MEETING OF THE BOARD OF DIRECTORS IN PUBLIC

Gateshead Health NHS Foundation Trust

Date: Wednesday 24th November 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 and receive the Declarations of Interest from Maggie Pavlou. *Check – Attendees to declare any potential conflict of items listed on the agenda to the Company Secretary on receipt of agenda, prior to the meeting*	Declaration	Enclosure 2
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 28 September 2021** To be agreed as an accurate record	Agree	Enclosure 4
5.	09:40 am	**Matters Arising/Action Log**	Update	Enclosure 5
6.	09:45 am	**Patient & Staff Story** To receive a presentation from: • AW staff story and Citizen's Advice Bureau	Assurance	Enclosure 6
		ITEMS FOR DECISION		
7.	10:05 am	**Board Committee Terms of Reference** To approve the Terms of Reference from the Company Secretary: • Finance and Performance Committee • Quality Governance Committee • People and OD Committee	Approval	Enclosure 7
		ITEMS FOR ASSURANCE		
8.	10:15 am	**Assurance from Board Committees** i. Finance and Performance Committee – 27th September & 26th October 2021 ii. Quality Governance Committee – 21st September & 20th October 2021 iii. Digital Committee – 18th October 2021 iv. POD Committee – 9th November 2021	Assurance	Enclosure 8
9.	10:35 am	**Chief Executive's Update Report** To receive a briefing report from the Acting Chief Executive	Assurance	Presentation
10.	10:50 am	**Governance Reports** i. **Organisational Risk Register** To receive the report presented by the Chief Nurse	Assurance	Enclosure 10
11.	11:00 am	**Quality Accounts Priorities – 6 month update** To receive an update report, presented by the Chief Nurse	Assurance	Enclosure 11

12.	11:10 am	**COVID Update** To receive an update, presented by the Medical Director	Assurance	Verbal
13.	11:20 am	**Finance Update** To receive the report, presented by the Group Director of Finance	Assurance	Enclosure 13
14.	11:30 am	**Integrated Oversight Report** To receive the report, presented by the Chief Operating Officer	Assurance	Enclosure 14
15.	11:45 am	**Nurse Staffing Exception Report** To receive the routine report presented by the Chief Nurse	Assurance	Enclosure 15
16.	11:50 am	**QE Facilities 6 Monthly Update Report** To receive a briefing report from the QEF Managing Director	Assurance	Enclosure 16
		ITEMS FOR INFORMATION		
17.	12:05 pm	**Cycle of Business** To receive the cycle of business outlining forthcoming items for consideration by the Board, presented by the Company Secretary	Information	Enclosure 17
18.	12:10 pm	**Questions from Governors in Attendance** To receive any questions from governors in attendance		Verbal
19.	12:25 pm	**Date and Time of the next Meeting** The next scheduled meeting of the Board of Directors to be held in public will be 26th January 2022 at 9:30 am		Verbal
20.	12:25 pm	**Chair Declares the Meeting Closed**		Verbal
21.	12:25 pm	**Exclusion of the Press and Public** To resolve to exclude the press and public from the remainder of the meeting, due to the confidential nature of the business to be discussed		Verbal

Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 2

Report Title:	**Declaration of Interests – Maggie Pavlou**			
Name of Meeting:	Board of Directors – Part 1			
Date of Meeting:	24 November 2021			
Author:	Jennifer Boyle, Company Secretary			
Executive Sponsor:	Jacqueline Bilcliff, Acting Chief Executive			
Report presented by:	Jennifer Boyle, Company Secretary			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☒	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☐
	To approve the inclusion of Maggie Pavlou's interests on the Board's register of interests. To be assured that the self-declaration in respect of fit and proper persons has been completed in accordance with the Trust's policy.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☒ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	-			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	• Maggie Pavlou, Non-Executive Director, joined the Board of Directors on 1 October 2021. • Assurance can be provided that Maggie Pavlou completed both the declaration of interests and fit and proper persons declaration on 26 August 2021 prior to commencing in post. • Declared interests are not deemed to be a direct conflict with Maggie Pavlou's NHS position and she confirmed compliance and understanding of the fit and proper person requirements.			
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Board is requested to: • Approve the inclusion of Maggie Pavlou's return in the Board's register of interests; and • Be assured that the self-declaration in respect of fit and proper persons has been completed in accordance with the Trust's policy.			

Trust Strategic Aims that the report relates to:	**Aim 1** ☒	We will continuously improve the quality and safety of our services for our patients			
	Aim 2 ☒	We will be a great organisation with a highly engaged workforce			
	Aim 3 ☐	We will enhance our productivity and efficiency to make the best use of resources			
	Aim 4 ☐	We will be an effective partner and be ambitious in our commitment to improving health outcomes			
	Aim 5 ☐	We will develop and expand our services within and beyond Gateshead			
Trust corporate objectives that the report relates to:	No specific linkages to a corporate objective				
Links to CQC KLOE	Caring ☐	Responsive ☐	Well-led ☒	Effective ☐	Safe ☐
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks and DATIX reference)	No risks identified from the declaration.				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

Declaration of Interests – Maggie Pavlou

1. Executive Summary

1.1. Declaring of interests and fit and proper person compliance are core requirements for all Board roles.

1.2. Maggie Pavlou joined the Trust as a Non-Executive Director on 1 October 2021 and completed both declarations in advance of this date.

1.3. Whilst interests were declared, they are not deemed to present a perceived or actual conflict with Maggie Pavlou's Board position.

1.4. Assurance can therefore be provided that appropriate declarations have been made and do not result in any identified risks for the Trust.

1.5. The Board is requested to approve the inclusion of Maggie Pavlou's interests in the Board's register of interests.

2. Introduction

2.1. In accordance with regulatory requirements and the Trust's own Constitution and Standing Orders, the Trust is required to maintain a register of interests for its Board of Directors. All new Board Members are required to declare their interests on appointment, with the declaration being formally presented to the Board of Directors for approval and incorporation into the register. This is governed locally through the Trust's Conflicts of Interest policy.

2.2. All new Board Members are also required to make a fit and proper person self-declaration on appointment. This is in accordance with Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Trust's own Fit and Proper Person Test policy.

2.3. Maggie Pavlou, Non-Executive Director, joined the Board of Directors on 1 October 2021. This paper outlines the outcome of the declaration of interests and fit and proper person self-declaration process.

3. Key issues / findings

3.1. Assurance can be provided that Maggie Pavlou completed both the declaration of interests and fit and proper person declaration on 26 August 2021 prior to commencing in post.

3.2. Maggie Pavlou declared a number of interests for inclusion in the Board's register of interest, as outlined below:

	A Maggie Pavlou
Directorships, including Non-Executive Directorships held in private companies or PLCs (with the exception of dormant companies)	**PEOPLE GAUGE PLC**
Ownership, or part ownership, of private Companies, businesses or consultancies likely or possibly seeking to do business with the NHS	**NONE**
Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	NONE
A position of authority in a charity or voluntary body in the field of health and social care	1. Vice Chair – Age UK County Durham 2. Trustee – Chronicle Sunshine Fund 3. Trustee – The People's Kitchen
Any connection with a voluntary or other body contracting for NHS services	NONE
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	NONE

3.3. None of the declared interests are deemed to present an actual or perceived conflict with Maggie Pavlou's role as a Non-Executive Director at the Trust.

3.4. In addition, no issues have been identified in respect of fit and proper person compliance and the self-declaration has been completed.

4. Solutions / recommendations

4.1. The Board is requested to:

- Approve the inclusion of Maggie Pavlou's return in the Board's register of interests; and
- Be assured that the self-declaration in respect of fit and proper persons has been completed in accordance with the Trust's policy.

Trust Board

Minutes of a meeting of the Board of Directors held at 9.30 am on Tuesday 28th September 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	Acting Chief Executive
Dr R Bonnington	Non-Executive Director
Mrs L Crichton-Jones	Director of People & OD
Mrs G Findley	Chief Nurse
Mrs K Mackenzie	Acting Group Director of Finance
Mr A Moffat	Non-Executive Director
Mr A Robson	Managing Director QEF
Mr M Robson	Vice Chair/Non-Executive Director
Dr M Sani	Associate Non-Executive Director (NExT Placement)
Mr D Shilton	Non-Executive Director
Mrs A Stabler	Non-Executive Director
In Attendance:	
Miss J Boyle	Company Secretary
Mr N Black	Chief Digital Information Officer
Ms D Waites	Corporate Services Assistant
Governors and Members of the Public:	
Mrs E Adams	Public Governor - Central
Mr L Brown	Public Governor - Western
Mrs J Coleman	Staff Governor
Mr S Connolly	Staff Governor
Mr A Dougall	Public Governor - Eastern
Reverend J Gill	Public Governor – Western
Mr G Riddell	Public Governor - Western
Mr C Toon	Appointed Governor
	No members of the public
Apologies:	
Cllr M Gannon	Non-Executive Director
Mrs Y Ormston	Chief Executive
Mrs H Parker	Non-Executive Director

Agenda Item	Discussion and Action Points	Action By
21/150	**CHAIR'S BUSINESS:** The meeting being quorate, Mrs A Marshall, Chair, declared the meeting open at 9.30 am and confirmed that the meeting had been convened in accordance with the Trust's Constitution and Standing Orders.	

Agenda Item	Discussion and Action Points	Action By
	She welcomed Mrs Gillian Findley to her first official meeting following her recent appointment as Chief Nurse. She also welcomed the Trust's Governors.	
21/151	**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. Mrs Marshall also presented the Declaration of Board Members' Interests and the Fit and Proper Persons Declaration for Mrs Gillian Findley, Chief Nurse, who joined the Board on 16th August 2021, for inclusion into the Board's register of interests. Assurance can be provided that Mrs Findley completed both the declaration of interests and fit and proper person declaration on 26th July 2021 prior to commencing in post. No interests have been declared and Mrs Findley confirmed compliance and understanding of the fit and proper person requirements. It was therefore: **RESOLVED:** i) to approve the inclusion of Gillian Findley's nil return in the Board's register of interests. ii) to be assured that the self-declaration in respect of fit and proper persons has been completed in accordance with the Trust's policy.	
21/152	**APOLOGIES FOR ABSENCE:** Apologies were received from Cllr M Gannon, Mrs Y Ormston and Mrs H Parker.	
21/153	**MINUTES OF THE PREVIOUS MEETING:** The minutes of the meeting of the Board of Directors held on Wednesday 28th July 2021 were approved as a correct record.	
21/154	**MATTERS ARISING FROM THE MINUTES:** The Board Action Plan was updated accordingly to reflect matters arising from the minutes.	

Agenda Item	Discussion and Action Points	Action By
21/155	**PATIENT & STAFF STORY:** Miss J Boyle, Company Secretary, presented a letter which was received from the family of a patient who recently sadly passed away on Ward 11. The letter and report demonstrates the impact colleagues on the ward had on both the patient and his family. Miss Boyle highlighted that feedback has been shared with Ward 11 and the Board expressed their sincere thanks to the family of the patient for sharing their experience. Following a query from Mrs L Crichton-Jones, Executive Director of People & OD, a process will be looked at to link these stories to the monthly recognition programme for staff.	JenB
21/156	**STANDING FINANCIAL INSTRUCTIONS (SFIs) AND DELEGATION OF POWERS:** Miss J Boyle, Company Secretary, informed the Board that the Trust's Finance team have proposed an amendment to the Standing Financial Instructions and Scheme of Delegation to reflect new legislation which replaces Schedule 1 of the Public Contracts Regulations 2015 with Schedule 1 of the Public Procurement Amendment Regulations 2021. She explained that NHS Foundation Trusts now fall within the definition of Central Government Authorities and are required to apply a lower financial threshold to the procurement of services and supplies. From 16 August 2021 the legal threshold reduced from £189,330 to £122,976. Miss Boyle highlighted that the Audit Committee reviewed the proposed amendments at its meeting on 2nd September 2021 and recommend them to the Board of Directors. She noted that there was a slight error in the report however and this will be amended within the final document. After consideration, it was: **RESOLVED:** to approve the proposed amendments, being mindful of the recommendation of the Audit Committee.	
21/158	**CALENDAR OF BOARD MEETINGS:** Miss J Boyle, Company Secretary, informed the Board of the planned Board meeting dates for Quarter 4 2021/22 and 2022/23. She reported that during 2022/23, the Board of Directors will hold 9	

Agenda Item	Discussion and Action Points	Action By
	public meetings including the Annual General Meeting and will ensure the dates are publicised. Following consideration, it was: **RESOLVED:** to approve and receive the dates of the Board of Directors' meetings to be held in 2022/23	
21/159	**DRAFT WINTER PLAN 2021/22 ASSURANCE REPORT:** Mrs J Baxter, Chief Operating Officer, presented the draft Winter Plan 2021/22 Assurance Report. She highlighted that the Trust has been through a period of change and has been faced with many challenges recently in responding to re-occurring waves of Covid, therefore planning for the challenges of Winter are an ongoing and dynamic process and this plan will evolve to meet those demands. The document sets out investment and actions to be taken to strengthen the position going into Winter including maintaining a robust elective recovery programme. Mrs Baxter reminded the Board of the recent discussions and learning around the new Operating Model and how this will support the plan. The Trust has co-operated and collaborated with system partners via the Regional Chief Operating Officer Group, Urgent & Emergency Care Network, the Integrated Care System (ICS), Integrated Care Partnership (ICP) and the Gateshead Cares System. The plan is also due to be submitted to NHS England within the specified timescales. Mrs A Stabler, Non-Executive Director, expressed her thanks to the teams in producing the comprehensive report and providing the Board with assurance that plans are in place. She queried whether there was any improvement feedback available following the implementation of the Same Day Emergency Care programme, and Mrs Baxter reported that this is working well however due to this being in the early stages, a position report will be provided to the Board at the next meeting. There are also plans for the Executive Team to undertake "back to the floor" visits every month and feedback around this has been beneficial so far. Following a query from Mrs Marshall, regarding whether consideration on a further predicted peak had been included in modelling work, Mrs Baxter reported that the current focus has been on front of house and discharge facilitation however there is the potential to open more wards although the teams recognise the risks around staffing. Mrs L Crichton-Jones, Executive Director for People & OD, reminded the Board of the commitment to continue with staff	JMB

Agenda Item	Discussion and Action Points	Action By
	health and well-being programmes. After further discussion, it was: **RESOLVED:** to approve the Winter Plan and provide assurance to support the work of the Trust during the Winter period 2021-22.	
21/160	**ASSURANCE REPORTS FROM BOARD COMMITTEES** The Board Committee Chairs provided updates from the assurance reports as follows: **Finance & Performance Committee** Mr M Robson provided the assurance report for the Committee meetings held on 25th August 2021 and 27th September 2021 (verbal). There were no matters for escalation however he highlighted the following key points: • Financial Revenue Report – the Trust remains in a surplus position although H2 plans are not yet issued and therefore it is difficult to forecast plans and constraints for rest of year. • Integrated Oversight Report – a comprehensive update was received which highlights the impact of Covid and bed availability. • Echocardiology Performance Update – a detailed report was received including the length of waiting lists for less urgent cases. The Committee has requested further updates to be provided. • Teesside Oncology Service – the Trust is assisting with recovery work however the impact on local services is noted. • Lack of planning guidance for performance remains area of concern. • Supply Procurement Committee update received for assurance on processes. • Board Assurance Framework (BAF) updated based on points raised in the meeting. **Audit Committee** Mr A Moffat provided the assurance report for the Committee meeting held on 2nd September 2021. There were no matters for escalation however he highlighted the following key points: • Assurance was received over Freedom To Speak Up (FTSU) plans. Regular meetings are now taking place with Board sponsors and reports are being received at Board. • Audit Committee meeting dates for 2022/23 received and approved.	

Agenda Item	Discussion and Action Points	Action By
	• Losses and Special Payments report received with no significant issues. • Risk Management Policy was presented for ratification – the Committee acknowledged the work which has been completed. Positive assurance was received and reflected in the policy. The development of the Risk Management Strategy was noted. • Counter Fraud update and Annual Report received. • Audit One Internal Audit Report received. Two audits were finalised in the period - Data Security and Protection (DSP) Toolkit and Medical Devices Training with moderate assurance provided. • The Committee approved the inclusion of four Technology Risk and Assurance (TRA) audits into the plan. • Executive Risk Management Group Report – regular reports now to be received regarding the work of this new group. • Proposed change to the Standing Financial Instructions and Scheme of Delegation approved as previously presented. **Quality Governance Committee** Mr D Shilton and Mrs A Stabler provided the assurance report for the Committee meetings held on 21st July 2021 and 21st September 2021 (verbal). Mr Shilton highlighted that a verbal update from the July meeting was given at the last meeting and noted that the August meeting was stood down due to operational pressure. Mrs Stabler reported that there were no matters for escalation from the September meeting however highlighted the following key points: • Integrated Oversight Report - partial assurance provided and further work requested in relation to Duty of Candour training. A further update report is to be provided in January 2022. • Infection Prevent and Control (IPC) BAF – this is now presented to the IPC Committee therefore it was agreed that this will only be received if there are any matters for escalation. • Maternity Assurance Report – it was recognised that the business case has been completed and further updates are to be provided as this progresses. • Learning from Deaths Report (also on the Board agenda) – partial assurance was provided. Further work was requested in relation to non-compliance for Do Not Resuscitate (DNR) orders for learning disabilities however there is recognition that this is a national issue, and further work was requested regarding fluid balance charts. Mr A Beeby, Medical Director, provided assurance that this was being addressed and Task and Finish Groups have been set up. Further reports will be received in January 2022. • Safe Staffing Report – partial assurance received overall due to current workforce gaps and staffing levels.	

Agenda Item	Discussion and Action Points	Action By
	• CQC Action Plan update – this will now report to the SafeCare Committee and will only be received at Quality Governance Committee if there are any matters for escalation. • CQC Mental Health update – there remain ongoing estates issues due to a delay in building materials. The Cragside opening is due to take place October/November 2021. Workforce gaps are recognised with further work to be completed. • Serious Incidents (SI) 6 monthly report – good assurance was received that SI panels continued during the pandemic with the additional of the Medical Examiner role. Partial assurance was provided regarding SI learning due to the 60 day reporting target being missed due to pressures resulting from Covid, however this was stood down by NHS England and Improvement (NHSE/I). • Picker Urgent and Emergency Care Survey – staff were commended following the excellent report. The Trust ranked as the top hospital across region. • External Review Report – this was received for assurance. This will be reviewed formally by the HR Committee and any issues to be escalated. • Waiting List Data – full level of assurance was provided that validation processes are in place. With regards to patient harm the Committee was assured that any trends will be escalated via DATIX and incident reporting mechanisms. • Medicine Quarterly Report – this was received for assurance • Health & Safety Quarterly Report – limited assurance was provided due to gaps in assurance. Further details will be included in the next report. • 3 Annual Reports received with full assurance regarding Research & Development, Palliative Care, and IPC. Mr M Robson, Vice Chair, queried whether the Picker Urgent and Emergency Care Survey covered the start of the pandemic and Mrs Stabler confirmed that the report was published in September 2021. The Board agreed that this was a positive achievement due to the pressures and demonstrated a good A&E patient experience. **Digital Committee** Mr A Moffat provided the assurance report for the Committee meeting held on 16th August 2021. He highlighted that the report states one matter for escalation however reported that the Trust has now met the compliance level for Information Governance training. The following key points were also discussed: • Trust Strategic Aims and Objectives – alignment work has been completed. Partial assurance was provided due to the need to formulate a plan regarding the migration of Windip. Concerns	

Agenda Item	Discussion and Action Points	Action By
	were raised regarding pressures on resources however a prioritisation process was being undertaken. Any expected slippage would be duly reported. • Digital KPIs – the Committee is keen to get the KPIs in place and reviewed therefore requires focus to ensure actions are taken. • Audit report regarding Data Protection Toolkit – this was also discussed at Audit Committee. A self-assessment methodology would be undertaken. Clinical Systems Management was marked reasonable and Nervecentre assurance was deemed to be good. • Risks were reviewed both from an operational and portfolio perspective with no items for escalation. Mrs J Bilcliff, Acting Chief Executive, highlighted the challenging programme of work due to national pressures. A Digital update will be provided later in the meeting. **HR Committee** Dr R Bonnington provided the assurance report for the Committee meeting held on 14th September 2021. There were no items for escalation however highlighted the following key points: • People and Organisational Development (POD) Portfolio Board report – 6 programmes of work were identified and key areas of focus included the Delivering Excellence in People Practices restructure and responding to wave 4 Covid pressures. • People Plan Operational Guidance – there are 13 priorities with 5 achieved, 7 on track and 1 where this is still work to do around workforce planning across the Trust. • Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) – updates would be provided later in the meeting regarding ongoing work. • Gender Pay Gap Reporting – full assurance was provided and this will be further developed via the Women's Network. • Integrated Oversight Report (IOR) POD metrics – a lot of work has been completed however plans are still being developed and there are challenges around recovery plans for core skills and appraisals. • A POD service review has been commissioned around Learning & Development. • Higher levels of turnover in Surgery and Medicine Business Units are to be reviewed and a deep dive will be undertaken to better understand this. • Health and Well Being Staff Report – a lot of work is being undertaken in this area. A Health and Well Being Board is being set up. • Strategic Workforce Planning – we are working with partners	

Agenda Item	Discussion and Action Points	Action By
	and meeting to discuss priorities to take place end of September 2021. A Task and Finish Group has been established to review nursing supply. • People Quality and Performance and Governance – a review has been commissioned to look at this in further detail. • POD Service Review Outcomes – the recruitment team have undertaken an audit and level of risk reduced. • Guardian of Safe Working Annual Report received with full assurance provided. • Medical Appraisal Revalidation Report received with full assurance that work will be completed. • People & OD Risk Register received and noted that current controls will be updated for the next meeting. Dr R Bonnington reported that it has been agreed to rename the Committee to the People and OD Committee going forward. Mrs Marshall thanked the Committee Chairs for their reports and felt that these set the scene for the Board for the rest of meeting. After consideration, it was: **RESOLVED:** to receive the reports for assurance	
21/161	**ACTING CHIEF EXECUTIVE'S UPDATE REPORT**: Mrs J Bilcliff, Acting Chief Executive, gave a verbal update to the Board and reported that slides are available to view on Convene. There are three main areas to highlight, including pressures and performance, engagement, and external and partnerships. **Pressures and Performance:** • Covid – case volume remains at a steady level however is still causing significant pressures • Urgent and Emergency Care – unprecedented pressures are being experienced across the local system. Meetings are taking place with local Chief Executives and Chief Operating Officers to understand this further. Capacity issues are contributing to pressures as well as staffing, IPC guidance and ambulance handovers. • Winter Planning – Chief Executives' weekly meetings are taking place to gain regional views, with capacity identified as a key risk. The Trust remains supportive of the new Operational Model and moves have already taken place in relation to Same Day Emergency Care. • Covid booster and flu vaccination programme – both are now up and running smoothly.	

Agenda Item	Discussion and Action Points	Action By
	• Planning Guidance (H2) – this is not yet available however there is an expected focus on elective recovery and long waiters. This is currently a priority with current Covid levels being stable. Regular discussions are taking place with Amanda Pritchard, NHSE/I Chief Executive, around plans to eradicate long waiters by the end of March 2022. Mrs L Crichton- Jones, Executive Director for People & OD, also raised further potential pressures in relation to the recent recommendations around mandated vaccines for care home staff. She highlighted that teams are working to refocus on community services. Mrs J Baxter, Chief Operating Officer, also described the pressures around the availability of care packages and subsequent challenges on patient flow and discharge. **Engagement:** • Star Awards – this event was well received with 11k social media views. The Board recorded its thanks to all involved and staff have asked if future events can also be filmed due to accessibility. • Great North Run - Debbie Southworth was picked as starter, which was a fantastic accolade. • Strategy – work is being undertaken around Trust vision and will be discussed later in the meeting. • NHS Providers – Mrs Bilcliff and Mrs Marshall are meeting regularly and recent discussions have included capital and Equality Diversity & Inclusion (EDI). • The presentation includes a hyperlink to a blog post from a Leeds Chief Executive on Freedom to Speak Up and highlights the importance of Board Members as role models. **External Partnerships** • ICS design framework – a task and finish group set up however the Trust not is currently represented. The Provider Collaborative group is providing updates • Recruitment to Integrated Care Board (ICB) – Neil Halford, Deputy Medical Director, has secured the interim Medical Director position. • The deadline of 1st April 2022 for the ICB to be set up remains unchanged. • Provider Collaborative Development planning – there are 3 areas of work including clinical, workforce and financial strategies. • Gateshead Cares – this is continuing to play into ICS development and meetings are continuing. Delegated authority arrangements will be key and place levels are not yet agreed.	

