MEETING OF THE BOARD OF DIRECTORS IN PUBLIC

Gateshead Health NHS Foundation Trust

Date: Wednesday 31st March 2021
Time: 09:30 am
Venue: via Microsoft Teams

AGENDA

	TIME	ITEM	STATUS	PAPER
1.	09:30 am	**Welcome and Chair's Business**		
2.	09:30 am	**Declarations of Interest** To declare any pecuniary or non-pecuniary interests *Check – Attendees to declare any potential conflict of items listed on the agenda to the Trust Secretary on receipt of agenda, prior to the meeting*	Declaration	Verbal
3.	09:30 am	**Apologies for Absence** *Quoracy check: (s3.3.31 SOs: No business shall be transacted at a meeting unless a minimum of **4** members of the Board (including at least **one** Non-Executive and **one** Executive Member of the Board) are present)*	Agree	Verbal
4.	09:35 am	**Minutes of the meeting held on 27th January 2021** To be agreed as an accurate record	Agree	Enclosure 4
5.	09:35 am	**Matters Arising/Action Log**	Update	Enclosure 5
6.	09:40 am	**Patient & Staff Story** To receive a presentation from: • Ged Knowles - Poem to Ward 22 • Aurial Reay - Deputy Sister, Critical Care	Assurance	Presentation
7.	09:50 am	**Staff Survey Results** To receive a presentation from the Executive Director of People & OD	Assurance	Enclosure 7
		ITEMS FOR DECISION		
8.	10:00 am	**Annual Declarations of Interest:** To receive the Declarations of Interest presented by the interim Trust Secretary	Approval	Enclosure 8
		ITEMS FOR ASSURANCE		
9.	10:05 am	**Assurance from Board Committees** i. Finance and Performance Committee – 26 January 2021 & 30 March 2021 (verbal) ii. Quality Governance Committee – 24 March 2021 iii. Audit Committee – 4 March 2021	Assurance	Enclosure 9
10.	10:15am	**Learning Lessons to Improve our People Practices** To receive the recommendations and Trust response presented by the Executive Director of People & OD	Assurance	Enclosure 10
11.	10:25 am	**COVID Update** To receive an update, presented by the Medical Director	Assurance	Verbal

12.	10:35 am	**Finance Update** To receive the report, presented by the Group Director of Finance	Assurance	Enclosure 12
13.	10:45 am	**Digital Update** To receive the report, presented by the Chief Informatics Officer	Assurance	Enclosure 13
14.	10:55 am	**Integrated Oversight Report** To receive the report, presented by the Chief Operating Officer	Assurance	Enclosure 14
15.	11:05 am	**Nurse Staffing Exception Report** To receive the report, presented by the Deputy Director of Nursing, Midwifery and Quality	Assurance	Enclosure 15
16.	11:10 am	**Integrated Quality and Learning Report** To receive the report, presented by the Deputy Director of Nursing, Midwifery and Quality	Assurance	Enclosure 16
17.	11:15 am	**Healthcare Associated Infections** To receive the report presented by the Medical Director	Assurance	Enclosure 17
18.	11:20 am	**EPRR Assurance Report** To receive the report presented by the Chief Operating Officer	Assurance	Enclosure 18
19.	11:30 am	**GP Practices Contract Update** To receive a briefing, presented by the Commercial Director	Assurance	Enclosure 19
		ITEMS FOR INFORMATION		
20.	11:40 am	**Questions from Governors in Attendance** To receive any questions from governors in attendance		Verbal
21.	11:50 am	**Date and Time of the next Meeting** The next scheduled meeting of the Board of Directors to be held in public will be 27th May 2020 at 9:30 am		Verbal
22.	11:50 am	**Chair Declares the Meeting Closed**		Verbal
23.	11:50 am	**Exclusion of the Press and Public** To resolve to exclude the press and public from the remainder of the meeting, due to the confidential nature of the business to be discussed		Verbal

Trust Board

Minutes of a meeting of the Board of Directors held at 9.30 am on Wednesday 27th January 2021, via Microsoft Teams

Gateshead Health NHS Foundation Trust

Present:	
Mrs A Marshall	Chair
Mrs J Baxter	Chief Operating Officer
Mr A Beeby	Medical Director
Mrs J Bilcliff	Group Director of Finance
Dr R Bonnington	Non-Executive Director
Ms L Crichton-Jones	Director of People & OD
Cllr M Gannon	Non-Executive Director
Mr P Harding	Commercial Director and Managing Director, QE Facilities
Mr P Hopkinson	Non-Executive Director
Mr A Moffat	Non-Executive Director
Mrs Y Ormston	Chief Executive
Mrs H Parker	Non-Executive Director
Mr M Robson	Non-Executive Director
Dr M Sani	Associate Non-Executive Director (NExT Placement)
Mr D Shilton	Non-Executive Director
In Attendance:	
Ms J Boyle	Well Led Peer Review
Mrs A Maskery	Interim Trust Secretary
Mrs D Renwick	Associated Director Planning & Performance
Dr K Roberts	Deputy Director of Nursing
Ms D Waites	Membership Office
Governors and Members of the Public:	
Mrs E Adams	Public Governor – Central
Mr J Bedlington	Public Governor – Central
Mr L Brown	Public Governor – Western
Mr S Connolly	Staff Governor
Reverend J Gill	Public Governor – Western
Mrs G Henderson	Public Governor - Western
Mr M Loome	Staff Governor
Mrs K Marley	Staff Governor
Mrs D Porteous	Appointed Governor
Mr G Riddell	Public Governor – Western
Mrs K Tanriverdi	Public Governor – Central
	3 x members of the public
Apologies:	
Dr H Lloyd	Director of Nursing, Midwifery and Quality

Agenda Item	Discussion and Action Points	Action By
21/01	**CHAIR'S BUSINESS:** The meeting being quorate, Mrs A Marshall, Chair, declared the	

<table>
<tr><th>Agenda Item</th><th>Discussion and Action Points</th><th>Action By</th></tr>
<tr><td></td><td>meeting open at 9.30 am and confirmed that the meeting had been convened in accordance with the Trust's Constitution and Standing Orders.</td><td></td></tr>
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<tr><td>21/02</td><td>DECLARATIONS OF INTEREST:

Mrs A Marshall, Chair, requested that Board members present report any revisions to their declared interests or any declaration of interest in any of the items on the agenda.</td><td></td></tr>
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<tr><td>21/03</td><td>APOLOGIES FOR ABSENCE:

Apologies were received from Dr H Lloyd, Director of Nursing, Midwifery and Quality. Dr K Roberts, Deputy Director of Nursing, was in attendance on her behalf.</td><td></td></tr>
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<tr><td>21/04</td><td>MINUTES OF THE PREVIOUS MEETING:

The minutes of the meeting of the Board of Directors held on Wednesday 25th November 2020 were approved as a correct record following a minor amendment.</td><td></td></tr>
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<tr><td>21/05</td><td>MATTERS ARISING FROM THE MINUTES:

The Board Action Plan was updated accordingly to reflect matters arising from the minutes.</td><td></td></tr>
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<tr><td>21/06</td><td>DECLARATIONS OF INTERESTS:

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

Mrs J Baxter, Ms L Crichton-Jones and Professor M Sani, 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>Mrs Joanne Baxter</td><td>Chief Operating Officer</td><td>None</td><td>None</td><td>-</td></tr>
<tr><td>Ms Lisa Crichton-</td><td>Executive Director of</td><td>Museums North</td><td>None</td><td>D</td></tr>
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Agenda Item	Discussion and Action Points	Action By

Jones	People & OD	East Durham College		E
Professor Mojgan Sani	Associate Non-Executive Director	Director of OEC Ltd (provider of clinical pharmacy education/ events) Public Governor at TEWV representing Stockton-on-Tees	None	A D

It was noted that Professor Sani also works as the Chief Pharmacist/ Associate Director of Medicine Optimisation for North Tees and Hartlepool NHS Foundation Trust however is not included in the categorisation.

Mrs Marshall confirmed that Mrs Baxter, Ms Crichton-Jones and Professor Sani have signed the declaration and a search of insolvency, bankruptcy and disqualified directors' registers has also taken place.

Following discussion, it was:

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

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

21/07 **COVID UPDATE:**

Mr A Beeby, Medical Director, provided a verbal update to the Board on the work being carried out due to new Covid requirements.

He reported that there is regional pressure on intensive care units however Covid cases are falling within the community and subsequently one of the Covid wards has been de-escalated. Outbreak management is well controlled within the Trust.

The Trust has administered over 5,000 first doses of the Covid vaccine and the first stage of the programme is almost complete. As outlined nationally, the second dose must be delayed until 12 weeks after the first and plans are in place for the second doses to commence early March 2021.

Ms L Crichton-Jones, Executive Director for People & OD, reported that the staffing position has been difficult and challenging. National Health and Well-Being tools are being promoted and there is also local support for teams. Funding has been secured to provide

Agenda Item	Discussion and Action Points	Action By
	additional staff for Critical Care and other funding will provide break out rooms and rest places. Mr D Shilton, Non-Executive Director, raised a query in relation to the escalation letter regarding increased capacity and Mr Beeby confirmed that plans are in place if required however this reflects the national variance and cases locally are declining. Following a query from Mr A Moffat, Non-Executive Director, on percentage levels for the uptake of the vaccine, Mr Beeby explained that some health and social care staff still required their first dose but the team have been unable to establish contact. Ms Crichton-Jones confirmed that regular publication across the Trust continues to take place as well as national campaigns. Cllr M Gannon, Non-Executive Director, commented that consideration may be required for the possibility of future legislation to ensure the health and safety of staff and Mr Beeby reported that similar measures have been taken in relation to the flu vaccination programme and audits are being carried out. Mrs Y Ormston, Chief Executive, queried whether there was any comparable data available in relation to the number of deaths and Mr Beeby reported that this is being discussed at the monthly regional mortality meetings however may be some time before the true effects of the pandemic are known. After further discussion, it was: **RESOLVED:** to receive the update for assurance	
21/08	**FINANCE UPDATE:** Mrs J Bilcliff, Group Director of Finance, provided the Board with a summary of performance as at 31st December 2020 (Month 9) for the Group (inclusive of Trust and QE Facilities, excluding Charitable Funds). The report highlights a current underspend against plan however Mrs Bilcliff reported that this is expected and the Trust is continuing to formally forecast a year end outturn to plan. The current cash position is above plan however will be regularised by year end. Mrs Bilcliff drew attention to the Board that there are a number of risks that must be noted alongside consideration of the financial position in particular the uncertainty around Covid and possible effects on demand and capacity. Formal discussions continue to take place via the Finance & Performance Committee.	

Agenda Item	Discussion and Action Points	Action By
	After consideration, it was: **RESOLVED:** to receive the report for assurance	
21/09	**INTEGRATED QUALITY & PERFORMANCE REPORT:** Mrs J Baxter, Chief Operating Officer, presented the Integrated Quality and Performance Report (IQPR) and highlighted the new format. She explained that this report is continually being developed and will be further streamlined once the process is up and running. It will now be produced on a monthly basis to monitor key performance indicators mapped to the CQC's Key Lines of Enquiry including national and local (plus phase 3) performance indicators together with clinical quality, patient safety indicators and workforce metrics. Mrs Baxter provided the Board with the following key messages and highlighted the challenges in recovering activity during the second and third wave of the pandemic and impact on performance: • Overall activity down – focus on discharge and maximising patient flow • A&E performance is currently below standard however there has been increased activity and re-organisation of front house to accommodate red zone patients • There has been increased demand for two week waits in cancer, particularly breast referrals and these are being prioritised on a weekly basis • Diagnostics, 18 weeks RTT and cancer compliance continues to be impacted by Covid-19 • Further investigation and report back required in relation to ensuring clinical prioritisation plans are implemented as per the recent guidance. This will take place via the Quality Governance Committee. Discussion took place regarding national performance targets and whether these measures were relevant during the pandemic. Mr M Robson, Vice Chair, highlighted that this had been raised in the Finance and Performance Committee and Mrs Y Ormston, Chief Executive, emphasised that these should continue to be monitored to highlight any patient risk and should be triangulated with quality and safety. Mrs Baxter reported that it is recognised that waiting lists will continue to go up and needs to be balanced with theatre capacity. Mrs Renwick, Associate Director for Planning & Performance, reported that letters have been distributed to patients to highlight any deterioration in conditions and ensure any changes are communicated.	

Agenda Item	Discussion and Action Points	Action By
	Mrs Marshall confirmed that detailed discussions have taken place at the Finance and Performance Committee and were assured that measures are in place. The new IQPR report will also be presented at other Board Committees as relevant to provide further assurances. Following further discussion and consideration, it was: **RESOLVED:** i) to receive the IQPR for December 2020 ii) to note Trust performance and regional achievement against standards iii) to seek further information and test robustness of plans as is required, allowing judgement regarding levels of assurance for future levels of operational performance.	
21/10	**HEALTHCARE ASSOCIATED INFECTIONS (HCAI):** Mr A Beeby, Medical Director and Joint Director of Infection Prevention and Control, provided an update to the Board on the current performance of HCAI mandatory reporting for Gateshead Health NHS Foundation Trust throughout the 2020-21 period. Mr Beeby reminded the Board that concerns were raised in October 2020 relating to the number of Covid outbreaks across the site and in accordance with the Trust's outbreak strategy, immediate action was taken which included a two week circuit break to allow the organisation to recover during the second lockdown. This resulted in a reduction in cases by the end of November 2020. A "deep dive" exercise is being undertaken in relation to nosocomial Covid infections and the Mortality Council will be reviewing the results in detail to provide learning and a greater understanding around control management. Following a query from Ms Crichton-Jones, in relation to the distribution of learning findings, Mr Beeby explained that communications are being distributed across the Trust and IPC Guardians have been introduced to ensure successes are adopted. In relation to other HCAI infections, there have been no influenza cases reported and Mr Beeby felt that this may be as a result of social distancing measures. There have also been no MRSA cases and there has been a reduction in reported C-Difficile infections. Mrs Marshall congratulated the teams on behalf of the Board and thanked them for their hard work. After consideration, it was:	

Agenda Item	Discussion and Action Points	Action By
	RESOLVED: to receive the report for assurance	
21/11	**NURSE STAFFING EXCEPTION REPORT & ANNUAL CAPACITY AND CAPABILITY REPORT** Dr K Roberts, Deputy Director of Nursing, Midwifery and Quality, provided assurance to the Board that staffing establishments are being met on a month by month basis for November and December 2020 and presented the annual report which provides a comprehensive review of inpatient/ward nurse staffing establishments across the organisation. Dr Roberts reported that during the months of November and December 2020, significant staffing challenges were experienced due to sudden absence and redeployment of staff related to Covid-19. Areas of deficit were escalated to the Senior Nurse on duty and mitigations were put in place by the wider Matron teams. The Trust also has a process in place via the Datix system for reporting and monitoring any concerns regarding nurse staffing levels however confirmed that there no incidents resulting in patient harm. Dr Roberts also presented the Annual Capacity and Capability Report and explained that this provides clear methodology for agreeing nursing and midwifery staffing numbers and establishments, including the responsive re-deployment of staff and rapid agreeing of the safest staffing levels to respond to Covid-19. It provides information on the agreed number of staff needed on a shift by shift basis on each ward and meets the requirement in expectations set out by the National Quality Board and provides assurance that the Trust has robust systems in place to safeguard the quality of care provided to patients. This report has been presented to the Quality Governance Committee in December 2020 for scrutiny and discussion. Dr Roberts highlighted that in response to the Covid-19 pandemic, forty eight Aspirant Nurses and two Aspirant Midwives joined the Trust on a short term basis and have now been offered full time fixed term contracts. Ms L Crichton-Jones, Executive Director of People & OD, highlighted that this work demonstrates the people approach and work will be undertaken to develop a strategy for Gateshead. It also highlights the importance of supply and data and reported that work is being undertaken to refresh key people risks which will be discussed in more detail at the Executive Team meeting and HR Committee in February 2021. This will then be reported to the Board via reporting of high scoring risks of 15 and above. Ms Crichton-Jones and Mrs Baxter will also discuss triangulation to the IQPR report to ensure	LCJ/ JMB

Agenda Item	Discussion and Action Points	Action By
	accurate data is available to populate reports which in turn will benefit ward and bed base planning as well as forecasting data. Following further discussion, it was: **RESOLVED:** to receive the Nurse Staffing Exception Report and Annual Capacity and Capability Report for assurance and information.	
21/12	**INTEGRATED QUALITY AND LEARNING REPORT:** Mr A Beeby, Medical Director, provided an update to the Board on the Trust's quality and safety performance in the last 18 months to December 2020. He highlighted that there were no outliers to report however drew attention to the new process which has been introduced in relation to pressure damage grading and Dr K Roberts, Deputy Director of Nursing, Midwifery and Quality explained that this was due to a new national framework and a report will be presented to the Quality Governance Committee due to concerns raised. Following a query relating to volunteers, Dr Roberts reported that volunteers were now being deployed on wards following the completion of the Trust's staff risk assessment. PPE marshalls have also been introduced to support frontline staff. Mrs Marshall wished to thank the volunteers for their support on behalf of the Board. Ms Crichton-Jones, Executive Director of People & OD, raised a query in relation to learning from never events and Mr Beeby explained that all never events are reviewed by the Serious Incident (SI) Panel. Mrs J Baxter, Chief Operating Officer, highlighted that there had been some delays in finalising SI reports due to capacity however teams are liaising closely with the CCG and plans to introduce a 72 hour learning report out are being put in place. Following consideration, it was: **RESOLVED:** to receive the report for assurance	KR
21/13	**MORTALITY QUARTERLY REPORT:** Mr A Beeby, Medical Director, updated the Board upon ongoing work in relation to mortality within the Trust. He reported that the Trust's latest published SHMI (Summary Hospital-level Mortality Indicator) is 1.07 placing the Trust with the	

Agenda Item	Discussion and Action Points	Action By
	banding of deaths 'as expected'. The Board noted that Covid activity has been excluded from the SHMI. The HSMR (Hospital Standardised Mortality Ratio) for Gateshead in the last 12 months (October 2019 to September 2020) is 118.6 which places the Trust with 'more deaths than expected' as calculated by the model. However Mr Beeby explained that caution is required when interpreting the mortality indices this year due to the removal of Covid activity which has resulted in smaller denominators being used in the calculation. NEQOS has been commissioned to undertake a review and analysis of the Trust's mortality data due to the HSMR result and Mrs Marshall highlighted that NEQOS have offered to provide a session to the Board to discuss the findings in more detail. Therefore this will be considered for a future Board Strategy Session. Mr Beeby informed the Board that that a process has been developed for hospital acquired Covid deaths and explained that all 'definite' hospital acquired Covid-19 infections will be automatically referred to the Mortality Council for review and 'community onset' 'indeterminate' and 'probable' cases will be reviewed if there are any issues identified at either Medical Examiner review or Level 1 review. After further discussion, it was: **RESOLVED:** to receive the report for assurance	AMa
21/14	**OCKENDEN REVIEW OF MATERNITY SERVICES LETTER OF RESPONSE:** Mr A Beeby, Medical Director, outlined the Trust's response to the Ockenden Review of Maternity Services which confirms compliance with the immediate actions set out in the NHSE/I letter and includes plans to meet the Birthrate Plus standard by 31 January 2021. Mr Beeby reported that the recommendations and immediate actions had been reviewed by the Trust and emergency measures have been put in place. These included additional consultant weekend ward rounds and the appointment of a temporary Midwife Lead. He highlighted that quality and performance information will be presented to the Board in the future in a similar format to the Integrated Quality & Leaning Report and this is being developed across the region. Trusts were also asked to complete an assurance assessment tool to provide further detailed evidence and a peer review is being undertaken to assist with this and an update will be provided at the next meeting. This will include work to ensure the Birth Rate Plus Standard is also being met.	AB

Agenda Item	Discussion and Action Points	Action By
	Mr D Shilton, Non-Executive Director, highlighted that discussions have taken place to ensure that Boards are made aware of maternity plans as well as service user views therefore it is important to receive information on a regular basis. Mrs Y Ormston, Chief Executive, thanked Mr Shilton for his input and highlighted that the Trust is in a good position following its review last year with plans in place around a number of improvement areas following discussions with staff. Consequently, maternity services have been raised as a priority area and discussions have commenced in relation to the Capital Programme. She also reported that there is a strong focus going forward in relation to Serious Incidents and it is therefore important that the Board is made of aware of these to ensure patient experience benefits. Following consideration, it was: **RESOLVED:** to receive the report for assurance.	
21/15	**ASSURANCE REPORTS FROM BOARD COMMITTEES** The Board Committee Chairs provided updates from the assurance reports as follows: **i) Finance & Performance Committee** Mr M Robson provided the assurance report for the Committee meeting held on Tuesday 24th November 2020 and a verbal update for the meeting on 26th January 2021. He reported that it is essential that assurances are provided in the current climate and the Committee recognised that some targets within the Financial Plan may not be met and a strong understanding of risks and non-delivery was required (red rating). Additional detail has been requested in relation to the Capital Plan and this will be discussed at the next meeting in February 2021 (amber rating). **ii) Quality Governance Committee** Mr D Shilton provided the assurance report for the Committee meeting held on 16th December 2020 and a verbal update for the meeting on 20th January 2021. He reported that the maternity review has been rated as Amber however this has been replaced by the Ockenden review work and action plan. SI reports and complaints has been rated as Amber however the Committee acknowledged that the delays were caused by Covid. Mrs J Baxter, Chief Operating Officer, reported that capacity was being looked at	

Agenda Item	Discussion and Action Points	Action By
	to undertake analysis work in relation to SI reports as well as complaints and interim measures were being put in place. A shortened meeting took place in January 2021 where the IPC BAF was reviewed and was agreed as being on target. The maternity action plan was also reviewed as reported previously. **iii) Audit Committee** Mr A Moffat provided the assurance report for the Committee meeting held on 3rd December 2020. He highlighted that appropriate action plans were in place to address any gaps. Due to ongoing issues in relation to the NHS Counter Fraud Authority reporting system, a letter from the Audit Chair and Mrs Bilcliff will be sent to NHS Counter Fraud to address this. Mr M Robson reported discussions took place around whether some learning was required around the outstanding audit actions review dates as some of these seemed unrealistic and Mrs Bilcliff highlighted that these actions would be reviewed by the Executive team and collective responsibility agreed to ensure a more robust process is put in place. She explained that some of these actions were historical however will ensure these are reduced by the next meeting. The Risk Management Policy was rated as amber however it was felt that robust processes were in place for the Risk Register and BAF. The findings from the Risk Review have been presented to the Executive team and will be included in the work around the new cycle of business. After consideration, it was: **RESOLVED:** to receive the reports for assurance	JB
21/16	**QUESTIONS FROM GOVERNORS IN ATTENDANCE:** Mr J Bedlington wished to express his appreciation to Trust teams in relation to the high percentage of staff vaccinations provided within the short timescales and the collection of data for performance indicators. He also highlighted the excellent work of the IPC team in ensuring that healthcare associated infections targets remain one of the lowest in the region during this difficult time. He also welcomed the news that cladding had been replaced in line with fire safety precautions and Mrs Marshall thanked Mr Harding and the QE Facilities team for this work.	

Agenda Item	Discussion and Action Points	Action By
	Mr M Loome raised a query in relation to workforce data and whether it was possible to breakdown into frontline clinical and clerical staff. Ms L Crichton-Jones reported that this will be available in future and will be included in information provided to the HR Committee. Mr S Connolly highlighted that he has been involved in the volunteer work within the red Critical Care area and has been working as one of the Marshalls. He reported that staff have adhered to advice given and the team received no challenges. A volunteer recruitment process is also being undertaken and he has been involved in 25 telephone interviews. Mrs Marshall thanked all volunteers for their support on behalf of the Board. Mrs K Tanriverdi raised a query in relation to flu admissions and whether there were any underlying cases within the community. Mr A Beeby reported that there were no signs of cases and felt that this was a positive outcome in light of the pandemic. Mrs Marshall brought the meeting to a close and highlighted that this is the last meeting for Mr P Harding and Dr H Lloyd. She reported that Mr Harding had been with the Trust for nearly 39 years and thanked him for his hard work and wished him well in his retirement. Dr H Lloyd has been with the Trust for the past 10 years leading on nursing, midwifery and quality. Mrs Marshall thanked her for her continued support and hard work and wished her well in her new role.	
21/17	**DATE AND TIME OF THE NEXT MEETING:** **RESOLVED:** that the next meeting of the Board of Directors will be held at 9:30 am on Wednesday 31st March 2021 via Microsoft Teams	
21/18	**EXCLUSION OF THE PRESS AND PUBLIC:** **RESOLVED:** to exclude the press and public from the remainder of the meeting due to the confidential nature of the business to be discussed	

PUBLIC BOARD ACTION TRACKER

Gateshead Health NHS Foundation Trust

Item Number	Date	Action	Deadline	Executive Lead	Progress
20/158	25/11/2020	People's Plan – wider discussion to take place at future board development/strategy session	31/03/2021	LCJ	April Board Strategy session
21/11	31/01/2021	Nurse Staffing – work to refresh workforce metrics/high scoring risks. To triangulate with IQPR report. To be discussed at HRC	01/04/2021	LCJ/JMB	
21/12	31/01/2021	IQFR – new process for pressure damage grading. To review and report to go to QGC next month	26/02/2021	KR	
21/13	31/01/2021	Mortality Report – NEQAS session re. HSMR. Schedule in for future Board Strategy Session	30/04/2021	AMa/DW	
21/14	31/01/2021	Ockenden Review – assessment tool to be submitted by 14.02.2021 and update to next Board.	31/03/2021	AB	Covid Committee 24.02.2021
21/14	31/01/2021	Serious Incidents – focus going forward to ensure Board sighted on details (inc maternity). To look at interim actions	31.03.2021	JMB	
21/15	31/01/2021	Audit Committee Assurance Report – outstanding audit actions/recommendations to be reviewed at Exec Team. New cycle of business to be implemented.	31.03.2021	JB	

Gateshead Health
NHS Foundation Trust

Report Cover Sheet

Agenda Item: 7

Purpose of Report	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☒
Report Title:	NHS Staff Survey 2020 – Board Overview			
Name of Meeting:	Trust Board			
Date of Meeting:	31 March 2021			
Author	Laura Farrington			
Executive Lead	**Lisa Crichton-Jones**			
Report presented by	**Lisa Crichton-Jones**			
Executive Summary	Following the publication of the 2020 NHS Staff Survey results a paper and supporting presentation of the Trust's headline results, benchmarked against Trusts within the region and including an outline of plans to drive engagement and improvements over the coming 12 months through a number of key initiatives, including the introduction of a representative Staff Survey Steering group. We also propose using part of the April Board Development session, which will focus on People and OD to explore the results in further detail.			
Recommended actions for Board/Committee)	Oversight & comments welcomed			
Trust Aims that the report relates to: **(Including reference to any specific risk)**	**Aim 1** ☐	We will provide consistently high quality care in all our services		
	Aim 2 ☒	We will be a great organisation to work in		
	Aim 3 ☐	We will deliver value for money and strengthen delivery of our clinical services		
	Aim 4 ☐	We will work with our partners to help make Gateshead a place where everyone thrives		
	Aim 5 ☐	We will use our expertise to provide specialist services beyond Gateshead		
Financial Implications:	None			
Links to Risks (identify significant risks and DATIX reference)	None			
People and OD Implications:	The Staff Survey is led by the People & OD Directorate, with the aim of improving the colleague experience through a representative steering group.			
Links to CQC KLOE	Caring ☒	Responsive ☒	Well-led ☒	Effective ☒	Safe ☒

Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)	**Obj.1** ☒	The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance between working life and personal commitments
	Obj. 2 ☐	All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers
	Obj. 3 ☒	Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve

NHS
Gateshead Health
NHS Foundation Trust

Staff Survey 2020 - Position Paper

1. Background & Current Position

The 2020 NHS Staff Survey launched across the organisation on 1 October 2020, using a combination of online and postal invitations and closed on the 27 November 2020. As in previous years we partnered with Quality Health, an external third party provider, who administered the survey on our behalf. Although the decision was made to proceed with the 2020 Staff Survey a number of changes were made, including the introduction of questions specifically related to the Covid-19 pandemic with the aim of further understanding the impact the pandemic has had on staff.

The response rate for the 2020 survey was 39%, compared with 41.9% in 2019 and the results of the 2020 NHS Staff Survey were published on 11 March 2021. Prior to the embargo being lifted Quality Health shared a Management Report, Summary Report and Directorate Reports with the Trust's senior team. They also delivered a presentation to the Executive team which offered an overview of the results and identified key insights and recommended areas of focus.

2. Headline Results

The results show staff feel a high level of engagement, with the staff engagement score, which is calculated as an average across advocacy, motivation and involvement, reaching 7.14 out of 10. This is higher than the sector score and in the area of advocacy the number of colleagues who would recommend our Trust as a place to work and receive care scored significantly higher than the sector average at 7.46 out of 10.

The results showed that our staff recognise the difference that they make to our patients and service users and also feel that they are treated fairly regardless of ethnic background, gender, religion, sexual orientation, disability or age. Staff also feel safe when raising concerns relating to errors and near misses, as well as unsafe clinical practices.

The results suggest areas where we have an opportunity to improve include continuing to open up communication channels between senior managers and staff and ensuring we celebrate our successes. The data also focuses on the role of line managers and the importance of supporting our line managers in the work they do to manage our people and the importance of health & wellbeing is also evident.

3. Actions Underway and Planned

A number of actions are already underway in our key areas of focus and include the appointment of a new Head of Communications. A review of the Trust's communication strategy is currently underway and fortnightly Executive Team Briefs have been introduced. Leadership & OD and Health & Wellbeing both feature in the Trust's strategic priorities and a post-covid Health & Wellbeing recovery programme has begun.

We are currently running a series of themed focus groups that are open to all staff and explore Equality, Diversity and Inclusion, Health & Wellbeing, Our Managers, Team Working and Communications. These workshops aim to provide a forum for staff to discuss the results in more detail and explore thoughts and ideas for improvement.

In addition and to provide a coordinating body that can lead, support and promote the staff survey, as well as encourage engagement at an operational level, we will launch a Staff Survey Steering Group with representatives from each business area. This group will play a pivotal role in determining priorities, overseeing the cascade of results and working within their area to support the development of action plans. A key deliverable of this group will be to increase the 2021 response rates.

To encourage ownership and increase the accessibility of the data, we will also grant access to Quality Health's online results portal to a number of key colleagues across the organisation including the E, D & I Manager, Communications Manager, Staff Steering Group Members and HR colleagues. This access will allow them to investigate areas of particular interest, view results on-demand and share them as appropriate. This devolved model allows the data to be more widely accessed, with the aim of increasing its visibility and practical application.

4. Thematic Analysis of Open Questions

A key element of the staff survey question set is a number of open questions that encourage participants to detail their thoughts and feedback. This data is expected within a few weeks and is currently being thematically analysed by the Coordination Centre. Once available, this data will provide a rich source of information that will help to inform local plans and will also be used to support the continued communications approach.

5. Communications Approach

The Communications team are currently promoting the Trust results internally via QE Weekly, staff emails and the Staff Zone intranet pages. The team are also using our external social media channels to promote the Trusts results to a wider audience and this will continue over the coming months. Work is also underway to draft and share case studies that will communicate the results in a relatable and personable way.

Please see link below:
https://www.nhsstaffsurveys.com/Page/1105/Latest-Results/NHS-Staff-Survey-Results/

Gateshead Health
NHS Foundation Trust

NHS Staff Survey 2020

Board Overview

Quality and excellence in health

Staff Survey – Key Facts

Gateshead Health
NHS Foundation Trust

- Quality Health were our delivery partner for the 2020 NHS National Staff Survey.
- The survey window remained open for 8 weeks.
- We ran a predominately online survey.
- Our comparator group was Acute & Acute & Community Trusts.
- There are 128 Acute & Acute & Community Trusts in total and 61 of these partner with Quality Health.
- The national results were published by NHS England on 11 March 2021.

Response Rates

Gateshead Health NHS Foundation Trust

Our response rates can be seen below:

	Usable Sample	*Completed*	*Response Rate*	
2020 Trust	3,855	1,505	39.0%	Online & Paper
2020 QH	568,073	257,321	45.3%	
2019 Trust	3,741	1,566	41.9%	Online & Paper
2019 QH	522,021	242,936	46.5%	

Headline Results

Gateshead Health NHS Foundation Trust

- Overall Staff Engagement is calculated as an average across Advocacy, Motivation and Involvement.
- Overall Trust Staff Engagement Score 2020 is 7.14 and the breakdown is shown below:

	2020 Score	2019 Score	Diff	Sector score	Diff
Advocacy	7.46	7.39	+0.07 (Not sig.)	7.17	+0.29 (Sig.)
Motivation	7.14	7.24	-0.10 (Not sig.)	7.23	-0.08 (Not sig.)
Involvement	6.83	6.91	-0.08 (Not sig.)	6.75	+0.09 (Not sig.)
Overall Staff Engagement	7.14	7.22	-0.08 (Not sig.)	7.04	+0.10 (Not sig.)

The Positives

NHS
Gateshead Health
NHS Foundation Trust

- We have a high level of engagement within our organisation, scoring significantly higher than the sector score in the area of advocacy: **7.46**/10 compared with the sector score of 7.17/10
- Colleagues would recommend our Trust as a place to work and receive care.
  - I would recommend my organisation as a place to work: **71%** compared with the sector score of 67%
  - If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation: **80%** compared with the sector score of 75%
- Staff recognise the difference that they make to our patients and service users
  - Care of patients/service users is my organisations top priority: **84%** compared with the sector score of 80%
  - I feel that my role makes a difference to patients / service users: **91%** compared with the sector score of 90%
- Staff feel that they are treated fairly regardless of ethnic background, gender, religion, sexual orientation, disability or age.
  - Does your organisation act fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age? **90%** responded positively compared with the sector score of 83%
  - Experienced discrimination at work from a manager / team leader or other colleagues in the last 12 months: **6%** compared with a sector score of 9%
- Staff feel safe to raise concerns
  - My organisation encourages us to report errors, near misses or incidents: **90%** compared with the sector score of 88%
  - I would feel secure raising concerns about unsafe clinical practices: **75%** compared with the sector score of 71%.

Areas of Focus

Gateshead Health
NHS Foundation Trust

- Need to continue to open up communication channels between senior managers and staff
  - I know who the senior managers are here: **82%** which is a drop of 4% from 2019.
  - Communication between senior management and staff is effective: **38%** which is a drop of 5% from 2019.
  - Senior Managers here try to involve staff in important decisions: **31%** which is a drop of 8% from 2019.
- Ensure we celebrate our successes.
  - How satisfied are you with the extent to which my organisation values my work? **48%** which is a drop of 3% from 2019
- Need to focus on the role of line managers
  - My immediate manager can be counted on to help me with a difficult task at work: **71%** which is a decline of 4% from 2019.
  - The team I work in often meets to discuss the team's effectiveness: **56%** which is drop of 8% from 2019
  - My immediate manager encourages me at work: **69%** which is a drop of 3% from 2019
- Continue our focus on health & wellbeing
  - During the last 12 months have you felt unwell as a result of work related stress? **44%** which is an increase of 8% from 2019
- Highlight the importance of appraisals
  - My immediate manager values my work: **71%** which is a drop of 3% from 2019

Action Taken

Gateshead Health
NHS Foundation Trust

In these key areas of focus, actions that have already been taken include:

- New appointment to the Head of Communications role
- A review of the trust's communication strategy is currently underway
- Executive Team Briefs have been introduced on a fortnightly basis
- Leadership & OD and health & wellbeing have been identified as strategic People & OD priorities.
- A post-covid Health & wellbeing recovery programme has commenced.

Next Steps

Gateshead Health
NHS Foundation Trust

- Staff Survey Steering Group will lead the approach
- Themed Focus Groups to inform the steering group
- Action Planning will be a key focus of Steering Group
- Devolved results cascade model
- Commitment to increasing our response rate for 2021

Gateshead Health
NHS Foundation Trust

Report Cover Sheet

Agenda Item: 8

Purpose of Report	Decision: ☒	Discussion: ☐	Assurance: ☐	Information: ☐
Report Title:	Declaration of Board Members Interests and Fit and Proper Persons Declaration			
Name of Meeting:	Trust Board			
Date of Meeting:	Wednesday 31st March 2021			
Author	Diane Waites, Corporate Services Assistant			
Executive Lead	Kirsty Roberton, Deputy Director of Corporate Services & Transformation			
Report presented by	Amanda Maskery, Interim Trust Secretary			
Executive Summary	In accordance with section 20 of Schedule 1 of the Health & Social Care (Community Health and Standards) Act 2003 NHS Foundation Trusts are required to maintain a register of Directors' and Governors' interests. This requirement is also enshrined in section 10 of the Trust's Constitution. Also included is the Fit and Proper Persons Test required by the Health Act 2012 and subsequently the Trust's Standard Licence Conditions. The register for Gateshead Health NHS Foundation Trust is held at Trust Headquarters and is available to the public through the Trust Secretary. This availability is published in the annual report and on the Trust's web site. The declared interests for 2020/21 for the Chair and Board members are attached as appendix 1 and the Fit and Proper Persons Declaration as appendix 2.			
Recommended actions for Board/Committee)	The Board is asked to: • Approve and record in the Board minutes the declared interests and Fit and Proper Persons Declaration as shown in appendices 1 and 2. • Note that the next full routine review of the declaration of Board members' interests will take place in March 2022.			
Trust Aims that the report relates to: **(Including reference to any specific risk)**	**Aim 1** ☐	We will provide consistently high quality care in all our services		
	Aim 2 ☐	We will be a great organisation to work in		
	Aim 3 ☐	We will deliver value for money and strengthen delivery of our clinical services		

	Aim 4 ☐	We will work with our partners to help make Gateshead a place where everyone thrives				
	Aim 5 ☐	We will use our expertise to provide specialist services beyond Gateshead				
Financial Implications:	None					
Links to Risks (identify significant risks and DATIX reference)	None					
People and OD Implications:	None					
Links to CQC KLOE	Caring ☐	Responsive ☐	Well-led ☒	Effective ☐	Safe ☐	
Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)	**Obj.1** ☐	The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance between working life and personal commitments				
	Obj. 2 ☐	All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers				
	Obj. 3 ☐	Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve				

Appendix 1

Gateshead Health NHS Foundation Trust

Register of Board Member Interests 2020/2021

Name	Position	Interest	Interest of Spouse	Category
Mrs Jo Baxter	Chief Operating Officer	None	None	
Mr Andrew Beeby	Medical Director	Joint Director of "A R Beeby Ltd" – medico-legal reporting company	Rebecca Beeby – Joint Director of same company	A
Mrs Jackie Bilcliff	Group Director of Finance	None	None	
Dr Ruth Bonnington	Non-Executive Director	(i) a partners in Gateshead General Practice (Bewick Road Surgery) (ii) a director of a R&M Bonnington	(ii)M Bonnington – Director in same company	A
Ms Lisa Crichton-Jones	Exec Director of People & OD	East Durham College		E
Cllr Martin Gannon	Non-Executive Director	Newcastle Airport Local Authority Holding Company Limited Leader of Gateshead Council	None	A F
Mr Paul Hopkinson	Non-Executive Director	Partner PL Law LLP Trustee – FACT – Fighting All Cancers Together	None	B D

Name	Position	Interest	Interest of Spouse	Category
Mrs Alison Marshall	Chair	NED of Northern Powergrid (Northeast) plc and Northern Powergrid (Yorkshire) plc Ambassador for North Northumberland Hospice Care	NED of North East Ambulance Service NHS Foundation Trust NED of North East Ambulance Service Unified Solutions Ltd NED of Newcastle Gateshead Initiative (Chair) Chair of North East England Chamber of Commerce Director of Newcastle United Foundation Projects Ltd NED of Believe Housing Ltd Chair of Trustees – Newcastle United Foundation Ambassador for North Northumberland Hospice Care Chair of Regional Development Committee, Prince's Trust	A D E
Mr A Moffat	Non-Executive Director	Board member – North East Local Enterprise Partnership (NELEP) Chair – NELEP Investment Board		F
Mrs Y Ormston	Chief Executive	None	None	
Mrs H Parker	Non-Executive Director	Director – Kingston Properties Ltd Chair – University of Newcastle Development Trust Consultant – Sintons LLP		A D F
Mr Anthony Robson	Interim Managing Director QEF	None	None	

Name	Position	Interest	Interest of Spouse	Category
Mr Mike Robson	Non-Executive Director	Vice-President St Oswald's Hospice	None	D
Dr Mojgan Sani	Associate Non-Executive Director	Director of OEC Ltd (provider of clinical pharmacy education/ events) Public Governor at TEWV representing Stockton-on-Tees Chief Pharmacist/Associate Director of Medicines Optimisation for North Tees & Hartlepool NHSFT		A D F
Mr David Shilton	Non-Executive Director	Member - Meadow Lodge Care Services LLP Director - Meadow Lodge Care Ltd	None	B C

Key to Interests Declared:

A Directorships, including Non-Executive Directorships held in private companies or PLCs (with the exeption of dormant companies).

B Ownership or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS

C Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS

D A position of authority in a charity or voluntary body in the field of health and social care

E Any connection with a voluntary or other body contracting the NHS service

F To the extent not covered in the declarations above, any connections with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust but not limited to, lenders or banks.

Appendix 2

All Members of the Board of Directors have signed the following declaration and an annual search of insolvency, bankruptcy and disqualified director's registers has also taken place.

Fit and Proper Person Declaration

1. It is a condition of employment that those holding director and director-equivalent posts provide confirmation in writing, on appointment and thereafter on demand, of their fitness to hold such posts. Your post has been designated as being such a post. Fitness to hold such a post is determined in a number of ways, including (but not exclusively) by the Trust's provider licence, the Health and Social Care Act 2008 (Regulated Activities) Regulations 2008 ("the Regulated Activities Regulations") and the Trust's constitution.

2. By signing the declaration below, you are confirming that you do not fall within the definition of an "unfit person" or any other criteria set out below, and that you are not aware of any pending proceedings or matters which may call such a declaration into question.

Provider licence

3. Condition G4(2) of Gateshead Health NHS Foundation Trust's Provider Licence ("the Licence") provides that the Licensee shall not appoint as a director any person who is an unfit person, except with the approval in writing of Monitor.

4. Licence Condition G4(3) requires the Licensee to ensure that its contracts of service with its directors contain a provision permitting summary termination in the event of a director being or becoming an unfit person. The Licence also requires the Licensee to enforce that provision promptly upon discovering any director to be an unfit person, except with the approval in writing of Monitor.

5. An "unfit person" is defined at condition G4(5) of the Licence as:

   (a) an individual:

      (i) who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged; or

      (ii) who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it; or

      (iii) who within the preceding five years has been convicted in the British Islands of any offence and a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him; or

      (iv) who is subject to an unexpired disqualification order made under the Company Directors' Disqualification Act 1986; or

(b) a body corporate, or a body corporate with a parent body corporate:

(i) where one or more of the Directors of the body corporate or of its parent body corporate is an unfit person under the provisions of sub-paragraph (a) of this paragraph, or

(ii) in relation to which a voluntary arrangement is proposed under section 1 of the Insolvency Act 1986, or

(iii) which has a receiver (including an administrative receiver within the meaning of section 29(2) of the 1986 Act) appointed for the whole or any material part of its assets or undertaking, or

(iv) which has an administrator appointed to manage its affairs, business and property in accordance with Schedule B1 to the 1986 Act, or

(v) which passes any resolution for winding up, or

(vi) which becomes subject to an order of a Court for winding up.

Regulated Activities Regulations

6. Regulation 5 of the Regulated Activities Regulations states that the Trust must not appoint or have in place an individual as a director, or performing the functions of or equivalent or similar to the functions of, such a director, if they do not satisfy all the requirements set out in paragraph 3 of that Regulation.

7. The requirements of paragraph 3 of Regulation 5 of the Regulated Activities Regulations are that:

(a) the individual is of good character;

(b) the individual has the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed;

(c) the individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed;

(d) the individual has not been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity; and

(e) none of the grounds of unfitness specified in Part 1 of Schedule 4 apply to the individual.

8. The grounds of unfitness specified in Part 1 of Schedule 4 to the Regulated Activities Regulations are:

(a) the person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged;

(b) the person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland;

(c) the person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986;

(d) the person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it;

(e) the person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland;

(f) the person is prohibited from holding the relevant office or position, or in the case of an individual for carrying on the regulated activity, by or under any enactment.

Trust's Constitution

9. The Trust's constitution places a number of restrictions on an individual's ability to become or continue as a director. A person may not become or continue as a director of the Trust if:

(a) they have been adjudged bankrupt or their estate has been sequestrated and in either case they have not been discharged;

(b) they have made a composition or arrangement with, or granted a Trust deed for their creditors and have not been discharged in respect of it;

(c) they have within the preceding five years been convicted in the British islands of any offence, and a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed on them;

(d) in the case of a Non-Executive Director they are no longer a Member of the Public or Patient Constituency.

(e) they are a person whose tenure of office as a Chairman or as a Member or Director of a Health Service body has been terminated on the grounds that his/her appointment is not in the interests of public service, for non-attendance at meetings, or for non-disclosure of a pecuniary/non-pecuniary interest;

(f) they have within the preceding two years been dismissed, from any paid employment for misconduct with a Health Service body;

(g) they are an Executive Director of the Trust, or a Governor, Non-Executive Director, Chairman, Chief Executive officer of another Trust;

(h) they are incapable by reason of mental disorder, illness or injury of managing and administering their property and affairs;

(i) they bring the Board of Directors or any of its Member organisations into disrepute;

(j) they have failed to comply with the required standard of behaviour as per the Trust policy for withholding treatment from violent and abusive patients;

(k) they have had their name removed, by a direction under section 46 of the 1977 Act from any list prepared under Part II of that Act, and has not subsequently had their name included in such a list;

(l) they have been placed on the Registers of schedule 1 Offenders pursuant to the Sex Offenders Act 1977 and/or the Children & Young Person Act 1933;

(m) they fail to abide by the Constitution

(n) they are under 16 years of age;

(o) they have failed to undertake the required training for Directors

I acknowledge the extracts from the provider licence, Regulated Activities Regulations and the Trust's constitution above. I confirm that I do not fit within the definition of an "unfit person" as listed above and that there are no other grounds under which I would be ineligible to continue in post. I undertake to notify the Trust immediately if I no longer satisfy the criteria to be a "fit and proper person" or other grounds under which I would be ineligible to continue in post come to my attention.

