including reference to any specific risk)	**Goal 2** All the services we deliver will be good or outstanding when assessed against being safe, effective, caring, responsive, and well-led. **Goal 3** In all locations and settings of delivery, our patients will experience excellent, timely and seamless care that meets their individual needs.			
Recommendations: (Action required by Board of Directors)	To receive the report for assurance.			
Financial Implications:	No.			
Risk Management Implications:	No.			
Human Resource Implications:	No.			
Equality and Diversity Implications:	**Objective 1** All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers.			
Author:	Wendy McFadden, SafeCare Lead – Clinical Effectiveness			
Presented by:	Hilary Lloyd, Director of Nursing, Midwifery & Quality			

Inpatient Survey 2018

Introduction

The Adult Inpatient Survey is the longest running survey in the NHS Patient Survey Programme. The Coordination Centre, based at Picker, manages and coordinates the programme at national level on behalf of the Care Quality Commission (CQC).

The survey is run on an annual basis, with all NHS acute trusts in England participating. The 2018 survey involved 144 NHS trusts in England.

The CQC published the Inpatient Survey 2018 results on Thursday 20th June 2019.

The Inpatient Survey 2017 looked at the experiences of 76,668 people who were discharged from an NHS acute hospital in July 2018. Between September and December 2018, a questionnaire was sent to 1,250 recent inpatients at each Trust. Responses were received from 589 of our patients.

Methodology

Patients were asked to answer questions about different aspects of their care and treatments. Based on their responses, Trusts are given a score out of 10 for each question (the higher the score the better).

Each Trust also received a rating of 'Better', 'About the same' or 'Worse'.

- Better: the trust is better for that particular question compared to most other trusts that took part in the survey.
- About the same: the trust is performing about the same for that particular question as most other trusts that took part in the survey.
- Worse: the trust did not perform as well for that particular question compared to most other trusts that took part in the survey.

Results

The Trust was rated as 8.4/10 for the overall experience.

- **Banding**

The Trust's results were better than most trusts for 4 questions:

4. Were you given enough privacy when being examined or treated in the A&E Department
6. How do you feel about the length of time you were on the waiting list before your admission to hospital?
14. Were you ever bothered by noise at night from other patients?

40. Were you given enough privacy when being examined or treated?

The Trust's results were worse than most trusts for 0 questions

The Trust's results were about the same as other trusts for 59 questions

- **Comparison with last year's survey**

The Trust's results were significantly higher this year for 2 questions:

29. In your opinion, were there enough nurses on duty to care for you in hospital?
40. Were you given enough privacy when being examined or treated?

The Trust's results were significantly lower this year for 11 questions

There was no statistically significant difference for 48 questions.

The full report is available at Appendix 1.

Recommendation

The Trust Board is asked to receive this report for assurance.

2018 Adult Inpatient Survey: Early release of CQC benchmark results

Results for Gateshead Health NHS Foundation Trust: Executive Summary

Respondents and response rate

- 589 Gateshead Health NHS Foundation Trust inpatients responded to the survey
- The response rate for Gateshead Health NHS Foundation Trust was 49.04%

Banding

Your trust's results were better than most trusts for **4** questions.

4. Were you given enough privacy when being examined or treated in the A+E Department?
6. How do you feel about the length of time you were on the waiting list before your admission to hospital?
14. Were you ever bothered by noise at night from other patients?
40. Were you given enough privacy when being examined or treated?

Your trust's results were worse than most trusts for **0** questions.

Your trust's results were about the same as other trusts for **59** questions.

Comparisons with last year's survey

Your trust's results were significantly higher ↑ this year for **2** questions.

29. In your opinion, were there enough nurses on duty to care for you in hospital?
40. Were you given enough privacy when being examined or treated?

Your trust's results were significantly lower ↓ this year for **11** questions.

The were no statistically significant differences between last year's and this year's results for **48** questions.