Agenda Item	Discussion and Action Points	Action By
	• Gateshead College – the Trust is working with the College regarding workforce and apprenticeship programmes. • Gateshead Citizens Advice Bureau – a meeting has been arranged to support signposting for patients and staff. • Charitable funds – work is ongoing to link this to the journey experienced by Mrs Ormston. Mrs Marshall thanked Mrs Bilcliff for the detailed update and commented that ICS support will be beneficial moving forward. Mrs Bilcliff informed the Board that further information on the principals of provider collaborative development was available in the Board Reading Room on Convene. After further discussion, it was: **RESOLVED:** to receive the verbal update for assurance	
21/162	**GOVERNANCE REPORTS:** Miss J Boyle, Company Secretary, and Mrs G Findley, Chief Nurse, presented the following reports: **Corporate Objective Delivery:** Miss Boyle highlighted that the report provides assurance over the delivery of the 15 priority objectives however recognises that some risks have been identified in some areas due to current pressures. She reported that this process is still being developed and future reports will provide more detailed and measurable assurance reporting. **Board Assurance Framework (BAF) 2021/22** Miss Boyle highlighted that the BAF has been reviewed by the Board committees and updated at each meeting to assess levels of assurance and identify gaps. For each strategic aim the overall rating has been maintained as partially assured (amber). Miss Boyle reported that there has been some movement in individual assurance ratings and new ratings assigned as the committees have considered new reports. Mrs Marshall felt that the new BAF process worked well at Board Committee level and Mr A Moffat, Non-Executive Director, felt that this was a positive development and focussed delivery at the right level. Mrs J Baxter, Chief Operating Officer, wished to thank Kendra Marley for her work around improving the BAF and risk reports and the Board recognised the improvements around the processes which	

Agenda Item	Discussion and Action Points	Action By
	has resulted in the reports being presented within the public part of the meeting. **Organisational Risk Register (ORR)** Mrs Findley drew attention to the identified organisational risks which has been presented to the new Executive Risk Management Group for discussion. She reported that there have been no movements relating to the 12 risks identified on the ORR. Ten of these risks are BAF risks and 6 are rated as 15+ risks. There have been no changes to current risk scores in the period, however 2 actions have been completed. There had been one recommendation for an additional risk to be added to the ORR regarding the shortage of blood tubes however following discussion at the Executive Risk Management Group this will be managed via the business unit risk register. After consideration, it was: **RESOLVED:** to receive the reports for assurance.	
21/163	**SENIOR INFORMATION RISK OFFICER REPORT AND DIGITAL UPDATE:** Mr N Black, Chief Digital Information Officer, provided an update on the Trust's Digital Strategy, the planned clinical systems options appraisal and the new national strategic direction being driven by NHSx. The paper also details some of the key achievements over the last six months. Mr Black drew attention to the work currently being carried out in relation to the Global Digital Exemplar (GDE) Fast Follower Programme and highlighted that the GDE is due to be formally accredited over the coming months to demonstrate the progress achieved. He highlighted that the Trust currently has around three years left on its core clinical system contracts and there are plans to bring in external support to develop a full options appraisal. It is likely that this will require approval by the Executive Team in January 2022. Mrs J Baxter, Chief Operating Officer, explained that the upgrades to NerveCentre and Careflow have been beneficial however felt that changes to the core clinical system will require a lot of planning to work through options and felt that it would be beneficial for this to remain on the agenda going forward. Mr Black explained that the Board and stakeholders across the Trust will have the opportunity to meet with the external consultancy team to ensure full organisational commitment to the change. Mr A Beeby, Medical Director, suggested that this could be discussed at a future Clinical Policy Group to gain clinical views. Mrs J Bilcliff, Acting Chief Executive, requested that this	

Agenda Item	Discussion and Action Points	Action By
	be discussed in Part 2 of the Board going forward. Mr Black also highlighted that work is taking place to review the Digital Clinical Safety Strategy and a meeting is being arranged with Mr A Beeby to better understand the Clinical Safety Officer role and any gaps with the organisation's approach. Mr A Moffat, Non-Executive Director and Digital Committee Chair, informed the Board that there has been a lot of recent development work and will continue to be monitored via the Digital Committee. Following further discussion, it was: **RESOLVED:** to receive the report for assurance. Mr Black left the meeting	JB
21/164	**EPRR CORE STANDARDS SELF-ASSESSMENT & ASSURANCE REPORT:** Mrs J Baxter, Chief Operating Officer, presented the assurance report and reported that the Trust has undertaken a self-assessment of assurance against the Emergency Preparedness, Resilience and Response (EPRR) core standards. The overall level of compliance within the Trust has currently been assessed as Partial Compliance and Mrs Baxter commented that some standards will continue to require further review however a robust action plan is in place to monitor this (Appendix A of Agenda Item 14). Mrs Baxter highlighted that one of the standards within Domain 1 (Governance) recommends that a Non-Executive Director is appointed for EPRR to support the Accountable Emergency Officer. Mrs Anna Stabler has been appointed as the EPRR Non-Executive Director lead with support from Dr Mojgan Sani, Associate Non-Executive Director. Dr Sani highlighted that she had attended the recent EPRR Committee meeting and confirmed that assurance was provided in relation to the overall standards and delivery of the action plan. Mrs Baxter reported that further work is required in relation to business continuity plans across the organisation due to different formats which subsequently increases the difficulties in compliance monitoring and testing. She felt that it would be beneficial to look at an electronic system and this has been suggested to Mr Black. The EPRR Core Standards Self-Assessment and work programme have been reviewed by NHSE/I and also approved by the Executive Risk Management Group.	

Agenda Item	Discussion and Action Points	Action By
	After consideration, it was: **RESOLVED:** to receive the report for ratification and assurance.	
21/165	**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 cases are currently at a steady level with 30 cases being reported including 4 patients on the Critical Care Unit. Processes remain in place in the event of an increase in pressures and plans are being made in relation to the Covid Booster Programme. Mrs J Bilcliff, Acting Chief Executive, highlighted that there are currently reports in the press in relation to changes to IPC guidelines and Mr Beeby reported that this will be reviewed in detail and feedback provided. After further discussion, it was: **RESOLVED:** to receive the update for assurance	
21/166	**FINANCE UPDATE:** Mrs K Mackenzie, Acting Group Director of Finance, provided the Board with a summary of performance as at 31st August 2021 (Month 5) for the Group (inclusive of Trust and QE Facilities, excluding Charitable Funds). She reported that there has been a modest surplus of £0.275m for the month of August and a year to date surplus of £1.030m prior to the adjustment for donated assets and a surplus of £1.183m after the adjustment for donated assets. As previously highlighted, the H2 planning guidance has not yet been received therefore funding allocations have not been finalised however there is reasonable confidence in the assumptions provided. After consideration, it was: **RESOLVED:** to receive the report for assurance	

Agenda Item	Discussion and Action Points	Action By
21/167	**INTEGRATED OVERSIGHT REPORT:** Mrs J Baxter, Chief Operating Officer, presented the Integrated Oversight Report (IOR) for August 2021, which provides details of the Trust's performance and achievement against standards and remedial actions being taken in areas where metrics are outside of expected parameters. Mrs Baxter highlighted that this report has been reviewed by the other Board Committees and covers the period of August 2021 where available however where this is not the case, the most recent data is shown. Work is ongoing to ensure data is available for the same period to allow for improved triangulation. Pressures continue across many of the standards in relation to Covid infection rates which have caused operational pressures including staff absences. Mrs Baxter assured the Board that any urgent and cancer cases are being prioritised and robust processes are in place. A monthly cancer meeting is being set up to track patients and map to service lines. Following a query from Mrs A Stabler, Non-Executive Director, Mrs Baxter confirmed that no P2 cases have been cancelled. As discussed earlier, echocardiology remains an area of concern and plans are in place to bring this back in line. Support from system partners and private sector remain in place including recruitment processes and access to agency and bank work. Discussion took place in relation to the format of the report and Mrs Baxter explained that this continues to be developed however due to current pressures a number of exceptions are being reported. Feedback on the report has been provided by the Board Committees and further development is also taking place in relation to workforce metrics. Mr M Robson, Vice Chair and Finance and Performance Committee Chair, confirmed that the report had been presented at the last meeting and the cover sheet has been completed for each Committee highlighting which areas to focus on. Mrs A Stabler, Non-Executive Director and Quality Governance Committee Chair, reported that following discussion at the last Committee meeting, Mrs G Findley, Chief Nurse, agreed to introduce a page on Serious Incidents and summary of trends will be presented going forward. Following further discussion and consideration, it was: **RESOLVED:** i) to receive the IOR for August 2021 ii) to note additional shadow monitoring of new Urgent and Emergency Care (UEC) measures identified within the UEC section of the report iii) to seek further information and test robustness of plans as is required, allowing judgement regarding	JMB/GF

Agenda Item	Discussion and Action Points	Action By
	levels of assurance for future levels of operational performance.	
21/168	**LEARNING FROM DEATHS REPORT:** Mr A Beeby, Medical Director, presented the Learning from Deaths Report and highlighted that this was also presented and discussed at the last Quality Governance Committee. The report states that the Trust's latest published SHMI (Summary Hospital-level Mortality Indicator) for April 2020 to March 2021 is 1.00 placing the Trust with the banding of deaths 'as expected'. The HSMR (Hospital Standardised Mortality Ratio) for Gateshead in the last 12 months (July 2020 to June 2021) is 110.44 placing the Trust with 'More Deaths than expected' as calculated by the model. Mr Beeby explained that the HSMR is still high but highlighted that the Board invited Dr T Roberts, Deputy Director for the North East Quality Observatory Service (NEQOS), to provide a presentation at its recent Extraordinary Board meeting on 13th September 2021 and this provided further assurance around the Trust's mortality performance data. As previously discussed, the Quality Governance Committee received partial assurance from the report and further work has been requested in relation to non-compliance for DNR CPR for learning disabilities and fluid balance charts. Mr Beeby reminded the Board that this was being addressed and Task and Finish Groups have been set up with further reports expected at the Quality Governance Committee in January 2022. He highlighted that the Medical Examiner service is going well and includes feedback mechanisms to clinicians and/or nursing staff whilst ensuring any escalation of concerns or areas for quality improvement are shared with the correct teams. Dr R Bonningon, Non-Executive Director, felt that it was important to recognise that learning disability deaths were being reviewed by the Trust's Mortality Council in line with the Learning Disabilities Mortality Review (LeDeR) improvement programme established by NHSE/I and that further learning and actions were being identified. After further discussion and consideration, it was: **RESOLVED:** to receive the report for assurance.	

Agenda Item	Discussion and Action Points	Action By
21/169	**NURSE STAFFING EXCEPTION REPORT:** Mrs G Findley, Chief Nurse, presented the nurse staffing exception report which provides information relating to ward staffing levels (funded against actual) and details of the actions taken to address any shortfalls. She reported that there were significant staffing challenges in the months of June and July 2021 as the organisation experienced an increase surge of Covid activity that impacted on staffing resource and the clinical operating model. Wards where staffing fell below 75% of the funded establishment, are shown within the paper and actions taken have also been highlighted. Mrs Findley explained that the implementation of the Same Day Emergency Care programme will impact on staffing levels going forward however 40 new registered nurses are expected to join the Trust via the Preceptorship Programme and mitigation work continues in relation to better use of bank and agency staff. Assurance can also be given that the escalation process is operating as expected and is provided via the number of Datix reports relating to staffing. As discussed earlier in the meeting, Mrs Findley highlighted that it is important to continue with the Executive walkabouts and plans are in place to formalise back to the floor work to support this further. Mrs L Crichton-Jones, Executive Director of People & OD, reminded the Board on some of the key actions required including the need to continue to work on creating a better understanding of the movement of staff and how best to retain staff in their preferred areas of work. Mrs J Baxter, Chief Operating Officer, highlighted that there are plans in place to look at staffing bubbles, which will address need and patient safety. Following a query from Mrs A Stabler, Non-Executive Director, Mrs Findley confirmed that there have been no patient safety concerns. After further discussion, it was: **RESOLVED:** to receive the report for assurance and note the work being undertaken to address the shortfalls in staffing	
21/170	**HEALTHCARE ASSOCIATED INFECTIONS (HCAI):** Mr A Beeby, Medical Director and Director of Infection Prevention and Control, provided an update to the Board on the current HCAI performance for the Trust. Mr Beeby reported that the Trust continues to adopt the national	

Agenda Item	Discussion and Action Points	Action By
	aspiration of attaining a zero tolerance approach to all avoidable infections and will set internal reduction objectives for all mandatory reportable organisms. He reminded the Board that the prominent area of focus has been Covid-19 and in Quarter 2, there have been a low number of outbreaks reported however these have been controlled quickly. After consideration, it was: **RESOLVED:** to receive the report for assurance	
21/171	**WRES and WDES UPDATE REPORT:** Mrs L Crichton-Jones, Executive Director of People & OD, presented the report which provides an overview of key findings, work being undertaken in relation to the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) and also highlights work that is still required as well as the expected outcome in both areas. Mrs Crichton-Jones reported that an engagement approach was undertaken whilst compiling the report and included a review of the staff survey as well as liaising with the staff networks (BAME, D-Ability, LGBT and Women's Networks). Business Units have also been involved to gain ownership and ensure EDI is embedded across the organisation. The action plans and findings have also been discussed at the newly established Human Rights Equality Diversity Inclusion Group (HREDIG), Senior Management Team, Executive Management Team and the Human Resources Committee. The overall rating for both the WRES and the WDES is partial compliance (amber) and the associated action plans for both reports identify actions required to move the ratings to full compliance. The HREDIG will monitor the ongoing progress of the actions and report into the People and OD Portfolio Board. Mrs Crichton-Jones drew attention to some of the key significant priority areas and recommendations, including the roll out of reverse/ reciprocal mentoring and reported that consideration will be taken to match a member of the Board with a protected characteristic group. She explained that training will be provided and a scheme will be set up where colleagues will be given the opportunity to meet and share experiences and learning. Dr R Bonnington, Non-Executive Director and HR Committee Chair, felt that this was a good opportunity for Board members to meet with Staff Network Chairs and further leadership development may also be required to ensure actions are taken forward.	LCJ

Agenda Item	Discussion and Action Points	Action By
	Mr M Robson, Vice Chair, thanked Mrs Crichton-Jones for the detailed report however felt that this was a big piece of work and required sufficient resources and buy-in. Mrs Crichton-Jones agreed that this was a collective commitment and requires working together via management and leadership development programmes. Mrs J Baxter, Chief Operating Officer, felt that it would be beneficial for this to be discussed at the monthly Operational Directors meetings as a key agenda item. Mrs J Bilcliff, Acting Chief Executive, confirmed that this requires building into the organisational structure and requires staff engagement however the appointment of the EDI & Engagement Officer will support with this work and will be discussed in more detail as part of the Trust's Strategy work. Mrs Crichton-Jones thanked the Board for their reflections and confirmed that the action plans will be uploaded to the Trust's website. She thanked Mr Kuldip Sohanpal, EDI & Engagement Manager, and Mrs Kirsty Roberton, Deputy Director of Corporate Services & Transformation, for their work on this. Mrs Marshall confirmed the Board's commitment with this piece of work and also thanked Mrs Crichton-Jones and her team for their work and support. Following further discussion, it was : **RESOLVED:** to note the content of the report and agree the WRES and WDES Action Plan.	LCJ
21/172	**CYCLE OF BUSINESS:** Miss J Boyle, Company Secretary, presented the cycle of business which outlines forthcoming items for consideration by the Board. This will provide advanced notice and greater visibility in relation to forward planning. There is also a separate version for Part 2 of the Board. Board members will provide any feedback and comments to Miss Boyle. After consideration, it was: **RESOLVED:** to receive the cycle of business for information.	All
21/173	**QUESTIONS FROM GOVERNORS IN ATTENDANCE:** Mr S Connolly requested further information on support mechanisms and processes which are in place for staff to raise concerns in relation to bullying and harassment. Mrs L Crichton-Jones, Executive Director of People & OD, reported that all members of staff are offered	

Agenda Item	Discussion and Action Points	Action By
	support packages via their line manager, independent mentoring support, mental health services and occupation health support. She reiterated that it is important for managers to have open conversations with members of staff. Rev J Gill queried how the Trust compares to other organisations in relation to Staff Survey results and Mrs Crichton-Jones reported that the WRES data will be compared to the Staff Survey results in January 2022 where they should also be in a position to share with the ICS Workforce Board.	
21/174	**DATE AND TIME OF THE NEXT MEETING:** Mrs Marshall closed the meeting by informing the Board that this will be Mr D Shilton's last meeting as Non-Executive Director and thanked him for his huge commitment and enthusiasm over the last 6 years particularly around the areas of patient safety and quality of services. Mr Shilton thanked the Board for their support and wished to highlight their commitment to the achievement of the organisational core values. **RESOLVED:** that the next meeting of the Board of Directors will be held at 9:30 am on Wednesday 24th November 2021 via Microsoft Teams	
21/175	**EXCLUSION OF THE PRESS AND PUBLIC:** **RESOLVED:** to exclude the press and public from the remainder of the meeting due to the confidential nature of the business to be discussed	

PUBLIC BOARD ACTION TRACKER

Gateshead Health NHS Foundation Trust

Item Number	Date	Action	Deadline	Executive Lead	Progress
21/14	31/01/2021	Serious Incidents – focus going forward to ensure Board sighted on details (inc maternity). To look at interim actions	30/09/2021	JMB/GF	SI learning under review – interim actions/system being undertaken/developed. Draft procedure and internal process to be shared at QGC. Completed
21/118	28/07/2021	Quality Governance Assurance Report – to invite some of the matron staff to discuss how the staffing system has been managed during the pandemic	30/09/2021	GF	Current staffing pressures – to discuss as part of Nurse Staffing Report. Completed
21/119	28/07/2021	FTSU report – to arrange a session at one of the future Board Strategy Sessions.	30/09/2021	JenB	Included on the annual Board development plan to be considered in 2022/23
21/155	28/09/2021	Patient story – to look at process to link stories to staff recognition programme	24/11/2021	JenB	Proposal for a nomination to be made to the monthly Star Awards on behalf of the Board for each story involving staff
21/159	28/09/2021	Draft Winter Plan – to provide position report for SDEC	26/01/2022	JMB	To go to January Board
21/163	28/09/2021	SIRO & Digital update – to continue discussions regarding core clinical system in Part 2 going forward	24/11/2021	JB	Added to Part 2 action tracker
21/167	28/09/2021	IOR – to introduce a page on Serious Incidents and summary of trends going forward	24/11/2021	JMB/GF	In progress.
21/171	28/09/2021	WRES & WDES – to look at roll out of reverse mentoring and set up training/scheme to share experiences and learning	31/12/2021	LCJ	
21/171	28/09/2021	WRES & WDES – collective commitment to progress actions via Trust Strategy work	31/12/2021	All	
21/172	28/09/2021	Cycle of Business – to provide feedback and comments	24/11/2021	All	Completed – cycle of business will continue to evolve and further feedback welcomed

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Report Cover Sheet Agenda Item: 6

Report Title:	**Staff Story**			
Name of Meeting:	Board of Directors – Part 1			
Date of Meeting:	24 November 2021			
Author:	Jennifer Boyle, Company Secretary			
Executive Sponsor:	Lisa Crichton-Jones, Executive Director of People and Organisational Development			
Report presented by:	Jennifer Boyle, Company Secretary			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☒
	To share a staff story which provides an insight into the care and compassion shown by colleagues and the powerful positive impact that occupational health and counselling services can have.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☒
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	-			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	• Looking after our colleagues and providing health and wellbeing support is a key priority for the Trust. • This powerful staff story by Andrew Ward (and written in his own words) demonstrates the importance of this and of ensuring that staff have timely access to supporting occupational health and counselling services. • Sincere thanks is extended to Andrew Ward for sharing his story in such an open and transparent manner to encourage other staff to seek help and support and demonstrate the positive impact these services can have.			
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Board is requested to: • Review Andrew Ward's powerful story, which demonstrates the importance of accessible and effective health and wellbeing services to staff; and			

	• Be assured from the positive feedback that Andrew has shared on the effectiveness of the services offered by the Trust.				
Trust Strategic Aims that the report relates to:	**Aim 1** ☐	We will continuously improve the quality and safety of our services for our patients			
	Aim 2 ☒	We will be a great organisation with a highly engaged workforce			
	Aim 3 ☐	We will enhance our productivity and efficiency to make the best use of resources			
	Aim 4 ☐	We will be an effective partner and be ambitious in our commitment to improving health outcomes			
	Aim 5 ☐	We will develop and expand our services within and beyond Gateshead			
Trust corporate objectives that the report relates to:	Board priority 2.1 - Establish a post-Covid health and well-being programme to incorporate: the development of a Health and Wellbeing (HWB) strategy; the roll out of HWB conversations; the continuing arrangement for a Trust Testing Track & Trace & vaccine service; and a review of the trust occupational health service				
Links to CQC KLOE	Caring ☒	Responsive ☐	Well-led ☐	Effective ☐	Safe ☐
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks and DATIX reference)	POD 2759 – risk that we are not able to appropriately support the health and wellbeing needs of our workforce				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

Staff Story

Working from home during 2020 was fine to start with however I did miss the day to day interaction my work colleagues but was coping fine.

I was upbeat that the turn of the year would mark a change and things would start to get a bit more normal in 2021.

Come the turn of the year I noticed my mood changed as the path ahead was still unclear and COVID wasn't getting any better.

I had a routine dental appointment (I've normally been fine with the dentist – I've had loads done and take it in my stride normally)

I had a tooth extracted and fainted in the chair. Looking back I think I had a panic attack linked to some issues / memories I had 10 years ago.

Background

I had severe nose bleeds (possibly from damage caused when I broke my nose when I was a teenager) that resulted in the blood not stopping and bleeding from the tear ducts.

I went to the hospital and following swallowing blood for a couple of hours fainted whilst waiting to be seen, then came round and threw up blood everywhere.

Following this I had my first panic attack at the cinema some weeks later and thought I was going to die on the floor.

A had further panic attacks and a spell of violent intrusive thoughts which was really difficult.

I then used to panic in the car thinking there was no air inside.

I managed to fend this off and actually recovered (for 10 years) and thought I was cured until earlier this year.

I started to recall my fainting at hospital as my tooth was being extracted was very close to where the nose bleeds occurred.

I wasn't expecting to panic so this came out of the blue.

I could laugh it off at first but then it consumed my mind.

I had my COVID vaccine the next day (I think or close to the fainting episode) and was suffering panic in the 15 minute waiting room feeling I was going to faint.

The staff were helpful and talked to me to keep me settled (even if I did just want to rip the window open for air or run out)

I've always been fine getting my flu jab previously and would be keen to get it straight away.

For weeks I relived these experiences trying endlessly to figure out how I was going to solve it from happening again.

I then started struggling with wearing face masks, just something else to get anxious about.

My mind got more and more tired, exhausted and just breeding fear.

I went for my second COVID vaccine and the anxiety and panic was unbearable. However the staff were great and took me to a side room, and I had to be put on a bed and given the injection.

It was Jane Flinn who gave me my injection and I was so pleased to see her as I know her and could tell her how I was feeling, and she could see I wasn't myself.

She did my observations (which were fine) and I told her the story and that it was all in my head. She recommended I get some help and to speak to my manager and Occupational Health.

I found it difficult to go to Teams meetings as my heart would race and I would feel sick and faint and actually was sick on occasions.