Name: _____ Signed: _____

Position: _____ Date: _____

Gateshead Health
NHS Foundation Trust

Report Cover Sheet

Agenda Item: 9

Purpose of Report	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
Report Title:	Assurance Reports from Board Committees			
Name of Meeting:	Trust Board			
Date of Meeting:	Wednesday 31st March 2021			
Author	Diane Waites, Corporate Services Assistant			
Executive Lead	Kirsty Roberton, Deputy Director of Corporate Services & Transformation			
Report presented by	**Board Chairs**			
Executive Summary	To receive the assurance reports from the following meetings: • Finance and Performance Committee held on 26th January 2021 & 30th March 2021 (verbal) • Quality Governance Committee held on 24th March 2021 • Audit Committee held on 4th March 2021			
Recommended actions for Board/Committee)	To receive the reports for assurance			
Trust Aims that the report relates to: **(Including reference to any specific risk)**	**Aim 1** ☐	We will provide consistently high quality care in all our services		
	Aim 2 ☐	We will be a great organisation to work in		
	Aim 3 ☐	We will deliver value for money and strengthen delivery of our clinical services		
	Aim 4 ☐	We will work with our partners to help make Gateshead a place where everyone thrives		
	Aim 5 ☐	We will use our expertise to provide specialist services beyond Gateshead		
Financial Implications:				
Links to Risks (identify significant risks and DATIX reference)				
People and OD Implications:				
Links to CQC KLOE	Caring ☐	Responsive ☐	Well-led ☒	Effective ☐	Safe ☐

Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)	**Obj.1** ☐	The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance between working life and personal commitments
	Obj. 2 ☐	All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers
	Obj. 3 ☐	Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve

ASSURANCE REPORT

Finance and Performance Committee – 26th January 2021

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 assurance that at month 9 the Trust is ahead of plan in line with the financial framework and were assured on the overall financial performance.		Monthly review of progress through the Committee
Financial Plan Months 7 -12		Forecast: The Committee received a comprehensive update noting that the Trust is working with the ICP to achieve our own and system wide targets. However a number of significant risks remain due to lack of clarity around national funding assumptions.		Monthly review of progress through the Committee
Financial Performance – Finance & Sustainability Programme		Year to Date: The report was not received due to suspension of internal control framework.		Monthly review of progress through the Committee
		Forecast: As above.		Monthly review of progress through the Committee
Review of Financial Plan 2020/21		The Committee noted that release of national planning assumptions were delayed and not expected until Quarter 1. Assurance was received for the first two quarters but noted the risks for the full year. A discussion will take place at Board Level in relation to the annual plan.		
Activity & Performance Report		Year to Date: The Committee received an update on the current performance noting Diagnostic targets have slightly improved however RTT and A&E targets were not met due to Covid. The Committee received assurance that plans are in place.		Monthly review of progress through the Committee

QE Facilities Update		The Committee received a comprehensive and positive update on the QE Facilities position. A meeting will take place to agree the content of the report going forward.		Update at the May Committee

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

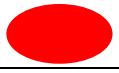
Quality Governance Committee – 24 March 2020

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

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

ISSUES TO BE RAISED TO BOARD	ASSURANCE LEVEL	COMMITTEE UPDATE	NEXT ACTION	TIMESCALE
Board Assurance Framework		The Committee noted that no changes had been made to the BAF since the last meeting.		
IPC Board Assurance Framework		The Committee received good assurance that robust processes are in place to support the services.		
Integrated Quality and Learning Report		The Committee received good assurance from this report.		
Nurse Staffing Exception Report		The Committee received good assurance from this report.		
Quality Account Update		The Committee noted that there was still a lot of work to do on the priorities and further clarification was required around timescales.		
Maternity Review		The Committee received good assurance from this report and noted that the action plan was well embedded into the service.		
Okenden Maternity Update		The Committee received good assurance for this report.		
CQC Mental Health Update		The Committee received good assurance for this report and noted the progress on the Cragside new build and additional mitigation in Sunniside.		
Mental Health Integrated Learning Report		The Committee noted that further work was required on this report including data issues.		

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

AUDIT COMMITTEE (AC) - ASSURANCE REPORT

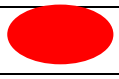
Arising from the Audit Committee Meeting of the 4 March 2021

The Audit Committee in fulfilling its role and functions, as defined within its terms of reference, wishes to bring to the Board's attention the matters set out below.

ISSUES TO BE RAISED TO BOARD	ASSURANCE LEVEL	COMMITTEE UPDATE	COMMENTS / NEXT ACTION	ACTION BY / TIMESCALE
Losses and Special Payments Register		The AC received and approved the Losses and Special Payments Register, for the period 1 Oct 20 to 31 Dec 20.	The AC at its December 2020 meeting requested an explanatory note as to how movements in pharmacy stock pricing and First In First Out (FIFO) valuation methodology is leading to 'stock losses ' being reported.	J Bilcliff / May AC Meeting
Accounts and Reporting Timetable		The AC received the 2020/21 year-end accounting timetable for consideration.	A workshop is to occur where the Executive will review the accounts with AC members, in advance of the draft accounts submission deadline of 27 April 2021. Final audited accounts are to be submitted by 15 June 2021.	JB / w/c 19 April 2021
Counter Fraud		The AC received a progress report from Audit One Counter Fraud for the period 18 Nov 20 to 15 Feb 21.		
		Overall good assurance provided by work (alerts, investigations and reviews) undertaken by Audit One Counter Fraud.	n/a	n/a
		Issues remain unresolved with regards to the sharing of referral data by the NHS Counter Fraud Authority (NHSCFA).	The NHSCFA has now provided their rationale for not sharing the data. The AC recommended that a letter be issued, signed by all DoFs and Audit Chairs across the Audit One domain, challenging the basis of its decision and asking NHSCFA to reconsider its position.	S Veitch / May AC Meeting
		Outstanding recommendations from previous Audit One Counter Fraud reviews.	It was reported to the AC that the implementation of agreed actions had much improved since the last AC meeting however, eight recommendations arising from a Employment Agency Review have agreed implementation dates in excess of 12 months overdue and two connected with a Purchasing Cards Review were greater than 9 months overdue. JB to take through Exec Team. A review to	J Bilcliff / May AC Meeting

			take place with J Bilcliff / S Veitch to review reports and deadlines previously agreed and update as appropriate.	
Internal Audit Gateshead Health Group Progress Report		The AC received a progress report against the 2020/21 Internal Audit Plan since its last meeting on 3 Dec 20. It was reported that progress against 2020/21 IA plan was positive with 97% of audits planned having either commenced or concluded.	The quality of Internal Audits appears robust and positively findings arising from audits during the period were categorised as either 'low' or 'medium', i.e. not 'high'.	n/a
Gateshead Health Group Progress Report		Outstanding Actions arising from previous internal audit reports.	Whilst it was reported to the AC that the implementation of agreed actions was much improved since its last meeting, a number remain outstanding. It was also noted that new Executive Team members are providing increased input and scrutiny to outstanding actions and have updated and set more realistic target dates for implementation.	J Bilcliff / Outstanding actions to be formally raised on an ongoing basis with Exec Team.
Draft Internal Audit Plan 21/22		The AC received a draft Internal Audit Plan for 2021/22.	The draft Plan was compiled after referencing the existing Business Assurance Framework, Risk Registers and after receiving input from Executive Directors. This will be further updated and presented to the AC at its next meeting.	AuditOne / J Bilcliff – May AC Meeting
External Audit Gateshead Health Group Audit Plan 2020/21		The Committee received Ernst & Young's (EY) Provisional Audit Planning Report for 2020/21.	The AC noted and discussed EYs approach to the year ended 31 March 2021.	n/a

Assurance Level 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

Report Cover Sheet Agenda Item: 10

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Report Title:	Learning Lessons to Improve Our People Practices Position Paper			
Name of Meeting:	Trust Board			
Date of Meeting:	31 March 2021			
Author	Natasha Botto, Senior HR Business Partner			
Executive Lead	Lisa Crichton-Jones, Executive Director of People and OD			
Report presented by	Lisa Crichton-Jones, Executive Director of People and OD			
Executive Summary	In May 2019 Baroness Dido Harding, Chair of NHS Improvement wrote to all NHS Trust and Foundation Trust's Chairs and Chief Executives to share the outcomes of an important piece of work undertaken in response to a very tragic event that occurred at a London NHS trust, three years prior, whereby a member of staff subject of an investigation and disciplinary procedure took their own life prior to and the appeal hearing. Baroness Harding shared a number of recommendations that followed an independent review. In December 2020 the NHS Chief People Officer urged Trust's to honestly reflect their organisation's disciplinary procedures, review the recommendations issued in May 2019 and consider what has worked well and what could be further improved. Where action is required, NHS organisations were urged to commit to tangible and timely action to review on a yearly basis and by the end of this financial year, all disciplinary procedures against the recommendations and that these are formally discussed/minuted at a Public Board or equivalent. This paper provides an initial position statement on our current practices and associated RAG rating.			
Recommended actions for Board/Committee)	Trust Board are asked to receive the report and note the actions within.			
Trust Aims that the report relates to: (Including reference to any specific risk)	**Aim 1** ☐	We will provide consistently high quality care in all our services		
	Aim 2 ☒	We will be a great organisation to work in		
	Aim 3 ☐	We will deliver value for money and strengthen delivery of our clinical services		

	Aim 4 ☐	We will work with our partners to help make Gateshead a place where everyone thrives
	Aim 5 ☐	We will use our expertise to provide specialist services beyond Gateshead
Financial Implications:	None	
Links to Risks (identify significant risks and DATIX reference)	There are a series of potential risks arising from adapting our people practices and implementing the recommendations, which could include a person who is subject of an investigation or disciplinary procedure suffering serious harm – either physical or mental. 2792 - Basic level workforce metrics in place, limited data, unable to drive improvements in performance. 2798 - Potential backlog on employee relations due to team diversion onto HR Covid Advisory line. 2802 - Significant workforce team workload capacity pressures due to covid requirements resulting in backlog of work and slow progress.	
People and OD Implications:	Staff wellbeing Staff attendance Staff engagement EDI implications Capacity pressures for managers and staff arising from this work	

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

Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)	**Obj.1** ☒	The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance between working life and personal commitments
	Obj. 2 ☐	All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers
	Obj. 3 ☒	Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve

NHS
Gateshead Health
NHS Foundation Trust

Learning Lessons to Improve Our People Practices Position Paper

1.0 Background

1.1 In May 2019 Baroness Dido Harding, Chair of NHS Improvement wrote to all NHS Trust and Foundation Trust's Chairs and Chief Executives to share the outcomes of an important piece of work recently undertaken in response to a very tragic event that occurred at a London NHS trust, three years prior (Appendix 1)

1.2 In late 2015, Amin Abdullah was the subject of an investigation and disciplinary procedure. The protracted procedure culminated in Amin's summary dismissal on the grounds of gross misconduct. Tragically, in February 2016 just prior to an arranged appeal hearing, Amin took his own life. This triggered the commissioning of an independent inquiry undertaken by Verita Consulting, the findings of which were reported to the board of the employing Trust and to NHS Improvement in August 2018.

1.3 Subsequently, NHS improvement established an Advisory Group to consider to what extent the failings identified in Amin Abdullah's case are either unique to this Trust or more widespread across the NHS, and what learning can be applied.

1.4 The analysis highlighted several key themes associated with the Verita inquiry which were also common to other historical cases considered. Principal among these were: poor framing of concerns and allegations; inconsistency in the fair and effective. application of local policies and procedures; lack of adherence to best practice guidance; variation in the quality of investigations; shortcomings in the management of conflicts of interest; insufficient consideration and support of the health and wellbeing of individuals; and an over-reliance on the immediate application of formal procedures, rather than consideration of alternative responses to concerns.

1.5 The NHS England and NHS Improvement People Committees in Common received a detailed report on the outcomes of the Advisory Group's activities, which included recommendations that aim to ensure the captured learning is used to best effect in informing positive changes across the NHS. The Committees recognised that, sadly, Amin's experiences are far from unique and acknowledged there needs to be greater consistency in the demonstration of an inclusive, compassionate and person-centred approach, underpinned by an overriding concern to safeguard people's health and wellbeing, whatever the circumstances.

1.6 The Advisory Group made a series of recommendations, many of which were used as the basis for the provision of additional guidance relating to the management and oversight of local investigation and disciplinary procedures which has been prepared based on the Advisory Group's recommendations. The purpose in issuing this guidance was to encourage all NHS staff, and in particular boards and HR teams, to reflect on its contents. Boards were further asked to review and assess their respective procedures and processes relating to the management of investigatory and disciplinary matters against the guidance, and to make any adjustments required to bring their organisation in line with best practice.

1.7 In addition, in November 2019, Prerana Issar, NHS Chief People Officer wrote to healthcare professionals and regulatory bodies, encouraging review and examination of any guidance and standards provided to members and registrants to address the issues highlighted to support compassionate leadership and improvement across the healthcare system (Appendix 2).

1.8 In December 2020, Prerana Issar wrote again to all NHS Trust Chief Executives, HR and Workforce Directors to share the revised policy for handling staff related concerns or complaints developed by Imperial College Healthcare NHS Trust (Appendix 3).

1.9 Prerena urged Trust's to honestly reflect their organisation's disciplinary procedures, review the recommendations issued in May 2019 and consider what has worked well and what could be further improved.

1.10 Where action is required, NHS organisations were urged to commit to tangible and timely action to review on a yearly basis and by the end of this financial year, all disciplinary procedures against the recommendations and that these are formally discussed/minuted at a Public Board or equivalent.

2.0 Current Position

2.1 The Trust recently appointed a new Executive Director of People and OD, who commenced in post in autumn 2020. There has been no Board level people expert for a period of circa 15 years and work is underway to review and modernise the function and ensure compliance with legislative, regulatory and sector requirements. Initial risks relating to this work have been scoped and reported to HRC and the Trusts covid committee and an interim Senior HR Business Partner (reporting to Deputy Director of People and OD) has been appointed with a specific focus on quality, performance and governance within the directorate.

2.2 Within the Trust, the management of employee relations case work is a core function of the Trust's HR Advisory Team. This centrally managed team provides advice and support to disciplinary and grievance casework as well as absence management and general advice.

2.3 With a new senior team in place, it appears that only recent reviews of the recommendations have taken place following receipt of the letters mentioned with seemingly no evidence of previous proactive or formal action taken. Although it is recognised that the pandemic situation has likely influenced this, it is also accepted that the initial letter received from Baroness Harding had been received in 2019.

2.5 Given the limited capacity within the HR team, Capsticks HR Advisory Service were commissioned in December 2020 to deliver an independent, comprehensive review of the way in which employee relations matters are managed within the organisation. Included within the scope of this work is a review of current process against current best practice (including just culture, case legislation, NHSI recommendations, CIPD/ACAS and NHS People Plan).

2.6 The formal review is now concluding; however from a People & OD perspective an initial position statement with regards to the recommendations has been compiled based on our current practices. Actions to follow will be informed by the outcome of the external review.

2.7 The Trust is fortunate in that a consultant colleague was a member of the national working group and in discussion with the CEO, has offered to help with this work moving forwards.

3.0 Next Steps and Actions

3.1 Await full report outlining findings and recommendations from Capsticks which is due week commencing 22 March 2021.

3.2 Review recommendations and agree an improvement plan – with clear lines of responsibility and realistic timeframes.

3.3 Provide an update and assurance to HR Committee on 8 June 2021 and Trust Board on 23 June 2021.

4.0 Appendices

Appendix 1 Baroness Dido Harding Letter, May 2019
Appendix 2 Prerana Issar Letter, November 2019
Appendix 3 Prerana Issar Letter, December 2020

Natasha Botto
Senior HR Business Partner
25 March 2021

Recommendation	Detail	Position	Action	RAG Rating
Adhering to best practice	Development and application of local investigation and disciplinary procedures should be informed and underpinned by the provisions of current best practice, principally that which is detailed in the ACAS 'Code of practice on disciplinary and grievance procedures' and other non-statutory ACAS guidance; the GMC's 'principles of a good investigation'; and the NMC's 'best practice guidance on local investigations' (when published). All measures should be taken to ensure that complete independence and objectivity is maintained at every stage of an investigation and disciplinary procedure, and that identified or perceived conflicts of interest are acknowledged and appropriately mitigated (this may require the sourcing of independent external advice and expertise).	The Trust's Disciplinary Policy is periodically reviewed and updated and relevant documentation such as the ACAS Code of Practice and professional body standards are considered as part of this process. The policy was last reviewed and updated in January 2020 and is due to expire on 1 December 2022. Prior to any investigation commencing there is a conversation between the commissioning manager and HR Advisory team to deem if an investigation is necessary. If so, an independent investigating officer who sits outside of the service line (and normally outside of the Business Unit) will be appointed to lead the investigation and based on the findings will make a decision if the matter should proceed to formal hearing. If a formal disciplinary hearing is deemed necessary, at least two independent managers, typically not from the Business Unit would hear the case, and receive professional HR advice from a member of the senior People & OD team. Depending on the nature of the allegation being heard an	A review and update of this policy has been included within the scope of the Capsticks review which has been commissioned.	Amber

		professional advisor would also form part of the disciplinary panel. Prior to COVID, regular case reviews took place with the HR Advisory and Business Partner Team led by the Deputy Director of HR or Head of HR to review recent cases and any lessons learned, supporting reflective practice.		
Applying a rigorous decision-making methodology	Consistent with the application of 'just culture' principles, which recognise that it is not always appropriate or necessary to invoke formal management action in response to a concern or incident, a comprehensive and consistent decision-making methodology should be applied that provides for full and careful consideration of context and prevailing factors when determining next steps. In all decision-making that relates to the application of sanctions, the principle of plurality should be adopted, such that important decisions which have potentially serious consequences are very well informed, reviewed from multiple perspectives, and never taken by one person alone.	The Trust participated in a Just Culture training course led by colleagues from Mersey Care NHS Foundation Trust. In order to initiate an investigation the Commissioning Manager is asked to complete a commissioning form. On review if it is felt a formal investigation is inappropriate this will be challenged by the HR Advisory Team/HR Operations Manager and escalated to the HR Business Partner or Head of HR as appropriate. We have a number of trained cultural ambassadors throughout the Trust who have participated in the Trust's Cultural Ambassador Programme. The Programme is designed to give staff from BAME background, who may be subject to formal processes, more	We will review how this is taken forwards as part of our emergent strategic objective on leadership and OD. There is an opportunity to develop a consistent framework and reporting process around this. We are currently looking to roll this the Cultural Ambassador programme out and embed this throughout the Trust.	Amber

		confidence in formal processes and provide with reassurance by the involvement of a Cultural Ambassador. As such Cultural Ambassadors will be included and regarded as part of any investigation team or disciplinary panel, to explore the facts of a case. As detailed above if a formal disciplinary hearing is deemed necessary (the mechanism to be able to apply a formal sanction), at least two independent managers, typically not from the Business Unit would hear the case, and receive professional HR advice from a member of the senior People & OD team.		
Ensuring people are fully trained and competent to carry out their role	Individuals should not be appointed as case managers, case investigators or panel members unless they have received related up to date training and, through such training, are able to demonstrate the aptitude and competencies (in areas such as awareness of relevant aspects of best practice and principles of natural justice, and appreciation of race and cultural considerations) required to undertake these roles.	As a Trust we have a pool of trained investigators who have all participated in investigation training however this was over two years ago and the pool shrinks as and when trained investigating officer leave, with no rolling programme to train new managers as they come on board. Pre-COVID, Disciplinary Bitesize courses were ran monthly. However with neither sets of training had a competency framework attached to them with formal sign off required. At present prior to sitting on a Disciplinary panel, some panel	As part of the service review commissioned by Capsticks, further training has been scoped to increase the Investigating Officer pool in addition to training for Disciplinary and Appeal Chairs. We are aiming to train around 125 managers at Band 7 level and above - 50% of these in investigations, 35% in hearings and 10-15% in appeals.	Amber

		members may not have participated in any formal training. Potential Disciplinary Hearing chairs are approached based on seniority and experience. As previously mentioned professional HR advice is provided to panels from a member of the senior People & OD team, at least at HRBP level.		
Assigning sufficient resources	Before commencing investigation and disciplinary procedures, appointed case managers, case investigators and other individuals charged with specific responsibilities should be provided with the resources that will fully support the timely and thorough completion of these procedures. Within the overall context of 'resourcing', the extent to which individuals charged with such responsibilities (especially members of disciplinary panels) are truly independent should also be considered.	Prior to an Investigating Officer being allocated a case capacity will be discussed with them and the HR Operations Manager also reviews the workload of members of the HR Advisory team prior to allocation. However, in reality, capacity remains a challenge both for the HR Advisory teams and Investigating Officers who are operational line managers in the Trust. In more recent times, where capacity to progress an investigation in a timely way is identified from the outset, external partners such as Capsticks have been engaged to support, however this comes at a cost to the Trust and is by exception only.	As we develop our workforce quality systems, we will move to more formally and closely monitor timescales for case work completion.	Amber
Decisions relating to the implementation of suspensions/exclusions	Any decision to suspend/exclude an individual should not be taken by one person alone, or by anyone who has an identified or perceived conflict of interest. Except where immediate safety or security issues prevail, any decision to suspend/exclude should be	Before a decision to suspend is taken a risk assessment is completed which identifies suspension as a last resort. In line with the Trust's Disciplinary policy the decision should also only be taken by a Senior Manager (Band 8a and above, or equivalent) and when	Moving forward it is proposed that the decision is taken at Operational Director level with clinical professional input and discussion with the	Amber

	a measure of last resort that is proportionate, time bound and only applied when there is full justification for doing so. The continued suspension/exclusion of any individual should be subject to appropriate senior-level oversight and sanction.	necessary guidance taken from a Senior HR representative. As part of the suspension process, the Trust may decide to notify the relevant professional body or other external organisations. In such cases advices should be sought from a senior member of the HR Department and Professional Lead of the Trust. Following a decision to suspend there are no checks and balances that follow other than the requirement to undertake a review. However there are no timeframes listed in the policy, or within the written documentation that is shared with the employee about the frequency of review.	Deputy Director or Executive Director for People & OD. The policy and associated supporting documentation has been included within the scope of the Capsticks review which has been commissioned.	
Safeguarding people's health and wellbeing	Concern for the health and welfare of people involved in investigation and disciplinary procedures should be paramount and continually assessed. Appropriate professional occupational health assessments and intervention should be made available to any person who either requests or is identified as requiring such support. A communication plan should be established with people who are the subject of an investigation or	Appropriate professional occupational health assessments and intervention are made available to any person who either requests or is identified as requiring such support. Individuals also have access to professional psychological services via our external partner Talk Works. As part of the investigation process although it is established how an individual would like contact to be maintained, no formal communication	Moving forward we would look to incorporate this has a core element of the process as rather than it simply being offered. Formal communication plans to be developed in line with recommendations.	Amber

	disciplinary procedure, with the plan forming part of the associated terms of reference. The underlying principle should be that all communication, in whatever form it takes, is timely; comprehensive; unambiguous; sensitive; and compassionate. Where a person who is the subject of an investigation or disciplinary procedure suffers any form of serious harm, whether physical or mental, this should be treated as a 'never event' which therefore is the subject of an immediate independent investigation commissioned and received by the board. Further, prompt action should be taken in response to the identified harm and its causes.	plan in line with the recommendations. Although it would always be the intention to maintain regular contact, in reality this does not always happen in as timely a way as possible.		
Board-level oversight	Mechanisms should be established by which comprehensive data relating to investigation and disciplinary procedures is collated, recorded, and regularly and openly reported at board level. Associated data collation and reporting should include, for example: numbers of procedures; reasons for those procedures; adherence to process; justification for any suspensions/exclusions; decision-making relating to outcomes; impact on patient care and employees; and lessons learnt.	At present the Trust's Workforce Metric Reports go into HR Committee – detailing the number of active suspensions, length of time they have been active for, investigation outcomes and panel decision and total suspensions. Due to current basic reporting systems that are in place extracting this data is not straight forward and time consuming, providing limited assurance. This is reflected in the People & OD department risk register, with two	A business case is currently in development to consider the purchase of an electronic Employee Relations system which would support with being able to provide the level of board reporting and assurance recommended.	**Amber**

		specific risks scoring 20. 2792- Basic level workforce metrics in place, with no real integration with wider performance standards (finance, quality etc.) resulting in limited and overly broad data only being available to Board and managers, to understand 'as is' and drive improvements in performance. 2762- No workforce quality system in place resulting in a lack of transparency on performance across workforce teams.	

Chief Executive and Chair's Office
Wellington House
133-155 Waterloo Road
London SE1 8UG

Tel: 020 3747 0000

To:
NHS trust and NHS foundation trust chairs and chief executives

24 May 2019

Dear colleagues

Learning lessons to improve our people practices

I am writing to share with you the outcomes of an important piece of work recently undertaken in response to a very tragic event that occurred at a London NHS trust three years ago.

In late 2015, Amin Abdullah was the subject of an investigation and disciplinary procedure. The protracted procedure culminated in Amin's summary dismissal on the grounds of gross misconduct. Tragically, in February 2016 just prior to an arranged appeal hearing, Amin took his own life. This triggered the commissioning of an independent inquiry undertaken by Verita Consulting, the findings of which were reported to the board of the employing Trust and to NHS Improvement in August 2018. The report concluded that, in addition to serious procedural errors having been made, throughout the investigation and disciplinary process Amin was treated very poorly, to the extent that his mental health was severely impacted. Verita's recommendations were accepted by the Trust, in full, and have largely been implemented.

Subsequently, NHS Improvement established a 'task and finish' Advisory Group to consider to what extent the failings identified in Amin's case are either unique to this Trust or more widespread across the NHS, and what learning can be applied. Comprising of multi-professional stakeholders and subject matter experts representing both the NHS and external bodies, together with an advocate for Amin's partner, the Group conducted an independent analysis of both the Verita findings and several historical disciplinary cases, the outcomes of which had attracted criticism in Employment Tribunal proceedings and judgements. HR directors of provider organisations were advised of the Group's activity and invited to share details of any local experiences and/or examples of measures being taken to improve the management of employment issues.

The analysis highlighted several key themes associated with the Verita inquiry which were also common to other historical cases considered. Principal among these were: poor framing of concerns and allegations; inconsistency in the fair and effective

application of local policies and procedures; lack of adherence to best practice guidance; variation in the quality of investigations; shortcomings in the management of conflicts of interest; insufficient consideration and support of the health and wellbeing of individuals; and an over-reliance on the immediate application of formal procedures, rather than consideration of alternative responses to concerns.

The NHS England and NHS Improvement People Committees in Common received a detailed report on the outcomes of the Advisory Group's activities, which included recommendations that aim to ensure the captured learning is used to best effect in informing positive changes across the NHS. The Committees recognised that, sadly, Amin's experiences are far from unique and acknowledged there needs to be greater consistency in the demonstration of an inclusive, compassionate and person-centred approach, underpinned by an overriding concern to safeguard people's health and wellbeing, whatever the circumstances. This view certainly echoed many of the comments we have received from across the NHS during our recent People Plan engagement.

Some of the proposed recommendations will require further discussion with key stakeholders, including regulatory and professional bodies (in particular, I am keen that consideration and assessment of the 'health' of organisational culture, including aspects relating to the management of workplace issues, is given more prominence in the 'well-led' assessment domain). The majority, though, can be immediately received and applied.

Enclosed with this letter is additional guidance relating to the management and oversight of local investigation and disciplinary procedures which has been prepared based on the Advisory Group's re-commendations. You will recognise the guidance as representing actions characteristic of responsible and caring employers and which reflect our NHS values. I would ask that you, your HR team and your Board review them and assess your current procedures and processes in comparison and, importantly, make adjustments where required to bring your organisation in line with this best practice. I would draw your attention to item 7 of the guidance and ask you to consider how your Board oversees investigations and disciplinary procedures. Further, with respect to any cases currently being considered and all future cases, I would ask you to review the following questions (and, where necessary, take corrective action in response):

- Is there sufficient understanding of the issues or concerns, and the circumstances relating to them, to justify the initiation of formal action?

- Considering the circumstances, in the eyes of your organisation and others external to it, would the application of a formal procedure represent a proportionate and justifiable response (i.e. have other potential responses and remedies, short of formal intervention, been fully assessed before being discounted)?

- If formal action is being or has been taken, how will appropriate resources be allocated and maintained to ensure it is conducted fairly and efficiently; how are you ensuring that independence and objectivity is maintained at every stage of the process?

- What will be the likely impact on the health and wellbeing of the individual(s) concerned and on their respective teams and services, and what immediate and ongoing direct support will be provided to them? Further, how will you ensure the dignity of the individual(s) is respected at all times and in all communications, and that your duty of care is not compromised in any way, at any stage.

- For any current case that is concluding, where it is possible that a sanction will be applied, are similar questions being considered?

In highlighting these issues, which I know will be important to you and your teams, I would like to thank all those colleagues who directly contributed to and informed the work completed by the Advisory Group. I would particularly like to acknowledge the endeavours of Amin's partner Terry Skitmore and his advocate Narinder Kapur, without whose dedication and sacrifices the Amin Abdullah inquiry and subsequent development work by NHS Improvement would not have taken place.

I know that we are all keen to ensure we treat our people fairly and protect their wellbeing. Implementing the attached guidance consistently well across the NHS will contribute to that goal. It is tragic that we are learning these lessons after Amin's death, but we owe it to him and the others who have suffered in similar circumstances to act now.

Thank you for your attention to these vital issues.

Best wishes

Baroness Dido Harding
Chair, NHS Improvement

Enclosure:

Additional guidance relating to the management and oversight of local investigation and disciplinary procedures

Copies:

Chair, Care Quality Commission
Chair, NHS Providers
Chair, Nursing and Midwifery Council
Chief Executive, NHS Employers

Additional guidance relating to the management and oversight of local investigation and disciplinary procedures

1. Adhering to best practice

a) The development and application of local investigation and disciplinary procedures should be informed and underpinned by the provisions of current best practice, principally that which is detailed in the Acas 'code of practice on disciplinary and grievance procedures' and other non-statutory Acas guidance; the GMC's 'principles of a good investigation'; and the NMC's 'best practice guidance on local investigations' (when published).

b) All measures should be taken to ensure that complete independence and objectivity is maintained at every stage of an investigation and disciplinary procedure, and that identified or perceived conflicts of interest are acknowledged and appropriately mitigated (this may require the sourcing of independent external advice and expertise).

2. Applying a rigorous decision-making methodology

a) Consistent with the application of 'just culture' principles, which recognise that it is not always appropriate or necessary to invoke formal management action in response to a concern or incident, a comprehensive and consistent decision-making methodology should be applied that provides for full and careful consideration of context and prevailing factors when determining next steps.

b) In all decision-making that relates to the application of sanctions, the principle of plurality should be adopted, such that important decisions which have potentially serious consequences are very well informed, reviewed from multiple perspectives, and never taken by one person alone.

3. Ensuring people are fully trained and competent to carry out their role

Individuals should not be appointed as case managers, case investigators or panel members unless they have received related up to date training and, through such training, are able to demonstrate the aptitude and competencies (in areas such as awareness of relevant aspects of best practice and principles of natural justice, and appreciation of race and cultural considerations) required to undertake these roles.

4. Assigning sufficient resources

Before commencing investigation and disciplinary procedures, appointed case managers, case investigators and other individuals charged with specific responsibilities should be provided with the resources that will fully support the timely and thorough completion of these procedures. Within the overall context of 'resourcing', the extent to which individuals charged with such responsibilities (especially members of disciplinary panels) are truly independent should also be considered.

5. Decisions relating to the implementation of suspensions/exclusions

Any decision to suspend/exclude an individual should not be taken by one person alone, or by anyone who has an identified or perceived conflict of interest. Except where immediate safety or security issues prevail, any decision to suspend/exclude should be a measure of last resort that is proportionate, timebound and only applied when there is full justification for doing so. The continued suspension/exclusion of any individual should be subject to appropriate senior-level oversight and sanction.

6. Safeguarding people's health and wellbeing

a) Concern for the health and welfare of people involved in investigation and disciplinary procedures should be paramount and continually assessed. Appropriate professional occupational health assessments and intervention should be made available to any person who either requests or is identified as requiring such support.

b) A communication plan should be established with people who are the subject of an investigation or disciplinary procedure, with the plan forming part of the associated terms of reference. The underlying principle should be that all communication, in whatever form it takes, is timely; comprehensive; unambiguous; sensitive; and compassionate.

c) Where a person who is the subject of an investigation or disciplinary procedure suffers any form of serious harm, whether physical or mental, this should be treated as a 'never event' which therefore is the subject of an immediate independent investigation commissioned and received by the board. Further, prompt action should be taken in response to the identified harm and its causes.

7. Board-level oversight

Mechanisms should be established by which comprehensive data relating to investigation and disciplinary procedures is collated, recorded, and regularly and openly reported at board level. Associated data collation and reporting should include, for example: numbers of procedures; reasons for those procedures; adherence to process; justification for any suspensions/exclusions; decision-making relating to outcomes; impact on patient care and employees; and lessons learnt.

4 November 2019

NHS Improvement & NHS England

Prerana Issar
NHS Chief People Officer
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80 London Road
London SE1 6LH
Prerana.issar@nhs.net

www.england.nhs.uk
www.improvement.nhs.uk

Dear Colleague,

You may well be aware of an important piece of work completed by NHS England and NHS Improvement in response to a tragic event that occurred at Imperial College Healthcare NHS Trust (ICHT) three years ago. Details of this work, conducted by an appointed Advisory Group, together with the reasons for its commission, are provided in the enclosed letter that was personally issued by Baroness Harding to all NHS trust and NHS foundation trust chairs and chief executives in May of this year.

The Advisory Group made a series of recommendations, many of which were used as the basis for the provision of additional guidance to provider organisations (also at the enclosure). The purpose in issuing this guidance was to encourage all NHS staff, and in particular boards and HR teams, to reflect on its contents. Boards were further asked to review and assess their respective procedures and processes relating to the management of investigatory and disciplinary matters against the guidance, and to make any adjustments required to bring their organisation in line with best practice. Feedback from the provider community suggests that the guidance was well-received and recognised as representing actions characteristic of responsible and caring employers, while also reflecting our NHS values.

Acknowledging the importance of promoting good practice in the management and conduct of local investigations and disciplinary procedures across the Service, a broader recommendation made by the Advisory Group was that: 'Healthcare regulatory and professional bodies should consider reviewing their respective guidance and standards issued to their registrants, which relate to the management and conduct of local investigations and disciplinary procedures, to ensure fairness, consistency and alignment'. Therefore, I am seeking the support of all healthcare professional and regulatory bodies in undertaking an examination of any such guidance that might already have been provided to members and registrants, or might be developed, to ensure it addresses the issues highlighted above. The General Medical Council already has in place guidance relating to the management and leadership functions of its registrants ('Leadership and management for all doctors' - 2012) and this is commended as being an example of good practice.

In conducting such an examination, respective bodies may also wish to consider offering guidance on a range of specific issues that are relevant to management responsibilities exercised by members and registrants. These could include, for

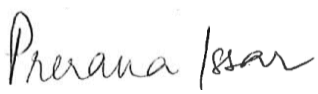
example: expectations regarding high standards of personal conduct and behaviour towards staff; the duty to always act with honesty, compassion, fairness, impartiality and discretion; avoiding, unless in exceptional circumstances, the use of 'some other substantial reason' (SOSR) to dismiss staff; and to ensure that management interventions and actions prioritise the welfare of individuals above any self-interest. Similarly, it is a duty of individuals undertaking management responsibilities to immediately challenge when contra-behaviours and actions are observed in others. In developing guidance, consultation with members and registrants is likely to highlight other considerations and potential remedies which may help to prevent and/or resolve future issues.

In the interests of promoting consistency of approach, NHS England and NHS Improvement would be keen to be consulted on, and to provide support in the development and/or revision of any new or existing guidance. In the first instance, the principal point of contact for this purpose is my office.

Lastly, a further recommendation of the Advisory Group was that the procedures established by 'Maintaining High Professional Standards in the Modern NHS' (a framework for the initial handling of concerns relating to doctors and dentists) should inform the development and implementation of a common management framework for handling concerns relating to all NHS Staff, regardless of profession, role or the type of NHS organisation within which they work. Soundings taken from the HR Director community suggests there is an appetite for the development of a common framework and some scoping work has begun. Clearly, in pursuing this work, there will need to be extensive engagement with all stakeholders, but at this early stage any initial thoughts you may wish to share would be gratefully received.

Thank you in anticipation of your support.

Yours Sincerely,



Prerana Issar
NHS Chief People Officer

Enclosure:

Learning lessons to improve our people practices - Letter from Baroness Harding to all NHS trust and NHS foundation trust chairs and chief executives, 24 May 2019.

Classification: Official

Publication approval reference: PAR293

Prerana Issar

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

01 December 2020

To:

- NHS trust CEOs, HR directors, workforce directors
- NHS foundation trust CEOs, HR directors, workforce directors

Dear Colleagues,

Re: Sharing good practice to improve our people practices

I hope you are doing well in these challenging times.

In May 2019 we shared with you an important piece of work in response to a tragic event that occurred at Imperial College Healthcare NHS Trust (ICHT) four years ago. Sadly, Amin Abdullah, a nurse who at the time was the subject of an investigation and disciplinary procedure, tragically took his own life. Details of the investigation, conducted by an appointed advisory group, together with the reasons for its commission, are provided in the enclosed letter (enclosure 1).

The advisory group made a series of recommendations, many of which were used as the basis for the provision of additional guidance to provider organisations (also at the enclosure). In addition, in November 2019, I wrote to healthcare professionals and regulatory bodies, encouraging review and examination of any guidance and standards provided to members and registrants to address the issues highlighted to support compassionate leadership and improvement across the healthcare system (enclosure 2).

Since Amin's passing, ICHT has worked collaboratively with Amin's partner Terry Skitmore and his advocate Narinder Kapur, alongside other stakeholders, to create a revised policy for handling staff related concerns or complaints. I am writing to share this with you as an example of good people practice, albeit arising from such tragic circumstances (enclosure 3).

The shared learning from Amin's experience has demonstrated the need for us to work continuously and collaboratively, to ensure that our people practices are inclusive, compassionate and person-centred, with an overriding objective as to the safety and wellbeing of our people. These values are central to our recently published People Plan and People Promise.

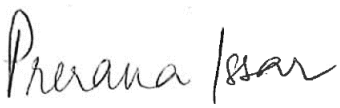
Our collective goal is to ensure we enable a fair and compassionate culture in our NHS. I urge you to honestly reflect on your organisation's disciplinary procedures, review the recommendations we issued in May 2019 and the attached example of good practice, and consider what has worked well and what could be further improved.

Where action is required, I urge NHS organisations to commit to tangible and timely action to review on a yearly basis and by the end of this financial year, all disciplinary procedures against the recommendations and that these are formally discussed/minuted at a **Public** Board or equivalent. We will continue work with the CQC to embed the learning from these reviews to form part of the formal oversight framework. I would also like to suggest your policy is made available on your organisation's public website by the end of the financial year.

As we prepare for the second wave of COVID-19, our staff should feel supported in every sense, including demonstrating a sensitive and compassionate approach to colleagues throughout the disciplinary procedure and process.

Many thanks for everything you are doing to provide services during this challenging time.

Best wishes,



Prerana Issar
NHS Chief People Officer

Enclosure

1. Learning lessons to improve our people practices – Letter to all NHS trust and NHS foundation trust chairs and chief executives, 24 May 2019.

2. Guidance and standards for registrants in relation to local investigations and disciplinary procedures - Letter from Prerana Issar to healthcare professional and regulatory bodies, 04 November 2019.

3. Imperial College Healthcare NHS Trust - Disciplinary Policy and Procedure, July 2020.

Trust Board

Gateshead Health NHS Foundation Trust

Report Cover Sheet

Agenda Item: 12

Purpose of Report	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☐	**Information:** ☐	
Report Title:	Part One – Executive Summary – Consolidated Finance Report				
Name of Meeting:	Trust Board				
Date of Meeting:	Wednesday 31st March 2021				
Author	Mrs Kris Mackenzie, Deputy Director of Finance				
Executive Lead	Mrs Jacqueline Bilcliff, Group Director of Finance				
Report presented by	Mrs Jacqueline Bilcliff, Group Director of Finance				
Executive Summary	The Trust has reported an adjusted financial performance surplus of £2.062m for the period April 2020 - February 2021 and is projecting a year end surplus of £1.256m				
Recommended actions for Board/Committee)	To note the summary of performance as at 28th February 2021 (Month 11) for the Group (inclusive of Trust and QE Facilities, excluding Charitable Funds).				
Trust Aims that the report relates to: (Including reference to any specific risk)	**Aim 1** ☐	We will provide consistently high quality care in all our services			
	Aim 2 ☐	We will be a great organisation to work in			
	Aim 3 ☒	We will deliver value for money and strengthen delivery of our clinical services			
	Aim 4 ☐	We will work with our partners to help make Gateshead a place where everyone thrives			
	Aim 5 ☐	We will use our expertise to provide specialist services beyond Gateshead			
Financial Implications:	As included in the report				
Links to Risks (identify significant risks and DATIX reference)	As included in the report				
People and OD Implications:	None				
Links to CQC KLOE	Caring ☐	Responsive ☐	Well-led ☒	Effective ☐	Safe ☐

Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)	**Obj.1** ☐	The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance between working life and personal commitments
	Obj. 2 ☐	All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers
	Obj. 3 ☒	Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve

1 Introduction

1.1 The purpose of this report is to provide a summary of financial performance as at 28th February 2021 (month 11) for the Group (inclusive of the Trust and QE Facilities, excluding Charitable Funds).

2 2020/21 Financial Framework

2.1 In response to the Covid 19 outbreak, guidance was issued suspending the 2020/21 national operational planning process. An interim financial framework was established to cover the period 1st April to 30th September 2020. During this period, the Trust received a level of income reflective of actual costs incurred sufficient to achieve a breakeven financial position.

2.2 For the period 1st October 2020 to 31st March 2021 the Trust submitted a financial plan predicated on centrally calculated block contract values and North ICP system funding. The submitted financial plan results in an agreed financial deficit of £0.680m for the Trust.

3 Income and Expenditure

3.1 The Trust has reported income of £31.960m for the month of February and £300.079m for the year to date. This means that the Trust has received £1.820m more income than it had planned to. The extra funding is additional money that the Trust has received to pay for the Pathology Pillar 1 Covid testing programme, the vaccination scheme, the Pathology Pillar 2 Covid testing programme and the newly awarded contract for the provision of GP services. This is offset by a redistribution of £4.000m system monies across the North.

3.2 The Trust has reported expenditure of £288.964m for the period to date. This is £0.772m more than plan and is due to increased costs resulting from additional services provided in support of the Pathology Pillar 1 Covid testing programme, the vaccination scheme, the Pathology Pillar 2 Covid testing programme and the newly awarded contract for the provision of GP services.

3.3 Adjusting for non-operating items, the surplus for the period to February 2021 is £2.062m against a planned surplus of £0.005m. The Trust Statement of Comprehensive Income (SOCI) is presented in Table 1.

3.4 The Trust has revised its forecast year end outturn to plan a surplus of £1.256m.

STATEMENT OF COMPREHENSIVE INCOME

FEBRUARY 2020/21	GROUP POSITION NHSI/E RevisedCovid Plan			VARIANCE		
Red >100k over	Revised Covid Plan Total	Covid Plan to Date	Actual to Date	Variance (Actual - Budget)		Previous Month Variance
Amber <> (£50k) - £99.99k						
Green <(£50.1k)	£000's	£000's	£000's	£000's		£000's
Operating						
Operating Income from Patient Care activities						
Income From NHS Care Contracts	(286,035.0)	(259,626.0)	(255,861.5)	3,764.5		4,144.1
Income From Local Authority Care Contracts	(93.0)	(85.0)	(82.5)	2.5		2.0
Private Patient Revenue	(320.0)	(281.0)	(379.1)	(98.1)		(63.8)
Injury Cost Recovery	(223.0)	(196.0)	(258.4)	(62.4)		(63.3)
Other non-NHS clinical revenue	(524.0)	(466.0)	(417.8)	48.2		40.6
Total Operating Income From Patient Care activities	**(287,195.0)**	**(260,654.0)**	**(256,999.2)**	**3,654.8**		**4,059.6**
Other Operating Income						
Education and Training Income	(7,273.4)	(6,599.4)	(7,276.7)	(677.3)		(312.5)
R&D Income	(625.0)	(577.0)	(624.6)	(47.6)		(33.5)
Top Up Funding	(20,174.0)	(20,174.0)	(20,172.8)	1.2		1.2
Funding ouside of System Envelope			(2,234.2)	(2,234.2)		(1,717.7)
Other Income	(11,095.6)	(10,159.6)	(12,771.0)	(2,611.4)		(177.5)
Donations & Grants Received	(115.0)	(95.0)	-	95.0		76.0
Total Other Operating Income	**(39,283.0)**	**(37,605.0)**	**(43,079.3)**	**(5,474.3)**		**(2,164.0)**
Total Operating Income	**(326,478.0)**	**(298,259.0)**	**(300,078.5)**	**(1,819.5)**		**1,895.6**
Operating Expenses						
Total Employee Expenses	**208,636.0**	**189,846.0**	**189,749.1**	**(96.9)**		**(995.1)**
Operating Expenses included in EBITDA	**316,169.0**	**288,192.0**	**288,963.6**	**771.6**		**(2,800.7)**
Operating Expenses excluded from EBITDA	**6,510.0**	**5,975.0**	**6,191.3**	**216.3**		**179.4**
Total Operating Expenses	**322,679.0**	**294,167.0**	**295,154.9**	**987.9**		**(2,621.3)**
(Profit)/Loss from Operations	**(3,799.0)**	**(4,092.0)**	**(4,923.6)**	**(831.6)**		**(726.7)**
Non Operating						
Non-Operating Income						
Finance Income	(25.0)	(25.0)	(48.7)	(23.7)		(17.1)
Total Non-Operating Income	**(25.0)**	**(25.0)**	**(48.7)**	**(23.7)**		**(17.1)**
Non-Operating Expenses						
Finance Costs	899.0	797.0	535.2	(261.8)		(206.0)
Gains / (Losses) on Disposal of Assests	-	-	(0.3)	(0.3)		(0.3)
PDC dividend expense	2,880.0	2,640.0	1,760.0	(880.0)		(805.0)
Total Finance Costs (for non-financial activities)	**3,779.0**	**3,437.0**	**2,294.9**	**(1,142.1)**		**(1,011.3)**
Total Non-Operating Expenses	**3,779.0**	**3,437.0**	**2,294.9**	**(1,142.1)**		**(1,011.3)**
(Surplus) / Deficit Before Tax	**(45.0)**	**(680.0)**	**(2,677.4)**	**(1,997.4)**		**(1,754.1)**
Corporation Tax	837.0	792.0	821.6	29.6		(4.5)
(Surplus) / Deficit After Tax	**792.0**	**112.0**	**(1,855.8)**	**(1,967.8)**		**(1,758.6)**
(Surplus) / Deficit After Tax from Continuing Operations	**792.0**	**112.0**	**(1,855.8)**	**(1,967.8)**		**(1,758.6)**
Remove capital donations / grants I&E impact	(119.0)	(117.0)	(205.6)	(88.6)		(71.0)
Adjusted Financial Performance (Surplus) / Deficit	**673.0**	**(5.0)**	**(2,061.5)**	**(2,056.5)**		**(1,829.6)**
Adjusted Financial Performance (Surplus) / Deficit	**673.0**	**(5.0)**	**(2,061.5)**	**(2,056.5)**		**(1,829.6)**
Top Up Adjustment	20,174.0	20,174.0	22,407.0	2,233.0		1,716.5
Adjusted Financial Performance (Surplus) / Deficit excluding Top Up	**20,847.0**	**20,169.0**	**20,345.5**	**176.5**		**(113.1)**

Table 1: Trust Statement of Comprehensive Income

4 Cost Reduction Programme (CRP)

4.1 As part of the planned M7 to M12 expenditure plan submitted by the Trust, an efficiency programme of £2.141m was identified in response to the requirement to live within the financial envelope issued. The relevant efficiency target to February is £1.780m and the Trust has been able to deliver on this due to non-recurrent underspends against planned pay expenditure.

5 Cash and Working Balances

5.1 The Trust opened the financial year with £14.400m of cash, which was £5.800m higher than initially planned. This mainly resulted from scheduled creditor payments in respect of the 2019/20 financial year. The cash position was then further strengthened with the receipt of £4.700m unplanned PSFD/FRF monies in respect of 2019/20 financial performance. The adjusted cash position of £29.291m as at 28th February is equivalent to 36.30 days operating costs (28.93 days in January) and represents a £5.947m increase from January.

5.2 The liquidity metric has deteriorated by 0.41 days against January to -8.92 days and is 1.89 days worse than the revised plan driven by a £1.605m reduction in the working capital balance. Debtors have reduced by £6.863m in the year due in the main to the receipt of PSF/FRF monies and are £1.239m above revised plan.