Tables of Results

Table 1: The Accident and Emergency Department

Question	Respondents	2018 Score	2018 Band	2017 Score	Change from 2017
3. While you were in the A+E Department, how much information about your condition or treatment was given to you?	336	8.6		8.7	
4. Were you given enough privacy when being examined or treated in the A+E Department?	370	9.5	Better	9.5	

Table 2: Waiting List or Planned Admission

Question	Respondents	2018 Score	2018 Band	2017 Score	Change from 2017
6. How do you feel about the length of time you were on the waiting list before your admission to hospital?	189	9.1	Better	9.0	
7. Was your admission date changed by the hospital?	190	9.1		9.4	
8. In your opinion, had the specialist you saw in hospital been given all of the necessary information about your condition or illness from the person who referred you?	190	9.3		9.4	

Table 3: Waiting to Get to a Bed on a Ward

Question	Respondents	2018 Score	2018 Band	2017 Score	Change from 2017
9. From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	579	7.4		7.8	

Table 4: The Hospital and Ward

Question	Respondents	2018 Score	2018 Band	2017 Score	Change from 2017
11. While in hospital, did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?	582	9.5		9.8	↓
13. Did the hospital staff explain the reasons for being moved in a way you could understand?	116	7.5		8.1	
14. Were you ever bothered by noise at night from other patients?	576	7.3	Better	7.8	
15. Were you ever bothered by noise at night from hospital staff?	579	8.4		9.0	↓
16. In your opinion, how clean was the hospital room or ward that you were in?	582	9.3		9.4	
17. Did you get enough help from staff to wash or keep yourself clean?	354	8.5		8.4	
18. If you brought your own medication with you to hospital, were you able to take it when you needed to?	337	7.5		7.5	
19. How would you rate the hospital food?	560	5.9		6.0	
20. Were you offered a choice of food?	577	8.4		8.4	
21. Did you get enough help from staff to eat your meals?	125	7.3		7.4	
22. During your time in hospital, did you get enough to drink?	567	9.4		9.5	
72. Did you feel well looked after by the non-clinical hospital staff (e.g. cleaners, porters, catering staff)?	535	9.3		9.5	

Table 5: Doctors

Question	Respondents	2018 Score	2018 Band	2017 Score	Change from 2017
23. When you had important questions to ask a doctor, did you get answers that you could understand?	516	8.3		8.4	
24. Did you have confidence and trust in the doctors treating you?	577	9.2		9.1	
25. Did doctors talk in front of you as if you weren't there?	573	8.9		9.0	

Table 6: Nurses

Question	Respondents	2018 Score	2018 Band	2017 Score	Change from 2017
26. When you had important questions to ask a nurse, did you get answers that you could understand?	491	8.4		8.7	
27. Did you have confidence and trust in the nurses treating you?	580	8.9		9.1	
28. Did nurses talk in front of you as if you weren't there?	580	8.8		9.1	↓
29. In your opinion, were there enough nurses on duty to care for you in hospital?	579	8.1		7.7	↑
30. Did you know which nurse was in charge of looking after you (this would have been a different person after each shift change)?	580	6.4		6.6	

Table 7: Your Care and Treatment

Question	Respondents	2018 Score	2018 Band	2017 Score	Change from 2017
31. Did you have confidence and trust in any other clinical staff treating you (e.g. physiotherapists, speech therapists, psychologists)?	385	8.7		8.9	
32. In your opinion, did the members of staff caring for you work well together?	562	8.9		9.1	
33. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?	576	8.1		8.6	↓
34. Were you involved as much as you wanted to be in decisions about your care and treatment?	575	7.3		7.5	
35. Did you have confidence in the decisions made about your condition or treatment?	575	8.6		8.7	
36. How much information about your condition or treatment was given to you?	549	8.9		9.1	
37. Did you find someone on the hospital staff to talk to about your worries and fears?	340	5.8		6.7	↓
38. Do you feel you got enough emotional support from hospital staff during your stay?	348	7.4		7.8	
39. Were you given enough privacy when discussing your condition or treatment?	573	8.9		9.0	
40. Were you given enough privacy when being examined or treated?	573	9.7	Better	9.5	↑
42. Do you think the hospital staff did everything they could to help control your pain?	372	8.2		8.1	
43. If you needed attention, were you able to get a member of staff to help you within a reasonable time?	537	8.0		8.1	