Then I struggled taking my kids to school, worried in case I started to feel sick and then retching in the school ground, which then happened.

I then struggled getting my hair cut as I might feel the same there, and I did.

Then struggled going shopping, going out in the car, going out with friends etc.

I sought help as soon I had to cancel a meeting as I was being sick and was thinking I can't go on like this.

I spoke to some of my close colleagues who were really supportive.

I spoke to my line manager and following that I was referred to Talk Works and started working with a counsellor.

I was so pleased with the speed that I could access the services as I really felt like I needed it immediately.

I thought I might be fine after a few sessions and was having some good days and bad days.

On the good days I felt like a bit of a fraud. I hadn't really endured anything near what some of my clinical colleagues must be enduring.

I had 6 weeks of counselling and made some progress and then my counsellor advised that I have more sessions and try EMDR (Eye Movement Desensitization Therapy)

My counsellor was amazing, really friendly, engaging and we struck up a good working rapport.

I mentioned in my feedback that I consider these services essential especially given the current climate and the challenges that countless staff must be facing day to day.

Undoubtedly far more troubling than my own challenges.

As the summer progressed I struggled to go on trips with the family, struggling with anxiety on busses and trains, at restaurants but forged forward committed to not let the anxiety control my life.

As I progressed through the 12 weeks counselling I was starting to feel better and cope better. I was doing meditation at home and trying to exercise and live my normal life.

As the sessions were coming to an end I could see that they had made a huge difference. I had been given the coping skills to start rebuilding my confidence.

I was discharged from the therapy and tried to celebrate this accomplishment. I recognised I was living my daily life more normally and had made considerable progress.

I'm not back to 100% but on the right path. I continue to put myself in anxious situations (that used to be normal everyday situations) and overcome them as best I can even if I find it uncomfortable.

I managed to get my flu jab and COVID jabs in the last couple of weeks coping with the anxiety that was present.

I saw this as opportunity to practice coping, and as doors I must pass through If I want to get better.

I'm not sure what else I can say.

I am extremely grateful and thankful that the services were available and consider myself extremely lucky to have been able to access them at short notice.

Andrew Ward
Senior Information Analyst – Quality & Patient Safety
October 2021

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Report Cover Sheet Agenda Item: 7

Report Title:	**Board Committee Terms of Reference**			
Name of Meeting:	Board of Directors – Part 1			
Date of Meeting:	24 November 2021			
Author:	Jennifer Boyle, Company Secretary			
Executive Sponsor:	Committee Chairs and Executive Director Leads			
Report presented by:	Jennifer Boyle, Company Secretary			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☒	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☐
	The terms of reference are presented for ratification following review and approval by the respective Board committees.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☒
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Finance and Performance Committee People and Organisational Development Committee (Formerly HR Committee) Quality Governance Committee			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	• The terms of reference for the Finance and Performance Committee, People and Organisational Development Committee and the Quality Governance Committee have been fully reviewed and updated. • The updates take into account adjusted remits of the committees (for example digital now reporting to a separate committee rather than via Finance and Performance Committee) and any related recommendations from the recent well-led peer review. A new standardised template has been introduced to ensure consistency of format for the terms of reference. • Detailed reviews and discussions on the content of the terms of reference took place at each Board committee prior to approval. • The terms of reference for the Audit Committee and Digital Committee will be presented for Board ratification in January 2022.			

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

Committee

Terms of Reference

Gateshead Health NHS Foundation Trust

Finance and Performance Committee

Constitution and Purpose – The Finance and Performance Committee is a formal committee of the Board with delegated responsibility to monitor, review and make recommendations to the Trust Board with regard to the detailed financial and operational performance of the Trust.

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

Date Adopted / Reviewed	September 2021 – approved by Finance and Performance Committee November 2021 – ratified by the Board of Directors (TBC)
Review Frequency	Annual
Review and approval	Finance and Performance Committee
Adoption and ratification	Board of Directors

Membership	The Committee shall be appointed by the Trust Board and shall consist of: • Two Non-Executive Directors • Trust Chair • Chief Executive • Group Director of Finance • Chief Operating Officer The Committee shall be chaired by a Non-Executive Director with relevant skills and experience. A Non-Executive Director shall be nominated as Deputy Chair for the Committee.
Attendance	Executive Directors and senior managers should ensure that a deputy attends in their absence. Other Executive Directors and Senior Managers may be invited to attend meetings depending upon the issues under discussion.
Meeting frequency and quorum	Meetings shall be held **monthly** and as required by the national planning timetable. Meetings shall be held prior to the Trust Board to support the timely flow of assurance and items for escalation. To be quorate there should be at **least 2 Non-Executive Directors** (one of

	whom can be the Trust Chair) and **1 Executive Director** present. Members and regular attendees are expected to achieve **75% attendance** annually.
Meeting organisation	The Committee shall be supported administratively by the Corporate Management Team secretarial body. In accordance with the Trust's Standing Orders, **papers will be circulated to members and attendees six days before the meeting** wherever possible, and no later than three clear days before the meeting, save in emergency. Minutes of the Committee's meetings are held by the Corporate Management Team secretarial body and are circulated (alongside the agenda for the following meeting), to members and attendees.

Committee duties and responsibilities	
Strategy, planning and risk	To undertake **detailed scrutiny** of the adequacy of the Trust's **financial, operational, capacity and demand estimates, forecasts and planning assumptions** (in line with the latest regulatory requirements), making a recommendation to the Trust Board with respect to their approval. To **seek assurance over the delivery of the corporate objectives** mapped to the Committee for monitoring at the commencement of the financial year. To seek assurance over the **delivery of national and local-level strategies** relating to finance and operations. To **review the sections of the Board Assurance Framework (BAF)** mapped to the Committee for oversight and assurance, triangulating the control and assurance assertions on the BAF with the assurances and risks identified during each meeting. To **review the Finance and Operations-related risks from the Organisational Risk Register**, seeking assurance over the effective management of these risks towards the achievement of their target scores. The Committee will triangulate the risk registers against the assurances and risks emerging from the meeting for completeness.
Finance	To **review and monitor the Trust's contractual performance** and associated income, considering the implications of longer-term financial strategy for the Trust, taking into consideration the outcomes reported to the Committee from contract review meetings. To undertake detailed scrutiny of the **monthly consolidated finance report** and financial regulatory returns. This includes seeking assurance over the following areas: • achievement of the financial and use of resources metrics

	identified in the Single Oversight Framework and planning guidance. • Achievement of cost reduction programme (CRP) plans • Budget versus actual performance, including forecasting where appropriate To review **exception reports from business units** and seek assurance over recovery plans, in line with the accountability framework requirements. To review a **register of contracts** and seek assurance over the performance of those deemed to be material – financially or reputationally.
Capital and investment	To receive quarterly reports and to monitor progress against the **capital plan** and make any recommendations to the Trust Board as required. To **review the Trust's Investment Strategy** at least annually, making recommendations for amendments to the Trust Board. To **review and discuss any significant initiatives, projects and issues that impact financially** on the Trust and that the Committee deem appropriate, and make recommendations to the Board as necessary. This should be in accordance with the Trust's Scheme of Delegation. **Review of business cases** in accordance with the delegated limits outlined within the Trust's Scheme of Delegation. To receive assurance reports from the Supplies & Procurement Group highlighting any areas of **non compliance with SFIs and a summary of single tender waivers**.
Performance	**Review the Integrated Oversight Report** with a particular focus on performance measures, seeking assurance over the plans in place to deliver against targets and the actions in place to address those areas reported as exceptions (including any major standalone performance recovery plans). This review will include specific focus on the performance metrics outlined in the NHS England and Improvement Single Oversight Framework. Operations Directors should be invited to attend where appropriate to support deep dive discussions into elements of performance and operational service development within the Trust. To monitor capacity, demand and delivery of national standards against planned levels and make recommendations to the Trust Board where required.
Subsidiary governance	To seek assurance over the **performance of the Trust's subsidiary**, QE Facilities, against its contract with the Trust. To monitor the impact of the subsidiary on **group financial performance**.
Transformation	Via the Transformation Board reporting, seek assurance over the **transformation programme, including its plan, delivery and outputs**.

Regulatory and governance	To receive for information and assurance **Internal Audit reports** pertaining to the remit of the Committee. To review **feedback from NHSI** relating to financial, operational and planning matters. To review any material **emerging regulatory guidance / requirements** in relation to finance and operational matters on behalf of the Board.

Reporting and monitoring	
Sub-groups	The following sub-groups report into the Committee: • Transformation Board • Supply Procurement Committee The minutes and summary of assurances and escalations document are received by the Committee as part of the flow of assurance through the Trust's governance structure.
Board reporting	An assurance report from the Committee will be presented by the Chair to the next meeting of the Board of Directors.
Monitoring	Compliance with the terms of reference will be reviewed via an annual self-assessment. This will inform any proposed revisions to the terms of reference and the cycle of business. The outcome of the effectiveness and terms of reference review is presented to the Board of Directors following considered by the Committee.

Committee

Terms of Reference

Gateshead Health NHS Foundation Trust

People and Organisational Development Committee

Constitution and Purpose – The People and Organisational Development (POD) Committee is a formal committee of the Board with delegated responsibility to monitor, review and make recommendations to the Trust Board with regard to the development and delivery of the Trust's People Strategy and other strategic people-related matters.

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

Date Adopted / Reviewed	September 2021 – approved by the People and Organisational Development Committee November 2021 – ratified by the Board of Directors (TBC)
Review Frequency	Annually
Review and approval	People and Organisational Development Committee
Adoption and ratification	Board of Directors

Membership	The Committee shall be appointed by the Trust Board and shall consist of: • 2 Non-Executive Directors, one of whom shall chair the Committee • Executive Director of People and Organisational Development • Chief Nurse • Chief Operating Officer • Medical Director A Non-Executive Director shall be nominated as Deputy Chair for the Committee.
Attendance	The following will be expected to attend the Committee on a routine basis: • Deputy Director of People and Organisational Development • Potential operational representative (to be confirmed at a future date) Executive Directors and senior managers should ensure that a deputy

	attends in their absence. Other Executive Directors and Senior Managers may be invited to attend meetings depending upon the issues under discussion.
Meeting frequency and quorum	Meetings shall be held **bi-monthly** and as required by the national planning timetable. Meetings shall be held prior to the Trust Board to support the timely flow of assurance and items for escalation. To be quorate there should be at **least 2 Non-Executive Directors** and **1 Executive Director** present. Members and regular attendees are expected to achieve **75% attendance** annually.
Meeting organisation	The Committee shall be supported administratively by the Corporate Management Team secretarial body. In accordance with the Trust's Standing Orders, **papers will be circulated to members and attendees six days before the meeting** wherever possible, and no later than three clear days before the meeting, save in emergency. Minutes of the Committee's meetings are held by the Corporate Management Team secretarial body and are circulated (alongside the agenda for the following meeting), to members and attendees.

Committee duties and responsibilities	
Strategy, planning and risk	To seek **assurance over the delivery of national and local-level strategies** relating to people and organisational development matters. This should include: • People Plan (national) and local People Strategy • Health and Wellbeing Strategy • Leadership and Organisational Development Strategy • Equality, Diversity and Inclusion Strategy • Freedom to Speak Up Strategy To **seek assurance over the delivery of the corporate objectives** mapped to the Committee for monitoring at the commencement of the financial year. To undertake **detailed scrutiny** of the adequacy of the Trust's **workforce and recruitment forecasts and planning assumptions** (in line with the latest regulatory planning requirements), making a recommendation to the Trust Board with respect to their approval. Note this will require some cross working with the Finance and Performance Committee. To **review the sections of the Board Assurance Framework (BAF)** mapped to the Committee for oversight and assurance, triangulating the control

	and assurance assertions on the BAF with the assurances and risks identified during each meeting. To **review the People and Organisational Development-related risks on the Organisational Risk Registers**, seeking assurance over the effective management of these risks towards the achievement of their target scores. The Committee will triangulate the risk registers against the assurances and risks emerging from the meeting for completeness.
Leadership, culture, and organisational development	To review the **annual NHS staff survey results** and **annual GMC staff survey results**, including any corresponding action plans, seeking assurance on behalf of the Board that actions are being progressed. To receive **staff stories** to support effective triangulation and a deeper understanding of staff experience and culture within the Trust. This should be thematic in nature and focus on assurance over shared learnings / shared good practice. To seek assurance that current and future **leadership, training and development plans** are robust, cover mandatory requirements and support career development within the Trust. This includes the receipt of the feedback and any associated action plans from the Health Education North East's Annual Dean's Quality Meeting (ADQM). Maintain oversight of the Trust's **equality, diversity and inclusion initiative**, taking a leadership role in securing positive progress, monitoring progress and visibly promoting EDI throughout the Trust. This includes review and approval of a number of annual reports on behalf of the Board, including: • Equality annual report • Workforce Race Equality Standard (WRES) • Workforce Disability Equality Standard (WDES) • Gender pay gap report To receive for assurance bi-annual reports on **Freedom to Speak Up** activity, themes and trends.
Looking after our people	To receive for assurance the quarterly **Guardian of Safe Working reports**, seeking assurance that rotas and working conditions are safe for doctors and patients. *Note that reports under the 'leadership, culture and organisational development' section, also link to the role of 'looking after our people'.*
People supply and new ways of working	**Monitor the delivery of the workforce plan,** seeking assurance over the achievement of the plan and the management of any associated risks.
People performance	**Review the Integrated Oversight Report** with a particular focus on people measures seeking assurance over the plans in place to deliver against targets and the actions in place to address those areas reported as exceptions. This review will include specific focus on the people and

	leadership metrics outlined in the NHS England and Improvement Single Oversight Framework. Review the **People and OD Metrics report** which provides more detailed breakdowns of people-related metrics. This should be undertaken in conjunction with the review of the Integrated Oversight Report.
Regulatory and governance	To receive an annual assurance report on the compliance with Regulation 5 – **Fit and Proper Persons (Directors)**. To receive an annual assurance report on the compliance with the NHS England and Improvement '**Developing Workforce Safeguards'** requirements. On behalf of the Board to review and approve the **Framework of Quality Assurance for Responsible Officers and Revalidation** Annual Board Report and Compliance Statement. To receive for information and assurance **Internal Audit reports** pertaining to the remit of the Committee. To receive for information and assurance any **reports from external reviews** pertaining to the remit of the Committee. To review **feedback from NHSI** relating to people and leadership. To review any material **emerging regulatory guidance / requirements** in relation to people and organisational development matters on behalf of the Board.

Reporting and monitoring	
Sub-groups	The People and OD Portfolio Board formally reports into the Senior Management Team (SMT), although the Chair of the People and OD Portfolio Board will also provide an update report to the Committee to provide assurance over its core workstreams.
Board reporting	An assurance report from the Committee will be presented by the Chair to the next meeting of the Board of Directors.
Monitoring	Compliance with the terms of reference will be reviewed via an annual self-assessment. This will inform any proposed revisions to the terms of reference and the cycle of business. The outcome of the effectiveness and terms of reference review is presented to the Board of Directors following considered by the Committee.

Committee

Terms of Reference

Gateshead Health NHS Foundation Trust

Quality Governance Committee

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

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

Date Adopted / Reviewed	September 2021 – approved by the Quality Governance Committee November 2021 – ratified by the Board of Directors (TBC)
Review Frequency	Annually
Review and approval	Quality Governance Committee
Adoption and ratification	Trust Board

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

	meetings depending upon the issues under discussion.
Meeting frequency and quorum	Meetings shall be held **monthly**. Meetings shall be held prior to the Trust Board to support the timely flow of assurance and items for escalation. To be quorate there should be at **least 1 Non-Executive Director** and 2 **Executive Directors** present. Members and regular attendees are expected to achieve **75% attendance** annually.
Meeting organisation	The Committee shall be supported administratively by the Corporate Management Team secretarial body. In accordance with the Trust's Standing Orders, **papers will be circulated to members and attendees six days before the meeting** wherever possible, and no later than three clear days before the meeting, save in emergency. Minutes of the Committee's meetings are held by the Corporate Management Team secretarial body and are circulated (alongside the agenda for the following meeting), to members and attendees.

Committee duties and responsibilities	
Strategy, planning and risk	To **seek assurance over the delivery of the corporate objectives** mapped to the Committee for monitoring at the commencement of the financial year. To seek assurance over the **delivery of national and local-level strategies** relating to the remit of the Committee, including the Quality Strategy and Quality Improvement Strategy. To **review the sections of the Board Assurance Framework (BAF)** mapped to the Committee for oversight and assurance, triangulating the control and assurance assertions on the BAF with the assurances and risks identified during each meeting. To **review the quality / medical–related risks on the Organisational Risk Register**, seeking assurance over the effective management of these risks towards the achievement of their target scores. The Committee will triangulate the risk registers against the assurances and risks emerging from the meeting for completeness.
Safety	The **Integrated Oversight Report** will be used to provide an overview of aspects of safety performance (in accordance with the metrics defined in NHS England and Improvement's Single Oversight Report) and enable spotlight reporting on areas of greatest risk. Seek assurance that the Trust has **effective systems for safety**, with particular focus on quality, patient safety, staff safety and wider health &

	safety requirements. This should also include routine assurance regarding compliance with **safe staffing levels**. Seek assurance over the **robustness of procedures to ensure that adverse incidents and events are detected, openly investigated, with lessons learned being promptly applied** and appropriately disseminated in the best interests of patients, of staff and of the Trust To seek assurance that the Trust embeds **learning from deaths** and had a robust process in place which complies with mandatory requirements. To seek assurance that the Trust appropriately **responds to requests and requirements from coroners and other regulatory bodies** in respect of patient safety. To gain assurance that the Trust has in place such systems of work and controls that **ensure medicines are effectively managed** and complaint with legislative requirements. To gain assurance that the Trust has in place such systems of work and controls that **ensure medical devices are effectively managed** and complaint with legislative requirements. To gain assurance that the Trust has in place systems of work and controls that ensure **infection prevention and control** is effectively managed and compliant with legislative requirements. To gain assurance that **safeguarding** is compliant with national and local requirements such that patients are safe in the Trust's care.
Patient experience	The **Integrated Oversight Report** will be used to provide an overview of aspects of patient experience metrics (in accordance with the metrics defined in NHS England and Improvement's Single Oversight Report) and enable spotlight reporting on areas of greatest risk. Seek assurance that the Trust has **effective systems for delivering a high quality experience** for all its patients and users, with particular focus on **involvement and engagement** for the purposes of learning and making improvement. To provide assurance to Trust Board that there are robust systems for **learning lessons from complaints**, and action is being taken to minimise the risk of occurrence of adverse events. This should include the **sharing of aspects of good practice identified through compliments** and patient feedback. To seek assurance that the Trust is **delivering high quality care for patients with learning disabilities** in accordance with nationally and locally prescribed standards.
Clinical effectiveness, leadership and training	The **Integrated Oversight Report** will be used to provide an overview of aspects of clinical effectiveness and outcomes (in accordance with the metrics defined in NHS England and Improvement's Single Oversight Report) and enable spotlight reporting on areas of greatest risk.

	Seek assurance that the Trust has **effective systems for monitoring clinical outcomes and clinical effectiveness,** with particular focus on ensuring patients receive the best possible outcomes of care across the full range of Trust activities. To seek assurance over the **effective engagement of clinical leads** in the development and delivery of quality improvement initiatives. To review the **clinical audit plan and progress reports** to support the assurance process regarding effective clinical practice. Through close working with the HR Committee, seek assurance that **statutory and mandatory training requirements** relating to quality of care and clinical practice are being fulfilled.
Regulatory and governance	To monitor, scrutinise and provide assurance to the Trust Board on the Trust's **compliance with core regulatory standards**, including the Care Quality Commission's Fundamental Standards, quality-related elements of NHS England and Improvement metrics and NICE guidance. On behalf of the Board, take a lead role in **seeking assurance that the Trust's annual Quality Report is compliant with regulatory requirements**, reflective of the main achievements and challenges during the year and has been appropriately consulted upon. To triangulate through assurance the **robustness of quality-assurance processes relating to all research undertaken** in the name of the Trust and / or by its staff, in terms of compliance with standards and ethics, and clinical and patient safety improvement processes. To receive an annual assurance report on the compliance with the NHS England and Improvement '**Developing Workforce Safeguards'** requirements. To receive for information and assurance **Internal Audit reports** pertaining to the remit of the Committee. To receive for information and assurance any **reports from external reviews** pertaining to the remit of the Committee. To review **feedback from NHSI** relating to quality and safety. To review any material **emerging regulatory guidance / requirements** in relation to quality and clinical matters on behalf of the Board.

Reporting and monitoring	
Sub-groups	The following sub-groups report into the Committee: TO BE ADDED FOLLOWING SUB-GROUP REVIEW (CURRENTLY ONGOING) The minutes and summary of assurances and escalations documents are received by the Committee as part of the flow of assurance through the Trust's governance structure. The Committee will receive detailed assurance reports from the Mental Health Act Legislation Committee.
Board reporting	An assurance report from the Committee will be presented by the Chair to the next meeting of the Board of Directors.
Monitoring	Compliance with the terms of reference will be reviewed via an annual self-assessment. This will inform any proposed revisions to the terms of reference and the cycle of business. The outcome of the effectiveness and terms of reference review is presented to the Board of Directors following consideration by the Committee.