5.3 The balance sheet is presented in Table 2.

Statement of Position - February 2021

	2020/2021 January 2021 Group £000's	2020/2021 February 2021 Group £000's	Variance - Prior Month £000's	2020/2021 February 20201 QEF £000's	2020/2021 February 2021 FT £000's
Assets					
Non-Current Assets					
Investments	80	80	0	80	16,824
Property, Plant and Equipment, Net	119,082	119,356	274	484	118,872
Trade and Other Receivables, Net	2,232	2,226	(6)	889	1,337
Finance Lease - Intragroup				43,416	0
Trade and Other Receivables - Intragroup Loan	0	0	0		19,771
Total Non Current Assets	121,393	121,662	268	44,870	156,804
Current Assets					
Inventories	4,141	4,406	265	2,288	2,118
Trade and Other Receivables - NHS	5,394	6,716	1,322	378	6,338
Trade and Other Receivables - Non NHS	6,329	3,692	(2,636)	646	3,046
Trade and Other Receivables - Other	0	0	0		0
Prepayments	3,514	3,085	(429)	238	2,847
Cash and Cash Equivalents	54,777	58,650	3,873	9,917	48,733
Other Financial Assets - PDC Dividend	0	0	0		0
Accrued Income	757	1,063	306	520	543
Finance Lease - Intragroup				64	0
Trade and Other Receivables - Intragroup Loan					326
Total Current Assets	83,170	77,613	2,702	14,050	63,952
Liabilities					
Current Liabilites					
Deferred Income	31,433	29,359	(2,074)	158	29,201
Provisions	647	434	(213)	0	434
Current Tax Payables	4,111	4,203	92	344	3,859
Trade and Other Payables - NHS	1,396	2,002	606	738	1,264
Trade and Other Payables - Other	9,482	7,079	(2,403)	2,309	4,770
Trade and Other Payables - Capital	45	(149)	(194)	0	(149)
Other Financial Liabilities - Accruals	30,151	36,924	6,772	7,049	29,875
Other Financial Liabilities - Borrowings FTFF	499	499	0	0	499
Other Financial Liabilities - PDC Dividend	184	349	165	0	349
Other Financial Liabilities - Intragroup Borrowings	0	0		326	0
Finance Lease - Intragroup	0	0		0	64
Total Current Liabilities	86,208	80,700	2,751	10,923	70,166
NET CURRENT ASSETS (LIABILITIES)	(3,038)	(3,087)	(49)	3,127	(6,214)
Non-Current Liabilities					
Deferred Income	2,733	2,743	10	1,869	874
Provisions	2,748	2,748	0	0	2,748
Trade and Other Payables - Other	0	0	0	0	0
Other Financial Liabilities - Accruals	0	0	0	0	0
Other Financial Liabilities - Intragroup Borrowings	0	0	0	19,771	0
Other Financial Liabilities - Borrowings FTFF	15,188	15,188	0	0	15,188
Finance Lease - Intragroup				0	43,416
Total Non-Current Liabilities	20,669	20,679	10	21,640	62,227
TOTAL ASSETS EMPLOYED	**97,687**	**97,896**	**209**	**26,357**	**88,364**
Tax Payers' and Others' Equity					
PDC	130,994	130,994	0	0	130,994
Taxpayers Equity	0	0	0	0	0
Share Capital	0	0	0	16,824	0
Retained Earnings (Accumulated Losses)	(42,428)	(42,219)	209	16,986	(59,206)
Other Reserves	0	0	0	0	0
Revaluation Reserve	9,022	9,022	0	0	9,022
Misc Reserve	99	99	0	0	99
TOTAL TAXPAYERS EQUITY	97,687	97,896	209	33,811	80,910
TOTAL ASSETS EMPLOYED	**97,687**	**97,896**	**209**	**33,811**	**80,910**

Table 2 – Statement of Position

6 Capital

6.1 The 2020/2021 capital programme was initially set at £7.090m at the planning stage; this CDEL limit has increased to £19.151m to reflect additional capital funding received for a number of additional programmes such as, but not limited to:

- £1.000m in respect of Critical Infrastructure Works,
- £1.435m for A&E Works,
- £1.370m for Mental Health Dorms
- £4.030m for Pathology Covid Works
- £1.094m for Covid related capital works
- £1.000m in respect of the Jubilee Wing

6.2 The Department of Health had previously advised that the capital costs relating to the Pathology Pillar 2 Covid testing programme would be funded via PDC. It is now confirmed that this funding will be provided as revenue with the exact value of the estimated £4.030m cost of scheme yet to be confirmed. This means that the Trust is likely to exceed its capital expenditure limit (CDEL) for the year, but NHSI/E are sighted on this and have advised that this can be accommodated within the ICS CDEL.

6.3 The revised capital plan is outlined within Table 3; Costs incurred to date are £9.548m but the Trust has reasonable confidence that the remaining capital commitments outlined in the plan will be delivered.

Capital Programme	£000s	£000s
Funding		
Internal generated	10,050	
Confirmed PDC	8,871	
Charitable Funds	230	
Total Funding		**19,151**
Expenditure		
Pathology Covid 19 Works	4,030	
IT GDE	2,350	
A&E Works	1,435	
Sunniside Reprovision	1,370	
Equipment Relacement	1,195	
CT Scanner Replacement	1,100	
Critical Infrastructure	1,000	
Jubilee Wing	1,000	
Alterations to Tranwell	897	
Virtual Ward Rounds	500	
Maternity Scheme (mitigation)	450	
Ward 21	400	
Building & Engineering Backlog Maintenance	396	
Other (aggregate of smaller schemes of less than £360k)	3,028	
Total Expenditure		**19,151**

Table 3: Capital Programme

7 Risk

7.1 There are a number of risks that must be noted alongside consideration of the financial position. Table 4 provides further detail of these risks, along with the current risk rating and any progress against actions to mitigate.

Risk	CRR	PRR	Progress / Mitigation
Risk that the level of efficiency savings required in year cannot be achieved	6	16	The financial framework has been suspended for M1 to M6 of the financial year. The M7 to M12 financial regime has now been published and work is on-going both internally and externally to agree financial targets. BUs have been unable to work on CIP plans due to the ongoing COVID pandemic however, CIP delivery is likely to be achieved via a non-recurrent reduction in pay costs.
Unable to agree a reasonable financial plan or envelope for 2020/21 given timescales inherent in the proposed planning guidance	6	16	The financial framework was suspended for M1 to M6 and replaced with a breakeven funding regime; for months 7-12 systems have been issued with system level financial envelopes. A collective detailed ICP financial plan, prepared in response to the system financial envelope, has been submitted to the ICS including financial risks. The Trust continues to work in partnership with the ICP on the agreement of a financial plan for M7 to M12. As directed by NHSI/E all plans have been prepared with the underlying assumption that phase 3 will continue to be delivered in the event of further Covid 19 pressures. Impact associated with escalation of further pressures are not inherent in the planning scenario. As at month 11 th Trust is forecasting a £1.256m surplus.
Robustness of the financial forecast given the uncertainty surrounding COVID and the effect on capacity and demand	16	12	DFBMs continue to work closely with the business units to ensure implications of potential further waves are identified but also the costs of 'catch up' are included, where relevant, within the forecast outturn scenario modelling.
Unmanaged escalation in costs leading to deterioration in underlying financial position and cost base of the Trust	15	15	Budgetary control framework remains in place, separate identification of COVID costs, continued focus on VFM and cost control to organisation.
Uncertainty relating to directives received from and adjustments being byt the natioanl team which may impact upon the ability of the Trust to deliver the forecast position	15	15	Senior team continue to review all guidance and documentation as it is issued, assessing local impact. Maintaining open lines of communication with NHSI/E and E&Y audit team. Continuation of close and effective working relationships with ICP DoF colleagues

Table 4: Financial Risk

Jackie Bilcliff, Group Director of Finance
22nd March 2021

Gateshead Health NHS Foundation Trust

Report Cover Sheet

Agenda Item: 13

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Report Title:	Digital Update			
Name of Meeting:	Trust Board			
Date of Meeting:	31 March 2021			
Author	Nick Black, Chief Digital Information Officer			
Executive Lead	Jackie Bilcliff, Group Director of Finance and Digital			
Report presented by				
Executive Summary	This update provides the Board with assurance on the Digital Governance processes that are in place to ensure that digital strategy and roadmap are fully aligned to the organisational strategy. The paper also provides an update on the digital achievements over the last six months, together with a forward-looking roadmap that describes the key digital milestones over the coming two years.			
Recommended actions for Board/Committee)	Accept the report and support the ongoing assurance through the Digital Committee			
Trust Aims that the report relates to: (Including reference to any specific risk)	**Aim 1** ☒	We will provide consistently high quality care in all our services		
	Aim 2 ☒	We will be a great organisation to work in		
	Aim 3 ☒	We will deliver value for money and strengthen delivery of our clinical services		
	Aim 4 ☒	We will work with our partners to help make Gateshead a place where everyone thrives		
	Aim 5 ☒	We will use our expertise to provide specialist services beyond Gateshead		
Financial Implications:	No additional financial implications			
Links to Risks (identify significant risks and DATIX reference)	All digital risks			
People and OD Implications:	Impact on all patients and staff			
Links to CQC KLOE	Caring ☒	Responsive ☒	Well-led ☒	Effective ☒	Safe ☒

Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)	**Obj.1** ☒	The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance between working life and personal commitments
	Obj. 2 ☒	All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers
	Obj. 3 ☐	Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve

1. Summary

This update provides the Board with assurance on the Digital Governance processes that are in place to ensure that digital strategy and roadmap are fully aligned to the organisational strategy.

The paper also provides an update on the digital achievements over the last six months, together with a forward-looking roadmap that describes the key digital milestones over the coming two years.

Recommendations

The Digital Committee is requested to:

- Accept the report and support the ongoing assurance through the Digital Committee

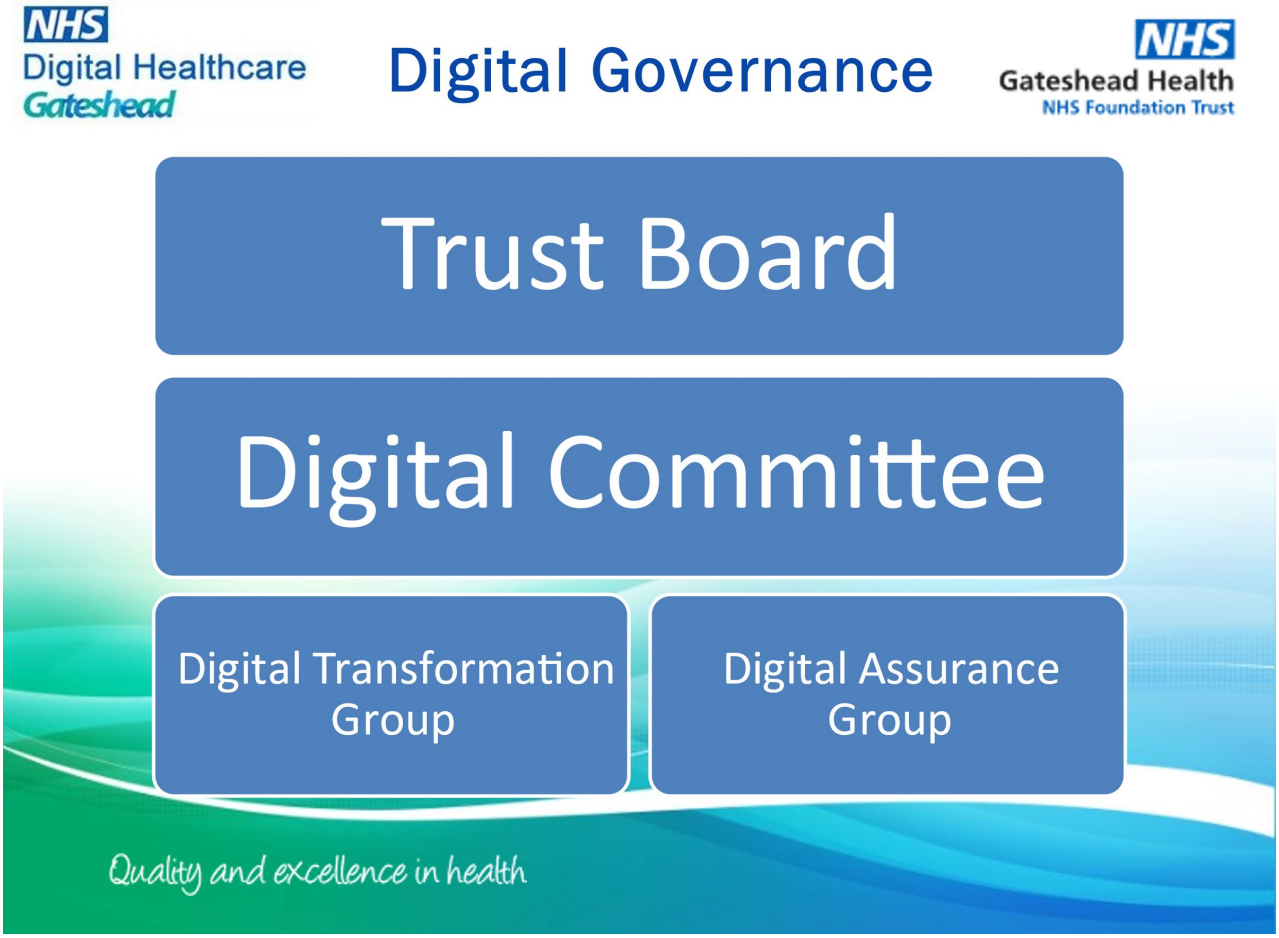
Nick Black, Chief Digital Information Officer

2. Digital Governance

The Digital Committee was established in 2020 with the first meeting in October 2020.

Since then, to support pressures in the Trust relating to Covid, the subsequent two meetings were cancelled; the next meeting is scheduled for 19 April 2021.

The Digital Committee has been established to give full visibility of Digital Transformation (change) and Digital Assurance (business as usual systems and services). To enable this to happen the Digital meeting structures have been realigned as per the slide below:



The Digital Transformation Group has been formed from Global Digital Exemplar Fast Follower (GDEFF) Programme Board and currently meets monthly. The updated terms of reference gives the group responsibility for managing all digitally enabled transformation/change; providing assurance on that to the Digital Committee.

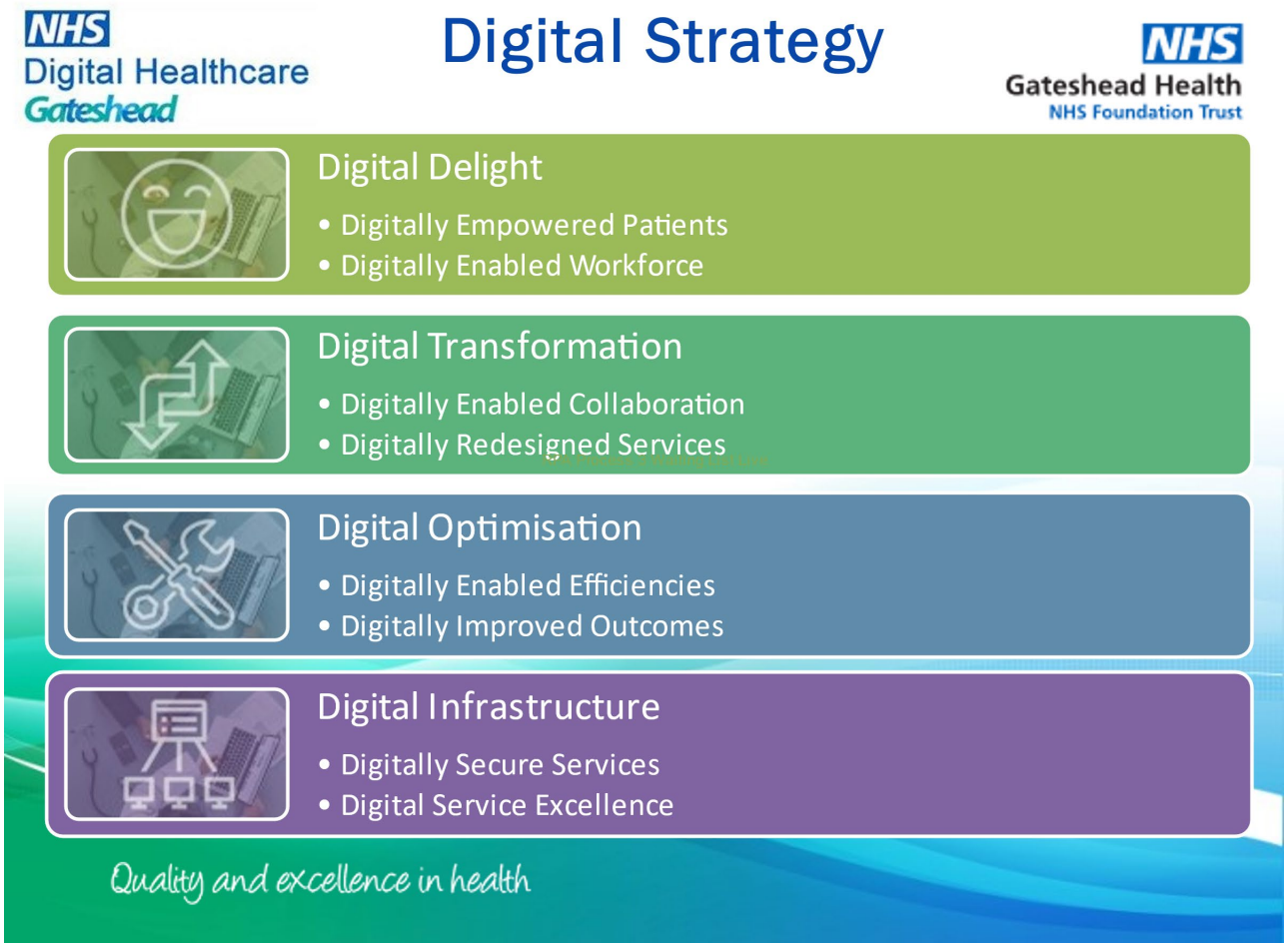
The Digital Assurance Group has been formed from the Information Governance Assurance Group and meets bi-monthly. The updated terms of reference gives the group responsibility for managing existing systems, records, infrastructure and digital services; providing assurance on those areas to the Digital Committee.

These groups are routinely meeting, and are working through plans, reporting and assurance to be provided to Digital Committee.

2.1 Digital Strategy

In October 2020, the Digital Committee reviewed and approved the Digital Strategy previously agreed at CMT in April 2019. It was recognised at the time that the strategy will need to be updated over the summer in line with the review of the Trust strategy which is currently underway. The Trust strategy will set out a clear vision for the organisation, what the Trust looks like, feels to work in and feels to be cared for as a patient. The Digital Strategy aligned to this will define the technologies that deliver these outcomes, for example:

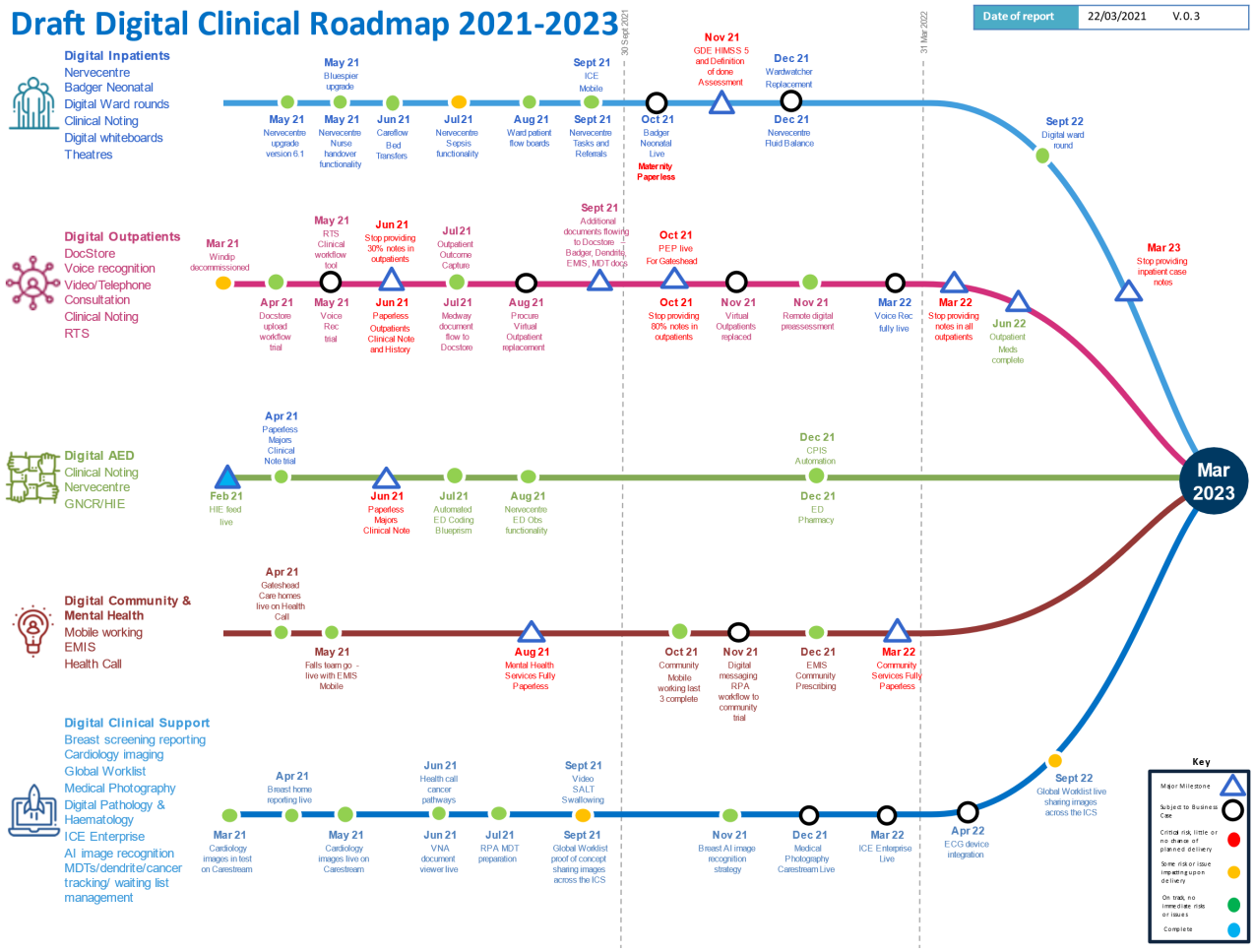
- Digital First - considering how we engage directly to patients – supporting a principle of Home First (empowering patient to be supported using technology to stay at home and not being admitted at all)
- Giving clinicians technology (that always works) they need to do their job, wherever they are and wherever the patient is
- Paperless case note – moving the legal record onto digital systems
- Using technology to fundamental transform services – rather than just automate tasks; although if they are essential that would optimise the process
- All underpinned by an Internet/Cloud First approach – migrating appropriate services off premise



The Digital Committee requested that a Digital Roadmap should be developed, focussing on the Clinical and Operational programmes of work that the digital teams are supporting. A draft of this is included on the next two slides. This is to be discussed in detail at the Digital Committee in April.

2.2 Draft Digital Clinical Roadmap

The draft Digital Clinical Roadmap (shown below) pulls together the stands of work and high-level milestones to support the key clinical aspects of the strategy – clinical transformation, service redesign, clinical safety, self-care etc. This draft roadmaps are being developed to tie in the outcomes the Trust is trying to achieve, tracking delivery of the benefits – not just the system level work underway.



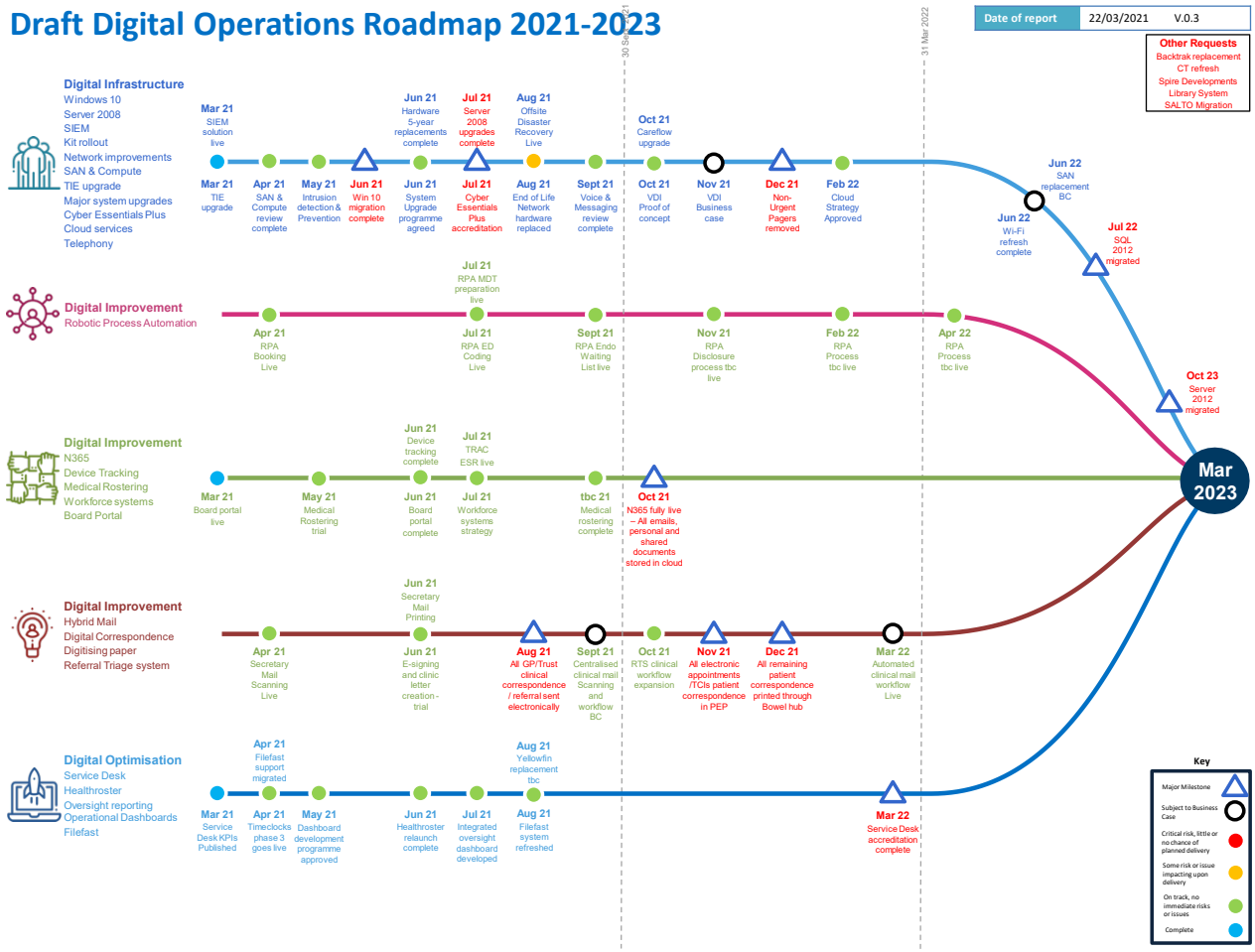
It should be noted that the restructure of the digital team and the reduction of the GDEFF funded capacity will mean a move to agile project management and very light project reporting/tracking.

In addition, it is important to recognise the contractual commitment to the GDEFF projects remain, and as such need to be factored in alongside any new digital transformation work. The roadmap starts to describe the scale of the overall programme to deliver over the next year with some timeframes fixed due to the HIMSS level 5 contractual requirement, planned for November 21.

The Digital Committee supported by the Digital Transformation Group will own and ensure this roadmap is manageable and that the resources have been allocated to deliver the plan, the required business change and realise the associated benefits.

2.3 Draft Digital Operations Roadmap

The draft Digital Operations Roadmap that pulls together the stands of work and high-level milestones to support the key aspects of the strategy – user-oriented technology design, service redesign, automation, efficiencies, cyber security etc.



It should be noted that the restructure of the digital team and the reduction of the GDEFF funded capacity will mean that the core priority will be the mandatory requirements (e.g. IT security) but with a focus on both customer experience and organisational efficiency.

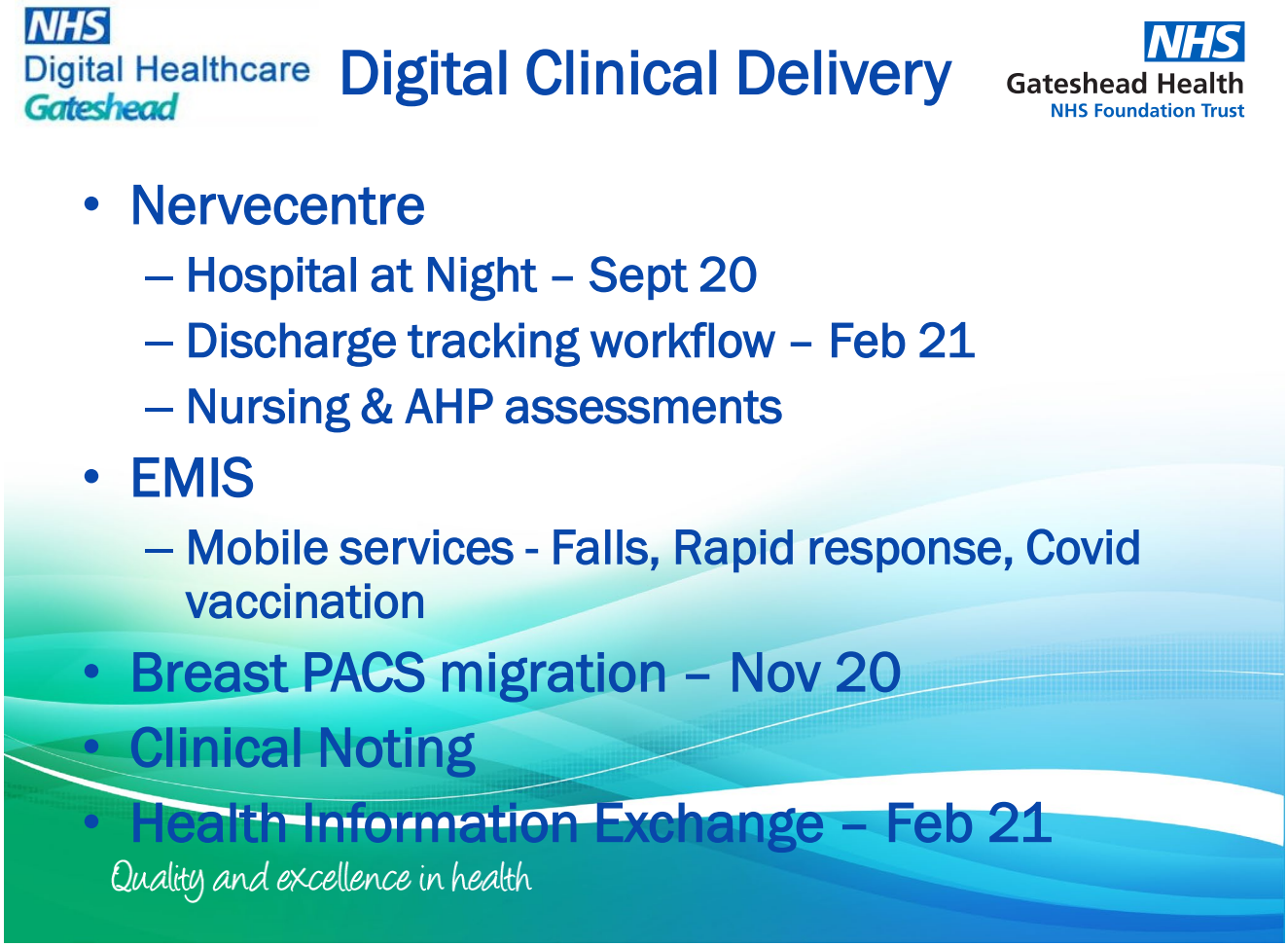
The Digital Committee supported by the Digital Transformation Group will own and ensure this roadmap is manageable and that the resources have been allocated to deliver the plan, the required business change and realise the associated benefits.

The Digital Assurance Group will monitor the metrics to ensure that any change or delivery doesn't impact negatively on the existing services the Digital teams support.

3. Digital Delivery and Assurance

3.1 Digital Clinical Delivery

The slide below pulls out the highlights of the Digital Clinical Delivery over the last 6 months.



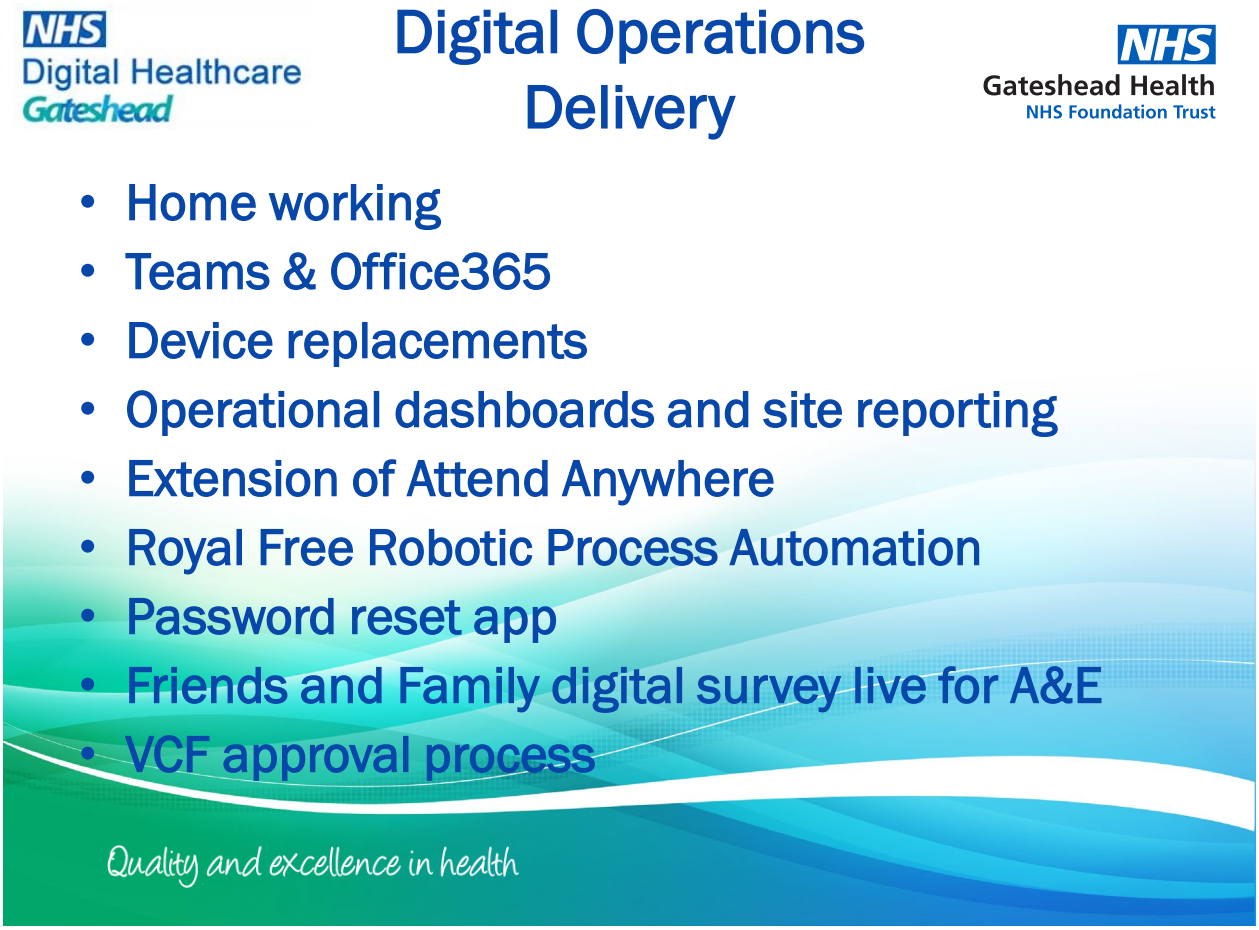
- Nervecentre use continues to expand, with the bulk of nursing/AHP assessments built to be captured digitally – though reduced access to the wards has delayed deployment. The rollout and the associated business change are currently being scheduled.
- EMIS use continues to expand with more services utilising the system and the capability to work in a truly mobile way. The team have also supported the development, implementation, and training of staff for Care Home and house bound patients supporting the vaccination of approx. 3,000 patients.
- The Breast PACS migration was completed in November, merging into the Carestream PACS. This enables more efficient system management, home working for the service and a simpler connection to share images beyond the Trust.
- Clinical noting also continues to expand with 74 clinical notes now live with the clinical services, with the focus now moving onto ensuring that the patient outcomes and follow up are captured digitally at the point of care.
- The Health Information Exchange (HIE) is now live, for us to view information from other trusts, GPs and community services; but in February our data feed went live, flowing appointments, pathology results and radiology reports into the system. Already had feedback on the benefits of this from Dr Jonathan Harness from Glenpark Surgery (and NGCCG) – as one of his

patients was running parallel clinical treatment pathways between Gateshead and Newcastle. Further phases of data uploads are being planned.

- The internal test and trace system was developed and implemented in Cherwell.
- Through this time, we have also completed major upgrades for many of our critical systems such as Careflow, Badger, EMIS and TIE.
- The team also implemented EDDI – as mandated by NHSE – enabling NHS 111 providers to give patients a time slot to attend the emergency department.

3.2 Digital Operations Delivery

The slide below pulls out the highlights of the Digital Operations Delivery over the last 6 months.



- Home working – the team continues to support staff to reliably work flexibly, whether fully working from home, running virtual outpatients or virtual ward rounds.
- Teams & Office365 – the expansion of Teams and exploitation of use is growing and is being supported, which alongside the roll out of Office365 (which has started) will fundamentally change how the organisation works – this must be completed by Sept.
- Device replacements – over 650 new PCs and laptops are being rolled out; with 170 already done since February!
- Operational dashboards and site reporting – the team developed live automated Covid bed status and site management reporting and are moving onto broader performance requirements.
- Extension of Attend Anywhere – ensured contract in place for Attend Anywhere at regional level to ensure continuity of service until March 2022.
- Royal Free Robotic Process Automation (RPA) – partnership agreement with the Royal Free to work together to develop and exploit RPA to automate routine tasks – focusing on automating A&E Coding; and Endoscopy waiting lists. The first internal automation in the booking team is due to go live in April.
- Password reset app – internally the team have developed a user self-service password reset for Trust applications; this app reduces user access delays and on call escalations.
- VCF approval process – another internal workflow development which is ready to go live to automate the sign off and filling of posts.

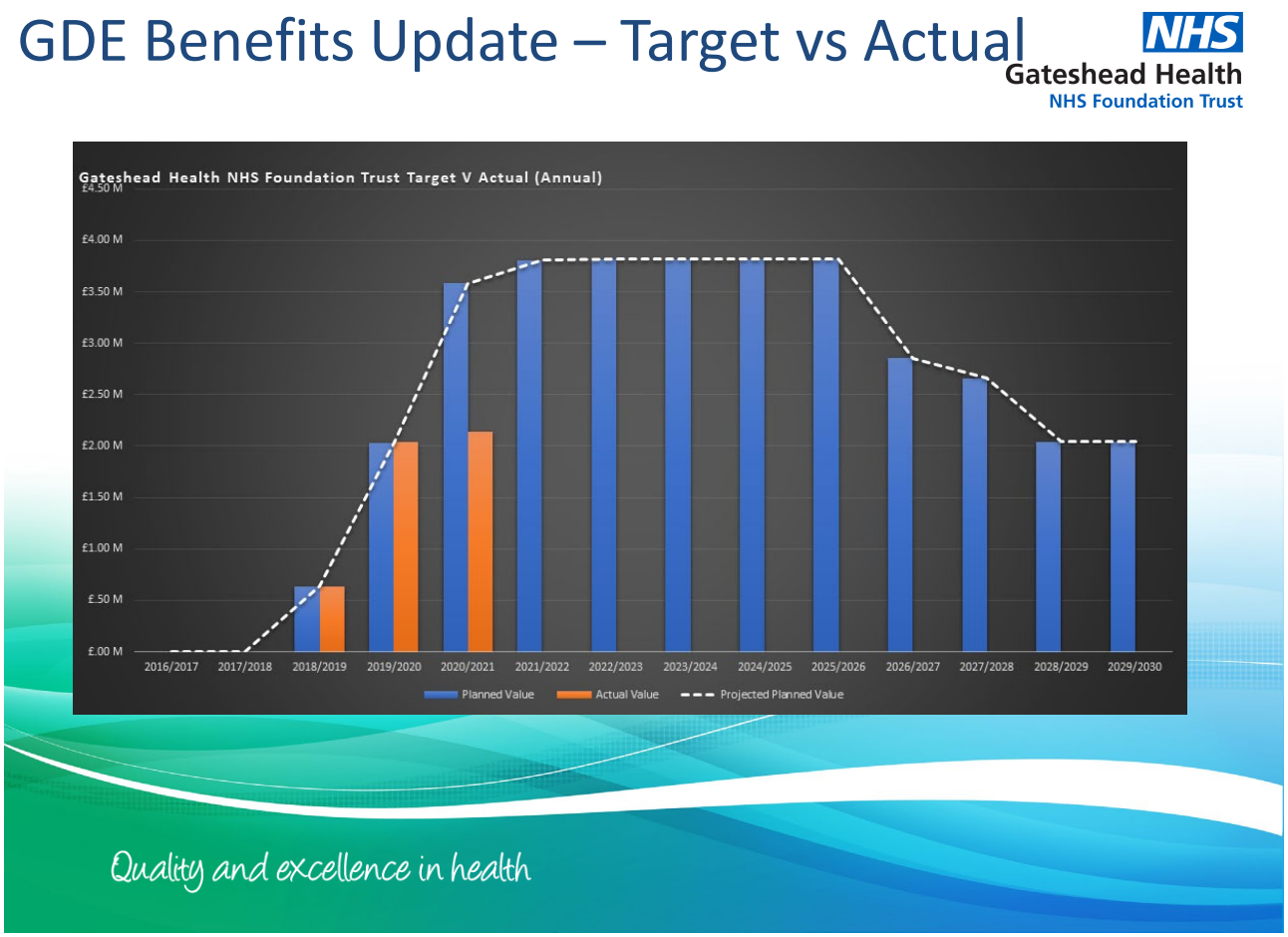
3.3 Financial position

The slide below pulls out the highlights of the Digital Service Assurance over the last 6 months.

- GDEFF Programme – final funding assurance was completed in February; the contractual end point has been moved to November 2021 to allow for Covid delayed work to complete. Approved and audited benefits recognised by NHS Digital are on the next section.
- The Digital restructure to ensure the function fits in the reduced budget the end of external GDEFF funding completes at the end of March. The digital leadership team have undertaken a programme of OD work to improve the culture within digital teams, we are looking to introduce a new operating model which will enable the teams to work more collaboratively. Culture improvement and team development will be a focus over the next year and we will also support staff via coaching/mentoring to increase morale. We have a focus on health and wellbeing to make sure the teams feel supported to take the next step in our development journey.
- The Clinical Coding service continues to operate off site, fully utilising digital records to complete the coding, a review is taking place to ensure coding from digital records is a robust approach moving forward as we look to remove paper from the clinical departments over time.
- 94% of desktop devices are now on Windows10.
- 71% of Windows servers are on Server2012 or above.
- SIEM – Security information and event management tool is live, providing real time threat monitoring, event correlation and incident response.

3.4 Global Digital Exemplar Benefits Update

The slide below displays the approved and audited benefits recognised by NHS Digital, the blue bars relate to target benefits, orange shows actual value delivered. The full detail of the signed off benefits was distributed in the papers for the February 2021 Digital Committee and will be brought forward to the April 2021 meeting.



Benefits are made up of cash releasing (actual cash reduction) and non-cash releasing benefits (time, quality etc).

3.4.1 Cash releasing benefits

The cash releasing benefits delivered to date audited by NHS Digital equate to £0.06M.

This comprises of a reduction in the amount of paper and plastic required to send and receive referrals and specimens to the Lab. Previous work within the pathology department with unique identifiers in labelling in conjunction with ICE interface with Medway and diagnostic systems. Point of Care scanners / printers achieving £10k per annum.

The ability to decommission WinDip has financial benefits for the Trust as the contract will no longer be required, this will contribute £50k per annum.

3.4.2 Non-cash releasing benefits

The non-cash releasing benefits to date audited by NHS Digital equate to £4.75M

These benefits are mainly made up of time and efficiency savings through the introduction of data/images being available more quickly/digitally, tap in tap out, Nervecentre etc.

Overall benefits continue to be reported through NHS Digital for GDEFF and will be reported through Digital Transformation Group quarterly for Trust visibility. In addition, we are actively working with the finance team to strengthened the use of benefits delivery within business cases moving forward, so that these are signed off and agreed with services up front, to ensure they are committed to delivering the business change.

4. Summary

The paper gives the Trust Board details on the breadth of achievements that the digital teams have delivered over the last 6 months, during the Covid pandemic and a major departmental restructure.

Going forward, the Digital Committee will provide the oversight and assurance of digitally enabled transformation and services once the meetings restart in April; this will also ensure that the digital strategy and workplan are aligned to the Trust strategy.

Nick Black, Chief Digital Information Officer

Gateshead Health
NHS Foundation Trust

Report Cover Sheet

Agenda Item: 14

Purpose of Report	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☐	**Information:** ☐
Report Title:	Integrated Oversight Report			
Name of Meeting:	Trust Board			
Date of Meeting:	31st March 2021			
Author	Debbie Renwick			
Executive Lead	**Jo Baxter**			
Report presented by	**Jo Baxter**			
Executive Summary	Key areas of note are: • Continued A&E performance below standard • Increased demand for 2 week waits in cancer, particularly breast referrals continues • Diagnostics, 18 weeks, RTT & cancer compliance continue to be impacted by Covid-19. Trust continues to plan for recovery. • Ongoing clinical prioritisation plans are implemented as per the recent guidance – from Quality Governance Committee. • Ongoing elective capacity plans to recover backlog of patients waiting and reduce waiting times.			
Recommended actions for Board/Committee)	The Board are asked to: a) Receive the IOR for February; b) Note Trust performance & achievement against standards c) To seek further information and test robustness of plans as is require, allowing judgement regarding levels of assurance for future levels of operational performance.			
Trust Aims that the report relates to: **(Including reference to any specific risk)**	**Aim 1** ☒	We will provide consistently high quality care in all our services		
	Aim 2 ☒	We will be a great organisation to work in		
	Aim 3 ☒	We will deliver value for money and strengthen delivery of our clinical services		
	Aim 4 ☐	We will work with our partners to help make Gateshead a place where everyone thrives		
	Aim 5 ☐	We will use our expertise to provide specialist services beyond Gateshead		

<table>
<tr><td>Financial Implications:</td><td colspan="6">There are direct financial implications to recovering the organisational performance position and delivering activity plans.
Across all indicators, potential future actions to improve operational performance are likely to incur additional spend.</td></tr>
<tr><td>Links to Risks (identify significant risks and DATIX reference)</td><td colspan="6">Ongoing risk to Trust's ability to deliver strategic objectives due to the diversion of resource (of all types) required to manage the pandemic.
A sustained exceptional level of demand for services that overwhelms capacity resulting in a prolonged widespread reduction in the quality of patient care and repeated failure to achieve the constitutional standards, with possible harm to patients.
Risk to deliver in the national access targets of 92% for 18 week RTT, and the ability to recover long waits and patient backlog:
- Gaps in workforce
- National ask to prioritise cancer patients first and share resource regionally
- Reduction in Independent Sector capacity
Risk to deliver cancer standards:
- Growing demand (breast)
- Workforce plans predicated on financial incentives</td></tr>
<tr><td>People and OD Implications:</td><td colspan="6">Several areas of reduced activity are assessed as being linked to unavailability of key clinical staff.
There may be an impact on staff wellbeing as a result of working in an increasingly pressurised operational environment.</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring ☐</td><td>Responsive ☐</td><td>Well-led ☐</td><td>Effective ☐</td><td>Safe ☐</td><td></td></tr>
<tr><td rowspan="3">Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)</td><td>Obj.1 ☐</td><td colspan="5">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</td></tr>
<tr><td>Obj. 2 ☐</td><td colspan="5">All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers</td></tr>
<tr><td>Obj. 3 ☐</td><td colspan="5">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</td></tr>
</table>

Integrated Oversight Report
Finance & Performance Committee: March 2021

Gateshead Health NHS Foundation Trust

Contents:

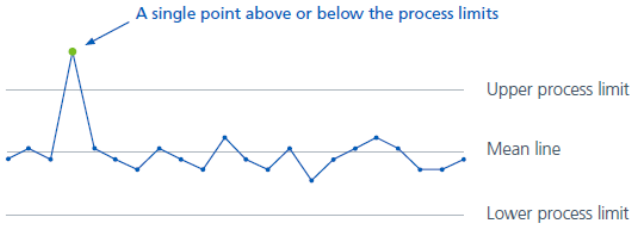
Integrated Oversight Report

Using SPC to identify special cause variation

Gateshead Health NHS Foundation Trust

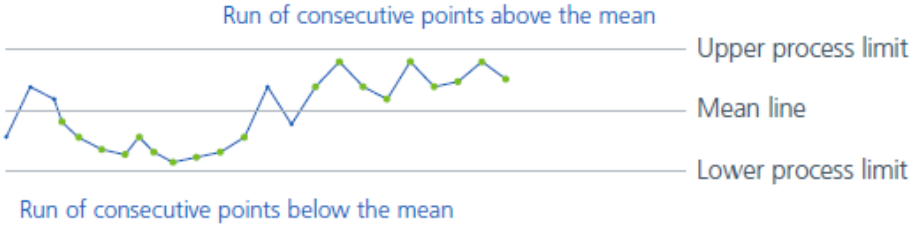
A single point outside the control limits

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.