Table 8: Operations and Procedures

Question	Respondents	2018 Score	2018 Band	2017 Score	Change from 2017
45. Beforehand, did a member of staff answer your questions about the operation or procedure in a way you could understand?	291	8.9		9.1	
46. Beforehand, were you told how you could expect to feel after you had the operation or procedure?	306	7.8		8.3	
47. After the operation or procedure, did a member of staff explain how the operation or procedure had gone in a way you could understand?	308	7.9		8.3	

Table 9: Leaving Hospital

Question	Respondents	2018 Score	2018 Band	2017 Score	Change from 2017
48. Did you feel you were involved in decisions about your discharge from hospital?	551	7.2		7.5	
49. Were you given enough notice about when you were going to be discharged?	574	7.4		7.7	
51. Discharge delayed due to wait for medicines/to see doctor/for ambulance	554	6.7		6.9	
52. How long was the delay?	552	7.9		8.0	
54. After leaving hospital, did you get enough support from health or social care professionals to help you recover and manage your condition?	310	6.7		7.4	↓
55. When you left hospital, did you know what would happen next with your care?	489	7.0		7.3	
56. Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?	547	5.7		6.6	↓
57. Did a member of staff explain the purpose of the medicines you were to take at	423	8.3		8.7	

home in a way you could understand?					
58. Did a member of staff tell you about medication side effects to watch for when you went home?	348	5.1		5.5	
59. Were you given clear written or printed information about your medicines?	379	7.5		8.1	↓
60. Did a member of staff tell you about any danger signals you should watch for after you went home?	421	5.6		6.2	

Table 9: Leaving Hospital *(continued)*

Question	Respondents	2018 Score	2018 Band	2017 Score	Change from 2017
61. Did hospital staff take your family or home situation into account when planning your discharge?	387	7.5		7.9	
62. Did the doctors or nurses give your family, friends or carers all the information they needed to help care for you?	399	6.3		7.0	↓
63. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	511	7.8		8.2	
64. Did hospital staff discuss with you whether you would need any additional equipment in your home, or any adaptations made to your home, after leaving hospital?	183	8.3		8.6	
65. Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital (e.g. services from a GP, physiotherapist or community nurse, or assistance from social services or the voluntary sector)?	305	8.5		9.0	
66. Was the care and support you expected available when you needed it?	377	8.6			

Table 10: Overall Views of Care and Services

Question	Respondents	2018 Score	2018 Band	2017 Score	Change from 2017
67. Overall, did you feel you were treated with respect and dignity while you were in the hospital?	576	9.1		9.2	
69. During this hospital stay, did anyone discuss with you whether you would like to take part in a research study?	495	1.7			
70. During your hospital stay, were you ever asked to give your views on the quality of your care?	482	1.5		2.3	↓
71. Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?	449	2.1		2.7	↓

Table 11: Overall Experience

Question	Respondents	2018 Score	2018 Band	2017 Score	Change from 2017
68. Overall... I had a very good experience	549	8.4		8.5	

Table 12: Section Scores

Section	2018 Score	Band
Section 1. The Accident and Emergency Department	9.0	Better
Section 2. Waiting List or Planned Admission	9.1	
Section 3. Waiting to Get to a Bed on a Ward	7.4	
Section 4. The Hospital and Ward	8.2	Better
Section 5. Doctors	8.8	
Section 6. Nurses	8.1	
Section 7. Your Care and Treatment	8.2	
Section 8. Operations and Procedures	8.2	
Section 9. Leaving Hospital	7.2	
Section 10. Overall Views of Care and Services	3.6	
Section 11. Overall Experience	8.4	

Table 13: Demographic Information

Characteristic	%
Total respondents	589
Response rate	49.0
Gender	
Male	39.9
Female	60.1
Age	
16-35	3.8
36-50	7.8
51-65	20.0
>65	68.4
Ethnicity	
White	93.5
Multiple ethnic groups	0.2
Asian or Asian British	0.7
Black or Black British	0.2
Arab or other ethnic group	0.3
Not known	5.1

Table 14: Demographic Information (Continued)

Characteristic	%
Religion	
No religion	16.5
Buddhist	0.2
Christian	80.4
Hindu	0.4
Jewish	0.2
Muslim	0.5
Sikh	0.0
Other religion	0.7
Prefer not to say	1.1
Sexuality	
Heterosexual	94.1
Gay/lesbian	0.9
Bisexual	0.2
Other	0.7
Prefer not to say	4.0