Finance and Performance Committee

Gateshead Health NHS Foundation Trust

Assurance Report

Agenda Item: 8

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	Finance and Performance Committee – 27.09.2021			
Name of Meeting:	Trust Board			
Date of Meeting:	24.11.2021			
Author:	Mrs K Mackenzie and Mrs J Baxter			
Executive Lead:	Mrs K Mackenzie and Mrs J Baxter			
Report presented by:	Mr M Robson, Chair of Committee			
Matters to be escalated to the Board:	Nothing to escalate to Board.			
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	<u>Echocardiology Performance Update</u> The Committee received a comprehensive update on the Echocardiology Service and noted that the target for the performance to be back on track has extended past March 2022 to June 2022 due to capacity of independent provider. The Regional COOs are considering how support can be offered across the ICS as it was noted that other Trusts are in a similar position. The Trust is looking at further external support from another independent provider to reduce waits by the end of March 2022 Partial assurance was received. <u>Terms of Reference for Finance and Performance Committee</u> The Committee noted the changes made to the Terms of Reference. A discussion took place in relation to membership, the key agenda items and to allow time for both Finance and Performance. <u>Financial Revenue Report – Month 5</u> The Financial Revenue Report for Month 5 was received and discussed in detail. The Committee noted that income is higher than planned and that expenditure is lower than planned. Partial assurance was received. The next steps will be to prepare for a significant surplus, Executive Team to make key decisions, focus on month 6			

	and September reporting, Task and Finish Group to be set up to work through the priorities, monthly monitoring and focus on outturn. <u>Budget Setting</u> The Committee received partial assurance in the absence of the H2 planning guidance which should be received w/c 27th September. The finalised budgets will be presented to the Trust Board at the earliest opportunity and there will be a focus on recurrent expenditure to inform 2022/23. <u>Integrated Oversight Report</u> A detailed discussion took place and although the Trust is performing well in some areas for example 104 and 52 week waiters and the overall RTT, there were still some challenges around cancer 62 day waits and the Committee also discussed the impact of South Tees Tertiary Gynae Oncology patient transfers to Gateshead. Cancer referrals have increased above 2019 baseline and the Trust is increasing focus on the Cancer standards. On that basis the Committee received partial assurance overall. <u>Supply Procurement Committee Summary Table</u> The Committee were fully assured with the decisions made at the Supply Procurement Committee noting the values approved for Hazardous Clinical Waste and Non Hazardous Clinical Waste. <u>Board Assurance Framework (BAF)</u> The Board Assurance Framework was updated accordingly. <u>Finance and Performance Committee Work Plan 2021/22</u> The Committee received this for information. <u>Committee Dates for 2022 to March 2023</u> The Committee agreed the dates for 2022 to March 2023.	
Recommended actions for Board		
Trust Strategic Aims that the report relates to: **(Including reference to any specific risk)**	**Aim 1** ☐	We will continuously improve the quality and safety of our services for our patients
	Aim 2 ☐	We will be a great organisation with a highly engaged workforce
	Aim 3 ☒	We will enhance our productivity and efficiency to make the best use of resources
	Aim 4 ☐	We will be an effective partner and be ambitious in our commitment to improving health outcomes
	Aim 5 ☒	We will develop and expand our services within and beyond Gateshead
Financial Implications:		

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			

Gateshead Health
NHS Foundation Trust

Assurance Report

Agenda Item: 8

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	Finance and Performance Committee – 26.10.2021			
Name of Meeting:	Trust Board			
Date of Meeting:	24.11.2021			
Author:	Mrs K Mackenzie and Mrs J Baxter			
Executive Lead:	Mrs K Mackenzie and Mrs J Baxter			
Report presented by:	Mr M Robson, Chair of Committee			
Matters to be escalated to the Board:	Nothing to escalate to Board.			
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	<u>Integrated Oversight Report</u> The Committee received partial assurance due to the uncertainly around the H2 planning and pressures within the hospital. Gynae Oncology and Front of House A&E are areas of pressure. Plans are in place to support those areas but are dependent on wider issues largely. ECIST are support the Trust with a full review of unscheduled pathway which conversations are starting on 2nd November, leading to observations on site 17th November with a view to running the 'perfect week' in December. , Project Boards have been set up for service improvement and the Cancer Recovery Group. <u>Cancer Services Update</u> The Committee discussed in detail noting that the hospital is required to reduce the 62 day cancer waits. Breast is performing well for diagnostics and 62 week waits. The Urology Service pathway will be reviewed with NUTH. There are challenges in Lower GI and Gynae Oncology but confirmation was given that the Trust is working with the Cancer Alliance Network and internal action is being taken. <u>Financial Revenue Report – Month 6</u> The Financial Revenue Report for Month 6 was received and discussed in detail. The reported surplus has increased to £2.5m for the period of April to September 2021. Discussions took place in relation to the runrate which demonstrates that pay is reasonably stable now but that the Trust is still seeing fluctuations with non-pay. The cash			

	position is £46m and the Trust is expecting to receive the £7m cash owed from DHSC in relation to the pillar two testing programme. Capital Plan Update The Committee received partial assurance and confirmed that there is no real change in CDEL allowable spends. The delivery of plan all depends on the market and materials available. Since the paper was written the Trust has approved a direct award of £1.5m to establish a modular maternity theatre. Planning Update It was confirmed that the H2 Planning Guidance has been received and that the greatest impact is as expected on the planning of activity. The submission is due on 2nd November and the finalised budgets will be brought back at the earliest opportunity. A proposal was made that the Trust would submit a plan within the parameters of break-even to a modest surplus. There is still work to be done in relation to Capital. Review of Objectives The Committee discussed the objectives in detail noting that the RAG ratings and format will be looked at for the next Committee. Supply Procurement Committee Summary Table The Committee were fully assured in relation to the information received. There is an issue with the modular building work which is in relation to the Community Diagnostic Hub and the Maternity Theatre which the options were discussed. Board Assurance Framework (BAF) The Board Assurance Framework was updated accordingly. Finance and Performance Committee Work Plan 2021/22 The Committee received this for information.	
Recommended actions for Board	Planning update The recommendation to Board is that the Trust continues with modelling, but submit a draft plan that suggests the Trust will either return a balanced position of return a modest surplus.	
Trust Strategic Aims that the report relates to: **(Including reference to any specific risk)**	**Aim 1** ☐	We will continuously improve the quality and safety of our services for our patients
	Aim 2 ☐	We will be a great organisation with a highly engaged workforce

	Aim 3 ☒	We will enhance our productivity and efficiency to make the best use of resources				
	Aim 4 ☐	We will be an effective partner and be ambitious in our commitment to improving health outcomes				
	Aim 5 ☒	We will develop and expand our services within and beyond Gateshead				
Financial Implications:						
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				

Gateshead Health
NHS Foundation Trust

Assurance Report

Agenda Item: 8

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☒
Committee Reporting Assurance:	Quality Governance Committee			
Name of Meeting:	Trust Board			
Date of Meeting:	28 September 2021			
Author:	Mrs A Stabler, Non-Executive Director			
Executive Lead:	Mrs G Findley, Chief Nurse			
Report presented by:	Mrs A Stabler, Non-Executive Director			
Matters to be escalated to the Board:	None			
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	**Items received for assurance:** **Integrated Oversight Report** The Committee acknowledged the ongoing development of the report and agreed the following assurances from extracts highlighted: • Good assurance received around the open and honest culture for early reporting of HSIB • Limited assurance received HSMR reporting, however noted that the Extra-ordinary Board on 13 September 2021 a presentation was received from NEQOS who indicated no areas of concern. • Good assurance that all Safety Alerts have now been completed Risks identified in relation to Duty of Candour (DoC) reporting. It was agreed that a deep dive would take place to review the current process in line with legal requirements and also include the compliance of staff training. It was agreed a formal paper would be received by the Committee in January 2022 to include deep dive overview and compliance against verbal and written DoC compliance and training compliance. Good assurance received against key performance and quality metrics.			

	The Committee agreed partial assurance received overall due to issues with compliance against DoC reporting. **IPC Board Assurance Framework** The Committee were informed that the IPC BAF will now report direct to the IPC Committee with any issues being escalated to QGC. **Maternity Assurance Report** The Committee agreed the following assurances from extracts highlighted from the Maternity assurance report: • Good assurance received around the open and honest culture for early reporting of HSIB • Good assurance received in relation to Continuity of Care work • Good assurance received in relation to Smoking Cessation work and the positive impact this is having on patients of Gateshead Risks identified around birth rate plus. Figures show the Trust as requiring an additional 11 WTE staff, however funding was only received for 5WTE leaving a gap of 7 WTE staff for the service. The ongoing risk on the corporate risk register was noted in relation to the Maternity Estate work. The Committee will be updated on any progress made as required. It was agreed a paper would be received back to the Committee around Maternity workforce planning in December2021. The Committee agreed partial assurance received overall due to ongoing issues with workforce and estate concerns. **Learning from Deaths Report** The Committee received good assurance that work has continued on SUI Panels and Mortality Councils throughout the Covid Pandemic with areas of good practice identified. Two areas of concerns were raised; • LeDeR DNACPR – Audit found that non-compliance in the completion of DNACRP forms was observed in a number of cases • Issues in relation to the completion of fluid balance and the use of correct fluid charts across the organisation The Committee were assured that a task and finish group had already been convened to look at both issues and

	training packages were being rolled out to staff. The Committee asked that a formal update paper was received for review at the January 2022 Committee in relation to the LeDeR DNACPR audit and fluid balance charts. The Committee agreed partial assurance received overall due to ongoing issues raised in relation to LeDeR and fluid balance. **Safer Staffing Report** The Committee received assurance that staffing figures have improved in August with processes now in place across the organisation for early escalation of issues. The Committee noted the welcome addition of 40 newly appointed qualified nurses who will be joining the Trust over the coming months with the support of the preceptorship lead nurse alongside the 'Gateshead Guardians' programme. The Committee noted that figures were not reported nationally for July 2021 due to the increased number of staff being contact by Track and Trace requiring self-solation periods of up to 10 days and staff movements due to Covid wards opening. It was decided that the figures available did not show a true overview of staffing levels. The figures for August have been submitted. The Committee agreed partial assurance received overall due to current workforce gaps and potential unsafe staffing levels. **CQC Action Plan Update** The Committee received good assurance that work had re commenced on the 2019 CQC action plan and joint working was now underway with the Matrons and QEF staff to undertaken safety audits. The Committee agreed that this action plan would now report to the SafeCare, Risk and Patient Safety Council going forward with updates being received by the Committee for exceptions only. **CQC Mental Health Update** The Committee received good assurance following a recent unannounced inspection of the Mental Health service noting the minor areas of improvement required. The Committee acknowledged the ongoing estates issues

	and the further revised competition date of the Cragside build to late October/ early November 2021. The original completion date was August 2021. They noted the risks around mix sex accommodation were mitigated against due to dormitory style accommodation being used as single rooms. The Committee also noted the risk in relation ongoing recruitment and retention issues. Good assurance was received around improvement plans and the overall Mental Health Service performance metrics, however an overall assurance partial was received due to the current workforce gaps. **Serious Incident Report** The Committee received good assurance that that SI Panels had continued during the Covid Pandemic with the welcomed addition of the Medical Examiner and FLO attendance at the panels. The Committee received full assurance that learning from SUIs had improved with themes being shared, however agreed a level of partial assurance due to the 60day reporting target being missed due to pressures resulting from the Covid Pandemic. **Inpatient Survey** Deferred to November 2021 Paper removed from agenda due to report being embargoed till late Oct 21. **Urgent and Emergency Care Survey** The Committee received good assurance from the Picker UEC survey results for 2020 also that NEQOS had ranked the Gateshead as the top hospital out of 66 hospitals which had taken part in the survey. **Key results:** • 89% - rated overall experience as 7/10 or more • 98% - treated with dignity and respect • 96% had confidence and Trust in Doctors The Committee received full assurance for the excellent outcome of the report and noted that the results will be shared and celebrated across the emergency department and wider Business Unit. **External Review Outcome Report** The Committee noted that this report had been received following a request at Trust Board for a deep dive review of HR checks. A total of 830 staff files have now been

	reviewed and good assurance was received that all appropriate checks had been carried out with no significant gaps or risks identified. It was agreed that this work would report directly to HR Committee. The Committee agreed a level of full assurance for this report. **Clinical Validation of Waiting List Data** The Committee noted good assurance levels in relation to current processes in place process for clinical validation of waiting list against the framework requirements with a caveat that any identified themes or trends of patient harm would be pick up via the Datix reporting tool. The Committee agreed a level of full assurance for this report. **Medicine Quarterly Report** The Committee noted good assurance in relation to the ongoing function of medicine management and controls. The Committee requested that future reports include all controlled drug requirements going forward. The Committee agreed a level of full assurance for this report. **Health and Safety Quarterly Report** The Committee welcomed the oversight of the report and agreed that this level of detail was required to be received on a quarterly basis to triangulate the work carried out by the Health and Safety Committee. The Committee noted the limited level of assurance received due to the gaps in compliance against fire training, risk assessments, RIDDOR as well as non-recording of themes in non-patient safety incidents. The Committee agreed a partial level of assurance for this report and asked that risk assessments were included in reports going forward. **Research and Development Annual Report** The Committee received full assurance for this report noting the level of engagement and activity carried out over the Covid Pandemic. The Committee asked that their thanks were passed to Mrs

	A Harvey and the R&D Team. **Palliative Care Annual Report** The Committee received full assurance for this report noting the launch of the Hospice to Home Team and future development plans of the Cancer Hub. The Committee asked that their thanks were passed to Mrs J Lamb and the Palliative Care Team. **Infection Prevention and Control Annual Report** The Committee received full assurance for this report and noted the enormous amount over work carried out by the IPC Team over the past 18 months in response to the Covid Pandemic. The Committee asked that their thanks were passed to Mrs L Caisley and the IPC Team.				
Recommended actions for Board	Board are asked to note the work of the committee and the assurances received and note the areas of risk identified but note the actions in place to resolve.				
Trust Strategic Aims that the report relates to: **(Including reference to any specific risk)**	**Aim 1** ☒	We will continuously improve the quality and safety of our services for our patients			
	Aim 2 ☐	We will be a great organisation with a highly engaged workforce			
	Aim 3 ☐	We will enhance our productivity and efficiency to make the best use of resources			
	Aim 4 ☐	We will be an effective partner and be ambitious in our commitment to improving health outcomes			
	Aim 5 ☒	We will develop and expand our services within and beyond Gateshead			
Financial Implications:	None to Note				
Links to Risks (identify significant risks and DATIX reference)	ORR Risks, 2879 – Maternity, 2779 CQC Compliance/ Improvement, 2868 – Further wave of Covid, 2880 – ICS / Place/ ICP alignment - DoC none-compliance (as above) - SI Performance - risks remain around timeliness of investigations and closing out actions - Maternity Estate and staffing gaps (as above) - Health and Safety Quarterly Report (as above)				
People and OD Implications:	Gaps in workforce in Maternity and Mental Health Services				
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

Assurance Report

Agenda Item: 8

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☒
Committee Reporting Assurance:	Quality Governance Committee			
Name of Meeting:	Trust Board			
Date of Meeting:	20 October 2021			
Author:	Mrs A Stabler, Non-Executive Director			
Executive Lead:	Mrs G Findley, Chief Nurse			
Report presented by:	Mrs A Marshall, Chair			
Matters to be escalated to the Board:	None			
Executive Summary:	**Items received for assurance:** **Integrated Oversight Report** The Committee acknowledged the ongoing development of the report and agreed the following assurances from extracts highlighted: • Good assurance received that verbal Duty of Candour is 100% compliant • Limited assurance in relation to Ambulance delays and Cancer 62day performance The Committee noted that going forward this report would include additional metrics from Maternity and Safeguarding and SI's. **Maternity Assurance Report** The Committee agreed the following assurances from extracts highlighted from the Maternity assurance report: • Good assurance received in relation to the processes which have been put in place to support the service • Limited assurance was received due to staffing gaps, ongoing estates issues and the dashboard metrics not being available within the report. The Committee agreed partial assurance was received overall noting the areas of limited assurance. **Objective Delivery Report:** The Committee agreed an overall assurance rating of amber as not all objectives have been fully implemented as			

	a result of the Covid Pandemic. Work continues to support the implementation of all objectives. **Learning from Deaths Report** The Committee received a presentation on learning from Covid deaths over the past year and agreed that a good level of assurance had been received. The Committee noted that a plan was in place to cascade the continuous learning for all patient deaths via the quarterly learning reports to the Quality Governance Committee and monthly medical bulletins as well as information being shared at Business Units meetings and ward managers meetings. **Safer Staffing Report** The Committee acknowledged the ongoing challenges around safe staffing levels, however noted that a task and finish group had been established which will be chaired by the Chief Nurse alongside discussions starting around International recruitment. The Committee agreed a partial assurance rating due to the current staffing shortfall across the Organisation. **Serious Incident Update** The Committee noted that a verbal brief would be received monthly going forward until the information was included in the IOR to ensure that any issues are shared in a timely manner. Three incidents were received for September 2021 which have all been reported to StIES. Learning from these will be shared in future serious incident reports to the Committee. **Final Internal Audit Report NICE Guidance 2021-22/16** The Committee received good assurance and noted the four minor actions highlighted by AuditOne. **Patient Experience Annual Report** The Committee received full assurance for this report noting the outstanding work carried out by the Volunteers during the Covid Pandemic. **Learning Annual Report** The Committee received full assurance for this report noting that this was the first of its kind looking back at learning which has been shared during the Covid Pandemic. The Committee were informed that this would be received

<table>
<tr><td></td><td colspan="6">on a quarterly basis going forward to ensure that learning continues to be shared and cascaded throughout the Organisation.

Safeguarding Annual Report
The Committee received full assurance for this report.</td></tr>
<tr><td>Recommended actions for Board</td><td colspan="6">Board are asked to note the work of the committee and the assurances received and note the areas of risk identified but note the actions in place to resolve.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:
(Including reference to any specific risk)</td><td>Aim 1
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<tr><td>Financial Implications:</td><td colspan="6">None to Note</td></tr>
<tr><td>Links to Risks (identify significant risks and DATIX reference)</td><td colspan="6">ORR Risks, 2879 – Maternity, 2779 CQC Compliance/ Improvement, 2868 – Further wave of Covid, 2880</td></tr>
<tr><td>People and OD Implications:</td><td colspan="6">Gaps in workforce in nursing, midwifery and mental health.</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☒</td><td>Effective
☒</td><td colspan="2">Safe
☒</td></tr>
<tr><td rowspan="3">Trust Diversity & Inclusion Objective that the report relates to</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>
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</table>

Gateshead Health
NHS Foundation Trust

Assurance Report

Agenda Item: 8

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	Digital Committee			
Name of Meeting:	Board of Directors			
Date of Meeting:	24 November 2021			
Author:	Nick Black, Chief Digital Information Officer			
Executive Lead:	Jackie Bilcliff, Acting Chief Executive			
Report presented by:	Andrew Moffat, Chair of Committee			
Matters to be escalated to the Board:	There are no matters to be escalated to the Board.			
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	<u>Strategic Objectives and Transformation Roadmap</u> The Committee received *partial assurance* and a detailed discussion took place in relation to concerns relating to timescales and capacity to achieve objectives and all items on the road map as originally planned. The roadmap has been prioritised to ensure the resources are allocated to the most appropriate projects with a focus on achieving the GDE accreditation, cyber security and supporting the new clinical operating model in the Trust. <u>Global Digital Exemplar Milestone</u> All milestones are on track for delivery by the end of 2021, the Committee received *partial assurance* due to the uncertain impact of capacity constraints. <u>Service Key Performance Indictors Report</u> The Committee received *partial assurance* noting that the time taken to process Freedom of Information and subject access requests, after some deterioration, have now returned to the required level. KPIs continue to be developed including new service desk metrics. <u>Policy Update</u> The Committee received *full assurance* that all policies are up to date and being maintained. It was however, noted there are two policies that have passed their expiry date as follows: • Telecommunications Policy – this is a QEF managed policy which the IT department are assisting with.			

<table>
<tr><td></td><td colspan="6">

- Code of Practice in the Use of Email – this policy will be archived as it will be merged into the N365 Policy due for approval in November 2021.

<u>Audit Reports</u>
The Committee received *full assurance* as there were no new Audit Reports to be presented but the Committee would like to see overdue items going forward. The Committee noted that there was one Audit action that had passed the target date in relation to cyber infection detection and prevention controls, this date having been updated to match the corresponding milestones in the GDE Programme.

<u>Digital Strategy</u>
The Committee received a comprehensive update for information and noted that Channel3 will be carrying out engagement work with the Trust to review the future clinical systems options. Meetings will be arranged with the relevant staff.

<u>Digital Transformation Group Assurance Report and Portfolio Risk Register</u>
The Committee received *full assurance* that work is progressing through the Digital Transformation Group.

<u>Digital Assurance Group Assurance Report, Minutes and Service Operational Risk Register</u>
The Committee received *full assurance* that work is progressing through the Digital Assurance Group.
</td></tr>
<tr><td>Recommended actions for Board</td><td colspan="6">Accept the assurances provided in the report.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:
(Including reference to any specific risk)</td><td>Aim 1
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<tr><td>Financial Implications:</td><td colspan="6"></td></tr>
<tr><td>Links to Risks (identify significant risks and DATIX reference)</td><td colspan="6"></td></tr>
<tr><td>People and OD Implications:</td><td colspan="6">Workforce implications within the Digital Team and the wider Trust.</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring</td><td>Responsive</td><td>Well-led</td><td>Effective</td><td>Safe</td></tr>
</table>

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

Gateshead Health
NHS Foundation Trust

Assurance Report

Agenda Item: 8iv

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	People and OD Committee – 9 November 2021			
Name of Meeting:	Trust Board			
Date of Meeting:	24 November 2021			
Author:	Ruth Bonnington, Non-Executive Director			
Executive Lead:	Lisa Crichton-Jones, Director of People & OD			
Report presented by:	Ruth Bonnington, Non-Executive Director			
Matters to be escalated to the Board:	N/A			
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	The People and OD Committee met on 9 November 2021. The key agenda items discussed were as follows: <u>Update Report from POD Portfolio Board</u> The Committee were partially assured and noted that the Board have now met on three occasions, programmes and developing workplans and there is a focus on membership in order that a partnership approach to all work strands is in place. <u>People Plan 2020-21 Update</u> The Committee were partially assured and noted the key highlights in the report. There are 42 actions where progress is being tracked, along with 15 outstanding actions. The level of support received in order for the directorate to progress the People Plan has been good. <u>GMC Survey Results & Action Plan 2021-2022</u> The Committee were partially assured and noted the Trust had performed well in the Region and the Trust were rated top in Clinical Supervision. The next step will be to look at the data and actions as these will then provide discussions with HENE at their next visit. Once actions have been developed these will be picked up and monitored via the Medical Workforce Group. <u>NHS Staff Survey 2021: Position Paper Quarterly Staff Survey Results – August 2021</u> The Committee were partially assured and noted that the			

	survey response rate was currently at 36% and that final reminders are due to be circulated. The Committee also noted that the quarterly Pulse survey has received low levels of engagement and this has been reported to SMT for them to focus on increasing the completion rate in the next round (early 2022). <u>People & OD Metrics</u> The Committee were partially assured and noted that the report focusses on 4 areas i.e. Sickness Absence, Staffing Establishment and Turnover, Appraisals and Core Skills Training. The Committee noted that there is a significant amount of work underway to continue to develop the range of workforce metrics. There has been a slight reduction in Core Skills compliance, however, some areas are progressing and SMT members have been asked to produce improvement plans by early December. There are lower levels of compliance with Conflict Resolution and Resus training as these are delivered face to face and it has not been possible to deliver classes of full capacity due to social distancing. Recruitment and employee relations metrics will recommence in January when new systems have c 3 months worth of data within. <u>Update on Delivery of Strategic Objective (2.1) Protecting & Understanding the Health & Wellbeing of Our Staff</u> The Committee were partially assured and noted that there are six areas that the HWB programme current work predominantly focuses on as follows: 1. launching the Covid booster and flu campaigns 2. supporting the mandating of vaccinations for our staff that work into care homes 3. continuing the HWB check ins 4. undertaking a health needs assessment 5. transition of the test, track, trace and vaccination work into business as usual, via Pathology and People & OD 6. supporting the October step challenge It was agreed to include vaccination data in future reports and retain oversight of redeployment issues for those members of staff who are not fully vaccinated may need to be escalated to the Board. Only 1 member of community staff working into care homes has needed redeployment due to vaccination status. <u>Update on Delivery of Strategic Objective (2.3) Strategic Workforce Planning</u> The Committee were partially assured and noted progress made. There are five risks that have been identified in

	relation to this objective, four of which are encompassed as part of the overarching workforce planning risk (2764) and one which is a standalone risk. <u>Update on Delivery of Strategic Objective (2.4)</u> <u>Develop a Leadership and OD Strategy for the Trust</u> The Committee received partial assurance and noted that the Trust will launch a reverse mentoring Programme in the near future as part of the overall programme. <u>Update on Delivery of Strategic Objective (2.5) People Quality, Performance & Governance</u> The Committee received partial assurance and noted that there had been very slight slippage in the timescale for the learning and development review, and that risk 2961 had been added. The implementation of the new POD structure is underway. <u>Senior Management & Board Visibility</u> The Committee were partially assured and noted that the Walkabouts had now been reinstated and that a breakdown of the small number which had not taken place had been included and there were a mix of reasons why these were stood down. A discussion took place on how in the future, themes and information from these visits could be more formally collated and a wider Board discussion or view on this would be helpful. <u>People & OD Audit Actions Update</u> The Committee received full assurance on the 2 internal risk based audits that were undertaken by Audit one on the Disciplinary process and the Covid 19 Risk Assessment process for staff. <u>Recruitment Team Update – External Review Recommendations and Implementation of TRAC</u> The Committee were partially assured as there are still some actions to complete. Additional capacity from an external partner is in place. A new risk (number 2961) relating to delays in recruitment due to increased activity, volume of work and lack of electronic system to manage workload, has been added to the risk register. <u>Guardian of Safe Working Annual Report 2021-22</u> The report was presented to the Committee for information and it was noted that there are no immediate safety concerns. The majority of exception reports raised are within General Medicine and General Surgery and the issues reported are extra hours worked and general workload. The Committee were partially assured.

<table>
<tr><td></td><td colspan="6"><u>People & OD Organisational Risk Register</u>
The Committee noted three risks which were in relation to Right People, Right Place, Right Skills, Leadership & OD and Health & Wellbeing, the score on the latter having been reduced due to the Leading Well approach being agreed and recruitment to the team having commenced.