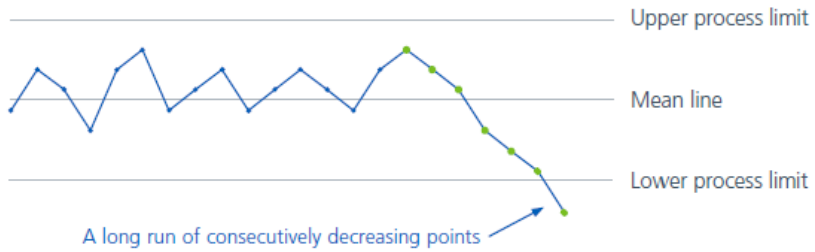
Consecutive points above or below the mean line

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 Oversight Report

Introduction and SPC

Gateshead Health NHS Foundation Trust

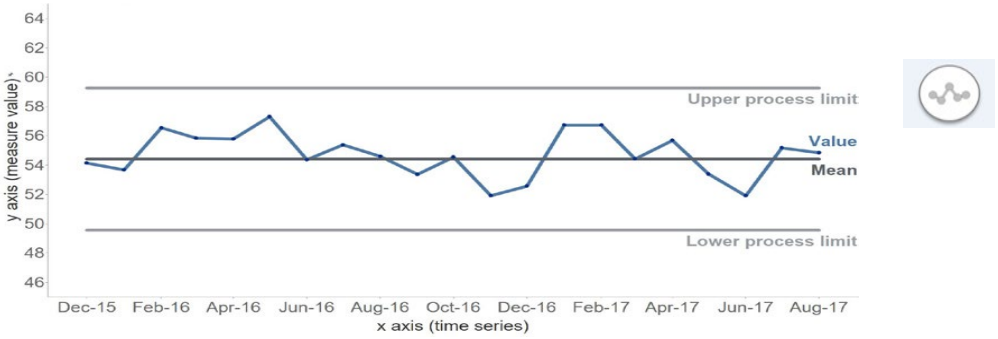
This report provides an integrated summary of the performance indicators from all domains of the Single Oversight Framework (SOF) that the Trust monitors and is monitored by NHSI and additional indicators as identified by the Trust's Board as priorities.

It is intended to complement, not replace, the more detailed reports for each domain that are scrutinised by Board Committees, i.e. the integrated quality and learning report, the operational performance report, the financial performance report, the HR metrics report.

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.

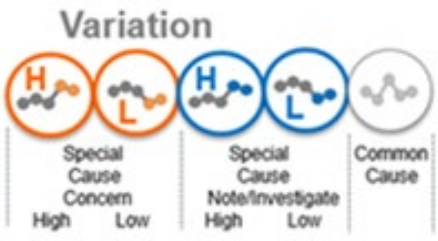
When the data falls within the process limits and there are no other statistically significant trends noticed in the data (those identified in the next page) we say the indicator is exhibiting 'normal variation'.

Integrated Oversight Report

How we use statistical process control in this report

We apply SPC to all the selected metrics that it is appropriate to do so.

After applying this we use the following symbols to denote where we have identified special cause variation, and to show where targets are consistently achieved, failed, or will likely vary between being achieved and failing.



Orange variation symbols indicate that there is special cause variation in a direction that is considered of concern.
Blue variation symbols indicate that there is special cause variation in a direction that is considered a potential improvement.
A grey variation symbol indicates that the measure is demonstrating common cause variation, with values that are expected within current normal practice.

Assurance symbols are used to denote a judgement of whether targets are currently being consistently hit (blue symbol), failed (orange symbol), or hit/missed at random within current observed values (grey symbol).
There is no single rule that drives this judgement, but recent performance and 12 month performance are considered.
Assurance judgements are based upon retrospective data – they do not include any intelligence about future predicted performance. Where the NHS SPC tool has been used the assurance judgement is calculated by the tool, if the performance fluctuates up and down this may not always highlight a target being passed or failed.

Reporting by exception

This Board report provides a summary overview of all the SOF and selected metrics, organised by CQC key line of enquiry.
It provides detail on the metrics which exhibit special cause variation OR where a target is consistently being failed.
Metrics which exhibit common cause variation, do not have targets attached, are hit and miss or are consistently hitting the target do not have detail provided.
Detail for all metrics can be found in the more detailed reports that are scrutinised by Board Committees, i.e. the integrated quality and learning report, the operational performance report, the financial performance report, the HR metrics report.

Executive Summary

Responsive

A&E: The Trust continues to underachieve against the 4 hour standard, failing February. This is the 7th consecutive month the Trust has failed the 4 hr target. In February the Trust saw 90.43% of the patients presenting through A&E within 4 hours, compared to 87.43% in February 2020 although footfall through A&E continues to be consistently lower than last year; since April the average daily reduction is 168 less patients (44.0%) - In February the rate is down by on average 157 patients (45.7%). The latest national benchmarking data places the Trust at 20th of 139 Type 1 providers.

Workforce pressures and Covid-19 pressures have impacted performance since August.

The Trust remains one of the better performing hospitals in the region for Ambulance Handovers, reporting 7 delays in February.

RTT: The waiting-list is above plan. February (finalised data) indicates 8,888 patients awaiting treatment, with 197 patients waiting over 52 weeks. Influencing factors are reduced elective capacity (theatres, beds and workforce) due to the pandemic and the circuit break. The Surgical Business Unit are exploring all options to maximise capacity both internally and externally using Independent Sector.

Cancer: The Trust's position against the 2 week wait target has improved from 51.9% in January to in February to 78.54%. There has been a marked increase in the performance within the breast service with an improvement from 31.71% in January to 67.02% in February. Indicative data for March shows this trend continuing.

The Trust's position for 62 Day cancer standards has slightly declined in January to 60.75% of our patients meeting the 85% standard. No tumour group achieved the 62 day standard within January. The increased numbers of patients requiring Critical Care support with COVID impacted on the ability to undertake cancer surgery procedures. The surgical business unit continues to regularly review Critical Care capacity and theatre staffing availability. Weekly target tracking meetings are in place to work through treatment plans and relieve the bottlenecks at tumour level to reduce the long waiters. The Trust has continued to see a reduction in the long-waiters (>104 days)

Diagnostics: Whilst the Trust failed the diagnostic standard in February reporting 68.8% of our patients seen with 6 weeks of referral. Additional sessions and workforce plans are recovering the endoscopy position, audiology have a recovery plan to eradicate the backlog by March 2021. The main diagnostic risk and pressure is in echocardiology. The service are maximising available outpatient rooms in the short term to alleviate weekly pressures and long term estate plans include assessing the options for a new cardiac diagnostic suite as part of the clinically led estates strategy.

Executive Summary

Safe

The NRLS (National Reporting & Learning System) incident reported rate was 45.3 incidents per 1000 bed days in February 2021. **Patient Safety Incidents**. *Special cause variation is shown in the patient safety incident rate per 1000 bed days , showing a shift in the incident rate. The top 5 incident types for February 2020 are : Patient falls, Pressure damage Infection prevention & control, Pathology sample issues, Medication. The rate may be explained by increased reporting of incidents by staff along with the retrospective reporting of patient safety incidents related to nosocomial infections as outbreak investigations remain ongoing. A review of IPC incidents reported in February has highlighted that a proportion of these date back to October 2020 .

A total of 47 medication errors were reported in February 2021. 1 moderate harm error. Common cause variation is observed in the medication error rate in February 2021. A general upward trend is observed with the indicator close to triggering special cause variation to signify an upward shift in medication errors.

The trust has had **zero incidence of Hospital onset MRSA** BSI in 2020-21.

February 2021 - **138 falls reported**; 107 no harm; 27 low harm; 3 moderate harm; 1 severe harm.

February 2021 **6 serious incidents reported.**

Effective

The latest **Hospital Standardised Mortality Ratio** (HSMR for Jan 20 – Dec 21) at 114.6 is showing more deaths than expected, which has decreased from the previously reported figure of 119.0 (Oct19 - Sept20). Due to C-19 this is likely to flag for sometime. 108 deaths were observed in Feb 21; of which 42 were COVID deaths.

Long Length of Stay: Work continues to review best practice as part of the Flow Programme Board in support of reducing our lengths of stay, maximising discharge and supporting Right to Reside data flows. The trust have requested the support of ECIST to support in this programme of work

Well Led

Core training and appraisals continue to raise cause for concern, as the Trust moves out of the pandemic HR partners will remind staff about the importance of appraisals and core training. Completion ratios across all areas have also dipped due to operational pressures and the practicalities of socially distanced training activities

A targeted programme of work to review all workforce indicators is planned for the new financial year.

Caring

Realtime Patient Experience Projects

The Trust have been selected, by NHSE, to take part in an Evidence Based Design project within the Same Day Emergency Care setting. The project will use some of the 'Always Events®' principles particularly around co-design. Preliminary discussions have taken place with NHSE and the data collection element has begun, supported by Trust volunteers.

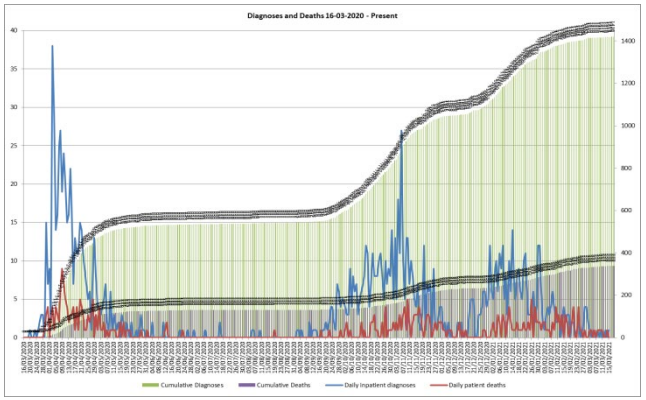
The Patient Experience Team are also working with the Pharmacy Department to undertake a programme of work surrounding patient safety and insulin. Here we will capture patient experience of those who are insulin dependent and this will support the outcome of the Pharmacy Department's project and drive patient centred care.

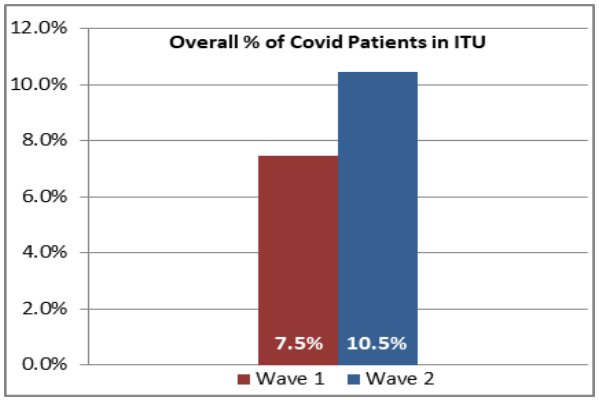
Friends & Family data collection is reinstated – volumes are low to date.

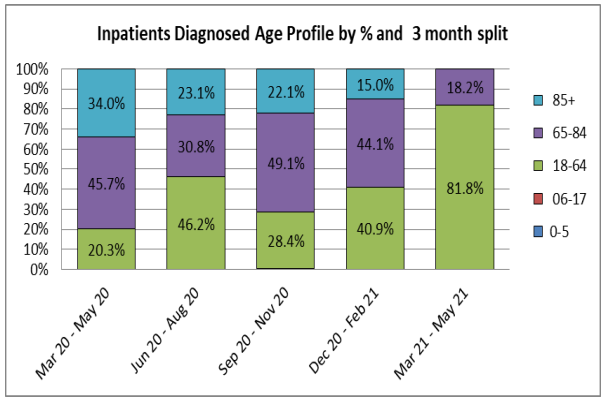
Covid-19: Statistical Update

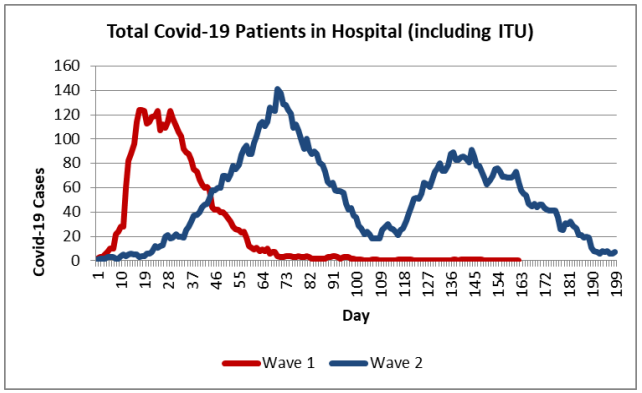
Gateshead Health NHS Foundation Trust

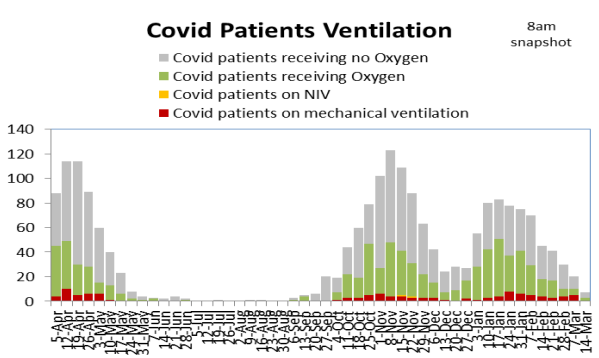
In totality the Trust has treated nearly 1.6k patients with a confirmed diagnosis of Covid.
The latest downward trend in positive diagnoses and % bed occupancy for Covid indicates early signs of recovery from 3rd wave; mindful of Community infection rates.
The age profile of patients has altered during wave 3: inpatients diagnosed with Covid are much younger with 40.9% are within the 18-64 age bracket, as compared to 20.3% in wave 1 and this is increasing further in March.
During March we have reduced critical care bed base by combining yellow and red critical care back into original critical care estate and disbanded the respiratory support unit front of house.

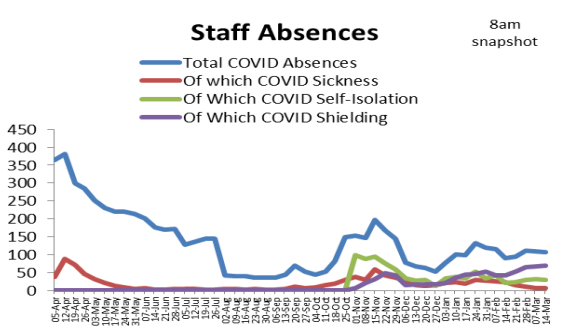












Covid-19: Recovery Context

Gateshead Health NHS Foundation Trust

As the Trust recovers from Wave 3 we have/are:

- Revised bed models to accommodate IPC measures to segregate covid & non covid patients, significantly reducing the risk of nosocomial infections. Q3 we experienced 39, Q4 we have seen 11 to date.
- Managed 31 outbreaks
- Critical care: 2 separate areas within the established unit. Currently supporting up to 7 positive patients & 10 non-covid patients.
- Respiratory Support Unit – (10 high flow nasal oxygen) stood down
- Re-opened all theatres
- Prioritising cancer patients whilst maximising capacity
- Completed 30k tests since April 2020

Planning and Reset: Planning guidance due w/c 22nd March

- **Clinically Led Estates strategy**: Reviewing clinical options & bed models to accommodate 'best fit' estates plans whilst accommodating Infection Prevention and Control measures whilst **planning for:**
  - Operational Elective Reset & Recovery (phase 3+)
  - Clinical operational models for normalisation of covid pathways with escalation & de-escalation to incorporate future surges (C-19/winter)
  - Winter 2021/22
  - Prioritising: Same Day Emergency Care, Home First & Discharge models
  - Re-building our reporting arrangements & aligning our BI development programme to support performance transparency from ward to board
  - Re-instating business as usual governance models

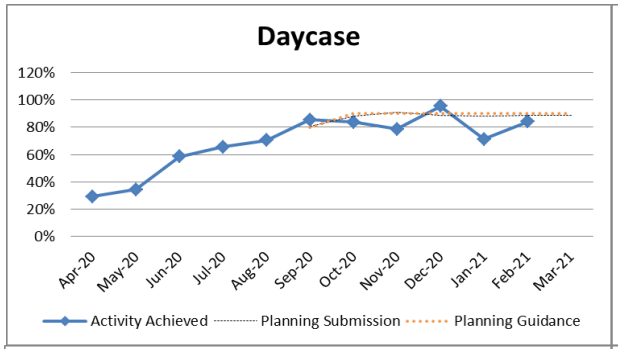
People & Workforce:

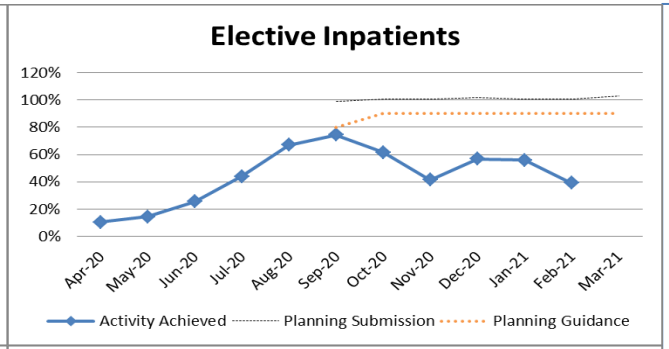
- Successfully rolled out C-19 vaccination plan covering 9,224 first & 4588 second vaccines for staff
- Revised staffing models to accommodate covid and non covid care, whilst flexing workforce resource and capacity front of house to accommodate a respiratory support unit RSU.
- Supporting our staff with enhanced health & wellbeing support programmes
- Continued to support and prioritised CEV staff groups / support for CEV staff returning to work

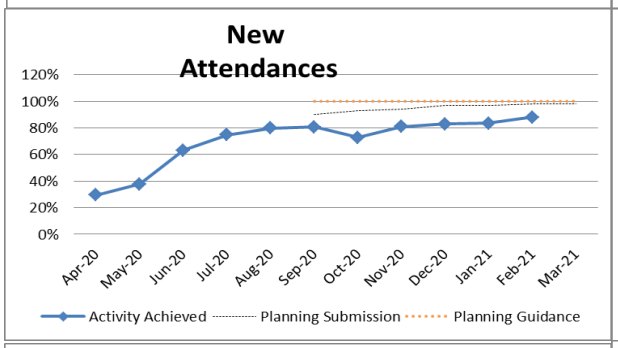
Phase 3 Planning & Recovery

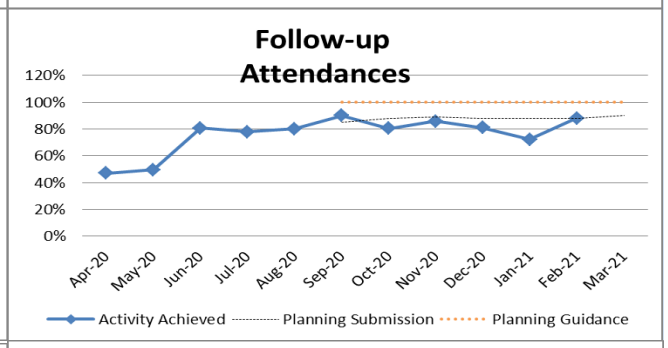
Gateshead Health NHS Foundation Trust

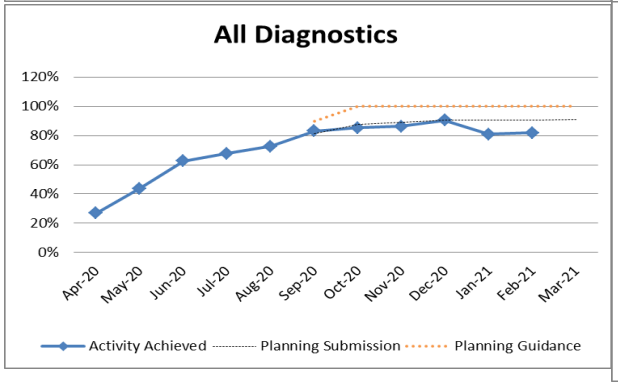
Phase 3 Planning guidance stated the hospital patient activity should return to 'normal' levels, the national expectation is Trusts return to activity levels delivered in 2019/20. As part of the phase 3 planning round the Trust submitted internal trajectories of could be delivered realistically given capacity constraints and altered pathways for new ways of working.

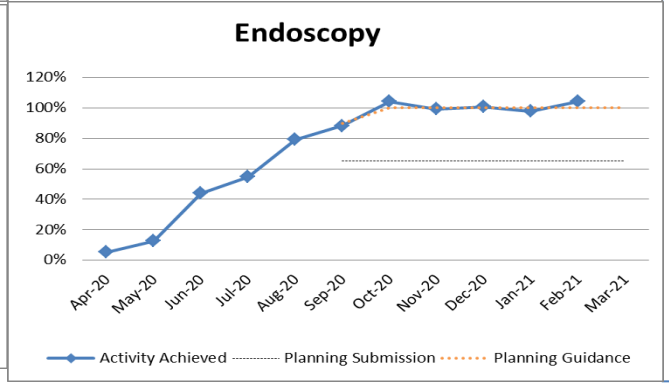












Commentary for February

Day case: Activity at 84% Below internal plan of 89% January. Below national PHASE 3 expectation of 90%.

Elective Inpatients: Activity at 39% Below internal plan of 90% January.

New OP Attendances : Activity at 88% Below internal plan of 98% January. Below national PHASE 3 expectation of 100%.

Follow-up OP Attendances : Activity at 88% Below internal plan of 88% January. Below national PHASE 3 expectation of 100%.

All Diagnostics: Activity at 82% below internal plan of 91 %, Below national PHASE 3 expectation of 100%.

Endoscopy: Activity at 104% Above internal plan of 65%, Above national PHASE 3 expectation of 100%.

Phase 3 Performance Monitoring & Operational Standards

Performance Measure	RO	Last period		This period		Variation	Assurance	Target (where applicable)	Target type
Referral to Treatment within 18 weeks	JBa	74.7%	Dec-20	74.4%	Jan-21	L	F	92%	National
Referral to Treatment Total Incomplete waiters	JBa	9542	Dec-20	8882	Jan-21			8590	Phase 3 monitoring
Referral to Treatment >52 week waiters	JBa	117	Dec-20	131	Jan-21	H		0	Phase 3 monitoring
A&E seen within 4 hours	JBa	86.0%	Jan-21	90.4%	Feb-21		?	95%	National
A&E attendances	JBa	5466	Jan-21	5524	Feb-21			10,587	Phase 3 monitoring
Handover delays 30-60 minutes	JBa	20	Jan-21	7	Feb-21			0	National
Handover delays >60 minutes	JBa	13	Jan-21	0	Feb-21			0	National
Bed occupancy	JBa	85.5%	Jan-21	86.9%	Feb-21			92%	National
Cancer 2ww to Treatment within 62 days	JBa	67.80%	Dec-20	59.1%	Jan-21		?	85%	National
Cancer 62 day treatment screening	JBa	92.3%	Dec-20	95.5%	Jan-21		?	90%	National
Cancer waits over 104 days (all pathways)	JBa	19	Dec-20	24	Jan-21			0	Local monitoring
Diagnostic waits % within 6 weeks	JBa	63.92%	Dec-20	64.6%	Jan-21	L	F	99%	National
Diagnostic waiters	JBa	4296	Dec-20	4432	Jan-21			-	National
Endoscopy waiters (subset of the above)	JBa	580	Dec-20	501	Jan-21			-	National

Pressures continue in ED, although February performance has improved slightly and the Trust experienced less ambulance delays front of house.
In February there has been more pressure for non-covid beds, as winter pressures became more challenging coupled with beds taken out of our compliment for additional cleaning regimes.

Elective pressures continue – further details are contained in the spotlight reports.

Single Oversight Framework

Responsive

Single Oversight Framework is recognised by all NHS Providers and is used as a core element to monitoring overall performance. The basis of this report continues to keep SOF metric and expands beyond into areas of regional and national importance. The operational element of the SOF monitors performance against national standards and will attach triggers to areas of performance deterioration.

2020/21 Trust Performance Dashboard
NHS Improvement - Single Oversight Framework

NHS Gateshead Health NHS Foundation Trust

Category	Performance Indicator Information	PSF Trajectory	2019/20	2020/21 Performance													Standard	Trigger for Potential Support Need:-
				Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	2020/21	(2 consecutive months of non delivery of standard/PSF trajectory)*
Operational	Incomplete RTT Pathways - Waiting < 18 weeks	N	91.1%	70.5%	62.0%	53.0%	52.9%	63.6%	71.8%	76.7%	75.9%	74.7%	74.4%			67.8%	92%	
	Maximum Waiting Time 4 hours in A&E	Y	89.6%	91.7%	94.7%	98.4%	97.5%	94.7%	94.6%	85.5%	83.3%	86.2%	86.0%	90.4%		91.5%	95%	
	62 day wait for 1st definitive treatments	N	76.7%	75.3%	41.0%	59.3%	69.4%	69.2%	74.1%	64.3%	67.2%	67.8%	59.1%			66.0%	85%	
	62 day wait for treatment (screening patients)	N	94.1%	77.8%	47.6%	0.0%	26.7%	45.5%	60.0%	96.6%	93.0%	92.3%	95.5%			74.6%	90%	
	Maximum 6-week wait for diagnostic procedures	N	98.8%	35.7%	32.5%	40.1%	53.4%	57.5%	61.2%	66.2%	61.8%	63.9%	64.6%			54.2%	99%	

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

The Trust continues to experience pressure in the delivery of routine elective pathways. Despite referrals being below pre-covid levels the main contributing factors continue to be the unavoidable cancellations of routine elective patients (with a surgical classification of P3/P4) due to significant covid pressures experienced throughout winter.
Treating cancer patients has remained our priority and during Q4 as reviewed in the spotlight report last month.

Integrated Oversight Report

Summary - Triggering indicators

Gateshead Health NHS Foundation Trust

	Measure	Latest period		Target	Latest 12 month	Variation	Assurance	Comment
SAFE	Potential under-reporting of patient safety incidents	46.3	Feb-21		41.5	H		
EFFECTIVE	Hospital Standardised Mortality Ratio	114.6	Jan-20 - Dec 20			H		12 month figure, The Trust is demonstrating 'More Deaths than Expected' for the most recent available period.
RESPONSIVE	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway	74.4%	Jan-21	92%	70.7%	L	F	Special cause variation since April 2020, performance below target since January 2020
	Number of patients waiting 52 weeks or more on an incomplete pathway	131	Jan-21			H		Special cause variation since August 2020
	Cancer 2ww compliance	51.9%	Jan-21	93%	70.2%	L	?	Special cause variation for July to September 2020, and January 2021. Performance below target since April 2020 .
	Maximum 6-week wait for diagnostic procedures	64.6%	Jan-21	99%	60.8%	L	F	Special cause variation since April 2020, performance below target since March 2020
WELL-LED	Appraisals	57.9%	Feb-21	85%	63.5%	L	F	Special cause variation - concern, deterioration since April 2020 and below target
	Core Training	75.1%	Feb-21	85%	77.9%	L	F	Special cause variation - concern, deterioration since May 2020 and below target

Variation & Assurance : Indicators that do not include a symbol for variation and /or assurance are either not appropriate for measuring by SPC charting or are not measured against a target.

Spotlight Report: Referral to Treatment

Gateshead Health NHS Foundation Trust

Referral to Treatment & Access to Elective Care:

In the NHS Operating Framework and under the NHS Constitution patients have a right to start consultant-led treatment within a maximum of 18 weeks.

Historically Trusts have been expected to ensure that 92% of patients are waiting within 18 week for treatment.

The Trust manages patient waiting times via the Access Policy to ensure all patients requiring access to outpatient appointments, diagnostics and elective inpatient or day-case treatment are managed equitably and consistently in line with the NHS Constitution and national waiting time standards.

Changes under Covid

Outpatient services should be provided virtually whenever possible to progress treatment where face-to-face contact is not required.

Most hospitals have incurred reduced elective capacity, across the entire pathways due to IPC guidance and the operational management of covid/non-covid patients.

In most areas patients are waiting longer for treatment.

Reasons for Longer Waiting times

- Patients who are self isolating – are temporarily unfit & are still waiting
- Vulnerable patients (> 70 years old and those included in 'vulnerable patient group) are still waiting even if unfit, to keep waiting times visible. An exception can be made if the patient and clinician agree to 'actively monitor' a clock stop can be added in this circumstance
- Patient choice: Where patients chose to decline numerous appointments local access policy rules apply, the clock will not be stopped without clinical intervention
- Hospital initiated cancellations (because of reduced elective capacity i.e. beds, theatre space, or Covid related workforce issues: redirecting do not stop the clock)

Spotlight Report: RTT & Elective Care

Gateshead Health NHS Foundation Trust

Referral to Treatment & Access to Elective Care:

The pandemic has naturally affected the trust ability to deliver this standard and patients are now waiting longer for treatment. SPC 1 RTT 18 weeks: The trust has not achieved this standard since December 2019. A shift in performance is observed from April 2020 with performance below the 18 month mean from this point onwards.

In January the Trust was required to cancel all non-urgent elective activity (NHSE/I) for a minimum of 3 months. Restart of elective recovery was well underway in August seeing an upward improving trend, however this was short lived when C-19 Wave 2 commenced with outbreaks and the introduction of the circuit break have impacted on the ability to deliver Inpatient overnight stays.

All specialties are under performing with the exception of general medicine, who have achieved the target since December 2020. Most general medicine treatments occur without a surgical intervention.

Surgical RTT pathways have been the most affected pathways by covid reporting the longest waits with the greatest volume of waiters.

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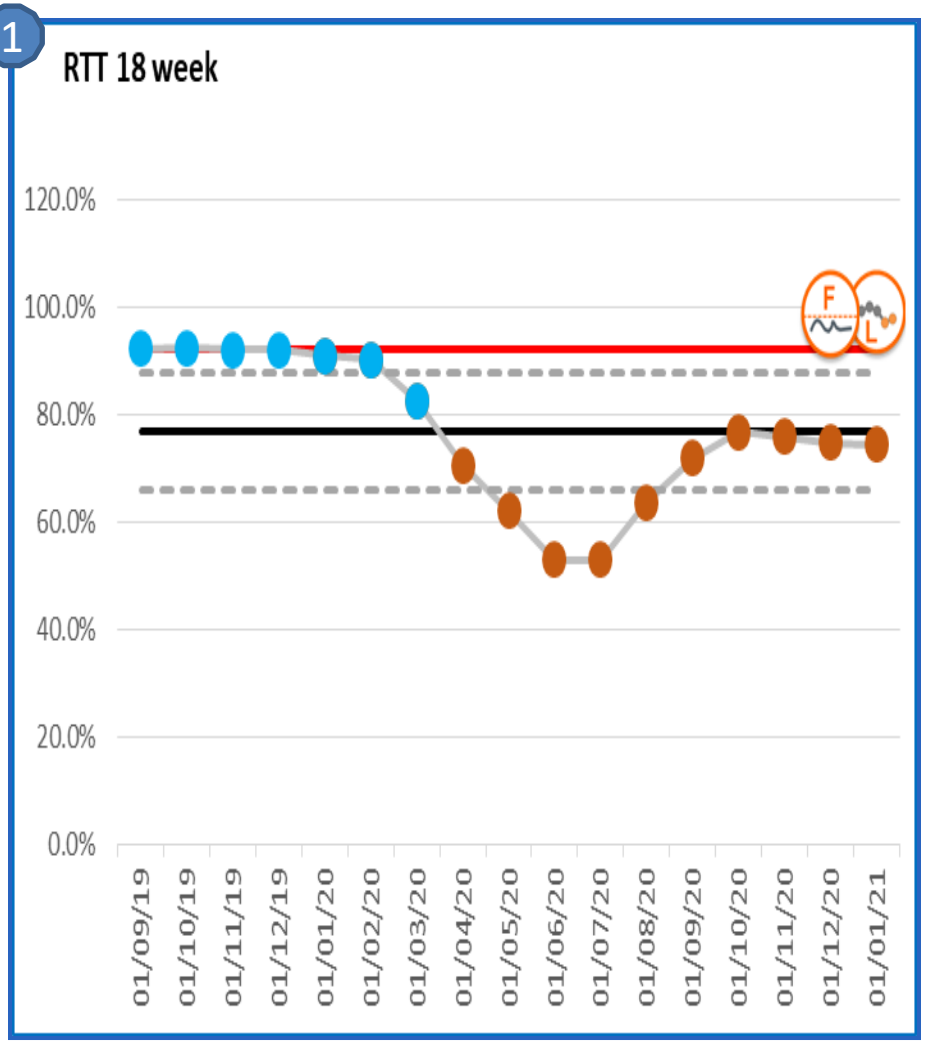


Spotlight Report: RTT & Referrals/Outpatients

Gateshead Health NHS Foundation Trust

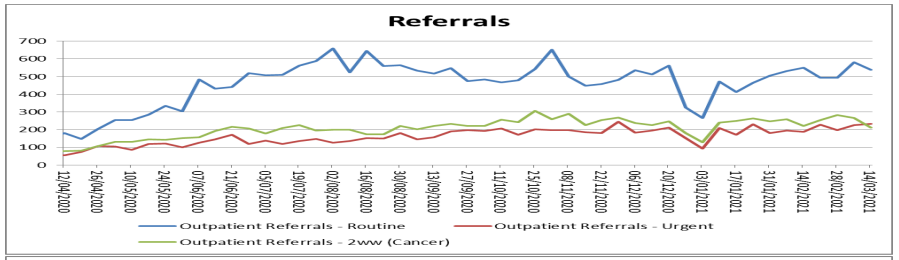
Referral Rates & Outpatient Appointments :

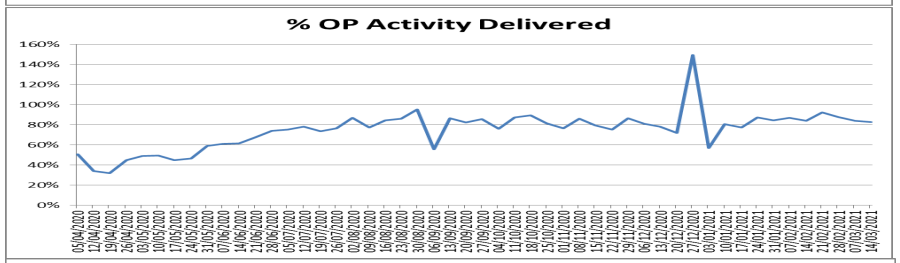
Whilst referrals rates have increased from very low levels at the start of the pandemic; our 'routine' rates continue to be circa 25% below pre-covid levels.

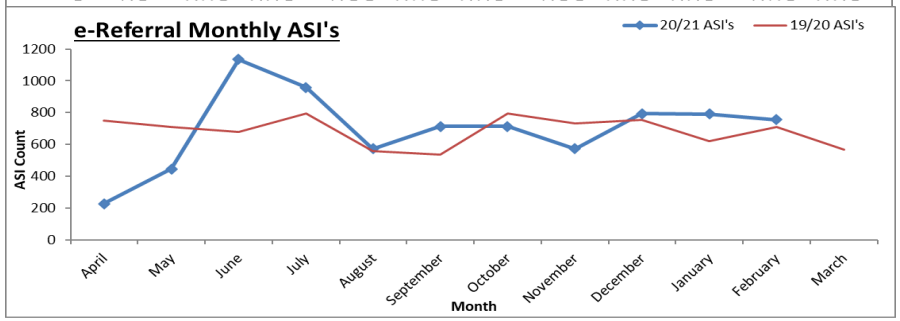
IPC guidelines introduced capacity restrictions, which have led to new ways of working to ensure patients are seen timely. Digital & telephone appointments are now part of every day outpatient activity. We are routinely achieving 80% of our activity delivered prior to C-19.

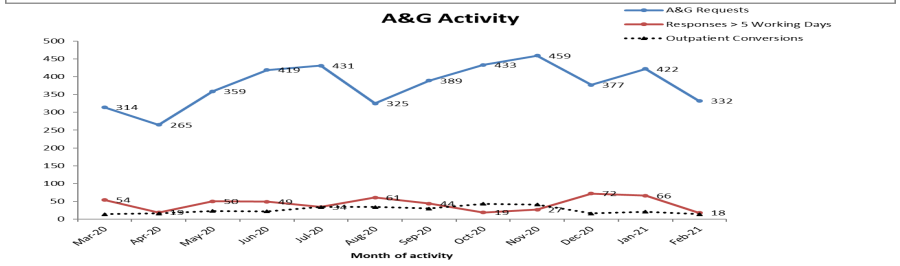
There are outpatient capacity pressures, NHSe-referral system (e-RS) generates an appointment slot issue (ASI's) when there are no appointment slots at the time of booking. These are now in-line with pre-covid levels.

Alternative options to attending hospital appointments include offering GP's an advice & guidance service which can prevent an outpatient attendance.



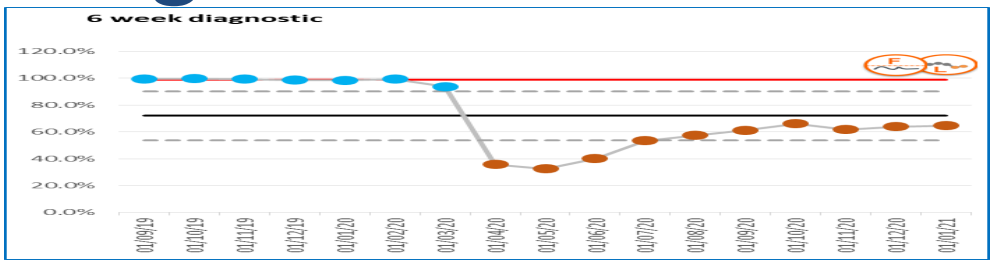




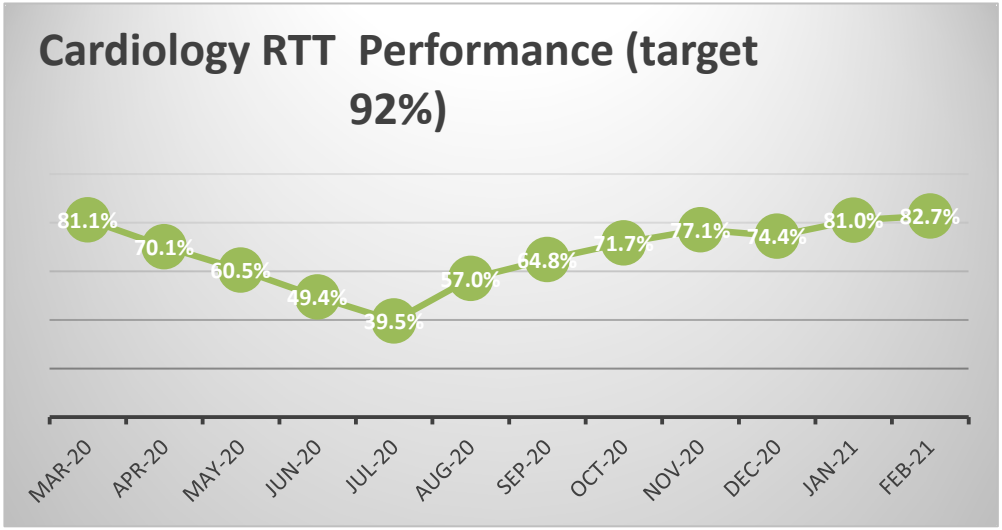


Spotlight Report: RTT & Diagnostics

Gateshead Health NHS Foundation Trust



	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
Barium Enema	85.1%	41.5%	29.7%	27.9%	75.0%	92.6%	100.0%	100.0%	100.0%	90.3%	93.5%	100.0%
CT	99.4%	59.9%	40.3%	54.7%	82.1%	91.4%	99.3%	99.4%	94.3%	96.6%	97.6%	98.9%
MRI	99.0%	41.0%	36.4%	72.0%	94.1%	97.5%	97.8%	99.1%	98.4%	98.9%	98.8%	99.3%
Non-Obstetrc Ultrasound	92.4%	30.5%	32.8%	38.3%	50.7%	62.1%	78.4%	99.4%	98.1%	98.8%	98.8%	98.8%
Audiology	96.2%	18.8%	14.9%	21.8%	21.9%	26.6%	27.3%	23.3%	40.8%	51.1%	74.7%	88.3%
Urodynamics	91.7%	54.5%	53.3%	61.9%	48.1%	80.0%	93.3%	87.5%	98.2%	48.6%	51.2%	57.8%
Colonoscopy	93.2%	43.7%	37.6%	51.3%	70.4%	72.6%	85.2%	93.2%	82.5%	94.0%	91.1%	90.6%
Flexi-Sig	94.4%	26.8%	29.4%	35.1%	35.6%	41.5%	44.2%	51.3%	45.5%	53.7%	91.8%	97.4%
Gastroscopy	92.1%	30.6%	30.7%	50.4%	66.4%	71.8%	81.2%	89.1%	95.8%	97.6%	97.5%	96.0%
Dexa	97.3%	46.7%	30.4%	40.5%	58.4%	63.7%	60.9%	85.7%	88.9%	88.9%	93.3%	94.3%
Echo Cardiology	90.4%	37.9%	37.6%	45.5%	46.8%	41.6%	30.5%	28.4%	24.6%	25.5%	20.7%	26.8%
Cystoscopy	92.7%	25.4%	27.0%	16.8%	25.5%	29.8%	38.1%	51.7%	68.8%	63.6%	61.2%	86.7%



Diagnostics:

RTT measures the full or whole RTT pathway, in many cases the diagnostics test (& wait) will be a key part of the wider RTT pathway. The 6 week diagnostic milestone is part of the NHS Constitution. This indicator measures, at the end of each month, how many patients are still waiting more than 6 weeks for any of a number of diagnostic tests. The standard is to achieve 99%.

Situation

The 6 week wait target has not been met since February 2020 with a significant reduction in performance observed from March 2020 onwards triggering special cause variation. Whilst February's performance of 68.8% fails the standard, at Trust level we continue with an upward trajectory from 35.7% in February.

Assessment

Recoveryprogress is demonstrable against most modalities, with most high volume pathways demonstrating a 'normal' waiting list profile. All modalities have recovery plans to re-instate additional capacity, aiming to fully recover by end of Q1 2021. Echo-cardiology still remains a particular area of concern:
- 90% of the patients waiting over 6 weeks are waiting for an echocardiogram.
Despite the long waits RTT cardiology performance target has demonstrated an upward trend since July.

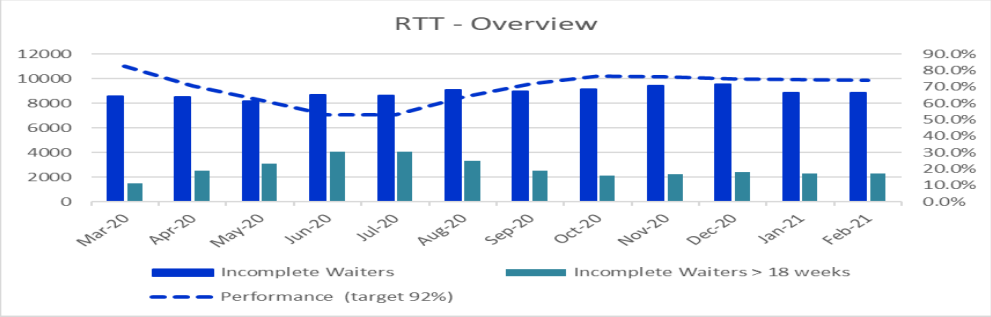
Actions

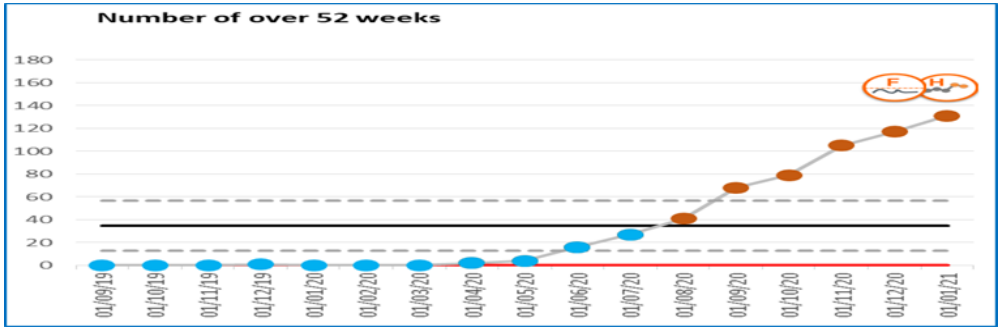
MBU – now have a recovery manager assigned to manage and oversee the diagnostic recovery plans. Main areas to target are: 50% reduction in clinic capacity (IPC measures).

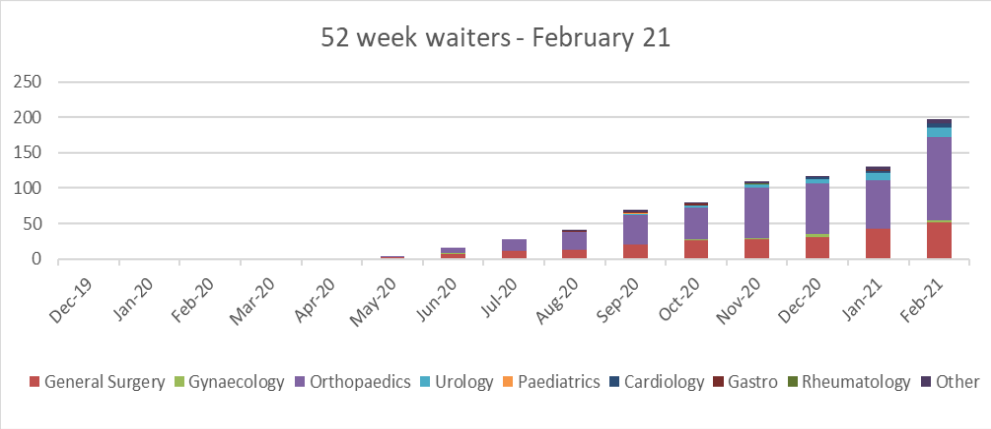
Short term plan include maximising clinic rooms available on a weekly adhoc basis
Medium term plans include converting 1 outpatient room into a designated echo-cariology room
Long term: Investing in a cardiac diagnostic suite as part of the clinically led estates strategy.
Reviewing IPC measures and workforce planning to attract weekend /additional clinic work.

Spotlight Report: RTT & Waiting-times

Gateshead Health NHS Foundation Trust







Waiting times:

Situation

RTT performance for February is reported at 74.2% (which is in line with January performance, but below the 92% standard.) The patient list size has remained static at just under 9k patients remaining to be seen.

The total number of patients waiting over 18 weeks increased slightly from January (+20) from 2,275 to 2,294, the number of patients waiting > 52 weeks increased (+ 36) from 131 to 197 in February.

Assessment

The Trust has prioritised surgical cancer cases in Jan/February in line with national guidance which has impacted on the RTT phase 3 delivery plans & trajectories.

RTT specialties most affected are in the surgical Business Unit; T&O (at the end of February are reporting 118 > 52 weeks & general surgery have 52 patients waiting.

Actions

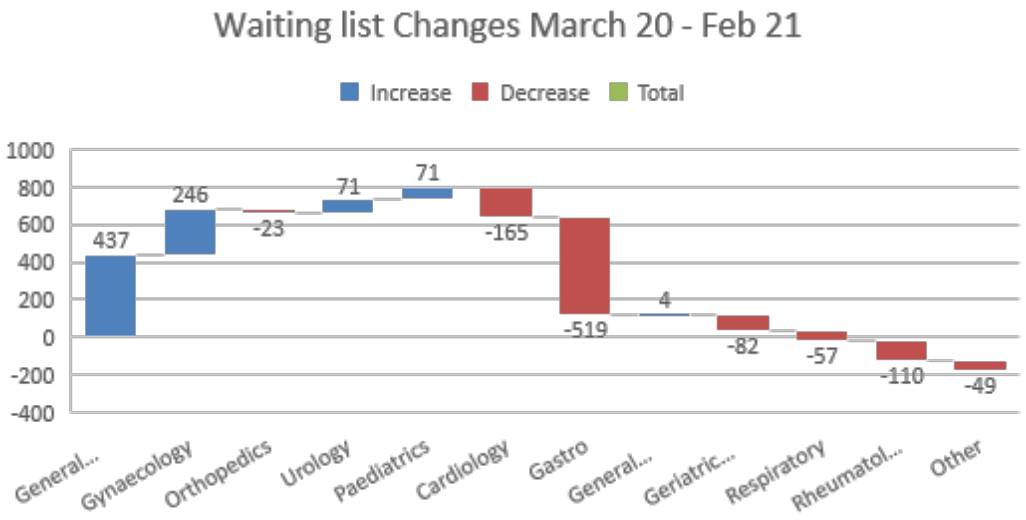
- Business Unit are exploring all options to maximise capacity – Independent Sector & treatments at neighbouring hospitals.
- Detailed theatre workforce plans underpin recovery – *(await finalised plans)*
- Weekly prioritisation of available capacity & workforce
- Maximising Day case potential where possible
- Technical validation of the waiting list completed to understand patients' treatment options and those choosing to delay treatment but remain on the waiting list.
- Treatment cancellations by priority type are now sit-rep reportable.
- High level recovery trajectories are being worked though to eradicate the backlog of T&O > 52 weeks waiters by end of Q1 2021.
- High level recovery trajectories include options to return to 92% standard.
- Reinstatement of elective care recovery group

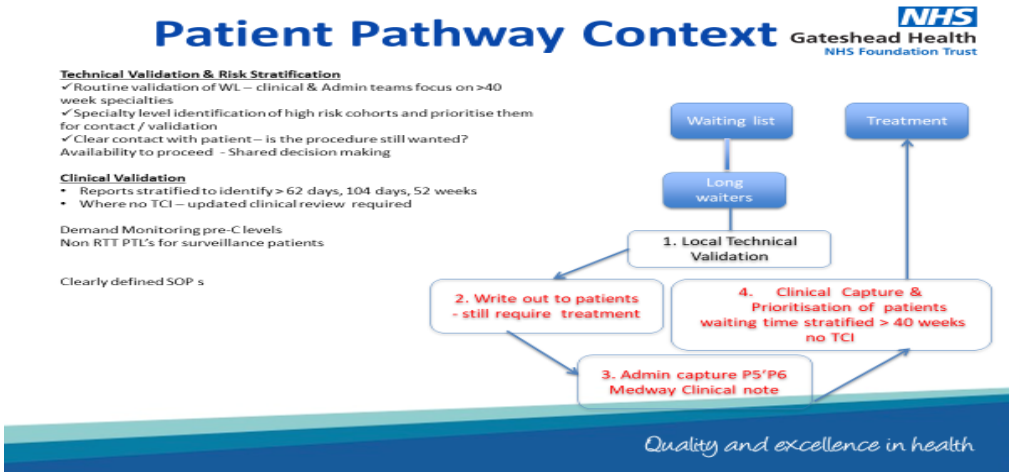
Risks

Workforce planning: Reduced theatre workforce is operating at -30%- -50% in some specialist areas. Speciality level capacity has been severely reduced due to management of CEV workforce.

Spotlight Report: RTT & Patients Waiting

Gateshead Health NHS Foundation Trust





Specialty Waiting Lists

Situation

The graphs on the previous slide shows the waiting-list as fairly static,

On the whole surgical waiting lists have increased, whilst medical specialties have reduced in overall size.

General surgery have incurred the greatest increase in patients since March 2020. The snap shot February position shows an increase (over time) of 437 representing 30increase.

Gastroenterology have removed the most from their waiting showing 519 patients less in February2021 than in March 2020, representing a 40% reduction.

Assessment

The Trust has prioritised surgical cancer cases in Jan/February in line with national guidance which has impacted on the RTT phase 3 delivery plans & trajectories.
The validation programme continues with limited internal resources.

Actions

- Recovery plans for all specialties
- Waiting list review continues
- Clinical prioritisation of waiting lists continues
- Internal RTT validation programme & review external support options
- Validation down to 30 weeks in surgical specialties

Risks

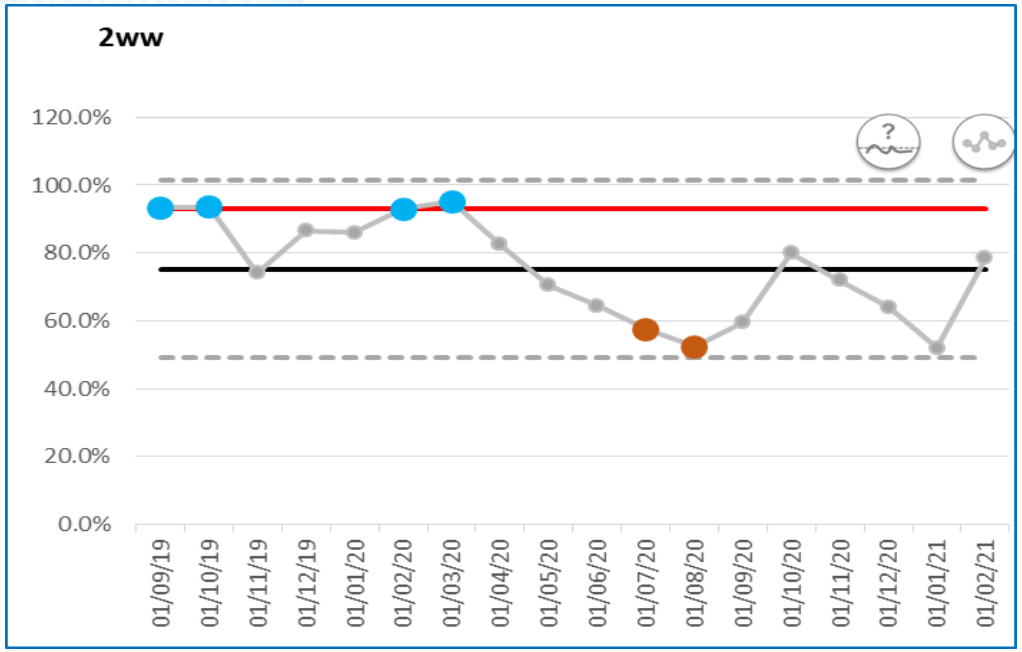
Validating model not sustainable
Reviewing external options of support to sustain waitlist management

Report by exception: Responsive – Cancer 2 week wait compliance

Gateshead Health NHS Foundation Trust

Detail on this measure is included as the standard has not been met since March 2020

Responsive



Situation

Cancer two week wait compliance has not met the standard since March 2020 triggering special cause variation from Jul-20 and Aug 20. The Trust's position against the 2 week wait target dropped to 51.9% in January but has improved in February to 78.54%. There has been a marked increase in the performance within the breast service with an improvement from 31.71% in January to 67.02% in February. Indicative data for March indicated this positive performance trend continuing.

Assessment In line with the North ICP trends , two week wait referrals are now back to precovid levels. The utilisation of additional capacity within the breast service is positively impacting on performance.

Actions:

Continue to utilise additional capacity including the ongoing use of Saturday and after hours

Anticipation that performance within medical specialities will improve as commitment to the general medical rota reduces and covid surge declines .

Recommendation

Ongoing weekly scrutiny and discussion.

Combined impact analysis

Financial impact

Quality impact

Workforce impact

Operational performance impact

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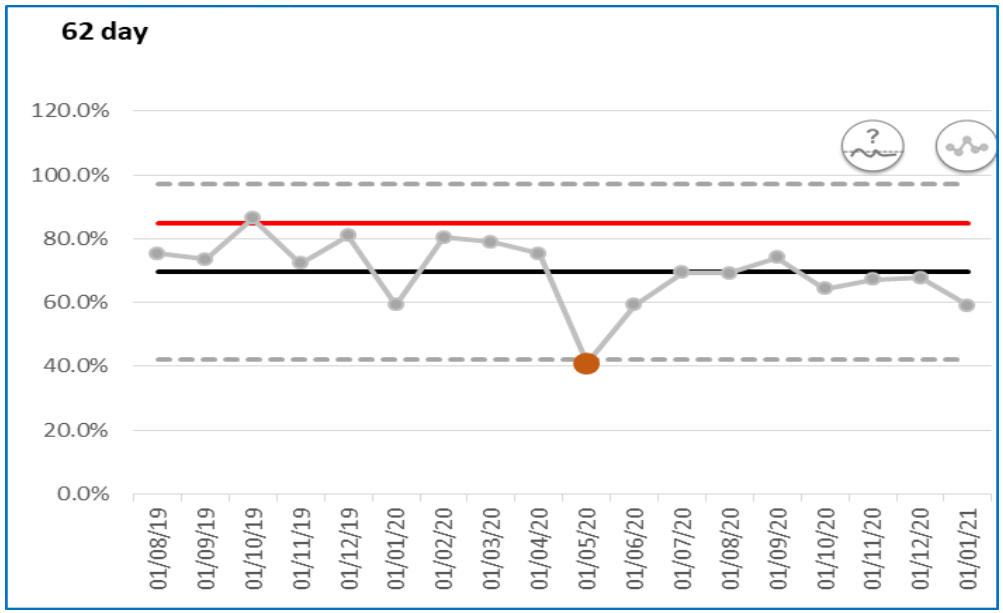
Report by exception: Responsive – Cancer 62 day treatment compliance

Gateshead Health NHS Foundation Trust

Detail on this measure is included as the standard has not been met since March 2020

Responsive



Combined impact analysis

Financial impact

Quality impact

Workforce impact

Operational performance impact

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Situation

Cancer 62 day compliance has not met the standard since October 2019.

Assessment

Pressures were evident prior to the pandemic :The Trust has not achieved this target since October 2019 , and had been on a downward trajectory since April 2018. All tumour sites have been affected. There are no signs of recovery against this standard as yet.

Assessment

The ongoing pandemic and further Covid surge experienced within the last few months has impacted on the Trusts ability to undertake cancer surgeries requiring Critical Care Support. Theatre capacity was also reduced due to the need to utilise theatre staff for their specialist skills within critical care. A number of theatre staff were also shielding which reduced staffing capacity.

Contractual issues within the use of the independent sector reduced the ability to undertake cancer surgeries within this area.

Actions:

Pre-bookable ITU beds to support cancer treatment
Any P1/P2 cancellations require executive sign off
Business Unit to maximise theatre capacity by proactive planning and pre-assessement of patients. .
Implement Chemotherapy Day Unit expansion plan
Reinstate elective recovery board

Risks:

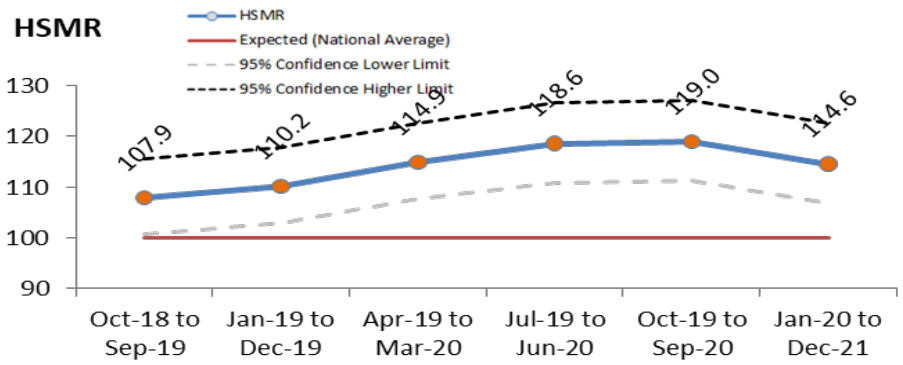
Workforce health and well being – needs to be considered when maximising the elective recovery plans (battle fatigue).

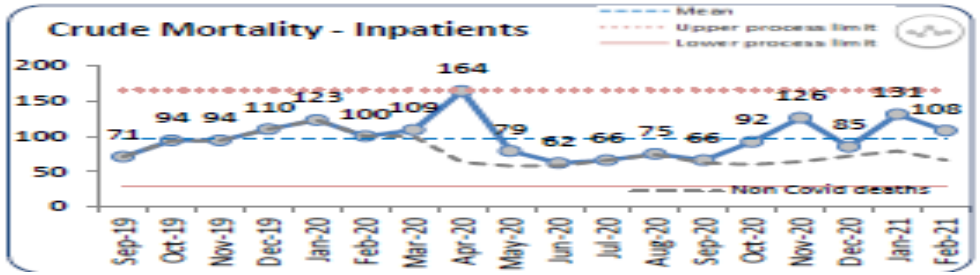
Report by exception: Effective – Hospital Standardised Mortality Ratio

Detail on this measure is included as HSMR is above the expected value and the lower confidence limit is also above the expected value

NHS Gateshead Health NHS Foundation Trust

Effective





Combined impact analysis

Financial impact

No direct financial impact yet identified.

Quality impact

No direct quality impact yet identified.

Workforce impact

No direct workforce impact yet identified.

Operational performance impact

No direct operational performance impact identified.

Situation

HSMR is above expected value. The Trusts HSMR has increased to 'Higher than Expected' levels since from the period Jul-18 to Jun-19 to date .

Background

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

Assessment

The mortality indicators show the Trust deaths relative to the expected deaths per the statistical models for HSMR and SHMI. For the Trust the two mortality indicators are diverging

The models are influenced by a trust's coding, in particular the Primary diagnosis, also the Secondary and Palliative Care coding.

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

There is some evidence that respiratory infection (pneumonia, septicaemia, COPD, acute bronchitis) contributes to the overall mortality position.

Due to the impact of Covid-19 and the fundamental weaknesses of the HSMR and SHMI indicators, the Trust should be more reliant on other methods and sources of intelligence to monitor mortality. For instance, outcomes from Mortality Reviews, Medical Examiner reviews and Serious Incident Patient Safety Investigations.

Actions

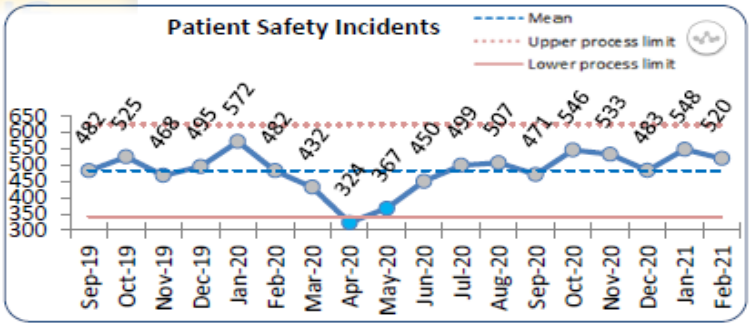
- NQOS to present the findings to the Trust Board and CCG Quality Review Group.
- Findings to be shared at the Mortality & Morbidity Steering Group.
- Explore the use of HIE to ensure all comorbidities are captured more efficiently in the initial clerking document in order to be coded appropriately.
- Review the admission document to ensure all differential diagnoses can be added and coded appropriately

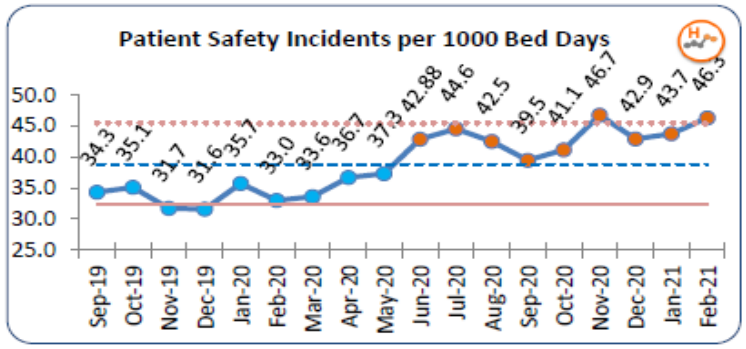
Recommendation

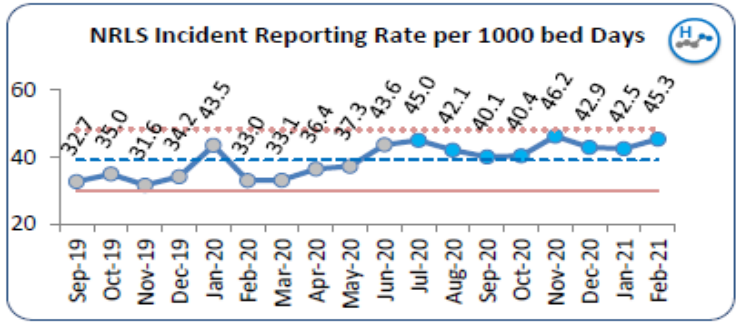
Continue to inform & note actions undertaken at Mortality and Morbidity steering group and Quality Governance Committee via the Integrated quality report and Mortality Paper.

Report by exception: Safety – Patient Safety Incidents

Safe







Patient Safety Culture

The NRLS (National Reporting & Learning System) incident reported rate was 45.3 incidents per 1000 bed days in February 2021.

Patient Safety Incidents – *These figures previously included community acquired pressure damage incidents. Community acquired pressure damage is reported earlier in the report(page 11) and is excluded from these patient safety incident figures.*

520 patient safety incidents were reported in February 2021

- Special cause variation is shown in the patient safety incident rate per 1000 bed days , showing a shift in the incident rate.
- The top 5 incident types for February 2020 are listed below:
  - Patient falls
  - Pressure damage
  - Infection prevention & control
  - Pathology sample issues
  - Medication

Learning from Patient Safety Incidents

The overall incident reporting rate has remained consistent for a number of months however as mentioned above, special cause variation is demonstrated in the patient safety incident rate per 1000 bed days.

The special cause variation demonstrated in the patient safety incident rate per 1000 bed days may be explained by increased reporting of incidents by staff along with the retrospective reporting of patient safety incidents related to nosocomial infections as outbreak investigations remain ongoing. A review of IPC incidents reported in February has highlighted that a proportion of these date back to October 2020 .

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

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Integrated Oversight Report

Gateshead Health NHS Foundation Trust

Caring

	Measure	Latest period		Target	Latest 12 months	Variation	Assurance	Comment
CARING	A&E scores from Friends & Family Test - % positive	87.6%	Feb-21		87.3%			
	Inpatient scores from Friends & Family Test - % positive	100.0%	Feb-21		100.0%			
	Community scores from Friends & Family Test - % positive	100.0%	Feb-21		100.0%			
	Mental Health scores from Friends & Family Test - % positive	100%	Feb-21		99.9%			
	Written Complaints rate	4.0	Feb-21					

Variation & Assurance : Indicators that do not include a symbol for variation and /or assurance are either not appropriate for measuring by SPC charting or are not measured against a target.

Friends and Family patient feedback mechanisms have recently restarted (December); some areas are therefore reporting low volumes. The Trust is preparing to move away from manual feedback mechanisms & is championing text messaging & digital solutions for slicker processing. Benchmarking data will be published in April to compare Trust performance.

Complaints As at 11th March 2021, there are 82 overdue formal complaints and 13 overdue PALs issues.
All overdue complaints and PALs issues have been reviewed and where possible have been answered by the Patient Experience Team in order to support the Business Units, this will continue. The team will continue to support Investigating Officers to facilitate responses. A Rapid Process Improvement Workshop (RPIW) is in the planning stages to look at the formal complaints and PALs processes. The aim of this RPIW is to review the current processes to ensure that there is a consistent trust wide approach to complaints management with an emphasis on providing compassionate responses , learning from patient and relatives experiences and evidencing that the necessary action has been taken to make improvements. Engagement and participation from key members of the Business Units will be key to developing the new processes. Following the RPIW a new policy will be launched across the Trust.

Winter Volunteers Project

The project remains ongoing, the first cohort commenced during week beginning 15th February 2021.

Realtime Patient Experience Projects

The Trust have been selected, by NHSE, to take part in an Evidence Based Design project within the Same Day Emergency Care setting. The project will use some of the 'Always Events®' principles particularly around co-design. Preliminary discussions have taken place with NHSE and the data collection element has begun, supported by Trust volunteers.
The Patient Experience Team are also working with the Pharmacy Department to undertake a programme of work surrounding patient safety and insulin here. Here we will capture patient experience of those who are insulin dependent and this will support the outcome of the Pharmacy Department's project and drive patient centred care.

Integrated Oversight Report

NHS Gateshead Health NHS Foundation Trust

Well Led

	Measure	Latest period		Target	Latest 12 months	Variation	Assurance	Comment
WELL-LED	Staff sickness	4.3%	Feb-21	4%	4.9%		?	Special cause variation - concern for April 2020
	Staff turnover	0.83%	Feb-21		1.24%			Special cause variation - concern for August 2020
	Appraisals	57.9%	Feb-21	85%	63.5%	L	F	Special cause variation - concern, deterioration since April 2020 and below target
	Core Training	75.1%	Feb-21	85%	77.9%	L	F	Special cause variation - concern, deterioration since May 2020 and below target
	Data Quality Maturity Index (DQMI) - MHSDS datset score	89.0%	Nov-20		88.40%			

Variation & Assurance : Indicators that do not include a symbol for variation and /or assurance are either not appropriate for measuring by SPC charting or are not measured against a target.

Core training and **appraisals** continue to raise cause for concern, as the Trust moves out of the pandemic HR partners will remind staff about the importance of appraisals and core training. Completion ratios across all areas have also dipped due to operational pressures and the practicalities of socially distanced training activities

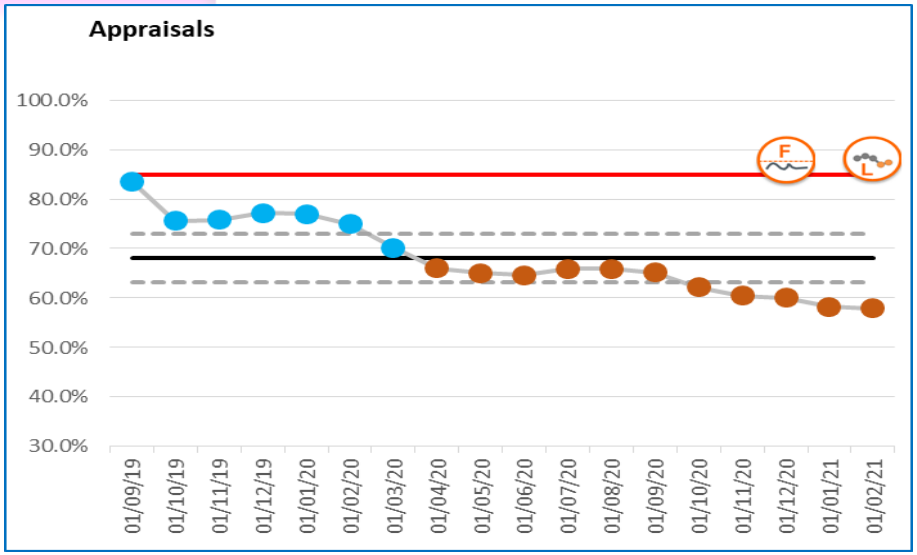
A targeted programme of work to review all workforce indicators is planned for the new financial year.

Report by exception: Well led – Appraisals

Detail on this measure is included because the target is consistently not met and special cause variation triggered demonstrating a shift in performance.

Gateshead Health NHS Foundation Trust

Well Led



Combined impact analysis

Financial impact

When staff don't feel valued, focussed or developed there is a higher risk of them leaving which is often a cost to the organisation.

Quality impact

Similarly, appraisals are an opportunity to reinforce our values and set objectives in pursuit of the highest quality of service/care. Valued staff = improved patient experience and outcomes.

Workforce impact

An appraisal is an opportunity to ensure staff are aligned to the goals and objectives of the organisation, are clear about work and behavioural expectations, and are supported in line with those objectives and future career plans. Without an appraisal, development is not identified, acted upon, and our talented workforce is not maximised.

Operational performance impact

Increased staff satisfaction/retention supports the provision of capacity necessary to meet operational demand.

Situation

Appraisal compliance consistently fails target with the target not being achieved during the past 18 months. The target cannot be achieved by normal variation alone. A general downward trend is observed.

Special cause variation is observed from April 2020 with a shift in performance identified by 8 consecutive points below the mean.

Background

The Trust expects all staff, who are a valued part of the organisation to have an annual conversation about their objectives, performance and development as a minimum.

Assessment

Compliance rates are monitored via ESR and reported to business units as part of the suite of workforce metrics that are produced.

Actions

Compliance rates are currently under review, with work being undertaken to project a recovery plan and trajectory for reaching agreed compliance levels.

Recommendation

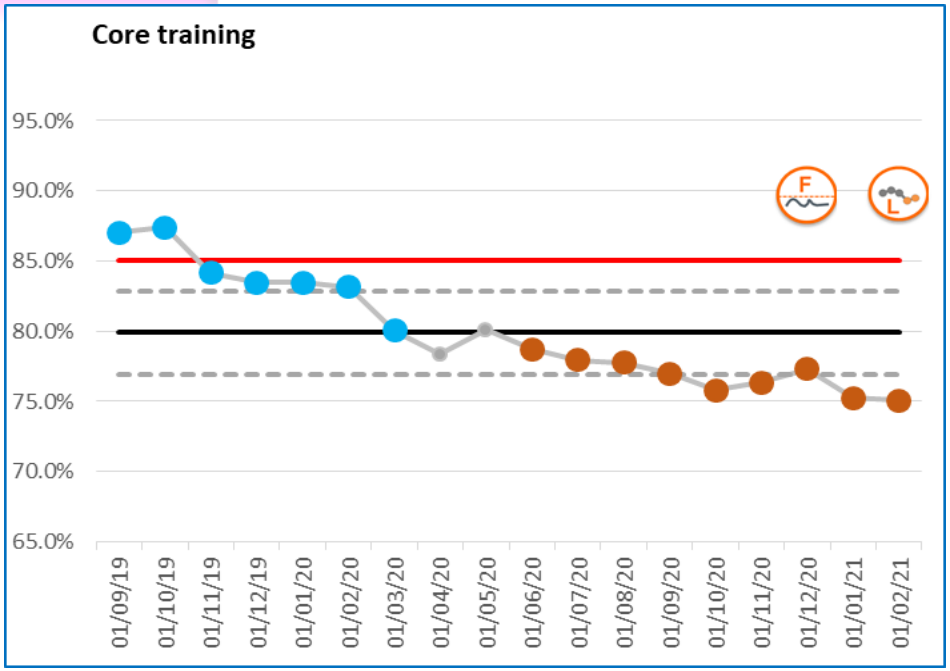
Continued scrutiny through HR committee.

Report by exception: Well led – Core training

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

Gateshead Health NHS Foundation Trust

Well Led



Situation
A shift in core skills compliance is observed from March 2020 with special cause variation (low) triggered and remaining from this point. A general downward trend is observed.

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

Background
Core training covers those programmes which are recognised as core or essential training for all employees.

Assessment
Current compliance is at 75.3% against an 85% target.

Actions
Compliance rates are currently under review, with work being undertaken to project a recovery plan and trajectory for reaching agreed compliance levels.

Recommendation
Continued scrutiny through HR committee

Financial impact
If Information Governance training does not meet the required standard, there is a risk the Trust will fail the Information Governance Toolkit.

Quality impact
Given the reduced compliance level is staff who have had the competency recently expired, the safety & quality risk is lessened.

Workforce impact
Protecting time for staff to complete their training is often welcomed in times of Winter pressure.

Operational performance impact
Balance will be struck between supporting staff with their core training, and the operational requirements/performance of the organisation at the time.

Trust Board

Cover sheet

Agenda Item:15

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☒
Report Title:	Nursing Staffing Exception Report			
Name of Meeting:	Trust Board			
Date of Meeting:	Wednesday 31 March 2021			
Authors	Dr Karen Roberts and Michael Shaw			
Executive Lead	Joanne Baxter, Chief Operating Officer and Interim Chief Nurse			
Report presented by	Karen Roberts, Deputy Director of Nursing, Midwifery and Quality			
Executive Summary	This report provides information and assurance that ward / department staffing levels are being met. There are 11 exceptions for low fill rates for the months of January and February which happened during the third wave of the COVID 19 pandemic. Four staffing incidents were reported on Datix during this period with no associated patient harm. The NHS as a whole experiences seasonal staffing challenges during the winter months although these have been further impacted by the COVID 19 Pandemic.			
Recommended actions for Board/Committee)	The Board are asked to receive the report for assurance			
Trust Aims that the report relates to: **(Including reference to any specific risk)**	**Aim 1** ☒	We will provide consistently high quality care in all our services		
	Aim 2 ☐	We will be a great organisation to work in		
	Aim 3 ☐	We will deliver value for money and strengthen delivery of our clinical services		
	Aim 4 ☐	We will work with our partners to help make Gateshead a place where everyone thrives		
	Aim 5 ☐	We will use our expertise to provide specialist services beyond Gateshead		
Financial Implications:	Costs associated with nurse bank to provide cover for maternity leave, COVID related absence and staff sickness			
Links to Risks (identify significant risks and DATIX reference)	Areas of potential risk have been mitigated against through the implementation of robust staffing plans and ongoing monitoring of staffing levels across the organisation			

People and OD Implications:	Nurse recruitment continues to be a challenge; however the Trust is being proactive and innovative in terms of recruitment solutions				
Links to CQC KLOE	Caring ☒	Responsive ☒	Well-led ☐	Effective ☒	Safe ☒

Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)	**Obj.1** ☐	The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance between working life and personal commitments
	Obj. 2 ☐	All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers
	Obj. 3 ☒	Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve

Gateshead Health NHS Foundation Trust

Nursing and Midwifery Staffing Exception Report

January and February 2021

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. This report provides information for January and February 2021.

2. Staffing

The actual ward staffing against the budgeted establishments for January and February are presented in Tables 1 and 2: Whole Trust wards staffing are in appendix 1 (Tables 3 &4): 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 1: Whole Trust wards staffing January 2021

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 (%)**
93.0%	104.0%	100.0%	118.0%

Table 2: Whole Trust wards staffing February 2021

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 (%)**
92.7%	104.4%	100.4%	127.7%

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

Exceptions:

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

The exceptions to report for January are as below:

January 2021	
Qualified Nurse Days	**%**
Ward 24	71.5%
Ward 27	68.4%
Ward 23	69.8%
Nursing Assistant Days	**%**
Ward 14 Medicine	63.9%

Qualified Nurses

The above exceptions took place during the third wave of COVID19 and the organisation as a whole was experience staffing difficulties directly rated to this. Ward 23, Ward 24, ward 27 all has staff absences related to COVID19. This together with other sickness resulted in the above reportable fill rates. Ward 24 were at the time carrying 4WTE RN vacancy and ward 27 with 3 WTE RN Vacancies.

Data for ward 1, ward 9 and critical care has not been submitted this period to NHS Choices as staff redeployment was high to and from those areas as a part of the covid response, therefore cannot be accurately assimilated in to the fill rate report. Ward 9 was also closed to admissions for a period of time.

Nursing Assistants

Whilst there were significant effects of the pandemic on this staff group the only exception to report was Ward 14 Medicine. Ward 14 Medicine lower fill rates were due to vacancy and sickness. No detriment to patient care was reported as a result.

Areas of higher fill rates are due to enhanced care requirements of patients and increased staff rostering in support of COVID 19 “donning and doffing”. Additionally Sunnside Unit is temporarily running an increased staffing establishment of Healthcare assistants on night shift as a mitigation to a CQC environmental action from 2020, and this has been agreed until the new unit which is under construction has been completed.

The exceptions to report for February are as below:

February 2021	
Qualified Nurse Days	**%**
Ward 11	68.1%
Ward 14 Medicine	74.0%
Ward 22	72.9%
Ward 23	73.6%
Ward 24	71.9%
Ward 27	62.7%
Healthcare Assistant Days	**%**
Ward 14 Medicine	58.5%

Qualified Nurses

The above exceptions in the month of February again took place with a background of the third wave of the COVID 19 pandemic. Ward 11, 14 Medicine, Ward 23, Ward 24 and Ward 27 were affected by COVID isolation requirements and general staff sickness. Additionally Ward 11 had 3 WTE RN vacancies, Ward 14 Medicine had 2 Vacancies, Ward 24 had 3 WTE vacancies and ward 27 had 4 WTE vacancies.

Ward 22 was closed to admissions for a period of time and the staff were redeployed elsewhere to support the covid response.

As in January, data for Ward 1, Ward 9 and Critical Care has not been submitted as staff redeployment to and from those areas as part of the covid response cannot be accurately assimilated in to the fill rate report together. These areas were a focus of daily discussions with the matrons to ensure their staffing was supported by redeployments across the hospital.

Healthcare Assistants

February's Health Care assistant fill rates are higher for a number of reasons with the exception of Ward 14 and the Medicine BU reported lower fill rates due to vacancy and Covid Sickness / self isolation. No detriment to patient care occurred as a result.

The Higher Fill rates are related to multiple reasons highlighted below :

- NHS England directive to reinstate optional paid 3rd year Student Nurse placements which commenced mid Feb.
- Back Fill of RN gaps.
- Enhance care requirements on various areas and also the introduction of the Enhanced Care team.

Throughout January and February areas of staffing pressures were escalated to the Senior Nurse on duty and mitigations were put in place by the wider Matron teams which included:

- Regular redeployments of Registered Nurses and HealthCare assistants on a shift by shift basis.
- Mobilisation of part of the None Ward Based Nursing workforce away from normal duties to support areas most in need of support.
- Mobilisation of the Student nurse paid placements occurred in mid-February as part of the NHS England Covid response. These students are counted in the HCA fill rate numbers for part of February.
- Monetary incentives were offered in the form of agreed enhanced rates of pay to cover short falls in critical shifts and also the instigation of a higher winter bank rate of pay for both Registered Nurses and HealthCare Assistants.

The matrons continue to closely monitor staffing across all wards and take immediate action to minimise deficits.

3. 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.

4. Monitoring Nurse Staffing via Datix

The Trust has in place a process for reporting and monitoring any concerns regarding nurse staffing levels. This is via the Datix incident reporting system. This report helps identify areas where nurse staffing may have fallen below planned levels and what actions were taken to manage the situation. We also identify trends for organisational learning.

There were 3 incidents reported for the areas in scope in January:

January
There were 3 staffing incidents reported in January. None resulted in patient harm.

February
There was 1 incident reported in February. This is currently under investigation although no harm reported.

The above staffing incidents are an effect of the Global COVID19 pandemic and subsequent government guidelines around self-isolation when staff have tested positive or have been found to be a significant contact.

5. 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.

6. Conclusion

This paper provides an exception report for nursing and midwifery staffing in January and February 2021. During these months significant staffing challenges remain due to increased number and acuity of patients occupying critical care beds, staff absence related to Covid 19 and greater need for respiratory bed capacity.

The averaged numbers in this report thus do not reflect the challenges faced at the time by the clinical teams to maintain staffing levels.

7. Recommendations

The Board is asked to receive this report for assurance.

Dr Karen Roberts
Deputy Director of Nursing, Midwifery and Quality

Appendix 1 – Table 3: Ward by Ward staffing January 2021

	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**
Ward 1	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Ward 2 SSU	94.4%	152.6%	124.3%	129.2%	556	3.9	3.9	7.8
Ward 4	109.7%	188.1%	102.0%	101.5%	854	2.6	3.0	5.6
Ward 8	91.7%	107.2%	101.7%	101.0%	540	3.6	3.5	7.1
Ward 9	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Ward 10	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Ward 11	80.0%	97.4%	98.7%	112.8%	606	3.4	3.8	7.3
Ward 12 Escalation	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Ward 14 Medicine	81.4%	63.9%	102.2%	104.1%	529	4.0	3.3	7.3
Ward 14A	78.6%	99.4%	111.7%	162.4%	516	4.3	5.5	9.9
Ward 21	82.4%	85.4%	100.4%	93.0%	346	4.8	3.7	8.6
Ward 22	76.0%	117.6%	101.5%	132.0%	771	2.6	3.6	6.2
Ward 23	69.8%	111.4%	99.3%	154.7%	579	2.8	5.2	8.0

	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 24	71.5%	93.8%	87.0%	102.5%	602	3.1	3.6	6.7
Ward 25	90.8%	113.6%	101.8%	110.5%	690	3.3	3.6	7.0
Ward 26	94.8%	97.0%	101.2%	112.0%	584	3.6	4.0	7.6
Ward 27	68.4%	86.5%	102.0%	102.9%	786	2.8	2.9	5.7
Cragside Court	88.8%	123.0%	102.5%	110.9%	259	7.4	8.7	16.0
Critical Care	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
EAU	109.5%	183.5%	79.7%	121.9%	608	6.8	3.3	10.0
Maternity	131.4%	86.9%	98.7%	108.3%	311	23.9	7.9	31.8
Paediatrics	108.5%	114.8%	135.3%	-	26	93.4	30.6	124.0
SCBU	94.3%	86.5%	100.9%	100.0%	129	13.6	4.5	18.1
St Bedes	111.9%	87.2%	99.9%	87.5%	238	7.1	4.8	12.0
Sunniside	104.1%	77.6%	92.6%	204.6%	190	8.7	8.6	17.3

Appendix 1 – Table 4: Ward by Ward staffing February 2021

	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**
Ward 1	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Ward 2 SSU	107.3%	168.9%	144.7%	147.3%	556	4.0	4.0	8.0
Ward 4	109.2%	198.5%	99.2%	111.3%	854	2.3	2.9	5.2
Ward 8	102.6%	96.3%	99.8%	131.4%	540	3.5	3.3	6.8
Ward 9	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Ward 10	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Ward 11	68.1%	104.0%	102.1%	107.2%	606	2.8	3.6	6.4
Ward 12 Escalation	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Ward 14 Medicine	74.0%	58.5%	102.1%	108.6%	529	3.4	2.8	6.2
Ward 14A	80.0%	92.0%	101.5%	147.7%	516	3.8	4.6	8.4
Ward 21	78.8%	93.6%	99.9%	94.7%	346	4.2	3.6	7.9
Ward 22	72.9%	94.1%	84.9%	103.8%	771	2.2	2.6	4.7
Ward 23	73.6%	110.0%	100.8%	223.6%	579	2.6	5.4	8.0

	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 24	71.9%	79.1%	90.9%	112.3%	602	2.8	3.0	5.8
Ward 25	87.7%	108.6%	101.5%	127.6%	690	2.9	3.3	6.3
Ward 26	97.1%	111.9%	101.3%	122.4%	584	3.3	4.1	7.4
Ward 27	62.7%	84.5%	102.4%	115.8%	786	2.4	2.7	5.1
Cragside Court	97.4%	120.7%	109.1%	102.3%	259	7.2	7.5	14.8
Critical Care	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
EAU	108.0%	216.4%	85.4%	135.2%	608	6.3	3.4	9.7
Maternity	133.4%	106.8%	98.1%	121.7%	311	21.7	8.5	30.3
Paediatrics	113.6%	114.9%	132.1%	-	26	86.2	27.7	113.9
SCBU	95.0%	87.9%	98.3%	100.2%	129	12.3	4.1	16.3
St Bedes	101.0%	89.1%	99.6%	135.0%	238	6.1	5.0	11.1
Sunniside	96.3%	75.2%	98.0%	192.3%	190	7.6	7.4	15.1

Trust Board

Gateshead Health NHS Foundation Trust

Report Cover Sheet

Agenda Item: 16

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☒
Report Title:	Integrated Quality and Learning Report			
Name of Meeting:	Trust Board			
Date of Meeting:	Wednesday 31 March 2021			
Author	Andrew Ward – Senior Information Analyst Andrea Tweddell - Strategic Lead for Patient Safety Wendy McFadden -SafeCare Lead –Clinical Effectiveness Jane Douthwaite - Patient Experience Lead			
Executive Lead	Joanne Baxter, Chief Operating Officer and Interim Chief Nurse			
Report presented by	Joanne Baxter, Chief Operating Officer and Interim Chief Nurse			
Executive Summary	Incident reporting rates show special cause variation (high) which can be explained by increased staff reporting along with the retrospective reporting in February of nosocomial infections dating back to October 2020, and their ongoing outbreak investigations. The top three patient safety incidents types are patient falls, pressure damage and infection prevention and control. The Trust's Hospital Standardised Mortality Ratio (HSMR) continues to show more deaths than expected when compared to the National expected value. However, recent analysis by the North East Quality Observatory Service (NEQOS) identified no specific cause for the high HSMR or cause for concern about quality of care and expects the Trust to flag high for some time. The Trust will use other sources of intelligence to closely monitor mortality. There were three falls which resulted in patient harm of moderate or above, which are currently under investigation. However, inpatient falls remain within normal variation in February as does pressure damage. F&FT has re-started in A&E using Health Call text messaging reporting an 88% positive experience this month. The patient experience team are currently working to address the backlog of overdue formal complaints (n=82) and an RPIW is in the planning stage to develop a consistent, efficient and compassionate response and optimise learning.			

Recommended actions for Board/Committee)	To receive for assurance and information on the Trusts key quality and safety indicators					
Trust Aims that the report relates to: (Including reference to any specific risk)	**Aim 1** ☒	We will provide consistently high quality care in all our services				
	Aim 2 ☐	We will be a great organisation to work in				
	Aim 3 ☐	We will deliver value for money and strengthen delivery of our clinical services				
	Aim 4 ☐	We will work with our partners to help make Gateshead a place where everyone thrives				
	Aim 5 ☐	We will use our expertise to provide specialist services beyond Gateshead				
Financial Implications:	Financial sanctions may be applied by NHS England and commissioners in relation to Health Care Associated Infection (HCAI)					
Links to Risks (identify significant risks and DATIX reference)						
People and OD Implications:	None					
Links to CQC KLOE	Caring ☒	Responsive ☒	Well-led ☒	Effective ☒	Safe ☒	
Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)	**Obj.1** ☐	The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance between working life and personal commitments				
	Obj. 2 ☒	All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers				
	Obj. 3 ☒	Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve				

Integrated Quality and Learning Report
February 2021

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

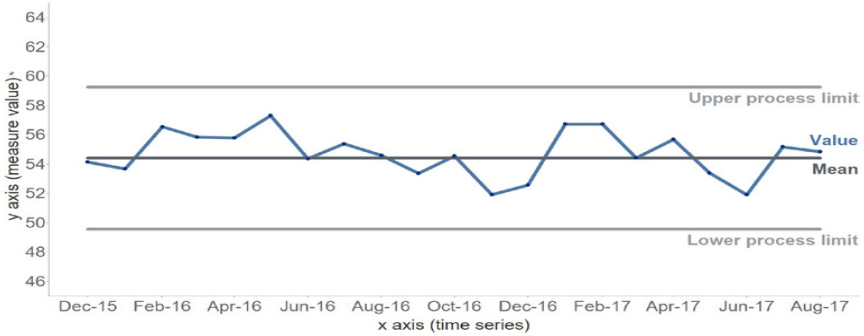
Gateshead Health NHS Foundation Trust

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.



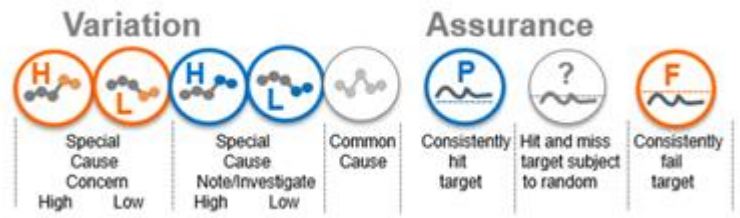
The reference lines are:

- 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.



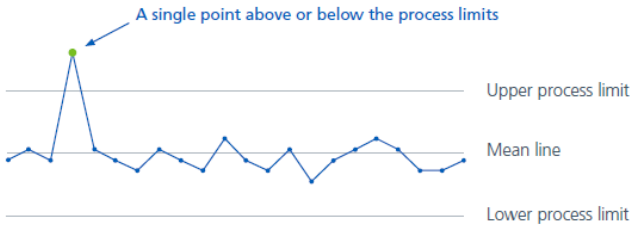
Integrated Quality and Learning Report

more about SPC

Gateshead Health NHS Foundation Trust

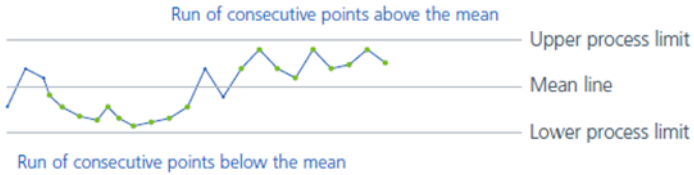
A single point outside the control limits

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.



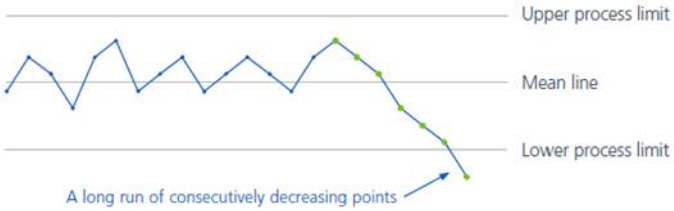
Consecutive points above or below the mean line

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

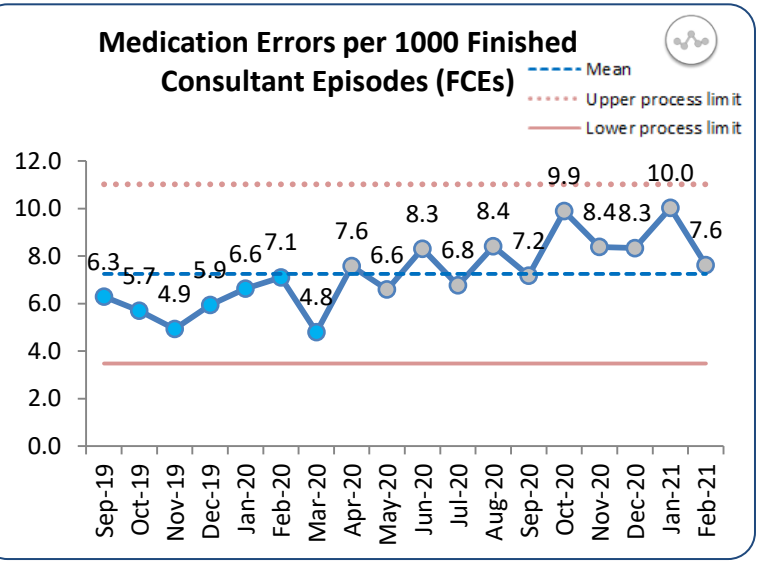
Please note that data in this report is accurate at the time of production. The severity and number of incidents may change due to additional information being available following investigation, meaning the severity may be re-categorised.