The following item was received for information -
HR Policies – Policy Schedule Update</td></tr>
<tr><td>Recommended actions for Board</td><td colspan="6">Note main assurances against the strategic People and OD themes detailed and key associated risks.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:
(Including reference to any specific risk)</td><td>Aim 1
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<tr><td>Financial Implications:</td><td colspan="6"></td></tr>
<tr><td>Links to Risks (identify significant risks and DATIX reference)</td><td colspan="6">• The following risks were highlighted: POD capacity to progress key pieces of work until Delivering Excellence in People Practice consultation concluded and structure recruited to.</td></tr>
<tr><td>People and OD Implications:</td><td colspan="6">As set out</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
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	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

Report Cover Sheet Agenda Item: 10

Report Title:	Organisational Risk Register			
Name of Meeting:	Board of Directors			
Date of Meeting:	24th November 2021			
Author:	Kendra Marley, Corporate Risk Manager			
Executive Sponsor:	**Gill Findley, Chief Nurse**			
Report presented by:	**Kendra Marley, Corporate Risk Manager**			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☐
	To ensure the Board and Committees are clearly sighted on those risks that have an organisational -wide impact, the organisational risk register is compiled by the Executive Risk Management Group of those risks that impact on the delivery of strategic aims and objectives. This includes risks included within the Board Assurance Framework (BAF) as well as risks identified by the Group for inclusion as having an organisational impact and impact on delivery of strategic aims and objectives. The supporting report shows the risk profile of the ORR, includes a full register, and provides details of review compliance, and risk movements.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☒ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	The attached report is now received in the Executive Team Meeting each week, and monthly at the Executive Risk Management Group.			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety*	• Risk 2945 - *Risk of ineffective and inefficient management of services due to lack of access to appropriate business intelligence resulting in impacts on patient safety, effectiveness and experience,* has now been added to the ORR. • Two risks have been reduced;			

<table>
<tr><td>

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

</td><td colspan="5">

- Risk 2765 - *No Leadership and OD strategy in place across the trust resulting in failure to support our workforce* – reduced from 16 to 12.
- Risk 2873 - *Risk that the Trust is unable to form a suitable capital plan and programme due to reduced levels of CDEL available.* – reduced from 16 to 9.

</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="5">The Board are asked to:

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

</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
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<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="5">Each risk is linked to a corporate objective, see report.</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☐</td><td>Responsive
☐</td><td>Well-led
☒</td><td>Effective
☐</td><td>Safe
☐</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td colspan="5">Included in report</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☐</td><td>Not applicable
☒</td></tr>
</table>

Organisational Risk Register

Executive Summary

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

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

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

This report covers the period 14th October to 11th November (extraction date for this report).

Organisational Risk Register - Movements

Following the agreement at the Executive Risk Management Group in October, risk 2945 - *Risk of ineffective and inefficient management of services due to lack of access to appropriate business intelligence resulting in impacts on patient safety, effectiveness and experience,* has been added to the organisational risk register.

Two risks have been reduced, as follows;

Risk 2765 - *No Leadership and OD strategy in place across the trust resulting in failure to support our workforce* – reduced from 16 to 12.

Risk 2873 - *Risk that the Trust is unable to form a suitable capital plan and programme due to reduced levels of CDEL available.* – reduced from 16 to 9.

One action has been completed on risk 2945 - *Risk of ineffective and inefficient management of services due to lack of access to appropriate business intelligence resulting in impacts on patient safety, effectiveness and experience* - relating to the review of current sitreps and culling what doesn't add value.

Recommendations

The Board are asked to:

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

Organisational Risk Register Report

14-Oct-2021 to 11-Nov-2021

Gateshead Health NHS Foundation Trust

Risk Profile (Current/Managed)

Resources - 2

POD 2764 - Risk of not having the right people in right place at the right time with the right skills to deliver current & future services (16)

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

Wellbeing - 1

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

Business Continuity - 1

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

Finance - 3

COO 2882 - Risk of commercial market climate changes, affecting the ability to maximise oppo (6)

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

FIN 2874 - Risk that we are unable to formulate a coherent financial plan due to undertainty surrounding the financial framework. (16)

Effectiveness - 1

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

Safety - 2

COO 2945 - Risk of ineffective and inefficient management of services due to lack of access to appropriate business intelligence (16)

COO 2879 - Risks relating to the trusts Maternity estate that have the potential to impact on the delivery of safe maternity services (15)

Compliance - 1

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

Delivery of Objectives - 2

COO 2868 - Risk of a further wave(s) of Covid -19 and increased demand. (12)

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

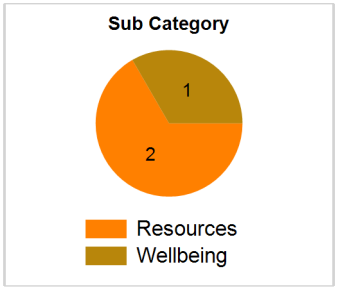
Organisational Risk Register Report

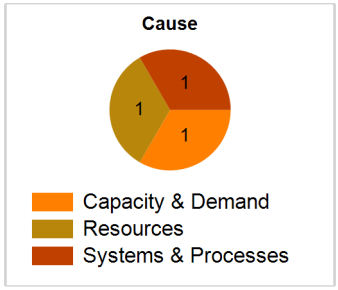
14-Oct-2021 to 11-Nov-2021

Business Intelligence

NHS Gateshead Health NHS Foundation Trust

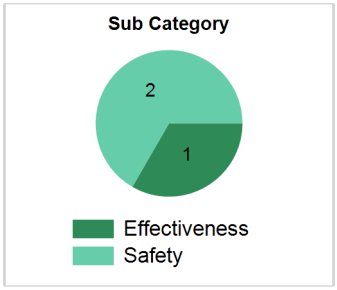
People & Resources

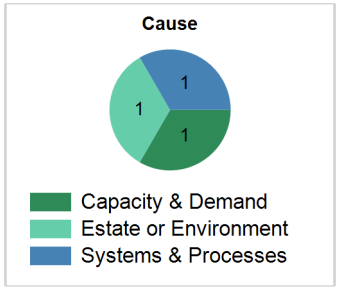




Risk Sub Cat	Risk Cause	No. Risks
Resources	Resources	1
	Systems & Processes	1
Wellbeing	Capacity & Demand	1

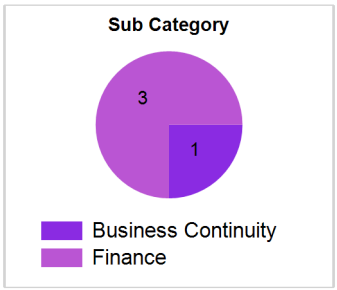
Quality Outcomes

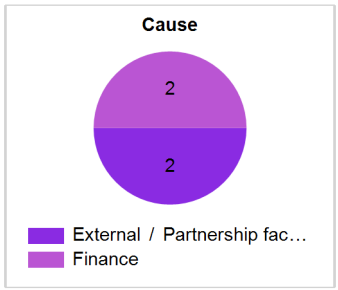




Risk Sub Cat	Risk Cause	No. Risks
Effectiveness	Capacity & Demand	1
Safety	Estate or Environment	1
	Systems & Processes	1

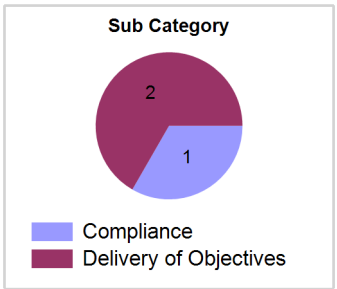
Finance & Efficiency

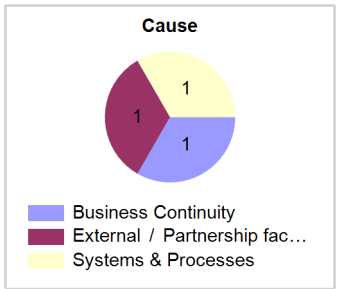




Risk Sub Cat	Risk Cause	No. Risks
Business Continuity	External / Partnership factors	1
Finance	External / Partnership factors	1
	Finance	2

Regulation & Compliance, Reputation





Risk Sub Cat	Risk Cause	No. Risks
Compliance	Systems & Processes	1
Delivery of Objectives	Business Continuity	1
	External / Partnership factors	1

Organisational Risk Register Report

14-Oct-2021 to 11-Nov-2021

Gateshead Health NHS Foundation Trust

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

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR
2764 17/11/2020 Natasha Botto People and OD Workforce Development 24/11/2021 BAF HRC ORG 2.3P Develop a trust wide approach to strategic workforce planning	Risk of not having the right people in right place at the right time with the right skills due to lack of workforce capacity, resources and expertise across the organisation to support workforce planning resulting in failure to deliver current and future services that are fit for purpose.	20	Deputy Director of People and OD appointed with strategic workforce planning experience. Interim Head of Workforce Development/Senior HRBP leading on work. A SWOT analysis has been undertaken by Senior People and OD directorate leadership team, considering how key strategic priorities such as this can be taken forward and what structure and resource is needed to support this as part of any updated POD structure, which has been drafted into a busienss case. Resource has also been advanced purchased from the Whole System Partnership to enable this work to be started - first stakeholder event has taken place. HRBP seconded to lead on a review of current workforce data which will support understanding our 'as is' position to support future planning and forecasting. Workforce supply task and finish group set up to scope ideas - action plan formed and work progressing. Appointed to Head of People Planning, Performance and Governance who will oversee this portfolio of work. POD linked in with staffing report task and finish group, overseen by Gill Findlay. Workforce Supply T&FG set up and provides an opportunity progress an operational solutions but also develop a longer term plan and strategy. In discussions with Gateshead colleague around potential different supply routes, which is progressing well. Started the conversations about International Recruitment with colleague in North Cumbria Integrated Care to learn about their international recruitment journey. Also opportunity around potentially utilising/tapping into a supply of newly qualified paramedics in the region.	16	Work to be scoped and future resource identified. Consider how workforce development group can be combined with Educuation, Training Group	Natasha Botto 03/12/2021 Laura Farrington (Completed 30/08/2021)	8

Organisational Risk Register Report

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Business Intelligence

Gateshead Health NHS Foundation Trust

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR
2869 27/04/2021 Helen Routh Chief Operating Officer Chief Operating Officer 10/10/2021 ORG 3.8P Deliver the Operational transformation programme to improve productivity and efficiency of service delivery and recovery post covid	There is a risk of unintended harm to patients, due to the impact of reduced services, delayed treatment and pathway starts, health and inequalities, Resulting in patients accessing treatment who are more unwell than otherwise would have been, longer stay in hospital and longer recovery periods	20	Detailed elective recovery plans have been developed Additional capacity is being facilitated to reduce waiting times Clear trajectory to reduce long waiters	16	Develop plans to understand, track and address health inequalities impact of the pandemic delivery trajectory to address all 52 week waiters	Joanne Baxter 31/12/2021 Helen Routh 31/03/2022	8
2874 30/04/2021 Kris MacKenzie Finance Finance 29/10/2021 BAF FPC ORG 3.4P Develop an approved capital and revenue plan	Risk that we are unable to formulate a coherent financial plan, Due to there being a lack of guidance and great deal of uncertainty surrounding the financial framework for the second half of the financial year, Resulting in unclear financial position and plan in year, impacting financial decisions, and unknown financial trajectory for full year.	20	Financial report regularly to F&P and Board.	16			8

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Business Intelligence

Gateshead Health NHS Foundation Trust

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR
2945 14/09/2021 Joanne Baxter Chief Operating Officer Chief Operating Officer 13/12/2021 BU_DIR ORG 3.8P Deliver the Operational transformation programme to improve productivity and efficiency of service delivery and recovery post covid	Risk of ineffective and inefficient management of services due to lack of access to appropriate business intelligence resulting in impacts on patient safety, effectiveness and experience.	20	Reporting in place: Static reporting – this is how we performed last month but often too late to intervene and pull back performance Live reporting is needed – this is how we are doing now and where we need to intervene to prevent poor performance Forecasting – these are the trends to be able to plan services much more effectively to meet demand the later two points need further development	16	• Work with the BU managers looking at what is available and start to build what is needed and get rid of what is not used/helpful	Debbie Renwick 30/10/2021	4
					• Assess what is currently available and set up in yellow fin under relevant business units	Michael Smith 30/11/2021	
					centralise sitreps - filed in central location so as not to clog up emails advice on dates publsihed so managers are aware	Michael Smith 30/11/2021	
					• Improve data quality by working with teams and provide resilience to teams doing the RTT etc	Debbie Renwick 30/12/2021	
					• Review current sitrep production and cull what doesn't add value	Michael Smith (Completed 15/10/2021)	
2879 29/04/2021 Joanne Baxter Chief Operating Officer Chief Operating Officer 13/12/2021 BAF ORG QGC 1.1P Implementation of the recommendations of the Ockenden report on Maternity Services	There are risks relating to the trusts Maternity estate that have the potential to impact on the delivery of safe maternity services and the ability to satisfactorily address actions from local and national requirements (HSIB/ Ockenden/ Continuing Care/ Birthrate Plus.	20	Ockenden Compliance Report – Assurance Assessment tool see separate risks.	15	Agree a plan to mitigate current risk	Kate Hewitson 31/12/2021	10
					Deliver the full project plan for a new maternity build in collabaration with QEF	Joanne Baxter 20/10/2022	

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NHS Gateshead Health NHS Foundation Trust

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR
2759 16/11/2020 Amanda Venner People and OD Human Resources 08/11/2021 BAF HRC ORG 2.1P Establish a post covid health and well being programme to incorporate; The development of a hwb strategy, roll out of HWB conversations, the continuing arrangement for a Trust Testing Track & Trace & vaccine service and a review of the OH service	Risk that we are not able to appropriately support the health and wellbeing needs of our workforce due to insufficient capacity to support these needs resulting in backlog of Occupational Health work and slow turn around times for management referrals, counselling and proactive management of staff HWB. Resulting in reduced resilience levels low, with mental and physical health needs emerging, potentially resulting in higher levels of absence and turnover and safety incidents as well as an inability to deliver of the relevant HWB aspects of the NHS people plan.	16	HWB Programme team recruited and fully in place from June 2021 Occupational Health Service Manager appointed. Board HWB Guardian identified. Regional HWB established which GHNT is part of. Partnered with Talk Works to provide talking therapies and counselling services to reduce waiting times for counselling and psychological support services. Access to local and national resources. Occupational health referral systems(self referral and management referral)and process in place. HWB stalls set up to seek the views on HWB gaps/needs/wants/views of staff. Rebranding of HWB programme underway. Occupation Health external review completed, with improvement plan now being implemented. HWB "check ins" rolled out across the Trust. Ts and Vs Business case to extend Covid testing and tracing service to end March 2022 agreed. HWB initiatives received confirmation of ICS funding for Emotional Health and Wellbeing support for staff. Health and Wellbeing dashboard of early warning metrics established and discussed at the programme board, ops meetings and HRC	12	OH review needed focussing on capacity and psychological support offer	Rebekah Coombes 26/11/2021	8
					More sophistocated workforce metrics needed	Rebekah Coombes 26/11/2021	
					Improved alignment with ICS	Lisa Crichton-Jones 26/11/2021	
					HWB strategy to be developed	Amanda Venner 31/01/2022	
2765 17/11/2020 Laura Farrington People and OD Workforce Development 25/11/2021 BAF HRC ORG 2.4P Develop a leadership and OD Strategy with clear outcomes	Risk that we have leaders in the organisation that do not demonstrate the Trust values and lead with an expected level of competence and that we do not invest in, develop and nurture leaders of the future due to no leadership and OD strategy being in place across the Trust resulting in a failure to support our workforce in the way we would strive to.	20	Interim Head of Workforce now appointed. OD practitioner support engaged via a contractor at present. OD practitioner post being recruited to on an fixed term basis. New Deputy Director of People and OD appointed with Leadership and OD experience. Leading Well at Gateshead' paper has been drafted and presented to SMT outlining the first stage to a stages approach to leadership development. Vision work currently underway. Focus group arranged with those who attended the joint Just Culture training within NEAS in 2019. Programme Board in place, met for 1st time 12/10/21. Appointed a substantive Head of Leadership, OD and staff engagement.	12	Establish a leadership and OD programme board	Natasha Botto (Completed 13/10/2021)	8

Organisational Risk Register Report

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Business Intelligence

Gateshead Health NHS Foundation Trust

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR
2779 01/07/2020 Jane Douthwaite Nursing, Midwifery & Quality Quality Governance 02/12/2021 BAF ORG QGC 1.10P Develop Route Map to CQC Outstanding	The Trust fails to meet the CQC Fundamental Standards resulting in potential regulatory action, harm to patients, decline in ratings, and resulting reputational damage.	16	CQC readiness action plan Inspection action plans Nursing Strategy and Safe Staffing planning & delivery Governance Framework Risk Management systems and processes Health & Safety Governance and processes NICE guidance governance processes Learning Disability Support processes Cancer Services delivery plans	12	Ensure any areas of improvement from last inspection are in place	Jane Douthwaite 31/12/2021	6
					Develop a route map to Outstanding	Jane Douthwaite 31/12/2021	
					Ensure the CQC action plan is regulalry reviewed as BU meetings and Executive team	Andrea Tweddell (Completed 26/08/2021)	
2868 27/04/2021 Joanne Baxter Chief Operating Officer Chief Operating Officer 29/10/2021 BAF EPRR FPC ORG QGC 3.8P Deliver the Operational transformation programme to improve productivity and efficiency of service delivery and recovery post covid	Risk of a further wave (s) of Covid -19 and increased demand, Due to different strains of the virus being prevalent in the community and current vaccination not providing the intended protection Resulting in failure to deliver corporate objectives	15	EPRR command and control governance in place. Reconfiguration from previous waves and learning applied. Workforce management plans	12	Revise trust operating model, estates, workforce and activity forcasting	Joanne Baxter (Completed 31/08/2021)	9

Organisational Risk Register Report

14-Oct-2021 to 11-Nov-2021

Gateshead Health NHS Foundation Trust

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR
1636 10/11/2014 Dianne Ridsdale Information IT 30/11/2021 DIGC MDMG ORG	UCRF R01/R03/R20/R23 Malware such as Ransomware Compromising Unpatched Endpoints, Servers, Equipment or due to Lack of Hardened Build Standards. There is a risk of potential exposure to published critical cyber vulnerabilities. Laptops, workstations and medical devices compromised by ransomware or botnets, due to endpoints being susceptible to compromise through the use of obsolete, old, or unpatched operating systems and third party software, including Java. Endpoints often not monitored for patch status. Endpoints compromised more easily through dangerous browser plugins (such as Java, Flash), or unsupported browsers. Servers compromised by ransomware, due to servers susceptible to compromise through the use of obsolete, old, or unpatched operating systems and software. Servers often not monitored for patch status. Due to failure to maintain all Digital assets, including installing Operating system patches, AV patches or other software and hardware updates across the IT estate, including network equipment and medical devices. Resulting in potential harm to patients, data leaks, impacts on service delivery.	25	AV on all end points AV up to date ATP in place site wide NHSD & Microsoft group policy templates Ongoing updates routinely planned as they are released Patching regime	10	Manage replacement of End of life Network Hardware Develop comprehensive Cyber KPIs & IT Security Assurance Report Complete Cyber Essential Plus Accreditation	Jon Potts 30/11/2021 Dianne Ridsdale 31/12/2021 Jon Potts 31/12/2021	5
2873 30/04/2021 Kris MacKenzie Finance Finance 31/12/2021 BAF FPC ORG 3.4P Develop an approved capital and revenue plan	Risk that the Trust is unable to form a suitable capital plan and programme Due to reduced levels of CDEL available and the management of capital within the ICS Resulting in the inability to fund capital requirements to meet the development needs of the Trust.	20	Approved Capital and Revenue Plan 2021/22 Additional funding is being made available centrally, which may impact on size of CDEL available	9			8

Organisational Risk Register Report

14-Oct-2021 to 11-Nov-2021

Gateshead Health NHS Foundation Trust

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR
2880 30/04/2021 Mr Andrew Beeby Chief Executive Office Medical Directorate 30/11/2021 BAF ORG QGC 4.3P Strong partner working at place, ICP, ICS levels and beyond to manage population health and tackle health inequalities - Appoint a consultant in Public Health jointly with LA & CCG	Risk that Place/ICS/ICP strategy and plans do not fully align with our objectives and aspirations to tackle health inequalities. Due to slightly different aims and objectives, or ways of doing things. Slow or no progress against health inequalities.	12	Being involved with ICS / ICP / Place in the development of work (co-production)	9	Joint Appointment of PH Consultant	Andrew Beeby (Completed 04/10/2021)	6
2882 30/04/2021 Joanne Baxter Chief Operating Officer Chief Operating Officer 15/09/2021 BAF FPC ORG 5.6P We will develop and expand our services within and beyond Gateshead - Manufacture FFP3 masks for NHS and commercial markets. We will work with our partners at Northumbria to make the manufacture of PPE a successful venture.	Risk of commercial market climate changes, due to political, environmental or other factors, affecting the ability to maximise opportunities.	12	Trust Business Case processes in place QEF Business development processes, risk assessment and authorisation route via QEF Board P&L for each venture Benefits realisation Report	6			6
							13

Changes in CRR - Current/Managed Risks

Risk ID / Date Identified	Risk Description	IRR	Current Controls	CRR	Action	Action Owner	TRR	Latest Progress Note	PRR

Handler BU Service Line Next Review Date BAF / Risk Register						Action Due			
									0

Risks Moved to Managed in Period

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

Risks Closed in Period

Risk ID / Date Identified	Risk Description	IRR	Current Controls	CRR	Action	Action Owner	TRR	Closure Details	PRR
Handler BU Service Line Next Review Date BAF / Risk Register						Action Due (Open Actions)			
									0

Risks Added in Period

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Business Intelligence

NHS Gateshead Health NHS Foundation Trust

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note / Date Added to ORR
2945 14/09/2021 Joanne Baxter Chief Operating Officer Chief Operating Officer 13/12/2021 BU_DIR ORG 3.8P Deliver the Operational transformation programme to improve productivity and efficiency of service delivery and recovery post covid	Risk of ineffective and inefficient management of services due to lack of access to appropriate business intelligence resulting in impacts on patient safety, effectiveness and experience.	20	Reporting in place: Static reporting – this is how we performed last month but often too late to intervene and pull back performance Live reporting is needed – this is how we are doing now and where we need to intervene to prevent poor performance Forecasting – these are the trends to be able to plan services much more effectively to meet demand the later two points need further development	16	• Work with the BU managers looking at what is available and start to build what is needed and get rid of what is not used/helpful	Debbie Renwick 30/10/2021	4	ERMG - Added to ORR 21-10-2021
					• Assess what is currently available and set up in yellow fin under relevant business units	Michael Smith 30/11/2021		
					centralise sitreps - filed in central location so as not to clog up emails advice on dates publsihed so managers are aware	Michael Smith 30/11/2021		
					• Improve data quality by working with teams and provide resilience to teams doing the RTT etc	Debbie Renwick 30/12/2021		
					• Review current sitrep production and cull what doesn't add value	Michael Smith (Completed 15/10/2021)		
								1

Risks Removed in Period

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

Organisational Risk Register Report

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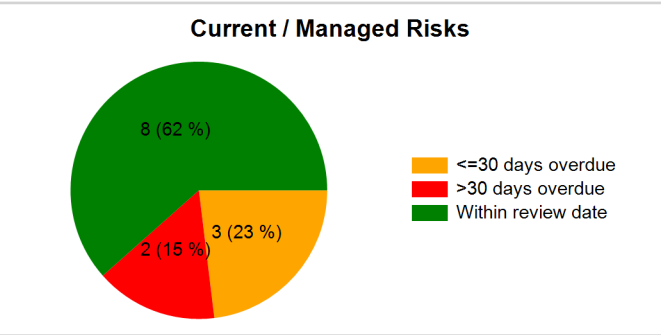
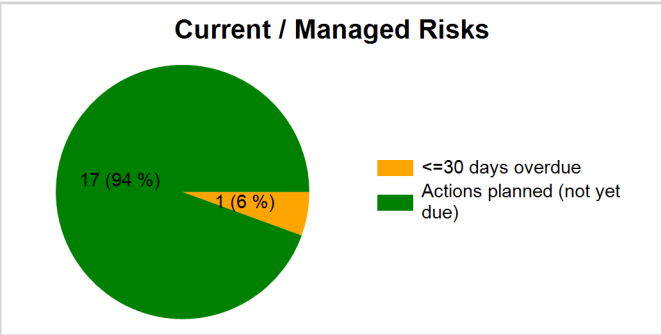
Gateshead Health NHS Foundation Trust