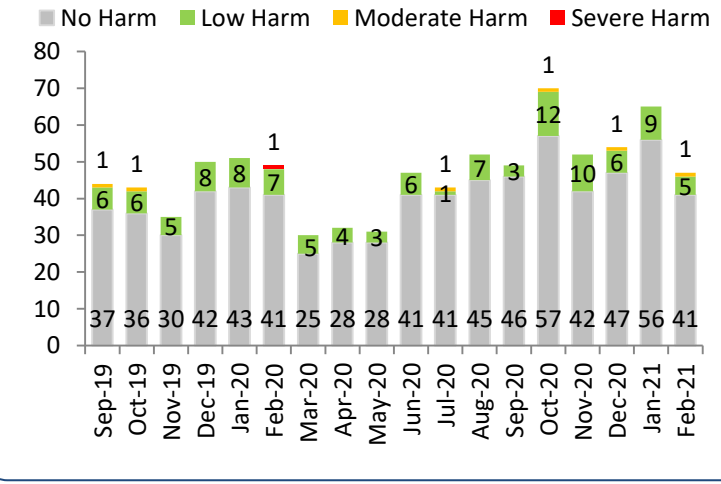
Safe	**5-15**	• Medication Errors • Health-Care Associated Infections • Falls • Pressure damage	• Never Events • Serious Incidents (SIs) • Patient Safety Incidents
Effective	**16-18**	• Mortality • HSMR • SHMI	• Learning from mortality review
Caring	**19**	• Friends and Family Test	
Responsive	**20-21**	• Compliments • Informal Complaints • Formal Complaints	
Well-led	**22**	• CQUIN	

Integrated Quality and Learning Report

Medication Reporting

Safe





Medication Errors

- A total of 47 medication errors were reported in February 2021.
- 1 moderate harm error.
- Common cause variation is observed in the medication error rate in February 2021.
- A general upward trend is observed with the indicator close to triggering special cause variation to signify an upward shift in medication errors.

Incident themes

Transfer of care – mental health prescribing

7% incidents relating to mental health medication in patients with dementia. Information regarding secondary care prescribed/shared care medication not readily available to clerking clinicians on acute admission to hospital – leading to treatment omission. Treatment not appearing on health information exchange (HIE).

Multiple contributing factors have been identified, some relating to COVID-19.
Learning shared: Acute medical and pharmacy teams in addition to primary care partners.

System change: Change in initiation letter from memory hub to GP practice to add to GP records as 'hospital prescribed medication' to ensure visible to all providers.

Positive patient identification

10% incidents relating to wrong patient administration and prescribing reported across multiple BU and differing medication routes.

Staff involved in incidents to be involved in memory capture and discussion exercise to establish areas for improvement.

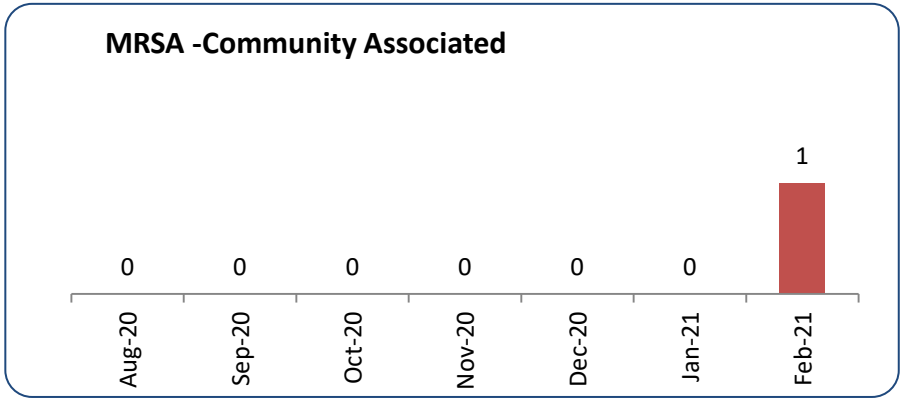
Integrated Quality and Learning Report

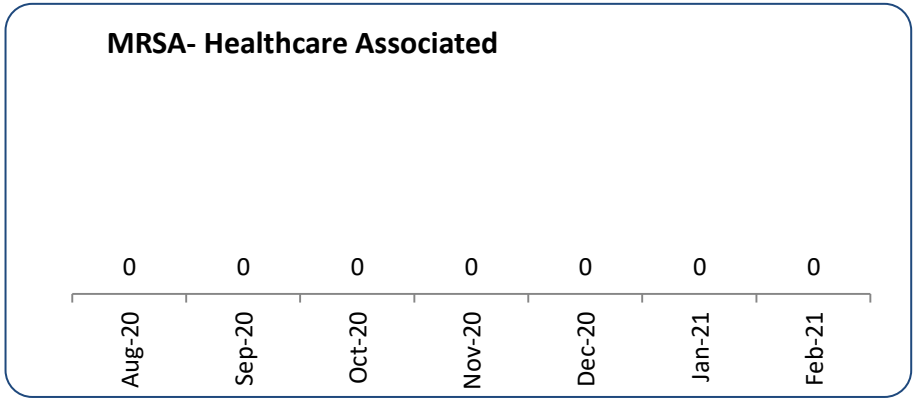
Safe

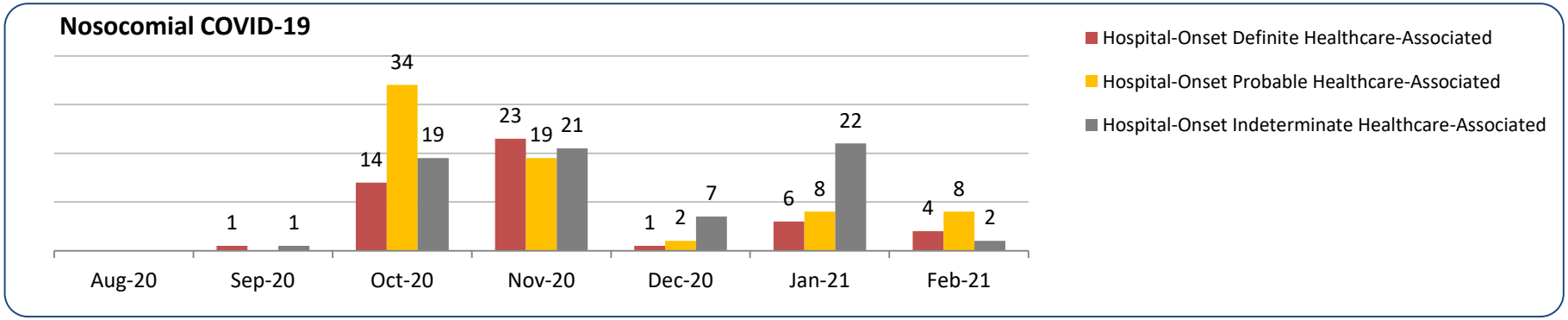
Healthcare Associated Infections
MRSA & nosocomial COVID-19

Gateshead Health NHS Foundation Trust

The Trust adopts the national aspiration of a zero tolerance to all avoidable infections including MRSA blood stream infections (BSI).
The trust has had zero incidence of Hospital onset MRSA BSI in 2020-21.
PIR completed for the Community Associated MRSA BSI and shared with neighbouring community team – patient not a Gateshead resident







Nosocomial COVID 19 cases

All Healthcare associated COVID cases are reported and investigated through the DATIX system. Due to the 14 day incubation period and the highly infectious nature of the organism, particularly in the new variants, this is a complex process . General themes have been identified and reported in the previously presented paper. Incidence of nosocomial cases continues to reduce.

Integrated Quality and Learning Report

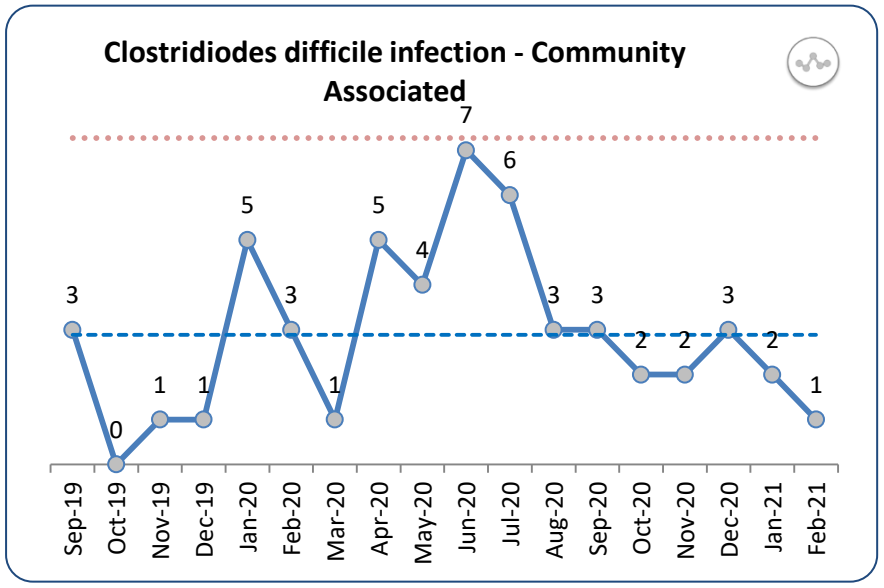
Healthcare Associated Infections

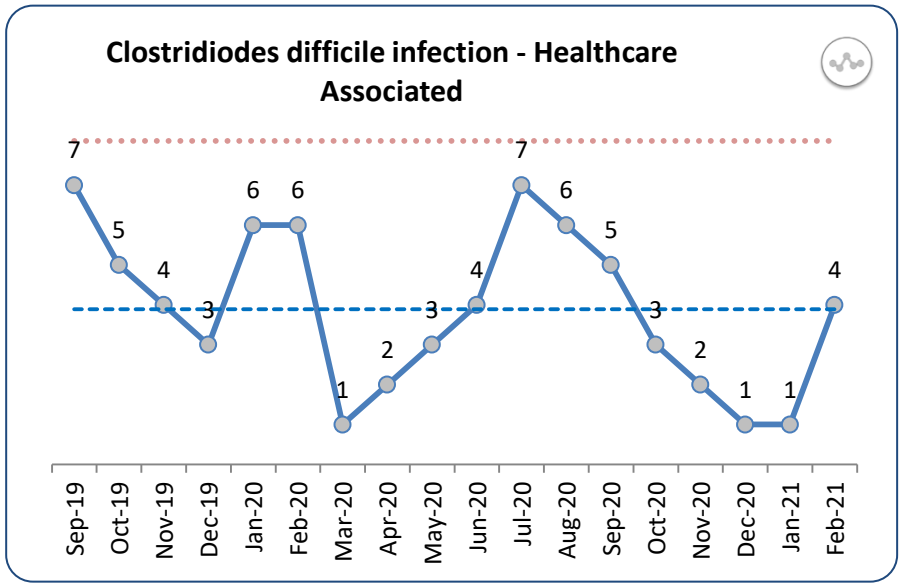
Clostridiodes Difficile Infection

Safe

NHS
Gateshead Health
NHS Foundation Trust

For the period 01/04/2020 to 28/02/2021 the Trust has reported 38 healthcare associated CDI.
There has been an increase in the incidence of HOHA during February. All incidence of healthcare CDI have been reviewed and learning shared with the relevant clinical areas.
Three of these patients were known to be colonised with *C.difficile* prior to this episode of CDI. Antibiotic and laxative management was appropriate





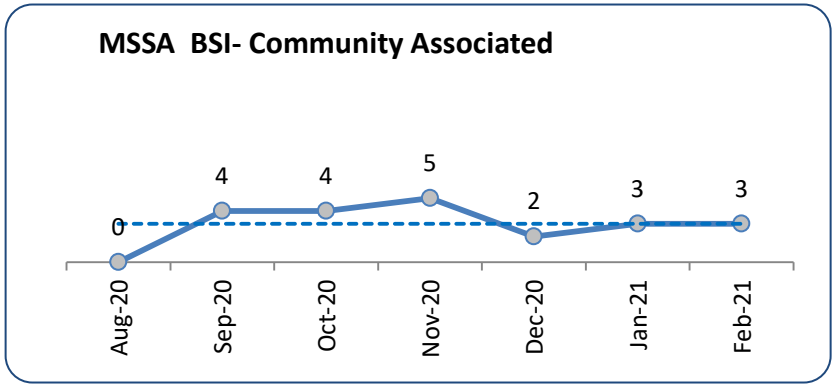
Integrated Quality and Learning Report

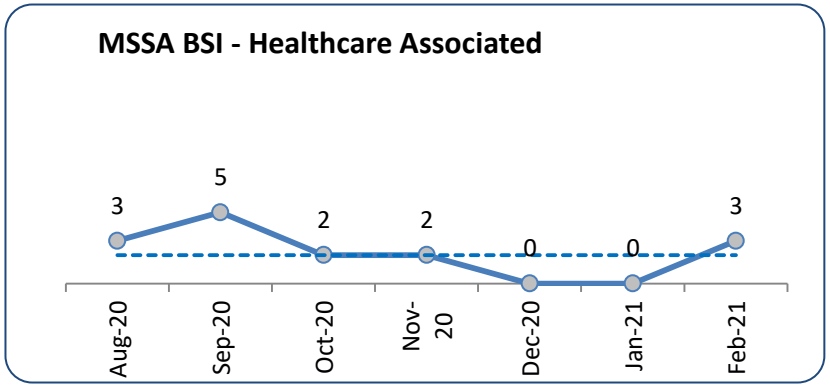
Healthcare Associated Infections

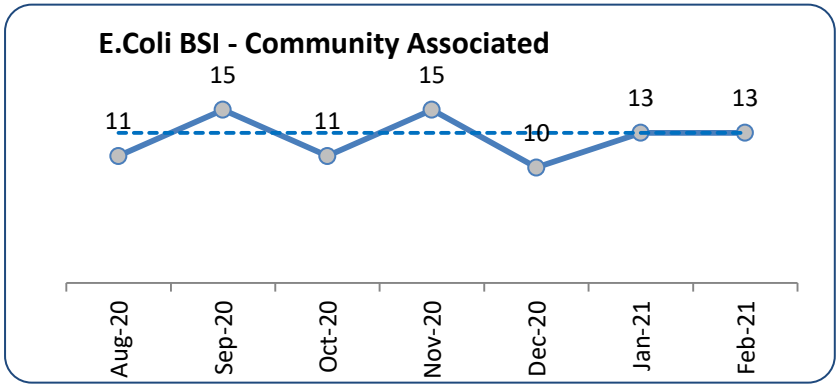
MSSA & E Coli

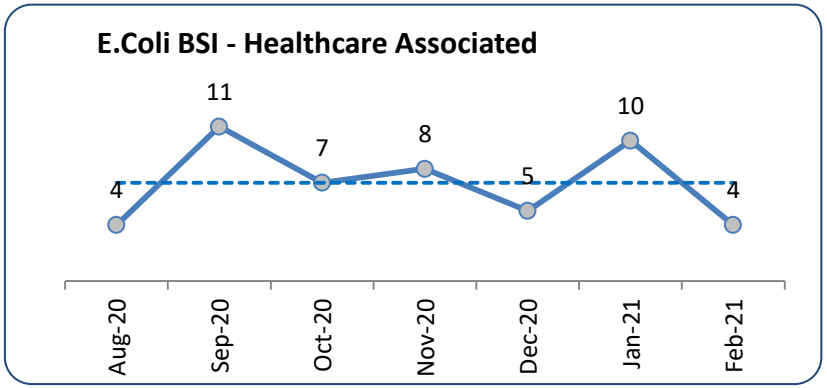
Safe

Gateshead Health NHS Foundation Trust









All Healthcare associated BSI are reviewed and actions are initiated if necessary.

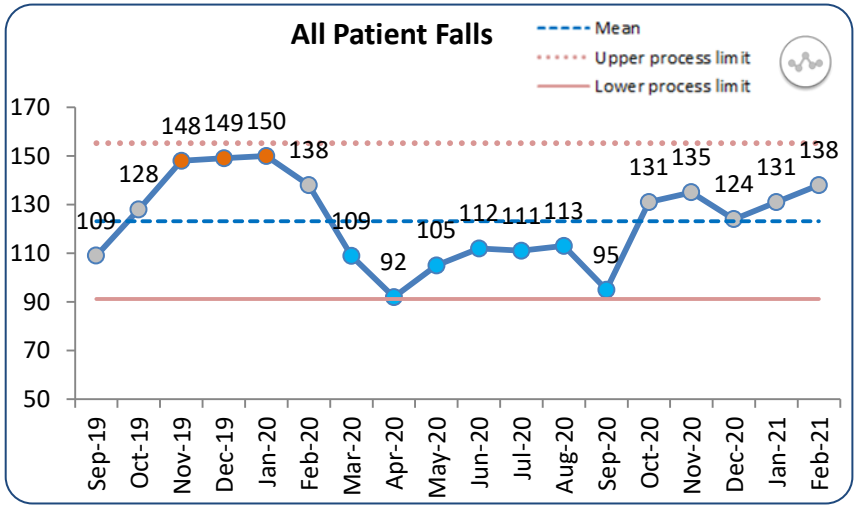
Healthcare associated MSSA BSI - two cases had skin and soft tissue damage identified as the source – and good practice was identified; the other sample was identified as a contaminated sample – learning around sample taking disseminated.

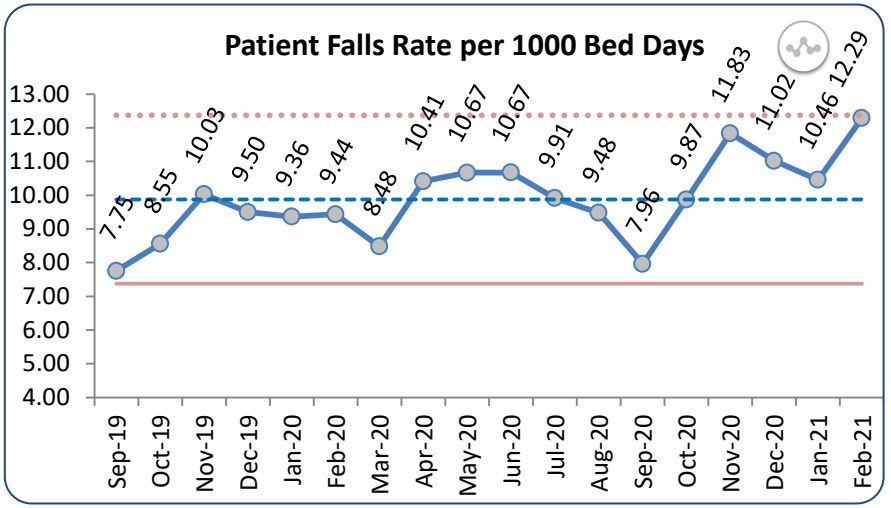
The incidence of Healthcare associated *E.coli* has reduced in February - predominately of urinary source and considered as unavoidable

Integrated Quality and Learning Report

Falls

Safe





Patient Falls – statistics and learning

February 2021 - 138 falls reported; 107 no harm; 27 low harm; 3 moderate harm; 1 severe harm.

The patient fall which was reported as severe harm is currently under investigation: a patient fell and hit her head on the floor. A CT scan of her head was performed which revealed a small haematoma. Her care was discussed with the Neurology team at Newcastle Upon Tyne Hospitals and observation was recommended; no other treatment was required and this fall did not lengthen her admission. It is anticipated that this incident will be downgraded to moderate harm once the investigation has been concluded.

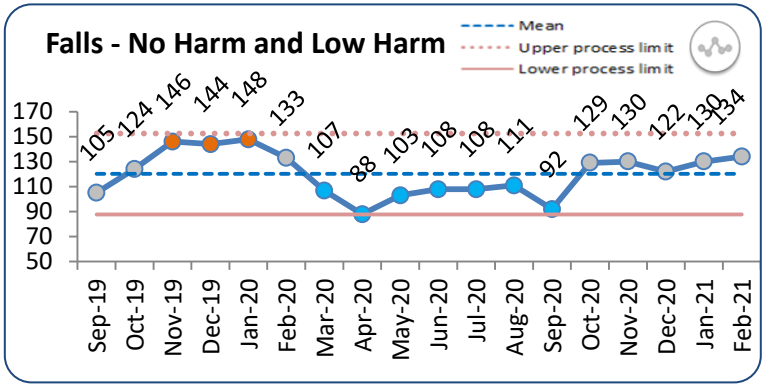
The 3 falls which resulted in moderate harm are all currently under review: 2 of the falls resulted in fractures (maxillary sinus and ankle respectively). The third fall did not result in any injuries and has been downgraded to no harm.

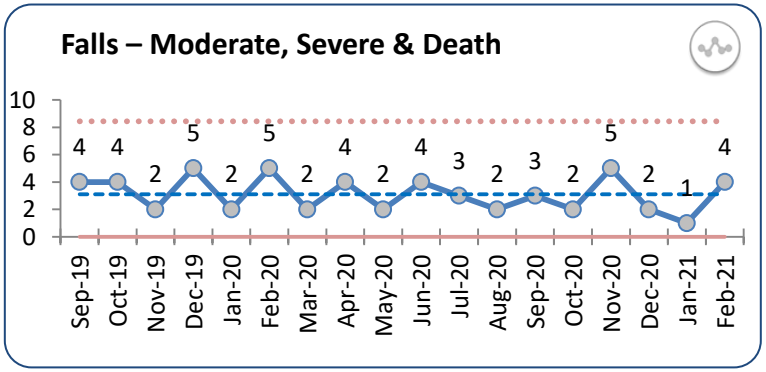
All patient falls data for February continues to demonstrate common cause variation.

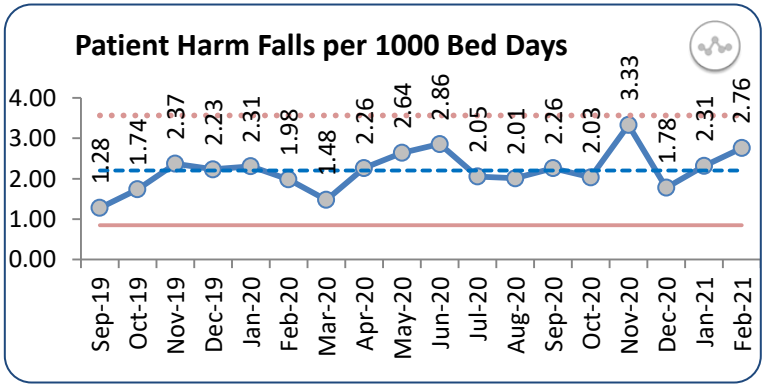
Integrated Quality and Learning Report

Falls

Safe







Further learning from Inpatient Patient Falls

The inpatient falls rate remains within normal variation.

The Patient Safety Team along with the Falls Team attended a meeting to discuss the regional approach to investigating inpatient falls incidents that result in severe harm.

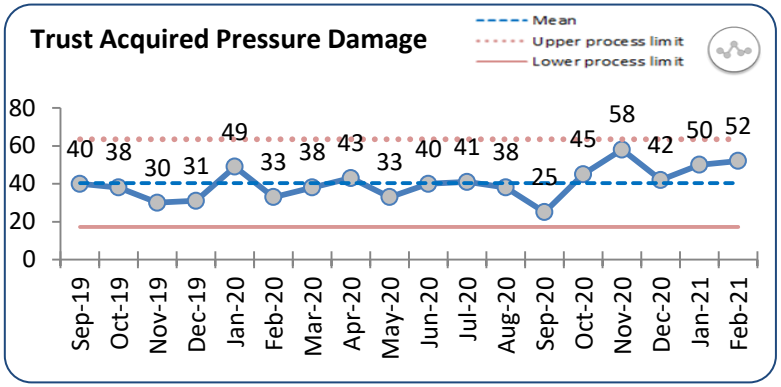
Key points from this meeting highlighted the development work which has been undertaken by the Trust on the Datix system to enable the monitoring of actions and collation of themes following the completion of falls investigations.

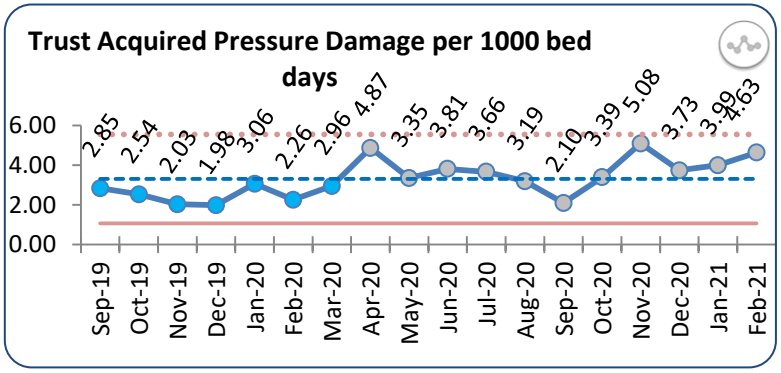
The Trust has offered to share the Human Factors investigation report template and supporting information with neighbouring trusts to support a systems –based approach to investigating these incidents in line with the NHS Patient Safety Strategy.

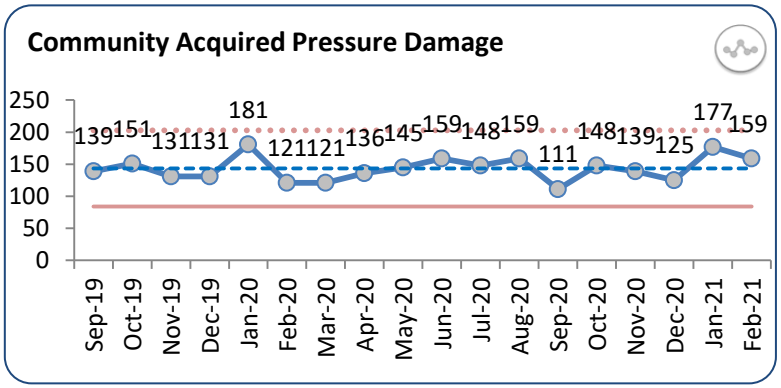
Integrated Quality and Learning Report

Trust & Hospital Acquired Pressure Damage

Safe







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

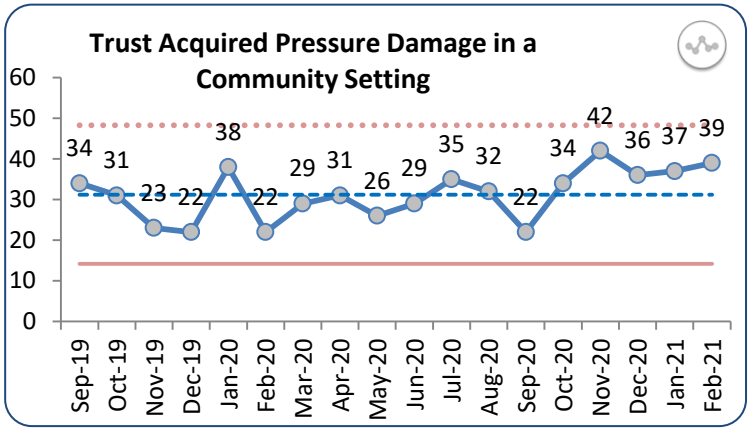
Please note that these figures include pressure damage acquired in both acute and community settings whilst under the care of the Trust.

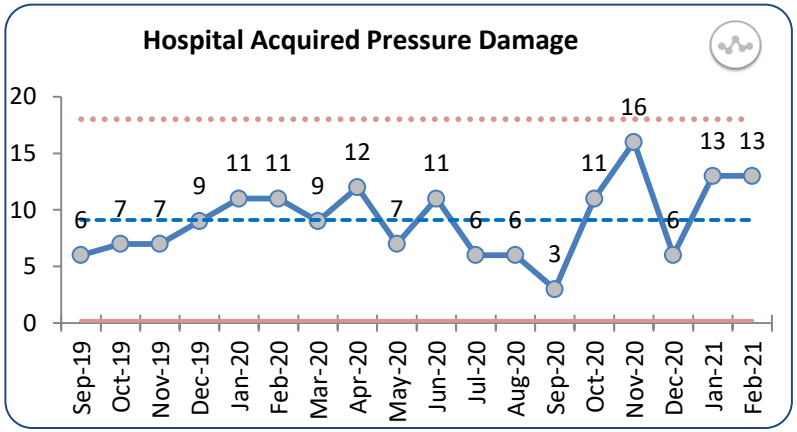
- Common cause variation is currently displayed in the rate of Trust Acquired pressure damage per 1000 bed days..
- 52 incidents of Trust acquired pressure damage were reported in February 2021.
- 13 incidents observed in an acute setting
  - 6 x category 2
  - 1 x device related category 2 pressure ulcer
  - 4 deep tissue injuries
  - 2 x unstageable
- 39 incidents observed in a community setting during Trust care
  - 25 x category 2
  - 2 x category 3
  - 5 x unstageable
  - 7 x deep tissue injuries

Integrated Quality and Learning Report

Trust & Hospital Acquired Pressure Damage

Safe





The data for February demonstrates common cause variation for both pressure damage acquired in the community and the acute settings.

A number of patient safety investigations are ongoing following the reporting of moderate harm pressure damage. These include incidents which have previously been graded as low harm (unstageable or deep tissue injury) and following validation by the Tissue Viability Nursing team, have been upgraded depending upon the category of damage identified.

The Trust sought guidance from the CCG in relation to the reporting of all Category 3 pressure damage and above to StEIS and reporting is now pending presentation and consideration of the findings at the Pressure Damage Serious Incident Panel which is held monthly.

There is an ongoing patient safety investigation following the reporting of unstageable pressure damage; the findings are awaited to inform the approach taken where there is unstageable pressure damage identified which has the potential to deteriorate to ensure any opportunities for learning are identified.

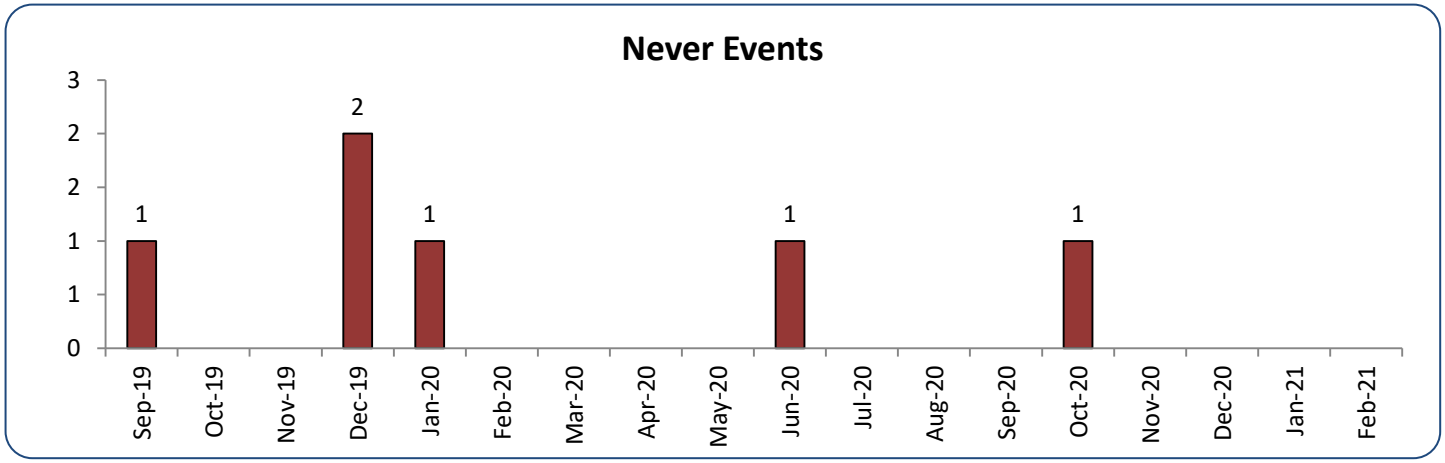
The incidence of pressure damage within the acute setting is distributed across a number of ward areas and Clinical Business Units.

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

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

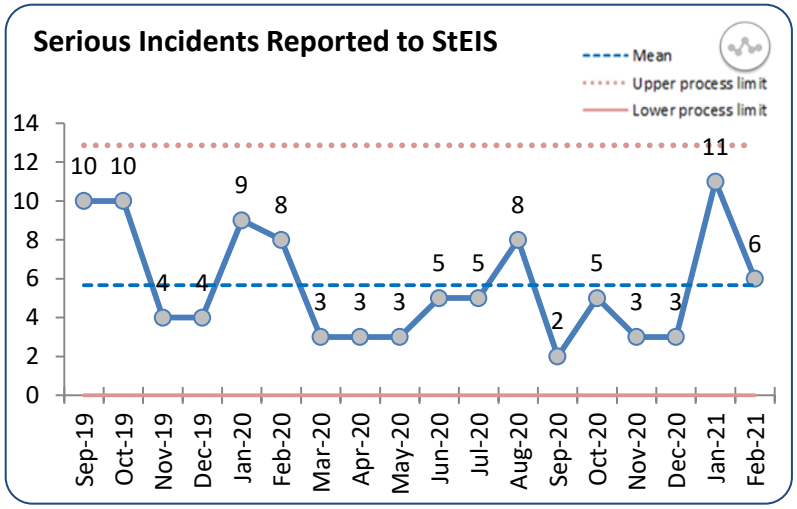
Integrated Quality and Learning Report

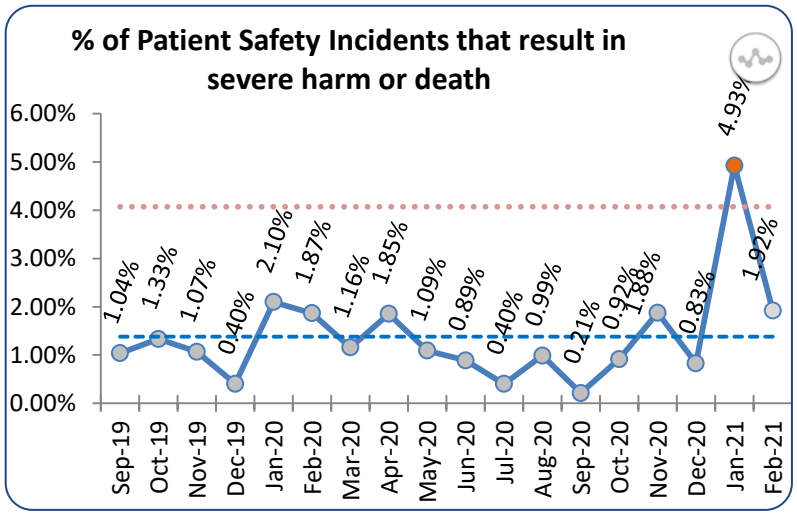
Serious Incidents

Gateshead Health NHS Foundation Trust

Datix Software for Patient Safety

Safe





Serious Incidents Reported to StEIS

February 2021 6 serious incidents reported
2 x Diagnosis – delay failure (2 death)
1 x Treatment / procedure - delay / failure (death)
1 x Fall on same level due to incontinence (death)
1 x Communication failure - with patient / carer (severe)
1 x Monitoring - delay in recognising complication of treatment (severe)

January 2021 11 serious incidents reported
6 x respiratory infections (4 death; 1 severe; 1 moderate)
1 x Test results / reports – incorrect (severe)
1 x Fall on same level - cause unknown (severe)
1 x Treatment / procedure - delay / failure (severe)
1 x Cord pH <7.10 (severe)
1 x Patient collapse (non-fall) (severe)

Learning from Serious Incidents Review

The Serious Incident Review Panel received the final report by the Healthcare Safety Investigation Branch (HSIB) which was produced following the reporting of a term baby being transferred to a tertiary neonatal unit for therapeutic cooling.

A small number of safety recommendations were made regarding the induction process and continuous fetal monitoring following the investigation. These included the revision of the Induction of Labour guideline to ensure that the prostaglandin dosage within the guideline, mirrors what is prescribed in clinical practice.

It was also recommended that all options including risks to mother and baby are discussed following an ineffective cycle of induction. This discussion between an obstetrician and the mother will facilitate informed choice, in line with the Montgomery Ruling.

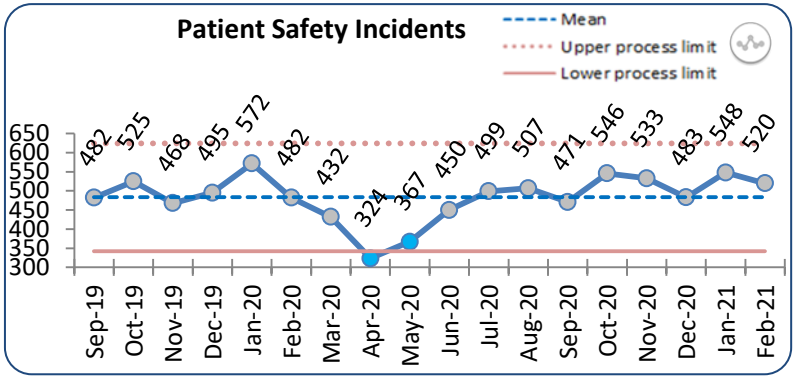
The report also recommended the use of telemetry to support continuous monitoring of the fetal heart when the mother is mobilising.

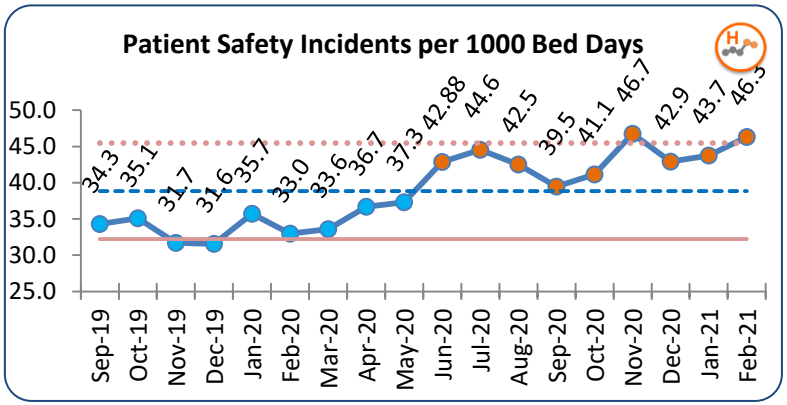
The Maternity team were able to confirm that the guideline has been amended to reflect prostaglandin prescribing and administration and new equipment has been ordered to enable continuous fetal heart monitoring.

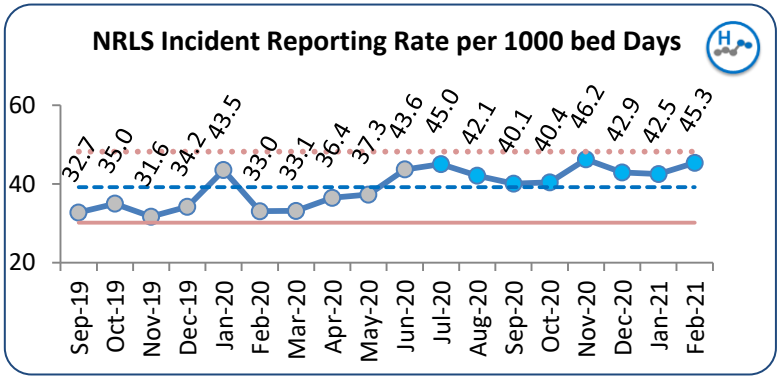
Integrated Quality and Learning Report

Patient Safety Incidents

Safe







Patient Safety Culture

The NRLS (National Reporting & Learning System) incident reported rate was 45.3 incidents per 1000 bed days in February 2021.

Patient Safety Incidents – *These figures previously included community acquired pressure damage incidents. Community acquired pressure damage is reported earlier in the report(page 11) and is excluded from these patient safety incident figures.*

520 patient safety incidents were reported in February 2021

- Special cause variation is shown in the patient safety incident rate per 1000 bed days , showing a shift in the incident rate.
- The top 5 incident types for February 2020 are listed below:
  - Patient falls
  - Pressure damage
  - Infection prevention & control
  - Pathology sample issues
  - Medication

Learning from Patient Safety Incidents

The overall incident reporting rate has remained consistent for a number of months however as mentioned above, special cause variation is demonstrated in the patient safety incident rate per 1000 bed days.

The special cause variation demonstrated in the patient safety incident rate per 1000 bed days may be explained by increased reporting of incidents by staff along with the retrospective reporting of patient safety incidents related to nosocomial infections as outbreak investigations remain ongoing. A review of IPC incidents reported in February has highlighted that a proportion of these date back to October 2020 .

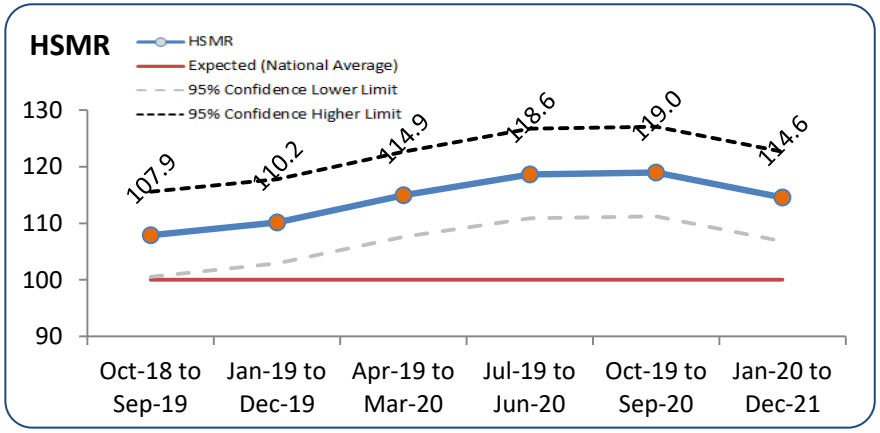
All staff should be assured that reporting incidents is a positive process. The purpose of reporting is to ensure processes practices are being adhered to, embed a just culture and to ensure best possible outcomes for patients.

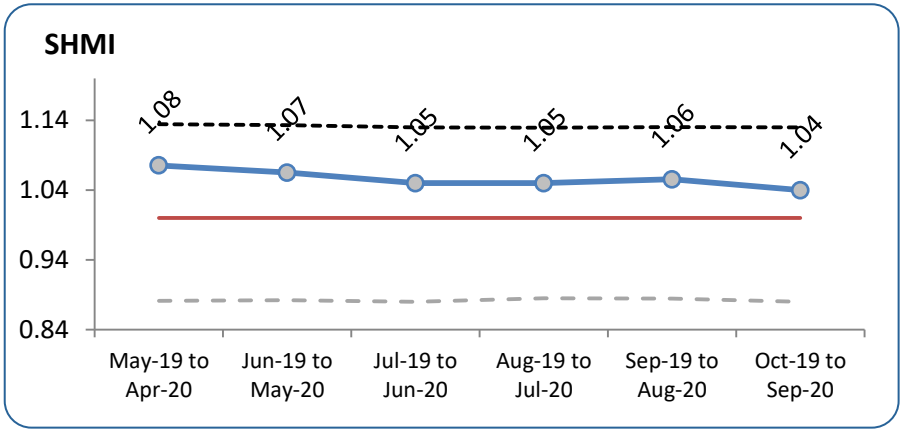
Integrated Quality and Learning Report

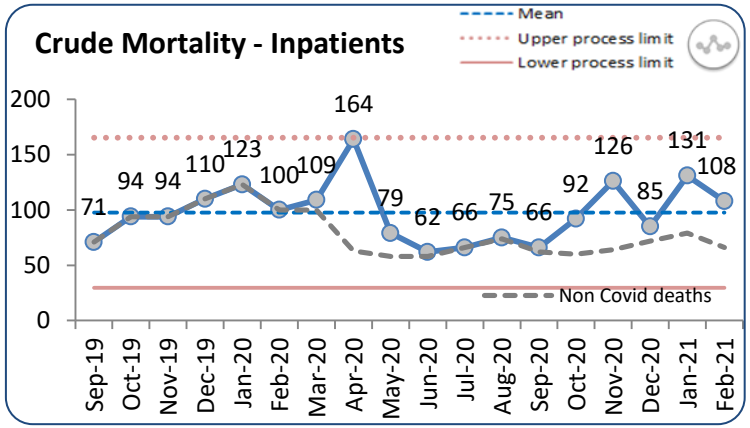
Gateshead Health NHS Foundation Trust

Effective

Mortality







Mortality Review

Period: February 2020 to January 2021

	Deaths in period	Deaths reviewed	%	Hogan 1	Hogan 2	Hogan 3	Hogan 4	Hogan 5	Hogan 6	Potentially Avoidable Deaths
All Deaths	1241	711	57.3%	96.1%	3.4%	0.3%	0.3%	0.0%	0.0%	0.3% (2)
Learning Disability Deaths	14	11	78.6%	90.9.%	0.0%	0.0%	8.3%	0.0%	0.0%	9.1% (1)

- HSMR – For the most recent 12 months the Trust is demonstrating more deaths than expected. Analysis by NEQOS identified no specific cause for the high HSMR or cause for concern about quality of care. Other quality of care indicators do not provide cause for concern. The effect of COVID-19 on the mortality indicators is unclear at present, there appears to be more variation in the HSMR across trusts in England. The Trust is likely to continue to f lag high for some time.
- 108 inpatient deaths observed in February 2021; of which 42 were COVID patient deaths.
- SHMI – The Trust has consecutive scores of over the England Average (1) and has a banding of 'As Expected'.
- The number of inpatient deaths is currently displaying common cause variation.
- 57.3% of deaths reviewed between February 2020 and January 2021. 96.1% Definitely not preventable. Two cases identified as potentially avoidable.

Integrated Quality and Learning Report

Gateshead Health NHS Foundation Trust

Effective

Mortality

Learning from Mortality Review

Mortality Council Update

Four Mortality Councils have been convened solely dedicated to reviewing Covid-19 deaths to establish whether there is any learning to be shared across the Trust. 48 cases have been reviewed to date. The scores are provided in the tables below:

Hogan 1 – Definitely not preventable	24 cases
Hogan 2 – Slight evidence of prevention	19 cases
Hogan 3 – Possibly preventable, less than 50:50	2 cases
Hogan 4 – Possibly preventable, more than 50:50	1 case

Two cases were unable to be scored and will come back after further investigation.

NCEPOD 1 – Good practice	17 cases
NCEPOD 2 – Room for improvement clinical care	1 case
NCEPOD 3 – Room to improve organisation of care	25 cases
NCEPOD 4 – Room to improve clinical and organisational	2 cases
NCEPOD 6 – Insufficient data	1 case

The following good practice was identified:

Documentation of discussions with family

Appropriate use of swabbing, PPE and restriction of visitors

Appropriate use of palliative care team and pathways

Rapid release of body was not affected

The following learning was identified:

Discussions with family re the use of DNACPRs had not taken place, family were unaware of these forms being completed

Excessive movement of patients through the hospital, often resulting in patients being on multiple wards

Delays in moving Covid-19 positive patients to appropriate wards resulting in staying in Covid-19 negative/holding wards for longer, potentially increasing the possible exposure to other patients

Discharges of Covid-19 positive patients home when there are vulnerable family members at home –patient information required

Clinically Extremely Vulnerable patients, for example, those on chemotherapy, have been nursed in bays as opposed to cubicles in some cases, which, due to the prominence of Covid-19 at that time, increased the risk of contracting Covid-19.

Issues identified within documentation particularly in the last days/hours of life – this is vital to be able to complete investigations and provide information to families.

The Infection Prevention & Control team will now attend the Mortality Council to ensure that any issues raised round ward moves, testing regimes etc can be clarified.

The way is which deaths of patients with learning disabilities are reviewed does not currently provide any learning or opportunities to identify good practice.

Integrated Quality and Learning Report

Effective

Mortality

Learning from Mortality Review

Mortality Council Update

Actions taken to date:

- A small group was set up to look at the documentation and communication processes for decisions made with regards to DNACPRs. A guide practice guide has subsequently been developed and is available to staff within the Covid-19 section of the intranet.
- There is an ongoing piece of work within the Trust around discharge; the learning from the Mortality Council has been fed into this. In order to triangulate all patient feedback in relation to discharge, a review of complaints and PALs issues received in relation to discharge is to be undertaken over the last 12 months to identify any further, along with the results of the National Inpatient Survey from the last two years as discharge, as it is evident from these results that elements of the discharge process require improvement.
- A process has been developed to review hospital acquired Covid-19 deaths. All 'definite' hospital acquired Covid-19 infections will be automatically referred to the Mortality Council for review. 'Community onset' 'indeterminate' and 'probable' will be reviewed should there be any issues identified at either Medical Examiner review or Level 1 review. As this relies on the outcome of the Level 1 review an increase in compliance in this area is a priority.
- Discharge leaflets produced for patients going home with either a positive or pending Covid-19 results.
- A discharge checklist has been drafted for patients either with a Covid-19 positive result or pending a result, this ensures that all necessary checks will take place prior to discharge. This is currently pending approval.
- Discussions have taken place with new Learning Disability Nurse, a proforma based on LeDeR best practice will be introduced as from April 2021. This will ensure that all learning opportunities and good practice can be identified. The patient notes will be reviewed by the Learning Disability Nurse prior to the Mortality Council and key points added to the existing templates used by the Mortality Council to capture all sources of data about the patient.

Integrated Quality and Learning Report

NHS Friends and Family Test- Trust Experience Rating February 2021

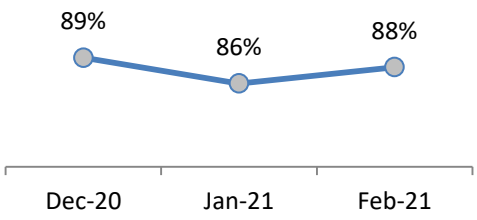
Gateshead Health NHS Foundation Trust

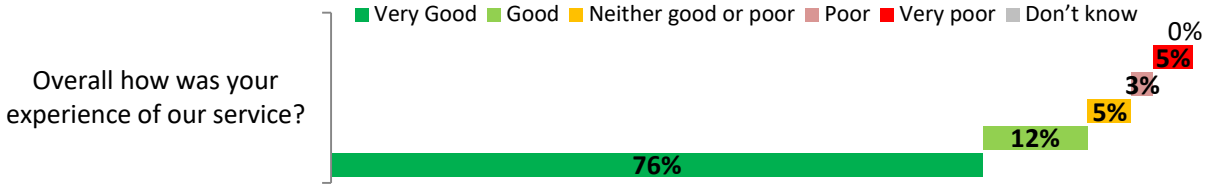
Caring

F&FT Trust Experience Rating A&E

- The Friends and Family test has restarted in A&E using Health call Text messaging.
- The A&E positive experience rating for February 2021 is 86%.

Friends and Family Test % Positive Experience





'From reception to discharge I felt the standards were extremely high.'

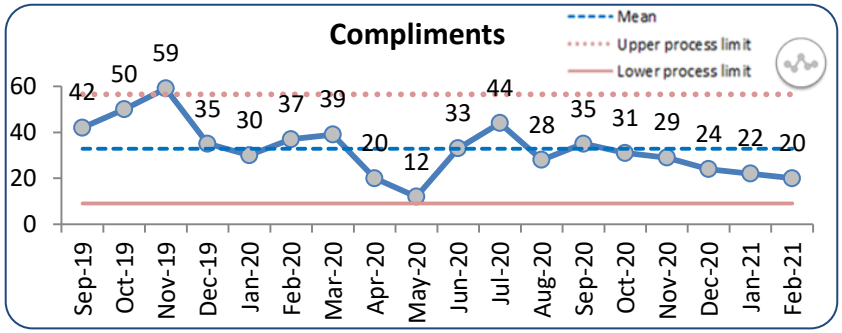
'The staff at walk in centre and accident and emergency, are fantastic, the level of care is 1st class, I cannot praise them enough, considering the pressures they are under at this present time.'

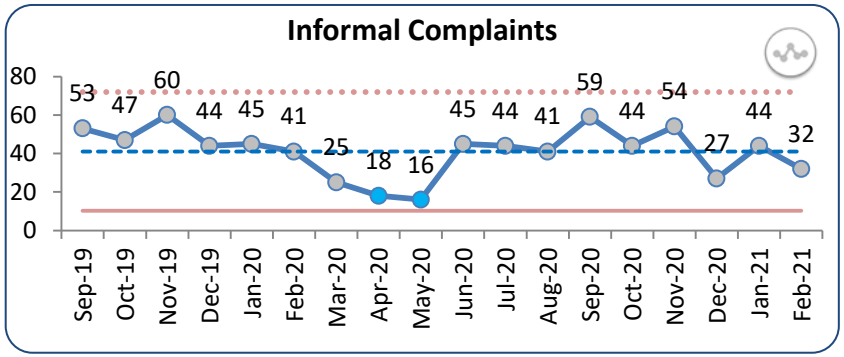
'As I had rang 111and they said to go straight to QE and they were alert to my symptoms. Hardly any waiting and very friendly staff'

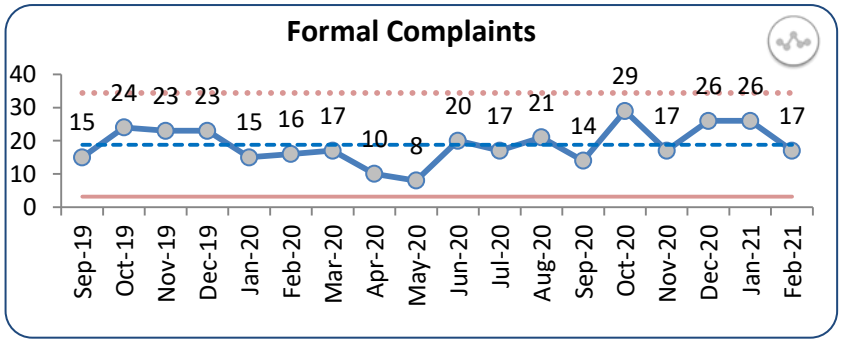
Integrated Quality and Learning Report

Learning From Compliments and Complaints

Responsive







The themes identified in Formal Complaints were :

Clinical Treatment (15)
Appointments including delays & cancellations (2)

Breakdown of Formal Complaints by clinical area:

Emergency Care (5) General Surgery (2) Planned Care (1) Mental Health (1) Screening Services (1) Endocrinology & Clinical Haematology (1) Obstetrics (1) General Medicine (1) Radiology (1) Acute Medicine (1) Care of the Elderly (1) Gynae-Oncology (1)

Learning from complaints

There appeared to be an increasing number of concerns raised via PALS and Complaints relating to missing property. This included very sentimental items an example was a missing wedding ring. In response to this reported missing property was audited over the previous 12 months to identify if there was any themes. The families experience was also shared with the Trust wide sisters weekly meeting to share at ward team meetings of vigilance when managing patients property in line with policy. The feedback from ward sisters suggested property going onto nerve centre and the nerve centre team had already started to draft this which should be ready to roll out where on admission and ward transfer property is logged onto the nerve centre device. This will support locating where items have gone missing The role of the volunteers in supporting where property has gone missing is also being developed.

Integrated Quality and Learning Report

Patient Experience

Responsive

Formal Complaints and PALs
As at 11th March 2021, there are 82 overdue formal complaints and 13 overdue PALs issues.

All overdue complaints and PALs issues have been reviewed and where possible have been answered by the Patient Experience Team in order to support the Business Units, this will continue. The team will continue to support Investigating Officers to facilitate responses.

A Rapid Process Improvement Workshop (RPIW) is in the planning stages to look at the formal complaints and PALs processes. The aim of this RPIW is to review the current processes to ensure that there is a consistent trust wide approach to complaints management with an emphasis on providing compassionate responses , learning from patient and relatives experiences and evidencing that the necessary action has been taken to make improvements. Engagement and participation from key members of the Business Units will be key to developing the new processes. Following the RPIW a new policy will be launched across the Trust.

Winter Volunteers Project
The project remains ongoing, the first cohort commenced during week beginning 15th February 2021.

Realtime Patient Experience Projects
The Trust have been selected, by NHSE, to take part in an Evidence Based Design project within the Same Day Emergency Care setting. The project will use some of the 'Always Events®' principles particularly around co-design. Preliminary discussions have taken place with NHSE and the data collection element has begun, supported by Trust volunteers.

The Patient Experience Team are also working with the Pharmacy Department to undertake a programme of work surrounding patient safety and insulin here. Here we will capture patient experience of those who are insulin dependent and this will support the outcome of the Pharmacy Department's project and drive patient centred care.

Integrated Quality and Learning Report

Gateshead Health NHS Foundation Trust

Well-led

National Acute & Community CQUIN 2020/21

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

Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 17

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Report Title:	**Healthcare Associated Infection (HCAI) Performance Report**			
Name of Meeting:	Trust Board			
Date of Meeting:	31st March 2021			
Author	**Louise Caisley** - Head of Infection Prevention and Control			
Executive Lead	**Andy Beeby** – Medical Director Director of Infection Prevention and Control			
Report presented by	**Andy Beeby** – Medical Director Director of Infection Prevention and Control			
Executive Summary	The Trust continues to adopt the national aspiration of attaining a zero tolerance approach to all avoidable infections. The mandatory reporting infection objectives for CDI and blood stream infections (BSI) for 2020/21 were not published and those for 2021/22 have not yet been published by NHS England/NHS Improvement. COVID-19 was the prominent area of focus in 2020, and continues to dominate the healthcare horizon in 2021. From April 2020 the financial sanctions and associated appeals process for CDI cases were discontinued. To the end of February 2021 the Trust has reported thirty eight (**38**) CDI healthcare associated samples - *compared to forty four (**44**) for the same period last year*. Twenty nine (**29**) hospital onset healthcare associated (HOHA) and nine (**9**) community onset healthcare associated (COHA). From the end of July 2020, BSI were no longer reported as healthcare associated and community associated (non-healthcare associated) and it is anticipated, when set, the Trust objective will be against the healthcare associated category. The Healthcare associated category comprises: - Hospital Onset – Healthcare Associated (HOHA) – when the sample is taken 48 hours following admission (equivalent to the previous Hospital onset category) **and** - Community Onset – Healthcare Associated (COHA) – when the sample is taken within the first 48 hours following admission **and** the patient has undergone a healthcare intervention in the preceding 28 days prior to sample collection			

	From April 2020 to the end of February 2021 the Trust reported zero (**0**) Hospital-onset/Hospital Onset Healthcare associated Meticillin resistant *Staphylococcus aureus* (MRSA) blood stream infections (BSI) and one (**1**) Community-onset/Community Onset Community Associated Meticillin resistant *Staphylococcus aureus* (MRSA) blood stream infections (BSI). From April 2020 to the end of February 2021 the Trust reported seventeen (**17**) Hospital Onset/Hospital Onset Healthcare Associated Meticillin sensitive *Staphylococcus aureus* (MSSA) blood stream infections (BSI) and forty four (**44**) Community Onset/Community Onset Healthcare/Community Associated Meticillin sensitive *Staphylococcus aureus* (MSSA) blood stream infections (BSI). From April 2020 to the end of February 2021 - *Escherichia coli* (*E.coli*): The Trust reported forty (**40)** Hospital-onset/ Hospital Onset Healthcare Associated BSI and one hundred and eighty two (**182**) Community-onset/Community onset Healthcare/Community Associated samples. - *Pseudomonas aeruginosa*: The Trust reported four (**4**) Hospital-onset/ Hospital Onset Healthcare BSI and twelve (**12**) Community-onset/Community Onset Healthcare/Community Associated samples. - *Klebsiella spp*: The Trust reported six (**6**) Hospital-onset BSI and thirty nine (**39**) Community-onset samples. There have been zero (**0**) cases of laboratory confirmed influenza identified between October and February 2021 compared to four hundred and sixty one (**461**) for the same period in 2019/20. From April 2020 there have been zero (**0**) norovirus outbreaks; however there have been thirty one (**31**) COVID-19 outbreaks to the end of February 2021 affecting both clinical and non-clinical areas. From May 2020 the Trust was required to report COVID -19 positive results against four categories: - Community-Onset – First positive specimen date <=2 days after admission to Trust; - Hospital-Onset indeterminate Healthcare-Associated (HOIHA)– First positive specimen date 3-7 days after admission to trust; - Hospital-Onset probable Healthcare-Associated (HOPHA) - First positive specimen date 8-14 days after admission to trust; - Hospital-Onset definite Healthcare-Associated (HODHA) – First positive specimen date 15 or more days after admission to trust. The Trust reports the number of COVID-19 positive in-patients via SitRep and investigates and reports all identified nosocomial COVID-19 cases and COVID-19 outbreaks. From May 2020 to end

	of February 2021 the Trust has identified – seventy four (**74**) indeterminate; seventy three (**73**) probable and fifty one (**51**) definite hospital onset healthcare associated cases.	
Recommended actions for Board/Committee)	Accept this report for assurance	
Trust Aims that the report relates to: (Including reference to any specific risk)	**Aim 1** ☒	We will provide consistently high quality care in all our services
	Aim 2 ☐	We will be a great organisation to work in
	Aim 3 ☐	We will deliver value for money and strengthen delivery of our clinical services
	Aim 4 ☐	We will work with our partners to help make Gateshead a place where everyone thrives
	Aim 5 ☐	We will use our expertise to provide specialist services beyond Gateshead
Financial Implications:	To note the Trust performance on mandatory HCAI reporting and other infection prevention activity as required.	
Links to Risks (identify significant risks and DATIX reference)	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.	
People and OD Implications:	Organisational culture and behaviours, engagement, responsibility and ownership required across the whole healthcare economy.	
Links to CQC KLOE	Caring ☐	Responsive ☐ / Well-led ☐ / Effective ☐ / Safe ☒
Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)	**Obj.1** ☒	The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance between working life and personal commitments
	Obj. 2 ☐	All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers
	Obj. 3 ☒	Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve

1.0 EXECUTIVE SUMMARY

The Trust continues to adopt the national aspiration of attaining a zero tolerance approach to all avoidable infections. The mandatory reporting infection objectives for CDI and blood stream infections (BSI) for 2020/21 were not published and those for 2021/22 have not yet been published by NHS England/NHS Improvement.

COVID-19 was the prominent area of focus in 2020, and continues to dominate the healthcare horizon in 2021.

From April 2020 the financial sanctions and associated appeals process for CDI cases were discontinued. To the end of February 2021 the Trust has reported thirty eight (**38**) CDI healthcare associated samples - *compared to forty four (**44**) for the same period last year*. Twenty nine (**29**) hospital onset healthcare associated (HOHA) and nine (**9**) community onset healthcare associated (COHA).

From the end of July 2020, BSI were no longer reported as healthcare associated and community associated (non-healthcare associated) and it is anticipated, when set, the Trust objective will be against the healthcare associated category.

The Healthcare associated category comprises:

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

and

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

From April 2020 to the end of February 2021 the Trust reported zero (**0**) Hospital-onset/Hospital Onset Healthcare associated Meticillin resistant *Staphylococcus aureus* (MRSA) blood stream infections (BSI) and one (**1**) Community-onset/Community Onset Community Associated Meticillin resistant *Staphylococcus aureus* (MRSA) blood stream infections (BSI).

From April 2020 to the end of February 2021 the Trust reported seventeen (**17**) Hospital Onset/Hospital Onset Healthcare Associated Meticillin sensitive *Staphylococcus aureus* (MSSA) blood stream infections (BSI) and forty four (**44**) Community Onset/Community Onset Healthcare/Community Associated Meticillin sensitive *Staphylococcus aureus* (MSSA) blood stream infections (BSI).

From April 2020 to the end of February 2021

- *Escherichia coli* (*E.coli*): The Trust reported forty (**40)** Hospital-onset/ Hospital Onset Healthcare Associated BSI and one hundred and eighty two (**182**) Community-onset/Community onset Healthcare/Community Associated samples.
- *Pseudomonas aeruginosa*: The Trust reported four (**4**) Hospital-onset/ Hospital Onset Healthcare BSI and twelve (**12**) Community-onset/Community Onset Healthcare/Community Associated samples.
- *Klebsiella spp*: The Trust reported six (**6**) Hospital-onset BSI and thirty nine (**39**) Community-onset samples.

There have been zero (**0**) cases of laboratory confirmed influenza identified between October and February 2021 compared to four hundred and sixty one (**461**) for the same period in 2019/20.

From April 2020 there have been zero (**0**) norovirus outbreaks; however there have been thirty one (**31**) COVID-19 outbreaks to the end of February 2021 affecting both clinical and non-clinical areas.

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

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

The Trust reports the number of COVID-19 positive in-patients via SitRep and investigates and reports all identified nosocomial COVID-19 cases and COVID-19 outbreaks. From May 2020 to end of February 2021 the Trust has identified – seventy four (**74**) indeterminate; seventy three (**73**) probable and fifty one (**51**) definite hospital onset healthcare associated cases.

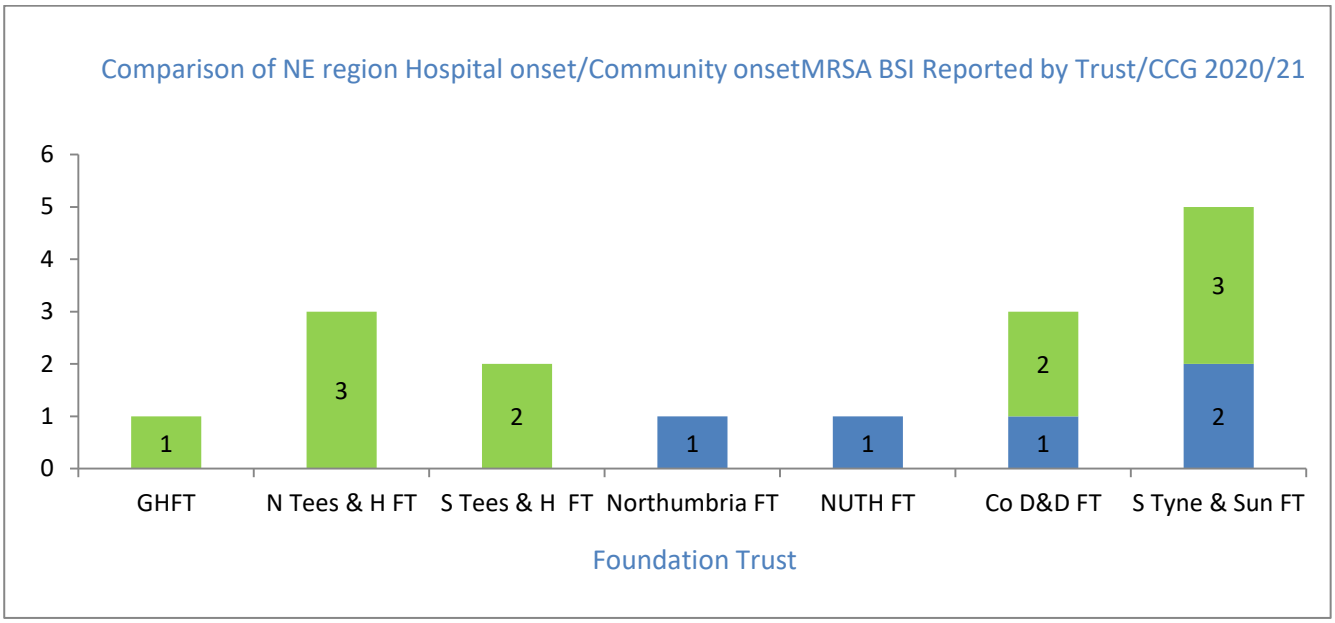
2.0 MANDATORY HCAI SURVEILLANCE

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

The Trust has reported zero (**0**) Hospital onset/Hospital onset Healthcare Associated samples of MRSA BSI and one (**1**) Community-onset/ Community onset – Healthcare, Community Associated MRSA BSI from April 2020 to end of February 2021 - *table 1*.

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

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

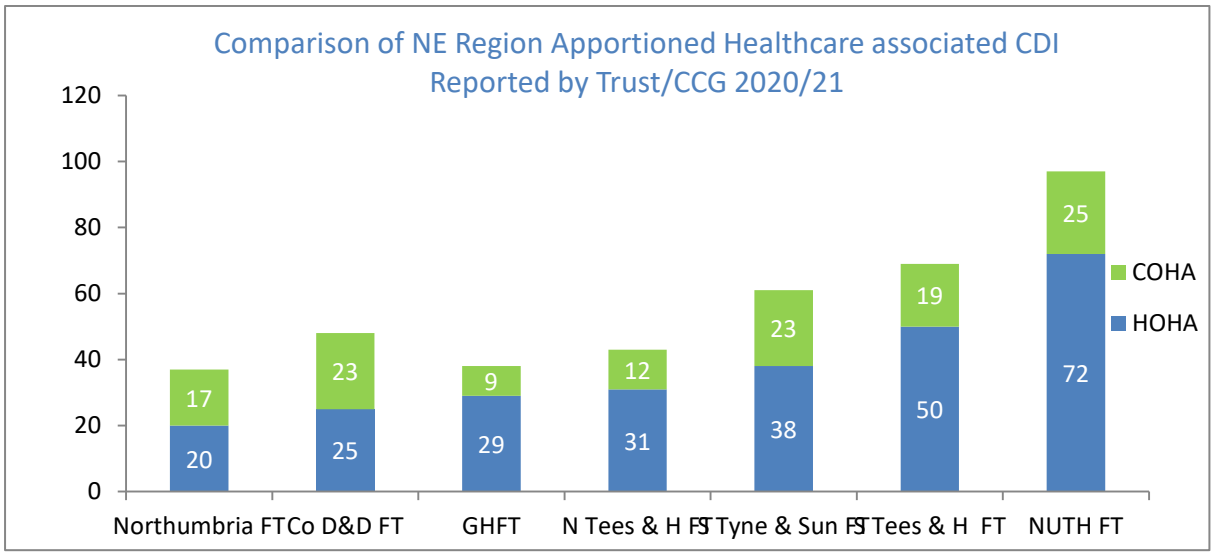


2.2 *Clostridioides difficile* Infection (CDI)

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

From April 2020 the financial sanctions and the associated appeals process for CDI cases were discontinued. From April 2020 to the end of February 2021 the Trust has reported thirty eight (**38**) CDI healthcare associated samples - *compared to forty four (**44**) for the same period last year*.

Twenty nine (**29**) hospital onset healthcare associated (HOHA) and nine (**9**) community onset healthcare associated (COHA).

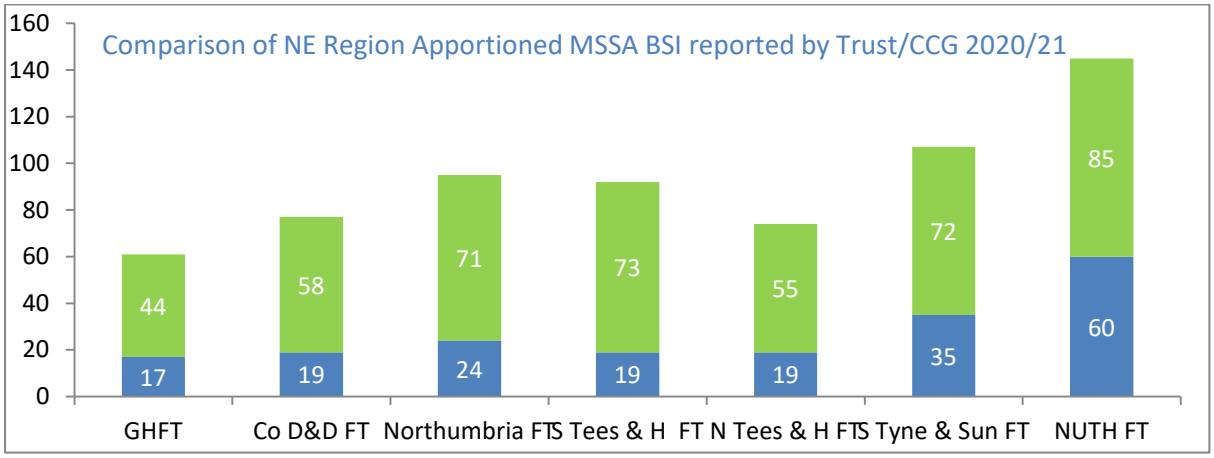


2.3 Meticillin Sensitive *Staphylococcus aureus* (MSSA) Blood Stream Infections (BSI)

The Trust has reported seventeen (**17**) Hospital-onset/Hospital-onset Healthcare Associated samples of MSSA BSI and forty four (**44**) Community-onset/ Community onset – Healthcare, Community Associated MRSA BSI from April 2020 to end of February 2021 - *table 2*.

***Table 2* – Hospital onset**	**Q1**			**Q2**			**Q3**			**Q4**		
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Hospital onset + Hospital onset Healthcare Associated **MSSA BSI**	**0**	**1**	**3**	**3**	**1**	**4**	**1**	**2**	**0**	**0**	**2**	
Cumulative YTD	**17**											
2019/20 Actual = 7	**0**	**0**	**2**	**1**	**0**	**0**	**2**	**0**	**0**	**1**	**1**	**0**

***Table 2* - Community Data**	**Q1**			**Q2**			**Q3**			**Q4**		
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Healthcare + Indeterminate + Community Associated **MSSA BSI**	**4**	**2**	**3**	**6**	**5**	**5**	**5**	**5**	**2**	**3**	**4**	
Cumulative YTD	**44**											
2019/20 Actual = 52	**7**	**3**	**4**	**2**	**5**	**3**	**3**	**4**	**12**	**2**	**4**	**3**



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

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

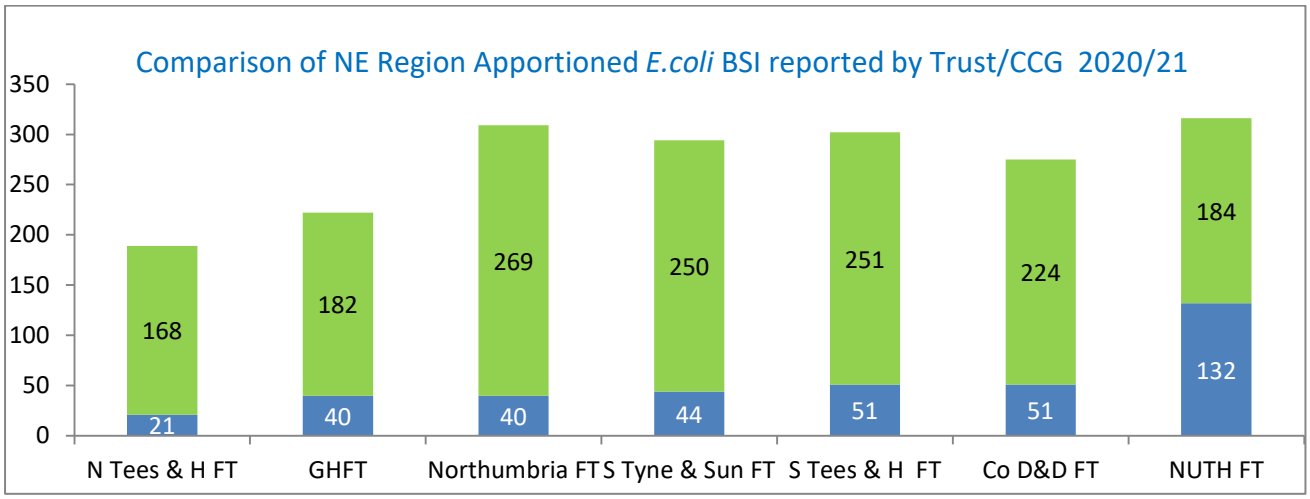
The following data representing *E. coli*, *Klebsiella* species and *Pseudomonas aeruginosa* blood stream infections (BSI) and demonstrate that the main proportion of BSI occur within the primary and social care environment.

3.1 Escherichia coli BSI (*E. coli*)

The Trust has reported forty (**40**) Hospital-onset/Hospital-onset Healthcare Associated samples of *E.coli* BSI and one hundred and eighty two (**182**) Community-onset/ Community onset – Healthcare, Community Associated *E.coli* BSI from April 2020 to end of February 2021 - *table 3*.

***Table 3* – Hospital onset**	**Q1**			**Q2**			**Q3**			**Q4**		
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Hospital onset + Hospital onset Healthcare Associated ***E.coli* BSI**	**2**	**3**	**3**	**2**	**3**	**5**	**5**	**4**	**3**	**8**	**2**	
YTD	**40**											
HO *E.coli* BSI 2019/2020 = 47	**2**	**5**	**4**	**3**	**2**	**5**	**4**	**3**	**2**	**6**	**3**	**2**

***Table 3*- Community onset**	**Q1**			**Q2**			**Q3**			**Q4**		
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Healthcare + Indeterminate + Community Associated ***E.coli* BSI**	**13**	**26**	**17**	**19**	**12**	**21**	**13**	**19**	**12**	**15**	**15**	
YTD	**182**											
CO *E.coli BSI* 2019/2020 = 186	**14**	**10**	**16**	**23**	**16**	**13**	**13**	**12**	**13**	**21**	**17**	**18**



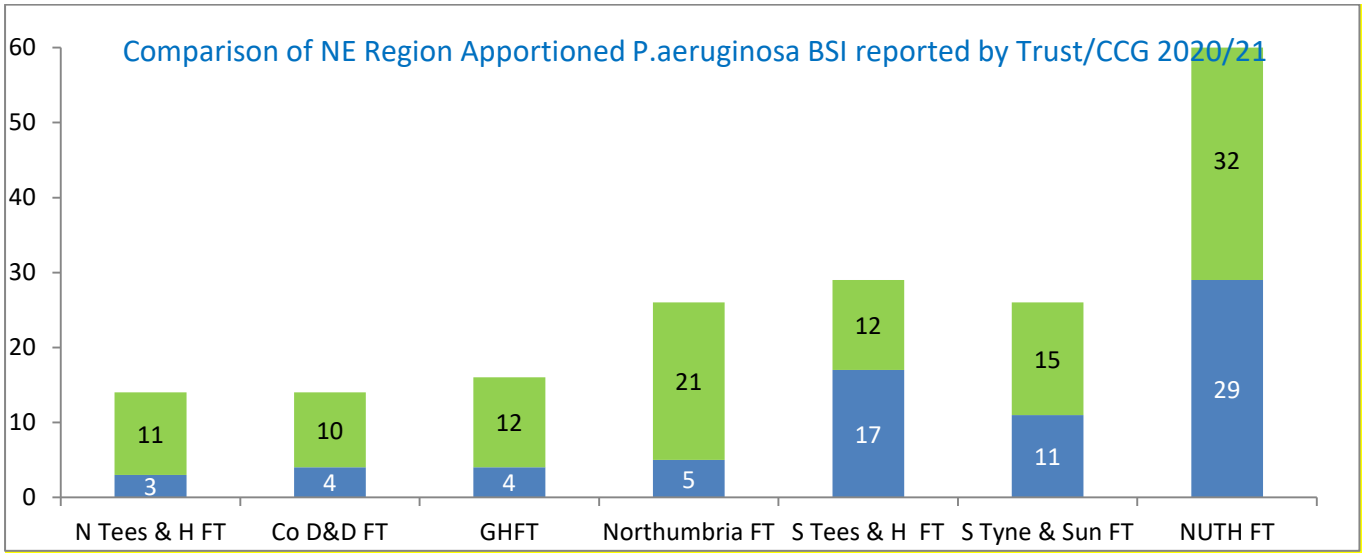
3.2 *Pseudomonas aeruginosa* BSI

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

The Trust has reported four (**4**) Hospital-onset/Hospital-onset Healthcare Associated samples of *P.aeruginosa* BSI and twelve (**12**) Community-onset/ Community onset – Healthcare, Indeterminate, Community Associated *P.aeruginosa* BSI from April 2020 to end of February 2021 - *table 4*.

***Table 4* – Hospital onset**	**Q1**			**Q2**			**Q3**			**Q4**		
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Hospital onset + Hospital onset Healthcare Associated ***P.aeruginosa* BSI**	**1**	**0**	**0**	**0**	**0**	**0**	**1**	**1**	**0**	**1**	**0**	
Cumulative YTD	**4**											
HO *P. aeruginosa BSI* 2019/2020 = 8	**2**	**0**	**2**	**1**	**1**	**0**	**1**	**1**	**0**	**0**	**0**	**0**

***Table 4* - Community onset**	**Q1**			**Q2**			**Q3**			**Q4**		
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Healthcare + Indeterminate + Community Associated ***P.aeruginosa* BSI**	**0**	**3**	**1**	**1**	**0**	**2**	**2**	**1**	**2**	**0**	**0**	
Cumulative YTD	**12**											
CO *P. aeruginosa* BSI 2019/2020 = 16	**4**	**1**	**0**	**1**	**1**	**0**	**1**	**2**	**1**	**4**	**0**	**1**



3.3 *Klebsiella species* BSI

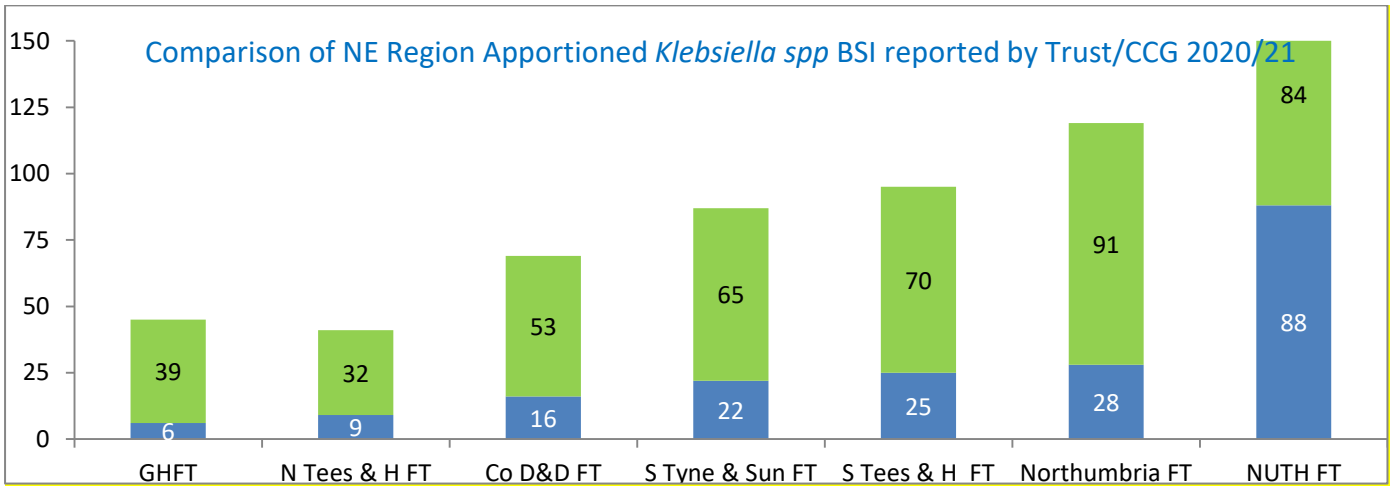
Klebsiella species are a type of bacteria that are found ubiquitously in the environment and also in the human intestinal tract and are commonly associated with a range of HCAI. In healthcare settings, Klebsiella infections are seen in vulnerable, immunocompromised and unwell patients who have other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

The Trust has reported six (**6**) Hospital-onset/Hospital-onset Healthcare Associated samples of *Klebsiella spp* BSI and thirty nine (**39**) Community-onset/ Community onset – Healthcare,

Indeterminate, Community Associated *Klebsiella spp* BSI from April 2020 to end of February 2021 - *table 5*.

***Table 5* – Hospital onset**	**Q1**			**Q2**			**Q3**			**Q4**		
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Hospital onset + Hospital onset Healthcare Associated ***Klebsiella spp* BSI**	**0**	**0**	**1**	**1**	**0**	**0**	**1**	**0**	**0**	**3**	**0**	
Cumulative YTD	**6**											
HO *Klebsiella spp. BSI 2019/20 = 10*	**0**	**0**	**0**	**0**	**1**	**2**	**1**	**2**	**1**	**1**	**1**	**1**

***Table 5* - Community onset**	**Q1**			**Q2**			**Q3**			**Q4**		
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Healthcare + Indeterminate + Community Associated ***Klebsiella spp* BSI**	**6**	**1**	**5**	**3**	**5**	**3**	**5**	**5**	**1**	**3**	**2**	
Cumulative YTD	**39**											
CO *Klebsiella spp.* BSI 2019/2020 = 47	**5**	**2**	**6**	**3**	**1**	**5**	**6**	**5**	**4**	**4**	**2**	**4**



4.0 PERIODS OF INCREASED INCIDENCE (PII) AND OUTBREAKS

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

The Trust has experienced zero (**0**) PII due to confirmed Norovirus infections from April 2020 the end of February 2021

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

Table 6 indicates the number of PII by month against 2019/20.

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

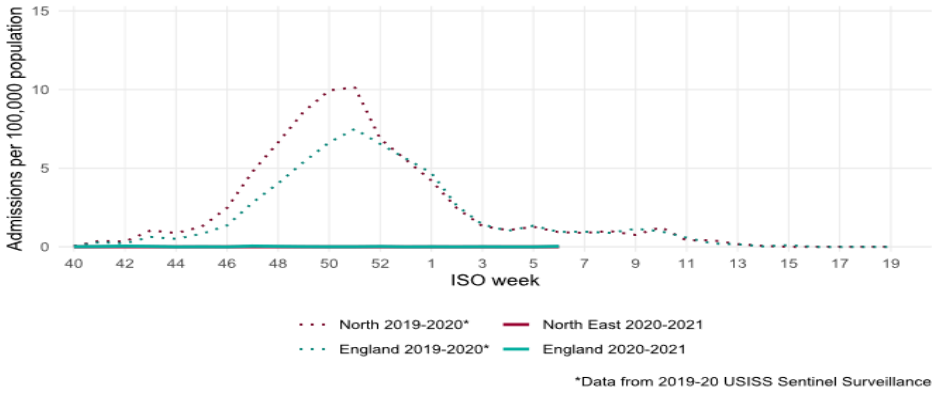
5.0 Influenza activity

Influenza is a highly infectious, acute viral respiratory tract infection which has a usual incubation period of one to three days. There are two types of influenza virus (Type A and B) that affect people

Annual surveillance of Influenza activity is implemented in the Trust since week 40 (1st October 2020).

From 1st October to end of February 2021 there have been zero (**0**) positive samples of hospitalised influenza A/B samples, compared to the four hundred and sixty one (**461**) reported for the same period 2019/20.

This is consistent with the lack of influenza incidence in the North East and Nationally.



5.0 COVID - 19

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

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

The trust are involved with the contact tracing required for all patients and staff that have a positive swab in line with the National Test and Trace service.

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

- Hospital-Onset indeterminate Healthcare-Associated – First positive specimen date 3-7 days after admission to trust.
- Hospital-Onset probable Healthcare-Associated - First positive specimen date 8-14 days after admission to trust
- Hospital-Onset definite Healthcare-Associated – First positive specimen date 15 or more days after admission to trust.

Table 7 indicates the number of cases reported by the organisation from April 2020.

Table 7	Q1			Q2			Q3			Q4			Total
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Hospital-Onset indeterminate Healthcare-Associated	n/a	1	0	0	0	1	19	23	8	20	2		74
Hospital-Onset probable Healthcare-Associated	n/a	0	0	0	0	0	32	21	1	11	8		73
Hospital-Onset definite Healthcare-Associated	n/a	0	0	0	0	1	14	24	1	6	5		52
Total	n/a	1	0	0	0	2	65	68	10	37	15		

The Microbiologists and IPC team support any investigation, management, and reporting of any COVID-19 outbreaks.

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

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

1st September 2020 the first COVID-19 outbreak, using the new national criteria, was declared in a non-clinical area. The first outbreak in a clinical area was declared on the 24th September 2020. To the end of February 2021 the Trust has reported thirty one (**31**) COVID-19 related outbreaks (table 7). Whilst some of these outbreaks have been very small involving just two or three office based staff, several outbreaks have caused significant concern and involved large numbers of patients and staff and have been very challenging to contain and manage.

Our outbreak strategy, in line with national guidance, has a low threshold for identifying COVID cases with the intention of aggressively terminating the cycle of transmission.

During October 2020, concerns were raised by the IPC team and DIPC's that the incidence and scale of COVID-19 outbreaks in our hospital. The DIPC escalated the concerns to the strategic senior management team and a combination of interventions proved extremely effective at quickly containing and terminating the open outbreaks and restricting new outbreaks and nosocomial COVID-19 infections from occurring.

Following the easing of national restrictions in December 2020 there was an increase in the incidence of COVID-19 circulating within the Gateshead community, including cases with the new more transmittable UK variant strain. Despite a significant increase in the local community

prevalence of COVID-19 in January 2021, fewer incidences of Hospital-onset probable/definite healthcare associated COVID-19 cases were seen than in October/November 2020. This can be credited, in some part, to the continued implementation of the lessons learnt from our experiences in October/November

However, continued vigilance and compliance with IPC recommendations are necessary to maintain low levels of transmission and it is essential that IPC remains a top organisational priority.

Table 7 **COVID-19 outbreaks 2020/21**	**Q1**			**Q2**			**Q3**			**Q4**		
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Clinical setting	**0**	**0**	**0**	**0**	**0**	**1**	**5**	**4**	**2**	**3**	**3**	
Non clinical setting	**0**	**0**	**0**	**0**	**0**	**3**	**5**	**1**	**1**	**3**	**0**	
Total	**0**	**0**	**0**	**0**	**0**	**4**	**10**	**5**	**3**	**6**	**3**	

Louise Caisley
Head of Infection Prevention and Control

Gateshead Health
NHS Foundation Trust

Report Cover Sheet

Agenda Item: 18

Purpose of Report	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
Report Title:	Emergency Preparedness Resilience & Response (EPRR) Assurance Report			
Name of Meeting:	Trust Board			
Date of Meeting:	31st March 2021			
Author	Tom Knox			
Executive Lead	**Joanne Baxter**			
Report presented by	**Joanne Baxter**			
Executive Summary	Provision of assurance on EPRR Core standards compliance and information on the Trust learning to date from our COVID-19 response with identified actions for the future EPRR work programme.			
Recommended actions for Board/Committee)				
Trust Aims that the report relates to: (Including reference to any specific risk)	**Aim 1** ☒	We will provide consistently high quality care in all our services		
	Aim 2 ☐	We will be a great organisation to work in		
	Aim 3 ☒	We will deliver value for money and strengthen delivery of our clinical services		
	Aim 4 ☒	We will work with our partners to help make Gateshead a place where everyone thrives		
	Aim 5 ☐	We will use our expertise to provide specialist services beyond Gateshead		
Financial Implications:	Funding has been identified from current streams to establish Site Resilience/EPRR re-structure			
Links to Risks (identify significant risks and DATIX reference)	Assessment of Trust position against EPRR Standards			
People and OD Implications:	Current re-structure of EPRR and Site Resilience			
Links to CQC KLOE	Caring ☐	Responsive ☒	Well-led ☒	Effective ☒	Safe ☒

Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)	**Obj.1** ☒	The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance between working life and personal commitments
	Obj. 2 ☒	All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers
	Obj. 3 ☒	Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve

EPRR Assurance Statement 2021

1) Introduction and context

It is a requirement that NHS Providers submit a current self-assessment statement of assurance against Emergency Preparedness, Resilience and Response (EPRR) core standards to their boards.

In recognition of the situation with COVID-19 in August 2020, a revised and amended approach to the annual assessment of EPRR standards was issued by the National Director of EPRR.

The following EPRR assurance statement provides a current position on the following amended requirements,

1) That EPRR assurance action plans have been reviewed in order to improve the level of compliance against 2020 EPRR Assurance Core Standards, and where non-compliance was reported as part of the overall assurance rating, that an updated and reviewed assurance level is provided with ongoing action plans.

2) That the Trust has undertaken, or plans to undertake, a formal review process on our response to the COVID-19 pandemic to date, and have associated plans to ensure that the lessons and recommendations from reviews are embedded as part of an ongoing EPRR work programme.

3) That the Trust response to the COVID-19 pandemic has been reviewed and steps taken to embed key lessons and actions in future planning for further escalation, winter planning and associated system response arrangements.

The attached Action Plan details the core standards and the Trust's current compliance and sets out an action plan and time-line to identify additional work to enhance resilience.

2. Assurance Elements

2.1 EPRR Core Standards and Action Plan review

A review of the EPRR core standards and the associated plan has been undertaken and the overall level of compliance for the Trust has been assessed as **Partially Compliant**.

It is evident that the Trust has been through a period of change and has been faced with the many challenges of responding to Co-vid-19. Simultaneously, a number of key individuals previously responsible for delivery of EPRR standards, have left the Trust and understandably during this period, the level of compliance has at times lapsed.

The Trust appointed a Chief Operating Officer (COO) in June 2020 with responsibility for the role of designated Accountable Emergency Officer (AEO) with a further appointment of a Head of EPRR in October 2020. These officers have been tasked with addressing issues of EPRR compliance,

reviewing standards and providing a strategy, framework and action plan to ensure future Trust resilience.

A summary of the standards submission assessment scores against the respective core standards is provided below;

NEW ASSESSMENT

Core Standards (As at 21/03/21)	Total standards applicable	Fully compliant	Partially compliant	Non compliant
1. Governance	6	2	4	0
2. Duty to risk assess	2	1	1	0
3. Duty to maintain plans	14	4	10	0
4. Command and control	2	1	1	0
5. Training and exercising	3	0	3	0
6. Response	7	3	4	0
7. Warning and informing	3	1	2	0
8. Cooperation	4	2	2	0
9. Business Continuity	9	0	9	0
10. CBRN	14	7	7	0
Total	**64**	**21**	**43**	**0**

A review and re-structure of the Trust Resilience Group and Strategic EPRR Committee has taken place in 2021 and terms of reference clarified and confirmed.

A number of the EPRR standards have been recently assessed and have received sign-off at the Trust EPRR committee. The further appointment of an EPRR and Business Continuity Manager in December 2020 and the launch of the restructured Site Resilience Team in April 2021 are expected to further enhance levels of resilience, collaborative working and compliance and ensure standards are improved as actions are progressed.

The current action plan is provided at Appendix A.

2.2 Assurance that the review process on our response to the COVID-19 pandemic to date, and have associated plans to ensure that the lessons and recommendations from that review are embedded as part of your ongoing EPRR work programme.

The Trust responded to the Covid-19 pandemic in line with the guidance set out by NHSE/I and put actions in place to redirect staff and resources to maximise in-patient and critical care capacity.

A Command Structure was introduced alongside an Incident Control Centre which ran as a centralised hub managing flow of information and supporting escalation.

This structure has now evolved to ensure that command, control and coordination (C3) is managed using one escalation model across the trust at Operational, tactical and strategic levels. The model is based on decisions being taken at the lowest appropriate level to ensure timely, informed decisions.