Risk Review Compliance



Risk Action Compliance



Movements in CRR

					CRR										
BU	Service Line	Department	ID	Risk Description	Dec-2020	Jan-2021	Feb-2021	Mar-2021	Apr-2021	May-2021	Jun-2021	Jul-2021	Aug-2021	Sep-2021	Oct-2021	Today
Chief Executive Office	Medical Directorate		2880	Risk that Place/ICS/ICP strategy and plans do not fully align with our objectives and aspirations to tackle health inequalities.						9	9	9	9	9	9	9
Chief Operating Officer	Chief Operating Officer		2868	Risk of a further wave(s) of Covid -19 and increased demand.					12	12	12	12	12	12	12	12
			2869	Unintended harm to patients, due to the impact of reduced services, delayed treatment and pathway starts					16	16	16	16	16	16	16	16
			2879	Risks relating to the trusts Maternity estate that have the potential to impact on the delivery of safe maternity services						15	15	15	15	15	15	15
			2882	Risk of commercial market climate changes, affecting the ability to maximise oppo						6	6	6	6	6	6	6
			2945	Risk of ineffective and inefficient management of services due to lack of access to appropriate business intelligence										16	16	16

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Gateshead Health NHS Foundation Trust

					CRR											
BU	Service Line	Department	ID	Risk Description	Dec-2020	Jan-2021	Feb-2021	Mar-2021	Apr-2021	May-2021	Jun-2021	Jul-2021	Aug-2021	Sep-2021	Oct-2021	Today
Finance	Finance	Capital & Financial Accounting	2873	Risk that the Trust is unable to form a suitable capital plan and programme due to reduced levels of CDEL available.						16	16	16	16	16	9	9
		Financial Management	2874	Risk that we are unable to formulate a coherent financial plan due to undertainty surrounding the financial framework.						16	16	16	16	16	16	16
Information	IT		1636	UCRF R01/R03/R20/R23 - Malware such as Ransomware Compromising Unpatched Endpoints, Servers and Equipment	8	8	8	8	10	10	10	10	10	10	10	10
Nursing, Midwifery & Quality	Quality Governance		2779	The Trust fails to meet the CQC Fundamental Standards.	15	15	15	15	12	12	12	12	12	12	12	12
People and OD	Human Resources	Health and Wellbeing	2759	We are not able to appropriately support the health and wellbeing needs of our workforce	9	9	16	16	16	12	12	12	12	12	12	12
	Workforce Development	Leadership and OD	2765	No Leadership and OD strategy in place across the trust resulting in failure to support our workforce	20	20	20	20	20	16	16	16	16	16	12	12
		Workforce Planning	2764	Risk of not having the right people in right place at the right time with the right skills to deliver current & future services	25	25	25	25	25	16	16	16	16	16	16	16

Risks Overdue

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Business Intelligence

Gateshead Health NHS Foundation Trust

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR
2869 27/04/2021 Helen Routh Chief Operating Officer Chief Operating Officer 10/10/2021 ORG 3.8P Deliver the Operational transformation programme to improve productivity and efficiency of service delivery and recovery post covid	There is a risk of unintended harm to patients, due to the impact of reduced services, delayed treatment and pathway starts, health and inequalities, Resulting in patients accessing treatment who are more unwell than otherwise would have been, longer stay in hospital and longer recovery periods	20	Detailed elective recovery plans have been developed Additional capacity is being facilitated to reduce waiting times Clear trajectory to reduce long waiters	16	Develop plans to understand, track and address health inequalities impact of the pandemic delivery trajectory to address all 52 week waiters	Joanne Baxter 31/12/2021 Helen Routh 31/03/2022	8
2874 30/04/2021 Kris MacKenzie Finance Finance 29/10/2021 BAF FPC ORG 3.4P Develop an approved capital and revenue plan	Risk that we are unable to formulate a coherent financial plan, Due to there being a lack of guidance and great deal of uncertainty surrounding the financial framework for the second half of the financial year, Resulting in unclear financial position and plan in year, impacting financial decisions, and unknown financial trajectory for full year.	20	Financial report regularly to F&P and Board.	16			8

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Gateshead Health NHS Foundation Trust

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR
2759 16/11/2020 Amanda Venner People and OD Human Resources 08/11/2021 BAF HRC ORG 2.1P Establish a post covid health and well being programme to incorporate; The development of a hwb strategy, roll out of HWB conversations, the continuing arrangement for a Trust Testing Track & Trace & vaccine service and a review of the OH service	Risk that we are not able to appropriately support the health and wellbeing needs of our workforce due to insufficient capacity to support these needs resulting in backlog of Occupational Health work and slow turn around times for management referrals, counselling and proactive management of staff HWB. Resulting in reduced resilience levels low, with mental and physical health needs emerging, potentially resulting in higher levels of absence and turnover and safety incidents as well as an inability to deliver of the relevant HWB aspects of the NHS people plan.	16	HWB Programme team recruited and fully in place from June 2021 Occupational Health Service Manager appointed. Board HWB Guardian identified. Regional HWB established which GHNT is part of. Partnered with Talk Works to provide talking therapies and counselling services to reduce waiting times for counselling and psychological support services. Access to local and national resources. Occupational health referral systems(self referral and management referral)and process in place. HWB stalls set up to seek the views on HWB gaps/needs/wants/views of staff. Rebranding of HWB programme underway. Occupation Health external review completed, with improvement plan now being implemented. HWB "check ins" rolled out across the Trust. Ts and Vs Business case to extend Covid testing and tracing service to end March 2022 agreed. HWB initiatives received confirmation of ICS funding for Emotional Health and Wellbeing support for staff. Health and Wellbeing dashboard of early warning metrics established and discussed at the programme board, ops meetings and HRC	12	OH review needed focussing on capacity and psychological support offer	Rebekah Coombes 26/11/2021	8
					More sophistocated workforce metrics needed	Rebekah Coombes 26/11/2021	
					Improved alignment with ICS	Lisa Crichton-Jones 26/11/2021	
					HWB strategy to be developed	Amanda Venner 31/01/2022	
2868 27/04/2021 Joanne Baxter Chief Operating Officer Chief Operating Officer 29/10/2021 BAF EPRR FPC ORG QGC 3.8P Deliver the Operational transformation programme to improve productivity and efficiency of service delivery and recovery post covid	Risk of a further wave (s) of Covid -19 and increased demand, Due to different strains of the virus being prevalent in the community and current vaccination not providing the intended protection Resulting in failure to deliver corporate objectives	15	EPRR command and control governance in place. Reconfiguration from previous waves and learning applied. Workforce management plans	12	Revise trust operating model, estates, workforce and activity forcasting	Joanne Baxter (Completed 31/08/2021)	9

Organisational Risk Register Report

14-Oct-2021 to 11-Nov-2021

Gateshead Health NHS Foundation Trust

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR
2882 30/04/2021 Joanne Baxter Chief Operating Officer Chief Operating Officer 15/09/2021 BAF FPC ORG 5.6P We will develop and expand our services within and beyond Gateshead - Manufacture FFP3 masks for NHS and commercial markets. We will work with our partners at Northumbria to make the manufacture of PPE a successful venture.	Risk of commercial market climate changes, due to political, environmental or other factors, affecting the ability to maximise opportunities.	12	Trust Business Case processes in place QEF Business development processes, risk assessment and authorisation route via QEF Board P&L for each venture Benefits realisation Report	6			6
							5

Actions Overdue

Organisational Risk Register Report

14-Oct-2021 to 11-Nov-2021

Business Intelligence

NHS Gateshead Health NHS Foundation Trust

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR
2945 14/09/2021 Joanne Baxter Chief Operating Officer Chief Operating Officer 13/12/2021 BU_DIR ORG 3.8P Deliver the Operational transformation programme to improve productivity and efficiency of service delivery and recovery post covid	Risk of ineffective and inefficient management of services due to lack of access to appropriate business intelligence resulting in impacts on patient safety, effectiveness and experience.	20	Reporting in place: Static reporting – this is how we performed last month but often too late to intervene and pull back performance Live reporting is needed – this is how we are doing now and where we need to intervene to prevent poor performance Forecasting – these are the trends to be able to plan services much more effectively to meet demand the later two points need further development	16	• Work with the BU managers looking at what is available and start to build what is needed and get rid of what is not used/helpful	Debbie Renwick 30/10/2021	4
							1

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 11

Report Title:	Quality Account Priorities Quarterly Report - Q1 & Q2			
Name of Meeting:	Board of Directors			
Date of Meeting:	Wednesday 24 November 2021			
Author:	Jane Conroy, Head of Quality and Patient Experience; Andrea Tweddell, Strategic Lead, Patient Safety; Wendy McFadden, Clinical Effectiveness Lead			
Executive Sponsor:	Gill Findley, Chief Nurse and Professional Lead for Midwifery and AHPs			
Report presented by:	Gill Findley, Chief Nurse and Professional Lead for Midwifery and AHPs			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	This report presents the progress made over quarters one and two of the eight Quality Account priorities (covering patient experience, patient safety and clinical effectiveness) and identifies the next steps.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	SafeCare/Risk and Safety Council, 10th November 2021			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	A two page Executive Summary is available on pages 3 and 4. **<u>Patient Experience priorities:</u>** • An interim Complaints and Concerns policy was ratified by SafeCare/Risk and Safety Council on 15th September 2021. A fully revised policy will follow. • Excellent examples are given around volunteers supporting staff and patients across the Trust. • In-house training on Always Events® will need to be balanced with operational pressures across the Trust. This is currently stood down. • A Co-design workshop was facilitated by the Patient Experience team with Cancer services in Q2 at an external venue. This resulted in over 50 patient stories and over 30 improvement ideas.			

	The Patient Experience team are working collaboratively with the Assistant Director of Transformation to consider how co-design workshops and wider methods can be used to ensure that patient voice and contribution is included in all aspects of quality improvement and delivery of care. **<u>Patient Safety priorities:</u>** • Preparatory work has been undertaken ahead of the launch of the Patient Safety Incident Response Framework (PSIRF). • Human factors training continues to be delivered within the organisation for all those who are required to undertake patient safety investigations. • Thematic analysis is being piloted to review the overdue low harm and no harm incidents. • Initiatives to share learning are being developed and implemented. • A number of places have been secured on the Northumbria University Restorative Just Culture NHSE/I Programme, taking place until early 2022. • Work continues with the Discharge Transformation Programme through two work streams – Ward Ways of working and Discharge to Assess. **<u>Clinical Effectiveness priorities:</u>** • Reduction of falls improvement work has commenced on Cragside resulting in no severe harm incidents reported. The falls rate per 1,000 bed days has reduced. • Improvement work has been undertaken to both Trust and Community acquired pressure damage. A reduction has been seen in both Trust and Community acquired pressure damage. • Future work planned includes reinvigorating the React to Red Campaign, trialling the PUSH tool, additional Nerve electronic documents and implementing weekly SSKIN bundle audits • 46% of patient deaths have received a level 1 Morality Review. Preliminary discussions have been held to update the mortality review process and policy in order to incorporate the Medical Examiner review into the level 1 review process. A task and finish group will be set up in Q3 to take this forward.
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Board of Directors are asked to review the detail provided within this report for assurance.

Trust Strategic Aims that the report relates to:	**Aim 1** ☒	We will continuously improve the quality and safety of our services for our patients				
	Aim 2 ☐	We will be a great organisation with a highly engaged workforce				
	Aim 3 ☐	We will enhance our productivity and efficiency to make the best use of resources				
	Aim 4 ☐	We will be an effective partner and be ambitious in our commitment to improving health outcomes				
	Aim 5 ☐	We will develop and expand our services within and beyond Gateshead				
Trust corporate objectives that the report relates to:	1.7 Deliver the requirements of the National Patient Safety Strategy 1.9 Develop and deliver the Trust's strategy and Quality Accounts					
Links to CQC KLOE	Caring ☒	Responsive ☒	Well-led ☒	Effective ☒	Safe ☒	
Risks / implications from this report (positive or negative):						
Links to risks (identify significant risks and DATIX reference)						
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☒	**Not applicable** ☐			

Executive Summary

Within the Quality Account 2021/22, 8 priority areas were identified as areas for improvement. This report presents the progress made over quarters one and two of these priorities and identifies the next steps.

Patient Experience:

Priority 1

The initial stages of a RPIW commenced in Q1 with the aim of revising the PALS and complaints processes. This included Process Mapping of both the PALS and Formal Complaints. The use of a RPIW was discussed and a decision was made that it was not the most effective model to use. An interim Complaints and Concerns policy was ratified by SafeCare/Risk and Safety Council on 15th September 2021. A fully revised policy will follow.

Volunteers have been supporting:

- The Practice Development Team completing questionnaires on the wards as part of CQAF.
- Each day (except weekends) the Patient Experience Volunteers visit the wards and spend time talking to patients and gaining real-time feedback.
- The electronic Friends and Family Test has now gone live across inpatients, outpatients and the emergency department with the exception of the Community and Maternity (this work is ongoing and will complete in 2022). This is providing a rich qualitative data narrative on care and can be viewed from an EDI perspective.
- The Patient Experience Team are scoping the potential for a new volunteer role - the Patient and Family Liaison Volunteer. These volunteers would be available to support Ward Clerks with administration including answering telephones on the wards.

Priority 2

In-house training on Always Events® has previously been facilitated across the Trust. This was stood down due to COVID-19. Multiple projects have been facilitated by the Patient Experience team which have generated a large amount of patient feedback and data. These projects are being reviewed to identify whether any of the areas may be suitable for the development of an Always Events®. The in-house training package around Always Events® will be reinvigorated in the next six months. This will need to be balanced with operational pressures across the Trust.

Priority 3

A Co-design workshop was facilitated by the Patient Experience team with Cancer services in Q2 at an external venue. This resulted in over 50 patient stories and over 30 improvement ideas.

The Patient Experience team are working collaboratively with the Assistant Director of Transformation to consider how co-design workshops and wider methods can be used to ensure that patient voice and contribution is included in all aspects of quality improvement and delivery of care.

Patient Safety:

Priority 4

In order to prepare for the launch of the Patient Safety Incident Response Framework (PSIRF), a review of the most frequently reported incidents over the past 3 financial years has been undertaken. This information will inform the Patient Safety Incident Response Plan. The NHS awaits the evaluation of PSIRF by the early adopter sites in order to guide the next steps required to implement the new process. Progress includes:

- Human factors training continues to be delivered within the organisation for all those who are required to undertake patient safety investigations.

- Thematic analysis is currently being piloted to review the overdue low harm and no harm incidents across the organisation.
- To highlight and share the learning from patient safety incident investigations; a monthly learning bulletin has been developed which is distributed via the QE Weekly.
- Work is underway to develop a 'Learning Library' which will hold examples and reports from all patient safety reviews including mortality reviews and patient experience alongside patient safety incident investigations.

Priority 5

A number of places have been secured on the Northumbria University Restorative Just Culture NHSE/I Programme, taking place until early 2022.

Priority 6

The Discharge Transformation Programme has two work streams – Ward Ways of working and Discharge to Assess:

- Ward Ways of Working have been driven by a series of Board Round Observations across a range of Medical and Surgical wards using the ECIST Framework and a Discharge Workshop. The findings of these pieces of work are being developed into an action plan.
- The Discharge to Assess work stream is underpinned by the principles of the National Discharge Guidance. An options paper to support the development of a Discharge to Assess model of care has been written for consideration at the Unscheduled Care Programme Board.

Additional outputs from the group include a Business Case for Discharge Coordinators, the development of Nerve Centre to create a Discharge Dashboards and a gap analysis of the current discharge guidance.

Clinical Effectiveness:

Priority 7

Reduction of falls improvement work has commenced on Cragside. Since the introduction of the initiatives there has been no severe harm incidents reported. The falls rate per 1,000 bed days has reduced from 9.78 in Apr-Sep 2020 to 9.40 in Apr-Sep 2021. In terms of harmful falls, the rate per 1,000 has reduced from 2.34 in Apr-Sep 2020 to 1.93 in Apr-Sep 2021.

A significant amount of improvement work has been undertaken to both Trust and Community acquired pressure damage. A reduction has been seen in both Trust and Community acquired pressure damage during April to September 2021 compared to the same period in 2020 per 1,000 bed days. Acute acquired has reduced from 3.43 to 1.86 and Community acquired has fallen from 0.70 to 0.58. Future work planned includes reinvigorating the React to Red Campaign, trialling the PUSH tool within Community, working with Nerve Centre team on a variety of electronic documents which will ensure a robust audit trail and compliance against the expected standard of care and implementing weekly SSKIN bundle audits.

Priority 8

During quarter 1 and quarter 2 there were 537 deaths in the Trust, 246 (46%) of these have received a level 1 review; of these 183 were carried out within 60 days of the patient's death. Therefore 34% of deaths have been reviewed within 60 days (183/537), however, of the total number that were reviewed 246, 183 were reviewed within 60 days which is 74% (183/246).

Preliminary discussions have been held to update the mortality review process and policy in order to incorporate the Medical Examiner review into the level 1 review process. A task and finish group will be set up in Q3 to take this forward.

Quality Account 2021/22
Quarter 1 and Quarter 2 – Update on Progress

Patient Experience

Priority 1: We will ensure that we have effective ways of receiving feedback from our patients, their relatives and carers which will lead to demonstrable improvements in practice.

- What did we say we would do?
- We will review and revise the PALS and complaints processes.
- We will re-establish a programme for collecting real-time patient feedback in clinical areas.

- Progress made:
- The initial stages of a RPIW commenced in Q1 with the aim of revising the PALS and complaints processes. This included Process Mapping of both the PALS and Formal Complaints processes and demonstrated a clear alignment. The use of a RPIW was discussed and a decision was made that it was not the most effective model to use. An interim Complaints and Concerns policy was ratified by SafeCare/Risk and Safety Council on 15th September 2021. This is an interim policy whilst the complaints pathway is under review. Minor changes have been made throughout including job titles and associated role responsibilities in relation to complaints and concerns. Small additions made in relation to complaints training that is now included in Investigating Officers' inductions.
- Volunteers have been supporting the Practice Development Team completing questionnaires with patients on the wards as part of CQAF. This is an ongoing real-time programme of work. Any comments or concerns on the questionnaires are placed on DATIX and shared with the relevant team/s
- Each day (except weekends) the Patient Experience Volunteers visit the wards and spend time talking to patients. This enhances patient experience. If a patient raises any concerns, the volunteers will feedback to the Ward Sister and/or patient experience team and concerns are logged or comments forwarded to the team/department for early resolution.
- During the Hidden Disabilities Week, the volunteers asked patients (with their consent) to record what their hidden disabilities were to give us as an organisation an understanding of those patients who would require support. Sunflower lanyards and pin badges were also available.
- The electronic Friends and Family Test has now gone live in-Trust (across inpatients, outpatients and the emergency department) with the exception of the Community and Maternity. The Friends and Family Test is now an automated telephone text service system, this is an 'opt out' process – there is a tick box on Medway with the patient contact details for this to be amended should the patient does not want to take part in test message FFT. Where patients do not have access to a smart phone, they still have the opportunity to provide real-time feedback on wards using Friends and Family cards, which is to be by exception only. The cards will be collected in the usual way from each ward/areas Friends and Family Test box at the end of each month.

- Next steps:
- There is a need to consider wider processes when looking to revise the PALS and complaints process such as patient safety incidents. A team away day is scheduled for November 2021 and this may highlight areas which need to be included within the review of PALS/complaints to ensure that there is an effective process in place that is aligned to that of incident investigations.
- The body of work described above regarding volunteers supporting with real-time patient experience feedback work will continue throughout the remainder of 2021/22.
- Patient feedback from PALS and complaints has revealed some concerns regarding family members being able to get through to the wards via telephone. The Patient Experience Team are scoping the potential for a new volunteer role - the Patient and Family Liaison Volunteer. These volunteers would be available to support Ward Clerks with administration including answering telephones on the wards. A SOP will be developed and this initiative will be tested on one ward and then evaluated. Should it be successful, it will be rolled out across the Trust to provide additional support to ward areas.
- The Patient Experience team are working collaboratively with both the Community Business Unit and Maternity and are looking to implement the digital FFT option in the coming months. The Community use EMIS and Maternity use Badger and therefore the timeframe for this implementation will be determined by the ease in which data can be connected from these systems with the text messaging

platform. Engagement work has also commenced to understand when would be the most appropriate 'trigger points' for service users to receive a FFT text – this will be slightly different within the Community and Maternity settings compared to the rest of the Trust.

Priority 2: We will ensure that patients, relatives and carers have the best experience possible when they are receiving our care.

- What did we say we would do?
- Following the success of the NHS England 'Always Events®' collaboration in one pilot, we will spread the use of the methodology as a tool to understand what is important to patients.

- Progress made:
- In-house training on Always Events® has previously been facilitated across the Trust. This was stood down due to COVID-19. The first stage of Always Events® is the capture of patient experience feedback and data. Multiple projects have been facilitated by the Patient Experience team which have generated a large amount of patient feedback and data.

- Next steps:
- The Patient Experience team are reviewing the rich data set gained from multiple patient engagement projects to identify whether any of the areas may be suitable for the development of an Always Events®.
- The in-house training package around Always Events® will be reinvigorated in the next six months. This will need to be balanced with operational pressures across the Trust.

Priority 3: We will ensure that patients, relatives and carers are engaged in our Quality Improvement work and that patient, relative and carer involvement is embedded as business as usual across the organisation.

- What did we say we would do?
- We will build on our patient, relative and carer involvement work to ensure their voice and contribution is included in all aspects of quality improvement and delivery of care.

- Progress made:
- A Co-design workshop was facilitated by the Patient Experience team with Cancer services on 17th August at an external venue. This resulted in over 50 patient stories and over 25 improvement ideas. Measuring, understanding and improving patients' experiences is of central importance to the Trust, and rather than doing things 'to' or 'for' patients, we will work with them as equal partners. This cannot be considered as an optional extra but must be considered a core component in everything we do. This co-design workshop provided:
    - a focus on designing experiences, not just improving performance or increasing safety
    - put patient experiences at the heart of the service improvement effort - but not forgetting staff
    - a space where staff and patients do the designing together (co-design rather than re-design)
    - and, in the process, improving day-to-day experiences of giving and receiving the care, and the way they feel about those experiences.

  Recent evidence also suggests positive associations between patient experience, patient safety and clinical effectiveness for a wide range of disease areas, and positive associations between patient experience and self-rated and objectively measured health outcomes.
- The Head of Quality and Patient Experience has met with the Trust's Deputy Director Corporate Services and Transformation to consider how co-design workshop and wider methods to ensure that patient voice and contribution is included in all aspects of quality improvement and delivery of care can be built into the Trust's strategy around quality improvement and ultimately, business as usual.

- Next steps:
- Further areas have expressed an interest in holding a co-design workshop. These workshops will be facilitated by the Patient Experience team as required.

- The Head of Quality and Patient Experience and Deputy Director Corporate Services and Transformation will continue to work collaboratively and a meeting will be scheduled in Q3 to discuss collaborative working across portfolios and how patient voice and contribution is included and will be delivered across the Trust.

Patient Safety

Priority 4: We will ensure there is a positive safety culture within the organisation in which openness, fairness, accountability and learning from high levels of incident reporting is the norm.

- What did we say we would do?
- We will implement the Patient Safety Incident Response Framework (PSIRF).

- Progress made:
- The implementation of the PSIRF requires organisations to move away from reactive and centrally-defined thresholds for 'Serious Incident' investigation and towards developing a thorough understanding of local patient safety risks and proactively planning the allocation of patient safety incident response resources through the development of Patient Safety Incident Response Plans (PSIRP). The table below demonstrates the top patient safety incident themes over the past 3 financial years: this highlights that there is minimal variance displayed regarding the most reported incident categories. This information will support the development of the organisation's Patient Safety Incident Response Plan.

	2018-2019	2019-2020	2020-2021
Patient Falls	1665	1519	1415
Medication	642	507 – 3rd	608 – 3rd
Pressure Damage	594	608 – 2nd	619 – 2nd
Delay/failure to treat/monitor	475	427	419 – 5th
Communication failure	439	370 – 6th	261 – 8th
Pathology samples	374	407 – 5th	537 – 4th
Patient Information	362	184 – 10th	92 – 14th
Medical Devices	291	220	74 – 17th
Discharge or transfer issues	281	344 – 7th	351 – 6th
Appointment issues	207	150 – 11th	96 – 13th
Maternal/fetal/neonatal	155 – 11th	206 – 9th	218 – 9th
Infection prevention and control	22 – 22nd	45 – 21st	276 – 7th
Patient accident – non fall	136 – 13th	148 – 11th	127 – 10th

- Investigation is one type of response however organisations are empowered to identify their own top themes of patient safety incidents and decide on the most appropriate process to be undertaken when review is required. The Trust has fully implemented the Human Factors approach to undertaking patient safety incident investigations to understand how systems and processes contribute to patient safety incidents occurring. Training continues to be offered to teams/departments and twenty two staff have attended Human Factors Investigation Training during Quarter 1 and 2.

- Thematic analysis of all low harm and no harm patient safety incidents is currently taking place, particularly those incidents which are overdue partly as a result of the effects of the Covid-19 pandemic.

The table below provides a snapshot of the top ten overdue incidents by category on 01.11.2021:

	CSS	SBU	MBU	Community	N,M & Q	Information	People & OD	CEO	Total
Communication failure – between staff/teams/departments	5	23	6	1	5	2	3	0	45

Treatment/procedure – delay/failure	3	22	4	0	1	1	0	0	31
Infection - respiratory	0	3	24	0	3	0	0	0	30
Non-controlled drug incident	1	0	18	1	1	0	0	0	21
Fall on same level – cause unknown	1	0	18	0	0	0	0	0	0
Communication failure – with patient / carer	0	11	4	0	1	0	0	1	17
Insufficient nurses (due to staff shortages/unfilled shifts)	1	3	9	0	0	0	0	0	13
Data sent by email to incorrect recipient	1	2	1	0	7	0	1	0	12
Discharge – planning failure	2	0	8	0	1	0	0	0	11
Fall from height - bed	0	0	11	0	0	0	0	0	11
Total	14	64	103	2	19	3	4	1	210

- A monthly learning bulletin has been developed to share the learning from serious incident investigations and a Learning Library is being developed to ensure that the learning from a wide range of reviews, including thematic learning from low and no harm incidents; audit; patient experience and mortality reviews is available for all staff to access. This electronic area will be used to store previous learning bulletins and any reports related to learning.

- The evaluation of the PSIRF programme has been completed and work is ongoing by the national patient safety team to determine how to proceed with further development and introduction of the framework. Organisations have been advised not to populate any of the templates (for PSIRF and PSIRP) provided by the national team until the next steps have been determined.

- Next steps:

- To continue to offer Human Factors Investigation Training for all staff who are required to undertake patient safety incident investigations.

- To develop the Learning Library with the IT and Comms Team to ensure it is accessible and easy to use.

- To share the feedback from the 'round table' discussion planned for 16th November 2021 to discuss the PSIRF with senior leaders within the organisation in order to plan for the launch of PSIRF in Spring 2022

Priority 5: We will promote a just, open and restorative culture across the organisation.

- What did we say we would do?
- We will implement and embed all principles of a just culture across the organisation.

- Progress made:
- A number of places have been secured on the Northumbria University Restorative Just Culture NHSEI Programme, which has been developed in partnership with Mersey Care. It is anticipated that the programme will be attended by those staff who are in the most appropriate position to impact on the delivery of a Just Culture across the organisation. Attendance will continue through until the end of 2021 and into the first part of 2022.

- Next steps:
- Attendees of the Northumbria University Restorative Just Culture NHSEI Programme will form the initial Just Culture Task and Finish group which is being delivered through the newly-formed Leadership and OD Programme Board.

Priority 6: We will ensure that our patient discharge processes are safe and effective.

What did we say we would do?

- We will ensure that the principles and requirements of the recently published national discharge requirements are realised.

- Progress made:
- The Discharge Transformation Programme is overseen by Multi- Agency group who report to the Unscheduled Programme Board. The programme has two work streams – Ward Ways of working and Discharge to Assess.

  The main areas for consideration of Ward Ways of Working have been driven by a series of Board Round Observations across a range of Medical and Surgical wards using the ECIST Framework and a Discharge Workshop. The findings of these pieces of work are being developed into an action plan.

  The Discharge to Assess work stream is underpinned by the principles of the National Discharge Guidance, supported by a NE&Y regional AHP Discharge to Assess Group. An options paper to support the development of a Discharge to Assess model of care has been written for consideration at the Unscheduled Care Programme Board.

  Additional outputs from the group include a Business Case for Discharge Coordinators, the development of Nerve Centre to create a Discharge Dashboard and a gap analysis of the current discharge guidance.

- Next steps:
- Unscheduled Care Programme Board to consider the Business Case for Discharge Coordinators and Discharge to Assess options paper.
- Progress the action plan for Ward Ways of Working

Clinical Effectiveness

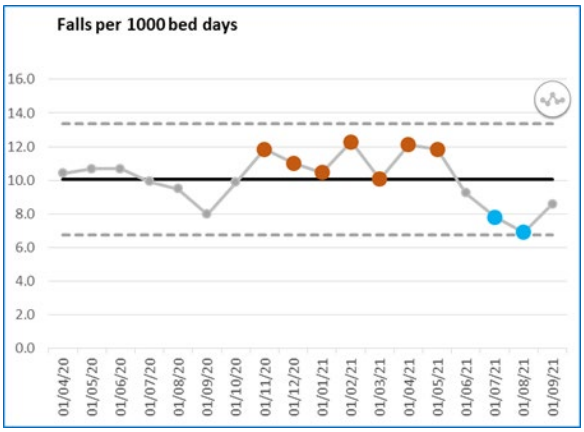
Priority 7: We will ensure the care that we provide to our patients is consistent with recognised best practice, leading to improved outcomes for patient.

- What did we say we would do?
- We will reinstate the falls collaborative to ensure falls can be prevented wherever possible.
- We will reduce the number of Trust (hospital and community) acquired pressure damage by 10%.

- Progress made:
  - Falls
  - Prevention of falls improvement initiatives have commenced within one area of the Trust so far; Cragside, as in February 2021 the number of falls spiked from on average four per month to 13 cumulating in 22 per month in April 2021.
  - As a consequence, in June 2021, one of the Practice Development Nurses was asked to support the reduction of falls in the area. In analysing the data and working in collaboration with all staff on the unit a quality improvement initiative was developed to support quality improvement in clinical practice.
  - One of the key drivers was education for staff, patients and visitors. Due to visiting restrictions and suspension of family forums, it has been difficult to provide education to visitors. However, information on falls prevention is given verbally and has been introduced into the welcome pack.
  - Liaison with family members of the most appropriate footwear to use as research has highlighted this will reduce the incidence of falls.

- Staff have received formal education from the Falls team as well as informal training specifically for patients who have fallen or have recurring falls.
- Patient's falls risks are discussed in the safety huddle by the multidisciplinary team and subsequent actions are agreed and cascaded to the whole team.
- The pathway for staff referrals to the physiotherapy team has been agreed and shared appropriately.
- When developing the education programme, it was highlighted that the patient's cognition and medication will have an impact and increase their falls risk. Therefore, the programme had input from the Specialist dementia nurses and the ward pharmacist, which was well received and evaluated positively.
- The quality of the completion of appropriate falls documents i.e. risk assessment, post falls checklist, was inconsistent. Therefore, this was addressed in the education programme, along with a reminder that all patients require a lying and standing blood pressure to be undertaken.
- There have been no significant harms reported since the quality initiatives commenced however the opportunity has been taken to do a review of patients who had multiple falls.

- Current Trust Level data:



Special cause variation between November 2020 and May 2021, however from June 2021 there are four consecutive points below the mean with special cause variation for improvement in July and August with 2 points close to the lower process limit.

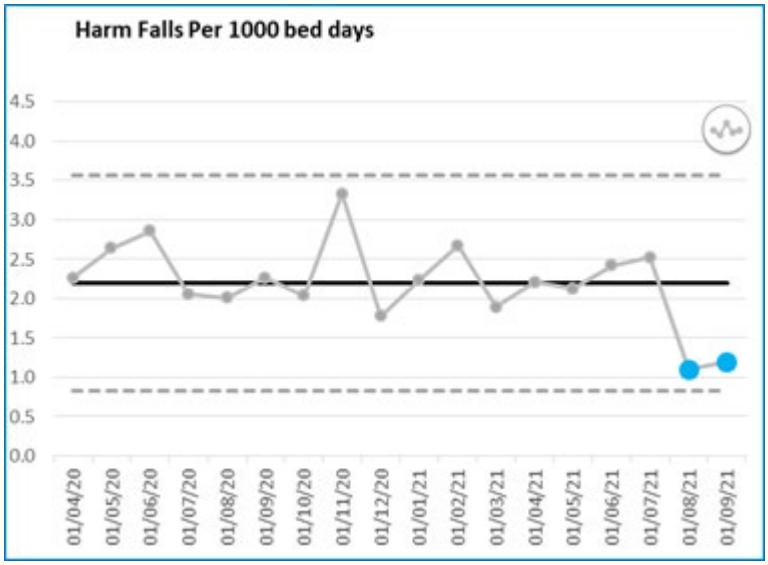
Comparing to the Apr-Sep period for 2020-21 shows a 3.9% reduction.

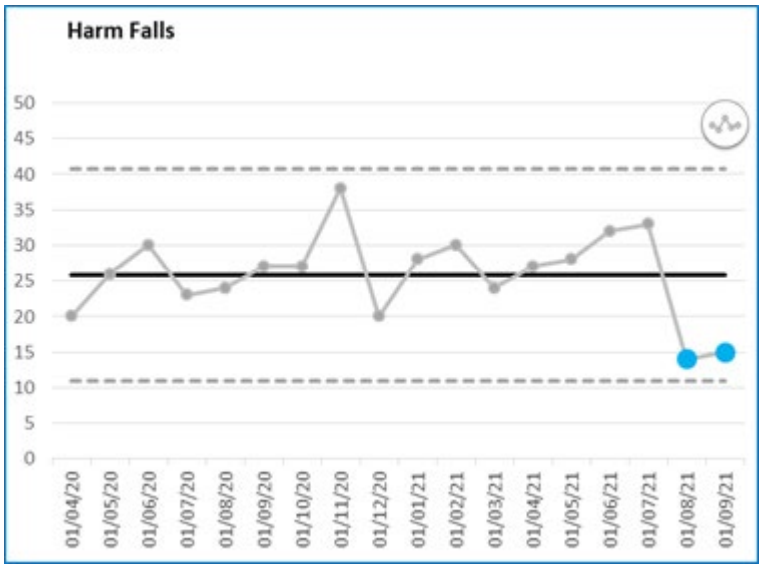
	Apr- Sep 2020-21	Apr-Sep 2021-22	Change
Falls rate per 1000 bed days	9.78	9.40	-3.9%

Harm falls and harm falls per 1000 bed days

August 2021 and September 2021 Harm falls and Harm falls rate per 1000 bed days are showing low values and are highlighted as being significantly (2 of 3 points close to the lower control limit rule). Needs further monitoring to see if this reduction is sustained.

Almost identical number of incidents reported over the April to September period for 2020-21 and 2021-22 with 150 vs 149. However, Bed occupancy was higher in 2021-22 hence a reduction is observed in the harm falls rate (17.2% Reduction)





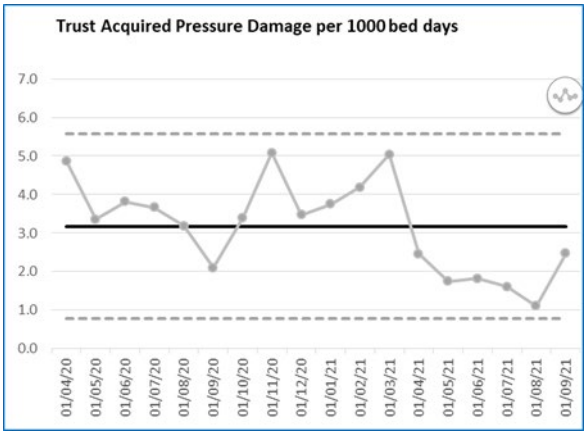
	Apr- Sep 20-21	Apr-Sep 21-22	Change
Harm Falls	150	149	-0.7%
Harm falls per 1000 bed days	2.34	1.93	-17.2%

- Next steps:
- Further pieces of work have been identified following a patient fall; a review and informal debrief has occurred this has led to new innovations which were suggested by staff and included additional walkabouts to look for obstacles which could cause a fall and ensure patient's safety. Falls are included in SBAR handover and safety huddle and this has led to discussions regarding preventative measures that could be introduced to prevent further falls. This is multidisciplinary approach and one of the new innovations to be trialled is non-slip mats slide sheets for patients who consistently slide off their chairs.

- Progress made:
  - Pressure Damage
- Implementation of the SSKIN bundle in community.
- Guideline devised to assist staff in nursing patients who are reluctant to comply with pressure ulcer prevention and management techniques.
- Pocket guides provided regarding the classification of pressure damage.
- All community dressings are provided via a Dressings Platform instead of individual pharmacies.
- Additional training has been delivered to complement our in-housing training sessions.

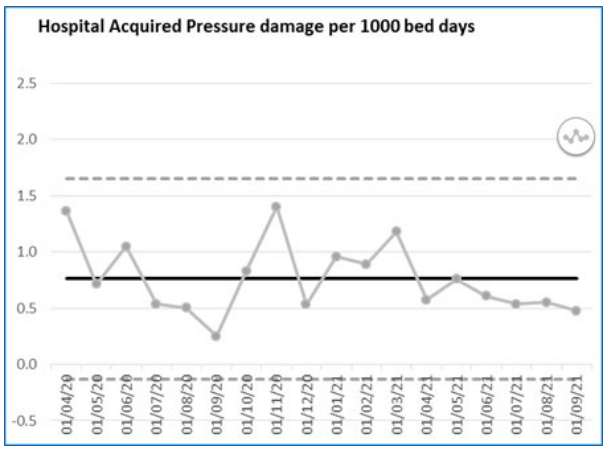
- A Pressure Ulcer Safety Huddle Rapid Review Tool (Push Tool) has been devised to identify any omissions in care concerning all Trust related Deep Tissue Injuries / Unstageable damage and Category 3 and Category 4 damage and implemented within the hospital setting A Rapid review meeting will take place within 72 hours of the injury being validated. Any omissions in care that are not related to themes and trends will be escalated to SI Panel.
- A baseline assessment of the SSKIN Bundle audit has been undertaken across the Trust highlighting inconsistencies with the recording wound assessments and positional changes.
- Weekly SSKIN bundle audits have been re-establishment across the ward areas.
- The Digital Transformation Team and the Tissue Viability Service have been developing an electronic solution to the Wound Management Booklet which will be available on Nerve Centre. The Wound Management Booklet will also be redesigned so it can be used on EMIS in the Community.
- Safety Cross Boards across the hospital site have been re-established incorporating the number of harm free days. (Ward 1 / Ward 11 / Ward 22 have achieved over 365 days harm free care).
- The Pressure Ulcer Collaborative has been re-established on Ward 14A and preliminary work has started on Critical Care (Red and Yellow Zone) using the Model of Improvement Methodology.

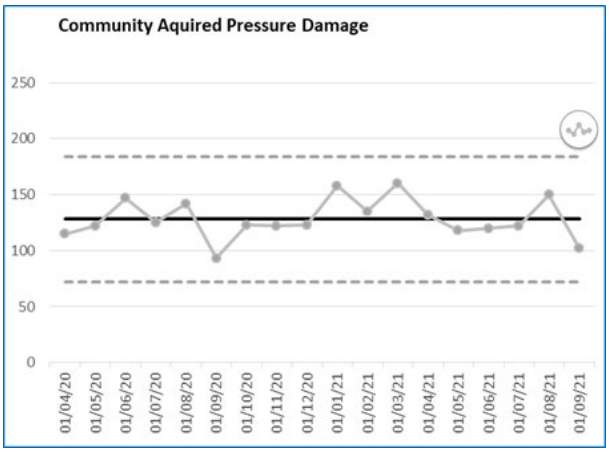
- Current data Trust Level data:



Comparing Apr-Sep 2021-22 the equivalent period in 2020-21 the Trust acquired pressure damage rate is 1.86 per 1000 bed days compared 3.43 per 1000 bed days for the previous period, a 46% reduction.

	Apr-Sep 2020-21	Apr-Sep 2021-22	Change
Trust acquired pressure damage rate per 1000 bed days	3.43	1.86	-46%
Hospital acquired pressure damage per 1000 bed days	0.70	0.58	-17%
Community acquired pressure damage (monthly average)	124	124	0%





- Next steps:
  - To continue to build upon the successes we have already achieved and sustain those changes already made.
  - The Intentional Rounding chart is the next document to be devised for use on Nerve Centre team which will ensure a robust audit trail and compliance against the expected standard of care.
  - The Pressure Ulcer Collaborative will be continue to be rolled out across the organisation.

Priority 8: We will review and revise our level 1 mortality review process, providing families, carers and staff to identify themes for improvement and to highlight areas of good practice and excellent care

- What did we say we would do?
- We will ensure that at least 80% of patient deaths will have received a level 1 review within 60 days.

- Progress made:
- During quarter 1 and quarter 2 there were 537 deaths in the Trust, 246 (46%) of these have received a level 1 review; of these 183 were carried out within 60 days of the patient's death. Therefore 34% of deaths have been reviewed within 60 days (183/537), however, of the total number that were reviewed 246, 183 were reviewed within 60 days which is 74% (183/246). The number of deaths reviewed has decreased significantly over the Covid-19 pandemic.
- During quarter 1 and 2, 95 level 2 reviews were carried out by the Mortality Council, 9 of these cases are required to return for final scoring once the requested patient safety investigations or complaint investigations have been completed. The deaths stipulated by the National Quality Board guidance have continued to be reviewed by the Council, including family concerns (formal/informal complaints), learning disability, elective, severe mental illness, staff concerns, serious incidents, medical examiner referral, level 1 referrals and a random sample for quality assurance. There has been a continued Mortality Council dedicated to Covid-19 deaths.
- Monthly reports providing compliance with level 1 reviews are provided at a Trust level to the Mortality & Morbidity Steering Group and also at business unit level via the monthly quality and safety reports presented at various forums.
- Learning from deaths has been shared via a number of reports in various Trust forums; namely:
  - Monthly via the Integrated Quality & Learning Report, this has been superseded by the Integrated Oversight Report, learning from deaths will be a quarterly addition to this report.
  - Six monthly mortality reports to the Quality Governance Committee and the Trust Board with the latest in September 2021.
  - Learning from deaths was shared in the newly developed Triangulated Annual Learning Report.
  - An annual learning from Covid-19 deaths report was shared with the Quality Governance Committee in September 2021.
  - Themes from mortality reviews are available for staff to access from the mortality database – these are analysed and updated on a six-monthly basis.
  - Learning from deaths at specialty level is shared annually at the Mortality & Morbidity Steering Group.
- Preliminary discussions have been held to update the mortality review process and policy in order to incorporate the Medical Examiner review into the level 1 review process. In areas where there are high volumes of expected and well-planned deaths, there are limited opportunities for learning. Therefore, using the medical examiner review as the level 1 review would be free capacity to concentrate the ward team's efforts on reviewing those where it was felt there was learning to be identified and improvements to be made. Some areas may continue to carry out a separate review and this will also be documented. This process will also increase the Trust's compliance with level 1 reviews being undertaken within 60 days of the patient's death.

- Next steps:
- A group will be set up in early 2022 with the task of incorporating the Medical Examiner review into the level 1 review process.
- An internal audit into the Trust's Mortality Review is currently underway, any resulting recommendations will be incorporated into the existing processes.

Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 13

Report Title:	**Consolidated Finance Report – Part One**			
Name of Meeting:	Trust Board			
Date of Meeting:	Wednesday 24th November 2021			
Author:	Mrs Jane Fay, Acting Deputy Director of Finance			
Executive Sponsor:	Mrs Kris Mackenzie, Acting Group Director of Finance			
Report presented by:	Mrs Kris Mackenzie, Acting Group Director of Finance			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☐
	The purpose of this paper is to provide assurance against priority objective 3.4 (develop an approved capital and revenue plan) and address risk 2874.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*				
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	Following the release of the H2 planning guidance and negotiation of associated funding envelopes, the Trust has submitted a balanced plan for 2021/22. For the period April to October 2021, the Trust has reported a modest revenue surplus of £2.422m. For the same time period the Trust has spent £3.216m of its capital programme.			
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	This report seeks to provide assurance in respect of the priority objective 3.4 – develop an approved capital and revenue plan; addressing risk 2874 – risk that the Trust is unable to formulate a coherent financial plan due to the uncertainty surrounding the financial framework. To note the summary of performance as at 31st October 2021 (Month 7) for the Group (inclusive of Trust and QE Facilities, excluding Charitable Funds).			

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

1. Introduction

1.1 The purpose of this report is to provide a summary of financial performance as at 31st October 2021 (month 7) for the Group (inclusive of the Trust and QE Facilities, excluding Charitable Funds).

2 2021-22 Financial Framework

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

2.2 During October 2021 financial planning guidance for the period October 2021 to March 2022 was issued referenced in the guidance as 2021-22 H2 and is underpinned by broadly the same principles as those in 2021-22 H1.

2.2 The 2021-22 H2 financial framework is underpinned by the following principles:

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

2.3 Work is currently progressing on the production of a detailed 2021-22 H2 financial plan for submission to NHSE&I on the 25th November. This detailed plan is reflective of a North ICP summary plan already submitted to the ICS forecasting a breakeven position for the period October to March 2022.

2.4 Within the summary North ICP plan the Trust is forecasting a planned 2021-22 H2 deficit totalling £2.588m to achieve an overall breakeven position for the 2021-22 financial year.

2.5 However as the timelines for the submission of the Trusts detailed H2 plan do not align to the reporting of the October 2021 financial position as an interim measure NHSE&I have proposed external reporting to the 31st October 2021 is against the Trust's 2021-22 H1 financial plan and

October 2021 reported actual. It is expected from November 2021 onwards NHSE&I will require external reporting against the detailed H2 plan.

3 Income and Expenditure

3.1 The Trust has reported a deficit of £196k for the month of October and a year to date surplus of £2.255m prior to and a surplus of £2.422m after an adjustment for donated assets and gain on disposal of assets.

3.2 This is a positive variance of £2.422m against the year to date plan as detailed on the Trust Statement of Comprehensive Income (SOCI) presented in Table 1.

3.3 For the month of October 2021 the Trust has reported actual income of £29.664m and £209.517m for the period to date resulting in a nil variance from the NHSEI plan in-month and a year to date favourable variance of £9.620m.

3.4 Included in the period to date total is £2.264m Elective Recovery Fund (ERF) income, as provided by NHSEI for the period April to June 2021, with no ERF income expected for the months July to October 2021.

3.5 For the month of October 2021 the Trust has reported actual operating expenditure of £29.458m with a year to date adverse variance of £6.943m. These figures include £5.259m of spend directly attributable to the Trusts response to the COVID-19 pandemic.