The C3 model has been enhanced by the re-writing of the Operational Pressures Escalation Levels (OPEL) document ensuring a coordinated and consistent process for managing daily Trust operational pressures. Other sub-groups (Outbreak Mgt., Clinical Advice, Workforce, Safer-working and Testing) have been formed to input specific and timely information and recommendations to allow informed Trust C3 decision-making during Co-vid.

Staff have been supported with provision of equipment, facilitating them to safely work from home where appropriate, and an enhanced health and wellbeing support programme was made available to staff including embracing the **Project Wingman** initiative.

The Trust held strategic recovery planning-workshops in April and December 2020 which identified key organisational learning and priorities for recovery in line with NHSE/I guidance.

Phased plans were implemented which considered Trust recovery of services and appropriate modifications to allow return to core business utilising the following principles;

- Adhere to Government guidelines: PPE, social distancing, hand-hygiene etc.
- Considering new ways of working: Digital use, home-working, Teams meetings etc.
- Identify what we need to prevent/stop doing
- Digital First – using technology to support best practice
- Process/Treatment opportunities: adopting practice to reduce face to face contacts & footfall

Further EPRR actions taken which will support our future plans and principles included the following;

Training and exercising

- The Trust reviewed the site resilience meetings, agendas and remits and provided On-Call training and revised consistent protocols and guidance for all operational, tactical and strategic management.
- Embedded internal decision making frameworks within EPRR command and control and coordination frameworks to embrace **subsidiarity** – empowering our people to make decisions at the lowest appropriate level
- The Trust to consider EPRR as part of annual mandatory training.
- Maximising partnership working by increasing Trust work with Local Resilience Forum and via health and non-health multi-agency partnerships
- Utilising trained loggists, often working from home, not only for incident management, but for key on-line Co-vid meetings

EPRR Governance

- Identified clinical lead for EPRR to support work programme
- Implemented consistent Command, Control and Coordination escalation arrangements for any Trust business continuity, critical or major incident
- Built capability, competence and capacity into all On-call rotas to support out of hours management of organisational pressures

- Anticipate future demand and pressures and build resilience into planning for significant impacts

Duty to maintain plans

- Full review by EPRR Team of all current plans and Trust capabilities and forward plan
- Identified time-line for training and exercising to mitigate key risks

Business Continuity

- Undertake a complete review of Business Continuity within the trust overseen by new EPRR & Business Continuity Manager to ensure a compliant, consistent and effective BC strategy
- Review of lessons identified during Co-vid response to embed learning
- Review continuity of PPE supplies and supply chain for future waves and assessing impact of Brexit on our supply-chains

2.3 That you have reviewed your response to the COVID-19 pandemic and taken steps to embed key lessons and actions in planning for winter and associated system response arrangements.

Our winter planning has changed fundamentally as a consequence of COVID-19. We are now operating in a totally different way including:-

- Infection control measures in place from wearing PPE to socially distancing requirements in waiting areas
- Having 2 metres between beds which has reduced bed capacity
- Regular testing of patients and staff
- Some staff shielding or self-isolating therefore reducing staffing numbers
- Increased disruption to social care
- A need to continue to support social care especially care homes
- The implementation of shielding requirements for patients
- A focus on managing care delayed by Covid and resultant impact on waiting times and referrals to treatment

The Trust initiated its Command and Control Emergency arrangements on 16 March 2020 and implemented strategic, tactical and operational command structures. These structures have been refined and evolved but remain in place in March 2021.

In line with national guidance the Trust also:

- Increased critical care capacity and redeployed staff
- Suspended elective surgery during peak Covid pressures
- Created Covid and non Covid areas
- Suspended some Community Services
- Carried out estates work to increase capacity for oxygen supply and therapy

- Implemented revised discharge arrangements

The Trust also joined locally created “cells” covering:

- Testing - With our pathology expertise, took a lead role in Covid detection
- Care Home Support
- Discharge
- Primary Care including supporting GP ‘hot sites’
- Outbreak Control-led by the Director of Public Health/IPC - Standard Operating Procedures

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

- The need, with the CCG, Primary Care and Gateshead Council to support care homes with nursing capacity. At the CCG’s request in Phase 1 and 2 we intervened to keep a number of care homes open.
- To adapt national guidance to local circumstances especially on testing regimes
- To continue with our additional wellbeing initiatives for staff
- To train more staff in critical care skills
- Increasing the frequency and methods of communications to staff
- With partners ensure primary care continues to provide key accessible services

We have developed and embedded pathways for Covid-19 positive patients as part of our approach to bed management and continue to learn the lessons of the earlier phases to ensure we have well tested Covid-19 systems and processes.

3. Conclusion

Assurance can be provided that the Trust has responded well to COVID-19 despite experiencing a period of change and transition. The Trust has undertaken a number of reviews and debriefing sessions to ensure organisational learning is captured from our response to the COVID-19 pandemic. The EPRR Team have reviewed all EPRR standards and are currently converting identified learning into practice and ensuring that actions are embedded within our future EPRR Action plans.

Tom Knox
Head of Emergency Preparedness Resilience and Response
GHFT

APPENDIX A

Review of NHS Core Standards and EPRR Work Programme – for continuous review and consultation

Red (not compliant) = Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months.
Amber (partially compliant) = Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.
Green (fully compliant) = Fully compliant with core standard.

BLACK TEXT – was previously submitted
RED TEXT – additional updates

Ref	Domain	Standard	Expected Detail	Organisational Evidence	RAG	Action to be taken	Lead / s	Timescale
1	**Domain 1 - Governance**	**Senior Leadership**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role. Name and role of appointed individual	Jo Baxter - Chief Operating Officer is the Accountable Emergency Officer (AEO), supported by Tom Knox, Head of EPRR. Clarification required on non-executive board member	Partially compliant	Identification of non-executive board member or alternative to support for a future EPRR Committee	COO / Head of EPRR	31-May-21
2	**Domain 1 - Governance**	**EPRR Policy Statement**	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Eprr policy contains this information and is available on request - this document was effective from July 2018 and is out of date with recent structural changes. The trust's revised Major Incident Policy (November 2020) provides the framework and commitment to EPRR including the Incident Response Plan	Fully compliant	No further action – annual review of policy November 2021	Head of EPRR	30-Nov-2021
3	**Domain 1 - Governance**	**EPRR board reports**	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process.	Annual board reports are submitted Previous Trust Report was submitted on 29 September 2020	Fully compliant	Future 6 monthly reports to be submitted Next Board report to be submitted March 2021 and 6 months thereafter	Head of EPRR	31-Mar-2021 Sept-2021

Ref	Domain	Standard	Expected Detail	Organisational Evidence	RAG	Action to be taken	Lead / s	Timescale
4	Domain 1 - Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes.	Workplan is discussed at the EPRR committee new format being developed to ensure assurance is improved.	Partially compliant	A new EPRR Team is in place from October and December 2020 respectively so new EPRR workplan to be developed to take into account of NHS Core Standards requirements and organisation trust priorities. Work-plan to be developed and presented to a future EPRR Committee	COO/ Head of EPRR/ EPRR & BC Manager	30-Apr-2021
5	Domain 1 - Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Feedback is received from the board following the submission of the board report as mentioned previously. Full new EPRR structure developed and being recruited to The trust's revised Major Incident Policy (November 2020) provides the framework and commitment to EPRR including a framework of the Incident Response Plan	Partially compliant	Site Resilience Team being put into place Annual review of Major Incident Policy	Head of EPRR Head of EPRR	May-2021 30-Nov-2021
6	Domain 1 - Governance	Continuous improvement process	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Following incidents and exercises hot debrief meetings are held asap, feedback information is requested which includes what went well, what didn't go so well and any improvements required. This information is used to develop action plans and improvement for the future. The new EPRR Team are structured debrief trained and utilise NE LRF Debrief Protocol for current debriefing which is referenced in revised Major Incident Policy (November 2020)	Partially compliant	Process is adhoc and not defined in policy/ SOP - further work required to look at formalising a trust approach to debriefing and increasing capacity to debrief EPRR – future approach to be clarified	Head of EPRR/ EPRR & BC Manager	30-Jun-2021
7	Domain 2 - Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	National and community risk registers are considered and discussed at the EPRR committee meetings	Partially compliant	The trust are to become standing members of Northumbria LRF and discussions ongoing to become part of the LRF Risk Assessment Working Group and work with the National Security Risk Assessment [NRSA]	Head of EPRR/ EPRR & BC Manager	30-Apr-2021
8	Domain 2 - Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	EPRR risks are addedd to risk register through the DATIX system and discussed at the EPRR committee meetings, especially risks rated at 12 and above due to their severity. EPRR risks recently reviewed and a number of extra have been added to the register following EPRR Committee (March 2021). There is routine assessment of risks and risk management with the Trust's Corporate Risk Manager.	Fully compliant	Continuous process of review of risk and presentation to Trust Resilience Group and EPRR Committee for awareness EPRR committee and associated risks will report into the trusts Executive Risk Management Commitee	Head of EPRR/ EPRR & BC Manager	Ongoing
9	Domain 3 - Duty to maintain plans	Collaborative planning	Plans have been developed in collaboration with partners and service providers to ensure the whole patient pathway is considered.	Plans are shared with partners e.g. police, NEAS, NHS colleagues and the LA through various meetings HSCRG, LHRP, Business Continuity and resilience groups. No recent evidence of plans been shared.	Partially compliant	plans are out of date, beig reviewed and presented to EPRR committee Sept 20. The trust to become a formal standing member of Northumbria LRF. Mapping of groups and trust representatives required to be undertaken. Need to formally record the submission on plans to partners and evidence collaborative approach. Update MIP policy and associated plans to evidence this standard	Head of EPRR/ EPRR & BC Manager	30-Jun-2021

Ref	Domain	Standard	Expected Detail	Organisational Evidence	RAG	Action to be taken	Lead / s	Timescale
11	**Domain 3 - Duty to maintain plans**	**Critical incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as defined within the EPRR Framework).	~~Arrangements are in place through the Major Incident Plan (available on request), regular exercises and training take place to test effectiveness.~~ Operational escalation for a Critical Incident included as part of new trust OPEL Framework (January 2021). Included a part of revised Major Incident Policy (November 2020). Over reliance on Majax Plan which is a casualty plan does not cover adequately a critical incident	Partially compliant	Included within the current escalation framework and on-call information Further work to take place as part of overall trust Incident Response Plan to bring all areas together	EPRR & BC Manager	30-Jun-2021
12	**Domain 3 - Duty to maintain plans**	**Major incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as defined within the EPRR Framework).	Arrangements are in place through the Major Incident Plan (available on request), regular exercises and training take place to test effectiveness.	Partially compliant	Further work to take place as part of overall trust Incident Response Plan (including Major Incident Response) to bring all areas together. Current trust Major Incident Plan and resources to be fully reviewed with an addendum to be added in the first instance following identified learning from COVID. Testing and exercising schedule to be developed once reviewed with training for key responders including on-call officers on a regular basis Full workplan to follow with a 12 to 18 month project to completion	EPRR & BC Manager EPRR & BC Manager	30-Apr-2021 30-Sept-2022
13	**Domain 3 - Duty to maintain plans**	**Heatwave**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heatwave on the population the organisation serves and its staff.	Arrangements are detailed in the Trusts Adverse Weather Plan (available on request).	Partially compliant	Current trust adverse weather plan to be reviewed and updated (suggests last update circa 2012-2013)	EPRR Team	31-May-2021
14	**Domain 3 - Duty to maintain plans**	**Cold weather**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Arrangements are detailed in the Trusts Adverse Weather Plan (available on request).	Partially compliant	Current trust (Adverse Weather Plan) to be reviewed and updated (suggests last update circa 2012-2013)	EPRR Team	31-Oct-2021
15	**Domain 3 - Duty to maintain plans**	**Pandemic influenza**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to pandemic influenza.	The Trust has an pandemic influenza plan which is reviewed and updated by the infection control team. Regular IPCC meetings are held as well as Flu planning meetings to discuss issues and promotion of the vaccination programme. The trust is Covid-19 compliant and has an escalation framework	Partially compliant	plan is out of date - IPC wouldn't consider they are resposbible for the plan, just their elements. Should consider adding to IPC committee TOR to review and contribute to the plan. Plan to be reviewed and updated (current version on file circa 2012/2013) to include identified learning from the response to COVID. Update the Plan, include lessons learnt from CV-19 response. IPC lead added committee TOR to review and contribute to formal review the plan and ownership of the content needs explicitly detailed as it is an organisational plan with various leads.	Head of EPRR / EPRR Team with Trust IPC Lead	31-Oct-2021

Ref	Domain	Standard	Expected Detail	Organisational Evidence	RAG	Action to be taken	Lead / s	Timescale
16	**Domain 3 - Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases such as Viral Haemorrhagic Fever. These arrangements should be made in conjunction with Infection Control teams; including supply of adequate FFP3 and PPE trained individuals commensurate with the organisational risk.	IPCC meetings will discuss any issues and/or incidents around infectious deseases such VHF staff are trainined in the use of FFP3 and appropriate PPE this takes place on staff away days with attendance records maintained. The trust has a current Management of a patient with suspected Viral Haemorrhagic Fever (VHF), Middle East Respiratory Syndrome Coronavirus (MERS-CoV) and Covid-19 (SARS-CoV-2) Plan and a Covid-19: Infection Prevention and Control Standard Operating Procedure for managing positive results including Covid-19 outbreak Plan – both to updated to be discussed at the IPC committee this week and will need to be ratified	Partially compliant	Plans exist but need reviewed. Both plans are to updated and discussed at the IPC committee and will need to be ratified EPRR Team to sit on future IPC Committees if appropriate to ensure there is collaboration	A&E Head of IPC/Head of EPRR	30-Sept-2021
17	**Domain 3 - Duty to maintain plans**	**Mass countermeasures**	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including arrangement for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. CCGs may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident. COVID-19 as an example	No evidence of up to date mass counter measure procedures in place currently. COVID-19 mass vaccination and influenza programmes are currently in place	Fully compliant	Current plans need updated and tested urgently. Pharmacy and Community teams would be expected to support. Dovetail with COVID vaccination mobilisation plans	Trust IPC Lead/ Head of EPRR / Chief Pharmacist	31-Oct-2021
18	**Domain 3 - Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level 3 ITU capacity for 96 hours (for those with level 3 ITU bed).	The Trust has a Mass Casualty Plan which has been reviewed, tested and used in exercises (available on request).	Partially compliant	Review of current plan to be undertaken and was exercised as part of Exercise Pelican Further work to take place as part of overall trust Incident Response Plan (including Major Incident Response) to bring all areas together including location of documents and use of Teams Channels	EPRR & BC Manager	30-Jun-2021
19	**Domain 3 - Duty to maintain plans**	**Mass Casualty - patient identification**	The organisation has arrangements to ensure a safe identification system for unidentified patients in an emergency/mass casualty incident. This system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	The Trust has an unidentified or unconscious patient identification system which includes the use of specific wrist bands, and pre-printed folders using a unique name, date of birth, gender which allows the patient to be registered as quickly as possible which then gives prompt access to systems, tests and treatment e.g. blood etc.	Fully compliant	Further work to take place as part of overall trust Incident Response Plan (including Major Incident Response) to bring all areas together including location of documents and use of Teams Channels	EPRR & BC Manager	30-Jun-2021
20	**Domain 3 - Duty to maintain plans**	**Shelter and evacuation**	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	The Trust has plans in place to evacuate wards and areas as necessary which have been used and tested, these are available on request.	Partially compliant	being reviwed and presented to EPRR committee. Plan to be reviewed and updated (current version suggests circa 2014)	EPRR Team	31-Mar-2022

Ref	Domain	Standard	Expected Detail	Organisational Evidence	RAG	Action to be taken	Lead / s	Timescale
21	**Domain 3 - Duty to maintain plans**	**Lockdown**	In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.	The Trust has a lockdown procedure which is reviewed regularly and updated acoordingly. A lockdown risk profile will be produced by the Local Security Management Specialist and the Health and Safety/Risk Management Team to make sure that any assessment made on the Trust's ability to lockdown is accurate and achievable in line with the security management guidance. This procedure is available on request.	Partially compliant	Copy of current arrangements requested from QEF Security	Head of Security - QEF	TBC
22	**Domain 3 - Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.		Fully compliant	Copy of current arrangements requested from QEF Security, and how this links with multi-agency arrangements	Head of Security - QEF	TBC
23	**Domain 3 - Duty to maintain plans**	**Excess death planning**	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	The Trust was involved and provided the required information to update the Northumbria LRF Mortuary capacities at present we have capacity for 90 bodies max but we can transfer to South Tyneside and Sunderland.	Fully compliant	No current further action – to review	Head of EPRR/EPRR & BC Manager	31-Aug-2021
24	**Domain 4 - Command and control**	**On-call mechanism**	A resilient and dedicated EPRR on-call mechanism is in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond to or escalate notifications to an executive level.	The Trusts single point of contact for receiving notification of an emergency or business continuity incident is designated as the Hospital Switchboard. Escalation of a notification will be to an executive level e.g. Director on Call (24/7)	Fully compliant	The trust's revised Major Incident Policy (November 2020) provides the framework of the on-call process - further work to take place to clarify roles and responsibilities of on-call and alterting processes Further work to take place as part of overall trust Incident Response Plan (including Major Incident Response) to bring all areas together including location of documents and use of Teams Channels	Head of EPRR/ EPRR & BC Manager	30-Jun-2021
25	**Domain 4 - Command and control**	**Trained on-call staff**	On-call staff are trained and competent to perform their role, and are in a position of delegated authority on behalf of the Chief Executive Officer / Clinical Commissioning Group Accountable Officer. The identified individual: • Should be trained according to the NHS England EPRR competencies (National Occupational Standards) • Can determine whether a critical, major or business continuity incident has occurred • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout.	Where an incident requires a defined management response the Trust will implement its Incident Command Centre (ICC). The ICC will operate for as long as required to deal with the incident including recovery.	Partially compliant	on call arrangement are being redefined, competence not assessed only assumed for C&C teams. Initial on-call training has taken place with further work to take place as part of overall trust Incident Response Plan (including Major Incident Response) to bring all areas together	Head of EPRR/ EPRR & BC Manager	30-Sept-2021

Ref	Domain	Standard	Expected Detail	Organisational Evidence	RAG	Action to be taken	Lead / s	Timescale
26	**Domain 5 - Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are competent in their role; training records are kept to demonstrate this.	The Trust is developing a TNA staff are attending external training sessions organised through NHSE/I as well as internal training sessions.	Partially compliant	Consideration to produce an EPRR training strategy and implement measure to ensure compliance. Further work to take place as part of overall trust Incident Response Plan (including Major Incident Response) to bring all areas together. The training and exercising will then be scoped as to what the requirements are but will be an evolving area of work	Head of EPRR/ EPRR & BC Manager	31-Aug-2021
27	**Domain 5 - Training and exercising**	**EPRR exercising and testing programme**	The organisation has an exercising and testing programme to safely test major incident, critical incident and business continuity response arrangements. Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement.	The Trust takes part in the 6 monthly communication test as organised through NEAS. Annual table top exercises take place, the Trust has taken an active role in the Pelican Exercises (1, 2 & 3) as organised by NHSE and PHE. Hot debriefs take place after each exercise and questionnaires are sent out to all participants on what went well, what didn't go so well and areas that could be improved, action plans are developed from this information to ensure continuous improvement.	Partially compliant	Exercise programme to be approved for 2021-2022; implement a formal process to record lessons learns and follow up actions via governance arrangements; Comms exercise Oct 21 to test revised EPRR MI Action Cards. Diary Live test 2021; Address issues with Internal Audit recommendations	Head of EPRR/ EPRR & BC Manager	31-Aug-2021
28	**Domain 5 - Training and exercising**	**Strategic and tactical responder training**	Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation	Records of training and attendees of Incident Management training courses are kept. On-call training has been held at a strategic, tactical and operational levels	Partially compliant	PDP process is not inclusilve of reponder training.Portfolio of evidence not maintained centrally via ESR competency. Further work to take place in conjunction of the MIP and Business Continuity review, and how recording is factored into future training and exercising through ESR. Previous training has lapsed and the PDP process is not inclusive of responder training. Portfolio of evidence not maintained centrally via ESR competency. Process to be defined and actioned. EPRR training strategy/ policy needs defined and approved	Head of EPRR/ EPRR & BC Manager	31-Mar-2022
30	**Domain 6 - Response**	**Incident Co-ordination Centre (ICC)**	The organisation has a preidentified Incident Co-ordination Centre (ICC) and alternative fall-back location(s). Both locations should be annually tested and exercised to ensure they are fit for purpose, and supported with documentation for its activation and operation.	The Trust has a dedicated Major Incident Co-ordination Centre (MICC) which has alll the required equipment inside to assist staff in their dealing with any incidents. There is also a secondary area which is used for the tactical response. Equipment is checked and tested on a monthly basis which is documented and recorded.	Fully compliant	Further work to take place as part of overall trust Incident Response Plan (including Major Incident Response) to bring all areas together	EPRR & BC Manager	30-Jun-2021
31	**Domain 6 - Response**	**Access to planning arrangements**	Version controlled, hard copies of all response arrangements are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	The Trusts Major Incident plan is located on the intranet with hard copy in the MICC copies of the relevant action cards for staff are held in the MICC in their relevant folders with electronic copies held with area leads.	Partially compliant	Review required Further work to take place as part of overall trust Incident Response Plan (including Major Incident Response) to bring all areas together including location of documents and use of Teams Channels	EPRR & BC Manager	30-Jun-2021

Ref	Domain	Standard	Expected Detail	Organisational Evidence	RAG	Action to be taken	Lead / s	Timescale
32	**Domain 6 - Response**	**Management of business continuity incidents**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Business continuity (BC) plans are in place to respond to any BC incident whether planned or unplanned, these are reviewed and updated as necessary and are based on ISO 22301.	Partially compliant	Current trust Business Continuity Strategy, Policy, Management System, Impact Assessment and reporting system to be reviewed along with engagement of staff and the development of a training and exercise programme - further work programme to follow with phased approach	EPRR & BC Manager	30-Sep-2022
33	**Domain 6 - Response**	**Loggist**	The organisation has 24 hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents. Key response staff are aware of the need for keeping their own personal records and logs to the required standards.	The Trust has access to trained loggists who were trained and are registered with PHE these will be used during business continuity incidents that effect the Trust. The trust has a pool of internally trained loggists across a range of departments and business units (training undertaken by Head of EPRR in November 2020).	Partially compliant	loggists trained by NEAS but formal arrangements needed. Formalising of coordination arrangements required to ensure access to loggists when required	Head of EPRR	30-Jun-2021
34	**Domain 6 - Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	The trust has a process for receiving, authorising, completing and submitting of SitReps these are usually filled in by the health, safety and resilience manager under the authority of the AEO . The trust has a process in place for the completion of Sit Reps that are completed by the trust Information teams and via the ICC in place with the Site Resiliene Team with the monitoring of the Covid-19 email box when additional requests are received.	Fully compliant	Further work to take place as part of overall trust Incident Response Plan (including Major Incident Response) to bring all areas together	EPRR & BC Manager	30-Jun-2021
35	**Domain 6 - Response**	**Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'**	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Copies of the EPRR framework, Major incident Plan are made available to the relevant staff. Version 2 of the guidance was published in September 2020 to be included into the new trust Major Incident Plan https://www.england.nhs.uk/wp-content/uploads/2018/12/B0128-clinical-guidelines-for-use-in-a-major-incident-v2-2020.pdf	Fully compliant	Further work to take place as part of overall trust Incident Response Plan (including Major Incident Response) to bring all areas together	EPRR & BC Manager	30-Jun-2021
36	**Domain 6 - Response**	**Access to 'CBRN incident: Clinical Management and health protection'**	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.	Guidance and training on CBRN is made available for staff with training carried out on staff away days. A version of the guidance is avilable electronically to be included into the new trust Incident Response Plan (including Major Incident Response) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/712888/Chemical_biological_radiological_and_nuclear_incidents_clinical_management_and_health_protection.pdf	Fully compliant	Further work to take place as part of overall trust Incident Response Plan (including Major Incident Response) to bring all areas together Future training and exercising required	EPRR & BC Manager	30-Jun-2021
37	**Domain 7 - Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Communication between partner organisations is identified in the Major Incident Plan, the Trust has a MAJAX email box which is specifically used during major incidents. Information and communications are shared through the various meetings (e.g. LHRP & LRF) that are attended by Trust representatives where partner organisations are also in attendance, where plans, policies and procedures can be shared and reviewed.	Fully compliant	Future review of internal comms to take place. Policy to be scoped in peace-time with an overall strategy for the trust and multi-agency	Comms & EPRR Teams	TBC

Ref	Domain	Standard	Expected Detail	Organisational Evidence	RAG	Action to be taken	Lead / s	Timescale
38	**Domain 7 - Warning and informing**	**Warning and informing**	The organisation has processes for warning and informing the public (patients, visitors and wider population) and staff during major incidents, critical incidents or business continuity incidents.	The Trust has a Media Relations policy (OP63) which is available on the intranet and deals with the distribution of information.The comms team also have a major incident action card which covers key messages,monitoring messages from news, social media etc. then decide what communications to send out to the public, partners and staff.	Partially compliant	Future review of internal, external, partners and public comms strategy to take place.	Comms & EPRR Teams	TBC
39	**Domain 7 - Warning and informing**	**Media strategy**	The organisation has a media strategy to enable rapid and structured communication with the public (patients, visitors and wider population) and staff. This includes identification of and access to a trained media spokespeople able to represent the organisation to the media at all times.	The Trust has a Media Relations policy (OP63) which is available on the intranet and deals with the distribution of information.The comms team also have a major incident action card which covers key messages,monitoring messages from news, social media etc. then decide what communications to send out to the public, partners and staff.	Partial compliant	Future review of internal comms strategyto take place. Future media training to be arranged for on-call staff Identification of the current spokespeople for the trust	Comms & EPRR Teams	TBC
40	**Domain 8 - Cooperation**	**LRHP attendance**	The Accountable Emergency Officer, or an appropriate director, attends (no less than 75% annually) Local Health Resilience Partnership (LHRP) meetings.	The LHRP for the NE has not sat during the pandemic as all members really focused on the response and in truth their time was just not available. There is a need to determine next steps re the LHRP due to the changing landscape and potential role of the statutory ICS in health and social care planning. It is envisaged that the LHRP will be resurrected linked to the risk work that needs to be completed.	Partially compliant	The trust to be included in any future discussions and resurrection of the LHRP	NHS E	TBC
41	**Domain 8 - Cooperation**	**LRF / BRF attendance**	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	The trust attends Northumbria LRF meetings intermittently, is not a current standing member and historically are represented by NHS E. The trust is an active member of the COVID response Tactical Coordination Group As part of the LRF Review, one of the recommendations is for all acute and MH Trusts to become future standing members within Northumbria and engaging participants at the Strategic Board, Tactical Business Group, standing groups and any task and finish groups	Fully compliant	The trust is to become a formal standing member of Northumbria LRF. Mapping of groups and trust representatives required to be undertaken with confirmation of engagement and co-operation with partner responders.	Head of EPRR/ EPRR & BC Manager	30-Jun-2021
42	**Domain 8 - Cooperation**	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Current NHS Mutual Aid Agreement on file is out of date and obsolete (Version 1.0 March 2011), however existing arrangements exist between trusts when mutual aid is required and requested	Fully compliant	Mutual aid exists as part of OPEL and other protocols Further work to take place as part of overall trust Incident Response Plan (including Major Incident Response) to bring all areas together including work with LRF partners	Head of EPRR/ EPRR & BC Manager	30-Jun-2021

Ref	Domain	Standard	Expected Detail	Organisational Evidence	RAG	Action to be taken	Lead / s	Timescale
46	Domain 8 - Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders, during major incidents, critical incidents or business continuity incidents.	The trust is part of the Northumbria Local Resilience Forum EPRR Information Sharing Protocol that was developed in March 2014. This is outdated and a review is currently ongoing within Northumbria LRF to bring the protocol in date with organisational changes and in line with GDPR regulations which will require internal trust consultation before final approval.	Partially compliant	Update of Northumbria Local Resilience Forum Information Sharing Protocol and internal trust consultation – ongoing	Head of EPRR/EPRR & BC Manager	30-Jun-2021
47	Domain 9 - Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the comitmement to a Business Continutiy Management System (BCMS) in alignment to the ISO standard 22301. Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement	The Trust has a Business continuity Strategy Policy which includes the statement It should be considered that whilst there is no legal requirement to adopt a standard for BCM, it is advisable to align the Trusts system to the main standards for BCM which are covered within:• ISO 22301. Standards for BCP broadly suggest that it should be a continual process whereby BCP should be embedded within the organisations business operations through a cyclical approach encompassing a range of requirements which include:1. Business impact analysis and risk assessment 2. Business continuity strategy3. Establish and implement business continuity procedures4. Exercising and testing The trusts BCP strategy will continue to follow this approach	Partially compliant	Current trust Business Continuity Strategy, Policy, Management System, Impact Assessment and reporting system to be reviewed along with engagement of staff and the development of a training and exercise programme - further work programme to follow with phased approach	EPRR & BC Manager & EPRR Team	30-Sep-2022
48	Domain 9 - Business Continuity	BCMS scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented.	The Trust has a Business Continuity Planning policy (SOP-QE-BCMO) which includes the scope, BIAs, roles and responsibilities, identification of business threats and risk assessments, KPIs and training etc.	Partially compliant	Current trust Business Continuity Strategy, Policy, Management System, Impact Assessment and reporting system to be reviewed along with engagement of staff and the development of a training and exercise programme - further work programme to follow with phased approach	EPRR & BC Manager & EPRR Team	30-Sep-2022
49	Domain 9 - Business Continuity	Business Impact Assessment	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s).	Business continuity plans are reviewed annually or when there has been a change tp processes or an incident where improvement is necessary, any risks will be put onto the Datix system and reviewed at the EPRR committee depending on their severity.	Partially compliant	Current trust Business Continuity Strategy, Policy, Management System, Impact Assessment and reporting system to be reviewed along with engagement of staff and the development of a training and exercise programme - further work programme to follow with phased approach	EPRR & BC Manager & EPRR Team	30-Sep-2022
50	Domain 9 - Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis. Statement of compliance		Partially compliant	Current trust Business Continuity Strategy, Policy, Management System, Impact Assessment and reporting system to be reviewed along with engagement of staff and the development of a training and exercise programme - further work programme to follow with phased approach	EPRR & BC Manager & EPRR Team	30-Sep-2022

Ref	Domain	Standard	Expected Detail	Organisational Evidence	RAG	Action to be taken	Lead / s	Timescale
51	**Domain 9 - Business Continuity**	**Business Continuity Plans**	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure These plans will be reviewed regularly (at a minimum annually), or following organisational change, or incidents and exercises.	A business impact analysis is carried out in the various wards, areas and departments to gather information on who or what they rely on and who or what relies on them using this information the business continuity plans are developed.	Partially compliant	Current trust Business Continuity Strategy, Policy, Management System, Impact Assessment and reporting system to be reviewed along with engagement of staff and the development of a training and exercise programme - further work programme to follow with phased approach	EPRR & BC Manager & EPRR Team	30-Sep-2022
52	**Domain 9 - Business Continuity**	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Business continuity is monitored and evaluated as part of the KPI fpr EPRR in the board report.	Partially compliant	Current trust Business Continuity Strategy, Policy, Management System, Impact Assessment and reporting system to be reviewed along with engagement of staff and the development of a training and exercise programme - further work programme to follow with phased approach	EPRR & BC Manager & EPRR Team	30-Sep-2022
53	**Domain 9 - Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board.	The BCMS is audited by "Audit One" with outcome in board report. The audit report is available on request.	Partially compliant	Current trust Business Continuity Strategy, Policy, Management System, Impact Assessment and reporting system to be reviewed along with engagement of staff and the development of a training and exercise programme - further work programme to follow with phased approach	EPRR & BC Manager & EPRR Team	30-Sep-2022
54	**Domain 9 - Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess the effectivness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	There is a Business Continuity policy and business continuity is also covered in the EPRR policy the BCMS is audited by external auditors to ensure it's effectiveness.	Partially compliant	Current trust Business Continuity Strategy, Policy, Management System, Impact Assessment and reporting system to be reviewed along with engagement of staff and the development of a training and exercise programme - further work programme to follow with phased approach	EPRR & BC Manager & EPRR Team	30-Sep-2022
55	**Domain 9 - Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	There is a Business Continuity policy and business continuity is also covered in the EPRR policy. Part of the documnetation for setting up a provider/supplier asks if they have BCPs in place. This is also being addressed by the local business continuity forum, with an action to audit provider/suppliers BCPs.	Partially compliant	Current trust Business Continuity Strategy, Policy, Management System, Impact Assessment and reporting system to be reviewed along with engagement of staff and the development of a training and exercise programme - further work programme to follow with phased approach	EPRR & BC Manager / EPRR Team and QEF Procurement	30-Sep-2022
56	**Domain 10 - CBRN**	**Telephony advice for CBRN exposure**	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents. Staff are aware of the number / process to gain access to advice through appropriate planning arrangements	Contact details for advice regarding CBRN e.g. radiation advisor are in the major Incident plan hard copies and intranet copies are available	Fully compliant	Current trust CBRN Plan and arrangements to be reviewed as part of EPRR Work Programme (previous review suggests circa Jan 2017)	EPRR Team	31-Jan-2022

Ref	Domain	Standard	Expected Detail	Organisational Evidence	RAG	Action to be taken	Lead / s	Timescale
57	**Domain 10 - CBRN**	**HAZMAT / CBRN planning arrangement**	There are documented organisation specific HAZMAT/ CBRN response arrangements.	The Trust has a CBRN Plan (SOP-QE-EPRR-08) which includes all the relevant information regarding the response to a CBRN incident, information on the type of patients we may receive and details on the type of contaminants that they may have been infected with. It also includes information on PRPS suits in regards to how staff are to put them on and their removal. Also includes instruction on Inital Operational Response and the various pieces of equipment to be used.	Partially compliant	Current trust CBRN Plan and arrangements to be reviewed as part of EPRR Work Programme (previous review suggests circa Jan 2017)	EPRR Team	31-Jan-2022
58	**Domain 10 - CBRN**	**HAZMAT / CBRN risk assessments**	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste. Impact assessment of CBRN decontamination on other key facilities	Risk assessments around CBRN decontamination are in place all hazardous waste is contained and disposed of in the correct fashion whether they be items of clothing or liquids involved in the decontamination process.	Partially compliant	Current trust CBRN Plan and arrangements to be reviewed as part of EPRR Work Programme (previous review suggests circa Jan 2017)	EPRR Team	31-Jan-2022
59	**Domain 10 - CBRN**	**Decontamination capability availability 24 /7**	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week. Rotas of appropriately trained staff availability 24 /7	All staff within the A&E department which is where patients would first attend are trained in CBRN decontamination techniques. Estates staff are trained in the erection of the CBRN decontamination tent should it be required.	Partially compliant	Current trust CBRN Plan and arrangements to be reviewed as part of EPRR Work Programme (previous review suggests circa Jan 2017)	EPRR Team	31-Jan-2022
60	**Domain 10 - CBRN**	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/ourwork/eprr/hm/ • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ Completed equipment inventories; including completion date	The Trust has 12 PRPS suits which is the required minimum number these are included in a monthly check by the medical devices team to ensure they are in date and services are carrried out as and when required. We have supplies of paper towels, Ramgene monitors, FFP3 masks, paper boiler suits but also:A UK Reserve National Stock is established for rapid deployment in major incidents, including mass casualty situations. Each Pod is for the needs of 100 people with a 24hour-7 day-a-week response capability. Deployment of all Pods will be the responsibility of North East Ambulance Service.• The equipment Pods are managed by ambulance services.• The modesty Pods are managed by ambulance services.• The Nerve Agent Antidote Pods are managed through Blood Services, but accessed via ambulance services.• The Biological Pods can be mobilised by Directors of Public Health and Consultants in Public Health Medicine, but accessed via the ambulance services	Partially compliant	Current trust CBRN Plan and arrangements to be reviewed as part of EPRR Work Programme (previous review suggests circa Jan 2017)	EPRR Team	31-Jan-2022

Ref	Domain	Standard	Expected Detail	Organisational Evidence	RAG	Action to be taken	Lead / s	Timescale
61	**Domain 10 - CBRN**	**PRPS availability**	The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment. There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date. Completed equipment inventories; including completion date	The Trust has 12 PRPS suits which is the required minimum number these are included in a monthly check by the medical devices team to ensure they are in date and services are carrried out as and when required. As at 15 March 2021, 9 additional suits have been allocated to Queen Elizabeth Hospital, from NHS E via the National Ambulance Resilience Unit (NARU) which will bring levels up to the minimum holding of 24 PRPS suits. The trust also has 13 suits with an EOL of 2023, further national analysis of demand will be undertaken to see if it will be possible to also replace these suits, along with the current trust own stock (2) allocation. Old suits will be retained for training purposes.	Fully compliant	Current trust CBRN Plan and arrangements to be reviewed as part of EPRR Work Programme (previous review suggests circa Jan 2017)	EPRR Team	31-Jan-2022
62	**Domain 10 - CBRN**	**Equipment checks**	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks Record of equipment checks, including date completed and by whom.	The CBRN tent is erected on a 6 monthly basis to ensure it is still in a usable condition this includes the shower facility and pumps. There are 2 gazebos which would be used as a disrobing area for privacy and dignity. The RAMGENE monitors are checked on a monthly rota to ensure they are calibrated and the batteries are charged. PRPS suits are included in a monthly check by the medical devices team to ensure they are in date and services are carrried out as and when required.	Fully compliant	The CBRN tent is approximately 15 years old and is on the trust Corporate Risk Register. A future business option appraisal is to be scoped for presentation at SMT to review arrangements to consider a permanent option; or replacement of the tent	EPRR & BC Manager with QEF Colleagues Andy Colwell and Tony Pratt	31-Aug-2021
63	**Domain 10 - CBRN**	**Equipment Preventative Programme of Maintenance**	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment Completed PPM, including date completed, and by whom	The CBRN tent is erected on a 6 monthly basis to ensure it is still in a usable condition this includes the shower facility and pumps. There are 2 gazebos which would be used as a disrobing area for privacy and dignity. The RAMGENE monitors are checked on a monthly rota to ensure they are calibrated and the batteries are charged.	Fully compliant	The CBRN tent is approximately 15 years old and is on the trust Corporate Risk Register. A future business option appraisal is to be scoped for presentation at EPRR Committee and SMT to review arrangements to consider a permanent option; or replacement of the tent	EPRR & BC Manager with Head of Facilities and Estates from QEF	31-Sept-2021
64	**Domain 10 - CBRN**	**PPE disposal arrangements**	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance. Organisational policy	We have agreed disposal of PRPS suits by means of giving to our partners in the police for training Respirex have been made aware. Other PPE when used is disposed of as described in our CBRN Plan.	Fully compliant	Current trust CBRN Plan and arrangements to be reviewed as part of EPRR Work Programme (previous review suggests circa Jan 2017)	EPRR Team	31-Jan-2022
65	**Domain 10 - CBRN**	**HAZMAT / CBRN training lead**	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training Maintenance of CPD records	The CBRN trainer was trained by NEAS in decontamination reponse and control methods.	Partially compliant	Arrangements to be reviewed - the EPRR & BC Manager is to attend future CBRN training from NEAS	EPRR & BC Manager	30-Jun-2021
66	**Domain 10 - CBRN**	**Training programme**	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programmes should include training for PPE and decontamination.	Staff are trained in CBRN including IOR on the staff away days with records of attendess held, this includes reception staff who have been made aware of the need to isolate patients who may be attending follwing a CBRN incident.	Fully compliant	Current trust CBRN Plan and arrangements to be reviewed as part of EPRR Work Programme (previous review suggests circa Jan 2017)	EPRR Team	31-Dec-2021
67	**Domain 10 - CBRN**	**HAZMAT / CBRN trained trainers**	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	The Trust has 2 members of staff that carry out the CBRN training	Partially compliant	Arrangements to be reviewed - the EPRR & BC Manager is to attend future CBRN training from NEAS	EPRR & BC Manager	31-Jul-2021

Ref	Domain	Standard	Expected Detail	Organisational Evidence	RAG	Action to be taken	Lead / s	Timescale
68	Domain 10 - CBRN	Staff training - decontamination	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Staff are trained in CBRN including IOR on the staff away days with records of attendess held, this includes reception staff who have been made aware of the need to isolate patients who may be attending follwing a CBRN incident.	Partially compliant	Current trust CBRN Plan and arrangements to be reviewed as part of EPRR Work Programme (previous review suggests circa Jan 2017)	EPRR Team	31-Jan-2022
69	Domain 10 - CBRN	FFP3 access	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.	FFP3 masks are made available for any staff that require them and fit tests are carried out.	Fully compliant	Current trust CBRN Plan and arrangements to be reviewed as part of EPRR Work Programme (previous review suggests circa Jan 2017)	EPRR Team	31-Jan-2022

Gateshead Health
NHS Foundation Trust

Report Cover Sheet

Agenda Item: 19

Purpose of Report	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐	
Report Title:	**GP Practices – Emergency Contract Award – Update Paper**				
Name of Meeting:	**Trust Board**				
Date of Meeting:	**31st March 2021**				
Author	**Peter Harding Commercial Director**				
Executive Lead	**Peter Harding Commercial Director**				
Report presented by	**Peter Harding Commercial Director**				
Executive Summary	3 month update on the Outer West GP contracts including a summary of key next steps.				
Recommended actions for Board/Committee)	To receive the report for assurance.				
Trust Aims that the report relates to: (Including reference to any specific risk)	**Aim 1** ☒	We will provide consistently high quality care in all our services			
	Aim 2 ☒	We will be a great organisation to work in			
	Aim 3 ☒	We will deliver value for money and strengthen delivery of our clinical services			
	Aim 4 ☒	We will work with our partners to help make Gateshead a place where everyone thrives			
	Aim 5 ☒	We will use our expertise to provide specialist services beyond Gateshead			
Financial Implications:	None				
Links to Risks (identify significant risks and DATIX reference)	None				
People and OD Implications:	None				
Links to CQC KLOE	Caring ☐	Responsive ☐	Well-led ☐	Effective ☐	Safe ☐
Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)	**Obj.1** ☒	The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance between working life and			

		personal commitments
	Obj. 2 ☒	All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers
	Obj. 3 ☒	Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve

GP Practices – Emergency Contract Award – Update Paper

1. Background

The board will recall that late in 2020 the trust was approached by Newcastle Gateshead CCG to take over the contracts to run four general practices in the outer west of the borough. The contracts were previously held by CBC Medicus Practice Division of CBC Health Ltd.

Accordingly four 12 month emergency contracts were agreed and commenced on 1st January 2021. The four contracts comprise

Practice Name	List Size (as at September 2020)	Property Owner
Rowlands Gill	6164	Private Landlord
Crawcrook Medical Practice	6870	PFI
Grange Road Medical Practice	3959	NHS Property Services
Blaydon	2687	NHS Property Services

The CCG are proposing to tender these GP services before the end of our current 12 month contract. The trust board have previously indicated that we should not simply hold these contracts in a caretaker role but should run and develop these services in the long term.

Given that the trust did not have sufficient time to undertake a full due diligence exercise on these contracts and therefore could not be exposed to any financial risk, certain assurances were secured from the CCG in order to mitigate these risks. Further due diligence is currently being undertaken so the trust is well informed in order to bid for these services at the tender stage.

2. The Staff

A total of 58 staff were successfully TUPE transferred into the trust on 1st January 2021. Having visited all four practices and talked to many staff there has been a very positive response to the trust taking over the contracts. Dr Loren Blisset has been appointed as GP Clinical Lead which was a post that had not been filled by CBC for some time and Anne Grieve was persuaded to remain as Practice Manager and TUPE transfer to the trust. These are excellent appointments and have been essential to ensure the smooth transfer of the contracts to the trust and for the future development of the services. In addition a number of other key appointments have been made and we are confident that by the summer of this year we will have recruited up to our full complement of GP's. This is particularly good news as these practices have had to rely heavily on GP locum cover in the past.

It has also been noticeable that the salaried GP's and other staff are more engaged in the management of services and looking at new ways of working. This has included looking at the appointment of Practitioner Associates and recruiting trainee pharmacists through the Primary care Education pathway scheme. Gill Betts one of the Nurse Practitioners has also stepped forward to take on the Digital Lead role for the practices.

3. The Services

The last year has been equally challenging for General Practice as a result of the Covid-19 pandemic. Similar issues such as social distancing and staff absence have put significant

strains on the delivery of services. As a consequence the Grange Road Ryton practice relocated and integrated into the Crawcrook practice. The premises was closed much of last year but has now reopened.

More recently there has been further strain put onto the staff as a result of the tremendous effort to contribute to the covid vaccination programme for patients and staff. This is predominately being delivered through the Blaydon vaccination hub through a co-ordinated effort by both the inner and outer west Primary Care Networks. This has been a fantastic achievement in delivering the first vaccination jabs to cohorts 1-9 with plans to complete the 2nd vaccination jabs by June. However this has put significant strains on staff resources and as a consequence has impacted on the delivery of other services. There is a requirement for practices to restart the Quality and Outcomes Framework (QOF) services along with other services by 1st April so the PCN's and the CCG are currently looking at different models to deliver the vaccines for cohorts 10 onwards including the use of mass vaccination sites.

4. Outer West Primary Care Network (OWPCN)

There are a total of 8 practices within the OWPCN and four being run by the trust. Under the recent white paper strong place-based partnerships will be a key component of the future health and care landscape. Accordingly it is clear that the emerging PCNs will play an increasing role in commissioning, coordinating and delivering services. PCN's have been funded to set up local management arrangements and we anticipate a significant increase in funding allocated to PCNs. We are now well represented at our local OWPCN where we are working on a range of PCN funded initiatives such as additional cervical screening sessions, Learning Disabilities Health Checks and digital development projects.

PCNs are also currently being consulted on their inclusion into the Alliance Agreement for Gateshead Cares and in what form of membership this should take whether full, associate or affiliate membership.

5. Next Steps

As stated it is important that work continues to complete the due diligence exercise to inform the tender for these services later in the year and also to develop a clear plan to develop and improve these services going forward. This will also enhance our tender submission.

The following is a brief summary of the work currently being undertaken:-

a) There are a few issues that remain from the transfer of service that are being finalised. These are of a minor nature and covered in either the contracts with the CCG or the Business Transfer Agreement with CBC
b) The trust finance department are working on the production of trading accounts so we can assess the financial sustainability of the practices going forward.
c) We are reviewing the various funding streams available to the practices so we maximise income received
d) None of the four practices have lease agreements in place however agreements have been made with all landlords to ensure continued occupation for this initial 12 month period. Occupation will need to be formalised beyond this time.

e) Consideration is being given to the establishment of a wholly owned subsidiary of the trust to manage these services. It is proposed to submit a separate paper to the board in April setting out the a range of options and an assessment of each option
f) It is proposed that the GP Clinical Lead is invited to present to the trust board on the services provided on a 6 monthly basis.
g) Most importantly work is underway on the development of an interim service strategy which will not only bring together all of the above work but provide a clear direction for these practices which will be essential in informing the trusts tender submission. The key areas of the service strategy will cover

    a. Financial sustainability
    b. Health Needs assessment including demographics
    c. Review of services provided and achievement of performance targets
    d. Property evaluation including backlog maintenance liabilities
    e. HR including staffing and skill mix
    f. OD & Training
    g. CQC compliance and service quality assessment
    h. Digital developments
    i. Horizon scanning for primary care
    j. Compatibility with emerging PCN strategy
    k. Stakeholder input and consultation plan

Finally it would be helpful if the four practices were given a collective name as the previous name of the Medicus Practices is still being referred to in various forums. Following discussion with the staff from the practices and views sought from the executive team the name 'QE General Practice' has emerged as the preferred name. The board's views would be helpful.

6. Recommendations

The board is asked to note the progress made to date

Peter Harding
Commercial Director