STATEMENT OF COMPREHENSIVE INCOME

October 2021-22 Red >100k over Amber <> (£50k) - £99.99k Green <(£50.1k)	GROUP POSITION NHSI/E APRIL - OCT 21 REVISED PLAN			VARIANCE	
	Revised Covid Plan Total	Covid Plan to Date	Actual to Date	Variance (Actual - Budget)	Previous Month Variance
	£000's	£000's	£000's	£000's	£000's
Operating					
Operating Income from Patient Care activities					
Income From NHS Care Contracts	(185,347.6)	(185,347.6)	(192,032.6)	(6,685.0)	(6,685.0)
Income From Local Authority Care Contracts	(52.5)	(52.5)	(52.5)	-	-
Private Patient Revenue	(683.3)	(683.3)	(536.9)	146.5	146.5
Injury Cost Recovery	(178.4)	(178.4)	(138.9)	39.5	39.5
Other non-NHS clinical revenue	(54.9)	(54.9)	(470.2)	(415.3)	(415.3)
Total Operating Income From Patient Care activities	**(186,316.7)**	**(186,316.7)**	**(193,231.0)**	**(6,914.4)**	**(6,914.4)**
Other Operating Income					
Education and Training Income	(5,847.3)	(5,847.3)	(5,642.2)	205.1	205.1
R&D Income	(425.5)	(425.5)	(371.4)	54.1	54.1
Funding ouside of System Envelope	(470.7)	(470.7)	(2,093.2)	(1,622.4)	(1,622.5)
Other Income	(6,836.4)	(6,836.4)	(8,179.2)	(1,342.8)	(1,342.8)
Donations & Grants Received	-	-	-	-	-
Total Other Operating Income	**(13,579.9)**	**(13,579.9)**	**(16,286.0)**	**(2,706.1)**	**(2,706.1)**
Total Operating Income	**(199,896.6)**	**(199,896.6)**	**(209,517.1)**	**(9,620.5)**	**(9,620.5)**
Operating Expenses					
Employee Expenses - Substantive	124,179.2	124,179.2	119,891.8	(4,287.3)	(4,287.3)
Employee Expenses - Bank	3,368.8	3,368.8	4,429.7	1,060.9	1,060.9
Employee Expenses - Agency	2,831.4	2,831.4	2,804.8	(26.6)	(26.6)
Employee Expenses - Other	568.1	568.1	700.1	132.0	131.9
Total Employee Expenses	**130,947.5**	**130,947.5**	**127,826.5**	**(3,121.1)**	**(3,121.1)**
Purchase of Healthcare - NHS bodeis	3,424.7	3,424.7	3,471.7	47.0	47.0
Purchase of Healthcare - Non NHS bodies	1,207.7	1,207.7	1,356.3	148.5	148.6
Purchase of Social Care	-	-	-	-	-
NED's	109.9	109.9	102.7	(7.2)	(7.2)
Supplies & Services - Clinical	20,987.4	20,987.4	22,257.1	1,269.8	1,269.8
Supplies & Services - General	2,782.2	2,782.2	3,899.7	1,117.5	1,117.5
Drugs	10,039.3	10,039.3	10,842.4	803.2	803.2
Research & Development expenses	1.5	1.5	30.3	28.8	28.8
Education & Training expenses	1,806.7	1,806.7	582.2	(1,224.4)	(1,224.4)
Consultancy costs	148.1	148.1	364.0	215.9	215.9
Establishment expenses	2,440.7	2,440.7	4,897.9	2,457.2	2,457.2
Premises	10,100.7	10,100.7	12,879.3	2,778.6	2,778.6
Transport	706.3	706.3	755.2	48.9	48.9
Clinical Negligence	4,795.1	4,795.1	4,769.5	(25.5)	(25.5)
Operating Leases	203.9	203.9	1,224.1	1,020.2	1,020.2
Other Operating expenses	4,090.3	4,090.3	5,225.4	1,135.1	1,135.1
Operating Expenses included in EBITDA	**193,792.1**	**193,792.1**	**200,484.4**	**6,692.4**	**6,692.4**
Depreciation & Amortisation - Purchased / Constructed	4,075.4	4,075.4	4,254.0	178.6	178.7
Depreciation & Amortisation - Donated / Granted	230.4	230.4	213.1	(17.3)	(17.3)
Depreciation & Amortisation - Finance Leases	-	-	-	-	-
Impairment & Revaluation	(259.7)	(259.7)	(172.9)	86.8	86.8
Restructuring Costs	-	-	-	-	-
Operating Expenses excluded from EBITDA	**4,046.1**	**4,046.1**	**4,294.2**	**248.1**	**248.1**
Total Operating Expenses	**197,838.1**	**197,838.1**	**204,778.6**	**6,940.5**	**6,940.5**
(Profit)/Loss from Operations	**(2,058.4)**	**(2,058.4)**	**(4,738.4)**	**(2,680.0)**	**(2,680.0)**
Non Operating					
Non-Operating Income					
Finance Income	(31.4)	(31.4)	(27.6)	3.7	3.7
Total Non-Operating Income	**(31.4)**	**(31.4)**	**(27.6)**	**3.7**	**3.7**
Non-Operating Expenses					
Finance Costs	322.2	322.2	281.7	(40.5)	(40.5)
Gains / (Losses) on Disposal of Assests	(0.0)	(0.0)	(46.3)	(46.2)	(46.3)
PDC dividend expense	1,676.2	1,676.2	1,676.7	0.5	0.5
Total Finance Costs (for non-financial activities)	**1,998.3**	**1,998.3**	**1,912.1**	**(86.2)**	**(86.2)**
Other Non-Operating Expenses					
Misc. Other Non-Operating expenses	-	-	-	-	-
Total Non-Operating Expenses	**1,998.3**	**1,998.3**	**1,912.1**	**(86.2)**	**(86.2)**
(Surplus) / Deficit Before Tax	**(91.5)**	**(91.5)**	**(2,853.9)**	**(2,762.4)**	**(2,762.4)**
Corporation Tax	288.0	288.0	598.5	310.5	310.5
(Surplus) / Deficit After Tax	**196.5**	**196.5**	**(2,255.4)**	**(2,451.9)**	**(2,451.9)**
(Surplus) / Deficit After Tax from Continuing Operations	**196.5**	**196.5**	**(2,255.4)**	**(2,451.9)**	**(2,451.9)**
Remove capital donations / grants I&E impact	(230.4)	(230.4)	(213.1)	17.3	17.3
Other Control Total adjustment	-	-	46.3	46.3	46.3
System Envelope Adjustments	-	-	-	-	-
Adjusted Financial Performance (Surplus) / Deficit	**(33.9)**	**(33.9)**	**(2,422.3)**	**(2,388.4)**	**(2,388.4)**
Adjusted Financial Performance (Surplus) / Deficit	**(33.9)**	**(33.9)**	**(2,422.3)**	**(2,388.4)**	**(2,388.4)**

Table 1: Trust Statement of Comprehensive Income

4 Cost Reduction Programme (CRP)

4.1 Included in the Trusts 2021-22 H1 financial plans is an efficiency requirement of £2.225m required to achieve a breakeven position and the corresponding figure for H2 being £2.100m giving a total efficiency plan of £4.325m. Non-recurring schemes totalling £2.575m have been identified and whilst this mitigates the financial risk for April to October it is imperative the Trust continues to identify recurring schemes via its transformation programme with work currently underway to refine and scope the supporting schemes.

5 Cash and Working Balances

5.1 The Trust opened the financial year with £43.862m of cash. The cash position of £55.173m as at 31st October is equivalent to an estimated 34.15 days operating costs and represents a £9.212m increase from September 2021.

5.2 The liquidity metric has deteriorated slightly by 0.21 days against September to -1.15 days driven by a £0.198m decrease in the working capital balance.

5.3 The balance sheet is presented in Table 2.

Statement of Position - October 2021

	2021/2022 September 2021 Group	2021/2022 October 2021 Group	Movement from Prior Month	2021/2022 October 2021 QEF	2021/2022 September 2021 FT
	£000's	£000's	£000's	£000's	£000's
Assets					
Non-Current Assets					
Investments	80	80	0	80	16,824
Property, Plant and Equipment, Net	117,059	117,163	104	1,163	116,000
Trade and Other Receivables, Net	2,045	2,033	(12)	729	1,304
Finance Lease - Intragroup				42,743	0
Trade and Other Receivables - Intragroup Loan	0	0	0		15,789
Total Non Current Assets	119,184	119,276	92	44,715	149,918
Current Assets					
Inventories	5,148	5,071	(77)	2,430	2,641
Trade and Other Receivables - NHS	16,840	14,693	(2,146)	529	14,165
Trade and Other Receivables - Non NHS	4,362	4,037	(325)	492	3,545
Trade and Other Receivables - Other	0	0	0		0
Prepayments	4,936	5,392	456	656	4,736
Cash and Cash Equivalents	45,961	55,172	9,211	9,178	45,995
Other Financial Assets - PDC Dividend	0	0	0		0
Accrued Income	1,940	1,752	(188)	1,094	658
Finance Lease - Intragroup				283	0
Trade and Other Receivables - Intragroup Loan					1,676
Total Current Assets	86,469	86,118	6,932	14,661	73,416
Liabilities					
Current Liabilites					
Deferred Income	7,593	11,346	3,753	167	11,179
Provisions	5,146	5,092	(54)	489	4,603
Current Tax Payables	5,188	4,158	(1,029)	356	3,802
Trade and Other Payables - NHS	1,541	2,879	1,338	725	2,154
Trade and Other Payables - Other	10,015	7,632	(2,383)	2,282	5,349
Trade and Other Payables - Capital	(646)	58	704	0	58
Other Financial Liabilities - Accruals	45,580	50,164	4,585	7,503	42,661
Other Financial Liabilities - Borrowings FTFF	499	499	0	0	499
Other Financial Liabilities - PDC Dividend	0	295	295	0	295
Other Financial Liabilities - Intragroup Borrowings	0	0		1,676	0
Finance Lease - Intragroup	0	0		0	283
Total Current Liabilities	82,198	82,123	7,208	13,197	70,885
NET CURRENT ASSETS (LIABILITIES)	4,271	3,995	(276)	1,464	2,531
Non-Current Liabilities					
Deferred Income	2,124	2,124	0	1,794	330
Provisions	2,582	2,584	2	0	2,584
Trade and Other Payables - Other	0	0	0	0	0
Other Financial Liabilities - Accruals	0	0	0	0	0
Other Financial Liabilities - Intragroup Borrowings	0	0	0	15,789	0
Other Financial Liabilities - Borrowings FTFF	14,010	14,010	0	0	14,010
Finance Lease - Intragroup				0	42,743
Total Non-Current Liabilities	18,715	18,718	2	17,583	59,667
TOTAL ASSETS EMPLOYED	**104,740**	**104,554**	(186)	**28,596**	**92,783**
Tax Payers' and Others' Equity					
PDC	139,314	139,314	0	0	139,314
Taxpayers Equity	0	0	0	0	0
Share Capital	0	0	0	16,824	0
Retained Earnings (Accumulated Losses)	(41,284)	(41,470)	(186)	17,931	(59,401)
Other Reserves	0	0	0	0	0
Revaluation Reserve	6,611	6,611	0	0	6,611
Misc Reserve	99	99	0	0	99
TOTAL TAXPAYERS EQUITY	104,740	104,554	(186)	34,756	86,623
TOTAL ASSETS EMPLOYED	**104,740**	**104,554**	(186)	**34,756**	**86,623**

Table 2 – Statement of Position

6 Capital

6.1 The Trusts 2021/2022 CDEL limit had been set at £6.825m, with additional capital funding of £8.387m approved in the year to date increasing the CDEL to £15.302m. The additional capital funding of £8.387m includes successful bids of £1.050m to support the Trust elective recovery programme; £5.329m recently approved PDC re the Community Diagnostic Hub; and £0.250m of PDC in respect of IT Cyber Security. Whilst the £1.050m is an increase to the Trusts available capital funding envelope it is not supported by additional cash. Previously an unconfirmed PDC award of £90k for oxygen infrastructure had been included, however as confirmation of the PDC has still to be received these works will now be funded internally.

6.2 As at the end of October the Trust had an approved capital programme totalling £15.969m, £0.657m above the Trust's approved CDEL. The programme will therefore need to be monitored and controlled to ensure expenditure does not exceed the Trust's approved capital programme.

6.3 Actual expenditure up to 31st October totals £3.216m mainly in respect of 2020-2021 carried forward schemes, information technology infrastructure, building maintenance and equipment replacement.

7 Risk

7.1 There are a number of risks that must be noted alongside consideration of the financial position. Table 3 provides further detail of these risks, along with the current risk rating and any progress against actions to mitigate.

Risk Number	Risk	IRR	CRR	TRR	Current Controls	Action
2872	Risk that new efficiency saving requirements cannot be achieved Due to the impact of COVID funding regimes which have necessarily meant that efficiency schemes have been paused for some considerable time, and it will be difficult to now identify these in line with requirement of the new financial framework, Resulting in the impact on financial performance and the achievement of the overall programme.	20	16	8	COVID funding regimes have necessarily meant that efficiency schemes have been paused for some considerable time	
2873	Risk that the Trust is unable to form a suitable capital plan and programme Due to reduced levels of CDEL available and the management of capital within the ICS Resulting in the inability to fund capital requirements to meet the development needs of the Trust.	20	16	8	Approved Capital and Revenue Plan 2021/22	
2874	Risk that we are unable to formulate a coherent financial plan, Due to there being a lack of guidance and great deal of uncertainty surrounding the financial framework for the second half of the financial year, Resulting in unclear financial position and plan in year, impacting financial decisions, and unknown financial trajectory for full year.	20	16	8	Financial report regularly to F&P and Board.	
1397	Divisions overspend against control totals leading to the Trust missing its financial targets.	16	16	8	Monthly monitoring of expenditure flag up immediately variances from control total. Headline inflation figures are monitored and action plans developed for variances. Forecasting tools are in place and effective information gathering including Horizon scanning and modelling impact of changes where known or suspected.Divisional positions are reported to the FRSB and the Finance and performance Sub Committee and action plans are developed to recover the position where appropriate. Monthly budget meetings held with respective managers in order to understand variances and produce action plans to bring back into balance.The Board is reviews financial performance monthly. This includes forecasting end of year activity levels and adjusting as required.	CTs to establish and monitor

Table 3: Financial Risk

Kris Mackenzie, Acting Group Director of Finance
15th November 2021

Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 14

Report Title:	**Integrated Oversight Report**			
Name of Meeting:	Board of Directors			
Date of Meeting:	24 November 2021			
Author:	Deborah Renwick and IOR Reporting Leads			
Executive Sponsor:	Joanne Baxter			
Report presented by:	Executive Directors at Committees			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☐
	Enter purpose here: To summarise performance in relation to key NHS standards, requirements and KLOE's to outline the risks and recovery plans associated with COVID -19. This report covers the reporting period of September and October.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Chief Operating Officer's Senior Management Team Meeting			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	**COVID:** Rising cases and general winter pressures continue to adversely impact on the delivery of services across the Trust, elective recovery continues at risk. **Workforce pressures:** Exhaustion, sickness absence and recruitment and retention issues continue to affect the delivery of services. **Operational pressures** directly impact on the Trust's performances in particular the deterioration of the in UEC measures.			
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Committees are recommended to: • Note the operational pressures directly impacting on the Trust's current performance in particular the deterioration in UEC measures.			

<table>
<tr><td></td><td colspan="6">Support the on-going health and well-being actions in support of front-line employees and the wider workforce
Acknowledge and be aware of the risk that there will be difficult decisions taken to balance non-elective pressures against elective recovery – prioritisation of cancer and P2 patients remain pivotal.
Note the inclusion of new Maternity (subset) measures</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="5">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td colspan="5">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td colspan="5">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☒</td><td colspan="5">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☐</td><td colspan="5">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="6">1.1 (QGC) Part of the implementation of Board level reporting: Okenden and maternity services

1.8 (QGC) Achieve accreditation of Nursing and Midwifery excellence programme

1.10 (QGC) Supporting the route map to CQC Outstanding

2.5 (P&OP) Strengthen approaches to people related quality, performance & governance measures

3.8 (F&P) Deliver operational transformation to improve productivity & efficiency

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

	Maternity pressures (1675)		
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒

INTEGRATED OVERSIGHT REPORT

1. Executive Summary

Area	Metric	**Update at a Glance**
Recovery	Activity	Performing at 94% across all points of care **Oversight via: Elective Care Board**
Responsive	A&E	Pressures are evident in October, although benchmarking (Sept) suggest excellent ranking: 11th out of 139 providers. **Oversight via: Urgent & Emergency Flow Board**
	2 Week waits	Activity delivered above 2019/20 baseline – performance just below access targets **Oversight via: Elective Care Board**
	RTT	Increase in waiting lists, summer activity and increased referrals in September. Good backlog management. **Oversight via: Elective Care Board**
	Cancer	Pressures across all tumour groups – action plans currently being worked up. **Oversight via: Elective Care Board**
	Diagnostics	Activity at 105% of pre-covid levels H2: Echo cardiology activity 79%, backlog plan in place, waiters over 6 weeks at 81.3% DM01: Audiology waits 43% over 6 weeks DM01: Slight pressures in urodynamics **Oversight via: Elective Care Board**
Safety	All Standards Except CHPPD	Oversight Safecare Council /Risk & Patient Safety Council
Effective	HMSR	Mortality and Morbidity Steering Group
Well Led	People & Workforce	People & OD Portfolio Board
Maternity	All sub-set standards	Maternity Review Group SafeCare Council

2. Introduction

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

Area	Data Item	Reporting Period
Recovery	Activity	Submitted October (not freeze)
Responsive	A&E	Submitted October
	2 Week waits	
	RTT	Submitted September
	Cancer	
	Diagnostics	
Safety	All Standards Except CHPPD	October (CHPPD is September)
Effective	HMSR	Unchanged (July 20 to June 21)
Well Led	People & Workforce	September
Maternity	All sub-set standards	October

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

Quality Governance Committee:

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

People & OD:

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

Finance & Performance Committee:

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

3. Key issues / findings

3.1 Covid Pressures continue: Through-out the summer and continuing into September the Trust (on average) treated 33 patients per day. During October and into November this has increased to between 40-58 per day. A RSU (Respiratory Support Unit) to support increasing respiratory admissions, staffing the unit remains problematic.

3.2 Workforce: Staff Absences have also increased during September with performance deteriorating to (5.8 %) in particular short notice absences and general vacancies have impacted on the ability to deliver services and have required flexible working models to deliver services. Management teams require real time oversight of work-force data to support real-time operational pressures. Recruitment and retention, absence management require on-going focus.

3.3 Activity: October's **elective activity** is at 94% of 2019/20 baselines, representing a marked improvement upon delivery in the summer (circa 89%), and a slight drop from 95% in August. Pressures continue against overnight electives (79%) and day cases (82%).

Non-elective activity is 116% higher than pre-covid levels. Patient activity for those we turn around in a day activity is at 195% of pre- pandemic levels and for those who go on to require a base ward bed activity is at 95% of pre covid levels.

Attendances through ED is at 81% of pre-pandemic levels, although average daily attendances are on average 77 per day higher than last year. SDEC have reviewed 590 patients of which 85% were discharged on the same day – this activity will also be included within Trust volumes of Non-elective admissions.

Supporting **Community Care** and keeping patients in their own home District Nursing teams across Gateshead saw 28,750 patients in October (averaging 927 per day).
In total the rapid response team reviewed and or treated 3,866 patients manged to see 100% of those referred within in 2 hours, 76% of patients within 4 hours, and 100% of patients requiring care within 12 hours.

Winter bed escalation plans were instigated early and the Trust is operating with Winter escalation beds open.

3.4 Performance - Access and Recovery of Back-log Waiters

3.4.1 A&E: 95% 4 hour Target: Together with the latest surge in COVID admissions this has put significant pressure on Trust services and on the wider local health system. Ambulance delays have increased to 87 (30-60 mins) and 54 (over 60 mins) and new UEC measured demonstrate that patients are waiting longer in ED, some waiting over 12 hours and the 4 hour performance has deteriorated to 75.3%, Key factors driving performance are increases in attendances with daily attendances average 77 more than October 2019 (37.6%). Overall ED activity is at 81% of pre-covid levels**.**

3.4.2 RTT : NHSE/I are focusing on reducing patient backlog.
Reduced activity over the summer has **i**ncreased the number of patients awaiting treatment from 9,025 in July to 9,422 in August and then an increase in referrals in September has increased the volume of waiters to 9,912. Backlog management of 52 week waiters has now decreased to 29 patients waiting longer than 52 weeks, there were no patients waiting over 104 weeks.

3.4.3 Cancer: Despite continuing increases in referrals into **Two week wait pathways** performance has improved from 86% in July to 90% in August and 92.7 % in September, and maintained performance at 92.2% in October - Just below the 93% standard.

The Trust achieved the **Faster diagnostic standard** with performance at 79.7% against the 75% target. Pressures are evident against the screening element of this target.

Treating our urgent and Cancer patients remains a key priority. Performance against **62 day cancer treatment** target is at 63.4% % in September, and there are notable improvements across Breast, Haematology, Lung and Upper GI above the performance standard of over 85%. NHSE/I recognises the pressure in achieving this target across the NHS and planning guidance now focuses on backlog reduction and increasing capacity to treat patients. At the end of October 59 patients were waiting longer than 62 days, this represents an in month decrease of 14 from September where 73 patients were waiting longer than 62 days. There is a risk that patients waiting longer than 62 days are likely to increase as pressures in Gynaecology continue as the Trust is supporting the ICS wide provision of cancer services.

3.4.4 Diagnostics Echocardiology capacity is still significantly below 2019/20 baselines, services continue to work through the improvement trajectory – with recovery forecast in Spring 2022.

3.5 Quality and Safety Effectiveness

3.5.1 Trust level SI's 8 were reported in October, which is just over the average for the last 18 months. Themes include deterioration of patients, diagnostic delays, falls, ambulance breach and incorrect diagnosis. No maternity SI's were reported.

3.5.2 HMSR – Indicator remains unchanged, data is the same as previously reported (July – June 21). Therefore, still indicating more deaths than expected.

3.5.3 Duty of Candour – Health & Social Care Act (2008) to notify patients within 10 working days following a safety incident. This metric is undergoing a review of categorisation of reporting.

3.5.4 Maternity – Total number of births were within expected range, C.sections were at 31.1% - just above the 30% threshold. Smoking at time of delivery remains high at 12.2% against a 5% target and breast feeding at discharge is at 20.96%, representing a drop in performance against the 72% target. Babies admitted directly to SCBU > 37 week gestation is within normal range, whilst the pre-term birth rate at 9.15% is above expected levels of 6%.

3.6 Benchmarking

The Trust is in a relatively strong position against available benchmarking data:

Indicator	QEH Performance	View	Position
A&E 4 hour waiting time target	83.4%	September	11th / 139 All NHS Providers
Latest weekly PTL: patients waiting > 104 weeks	0	w/e 24th October	Joint 1st / 8 Providers in ICS
Latest weekly PTL: patients waiting > 52 weeks	23	w/e 24th October	1st / 8 Providers in ICS
Latest weekly PTL: patients waiting > 62 days for cancer treatment	59	w/e 24th October	2nd / 8 Providers in ICS
62 day backlog as % of waiting list 739	7.4%	w/e 24th October	76 (top 20 under NHSE/I scrutiny)

4. Recommendations

The Committees are recommended to:

4.1. Note the operational pressures directly impacting on the Trust's current performances in particularly the deterioration in UEC measures.

4.2. Support the ongoing health and well -being actions in support of frontline employees and the wider workforce.

4.3. Acknowledge the risk that operational decisions taken to balance non - elective pressure against elective recovery, may lead to lower levels of elective recovery.

4.4. Note the inclusion of SI measures and maternity metrics.

Integrated Oversight Report: November 2021

Gateshead Health NHS Foundation Trust

Contents:

Key Messages

The Trust has where possible continued with elective recovery plans whilst ensuring a greater focus on staff wellbeing for this reporting period. Balancing elective recovery with the volumes of COVID admissions and staff absences are proving extremely challenging.

Areas of positive performance include:

- No reported never events (last reported October 2020)
- No outstanding national patient safety alerts
- Maintaining our Elective activity programme: 94% of 2019/20 activity was delivered in October
- RTT >52 weeks 29 *(September position)* Lowest volume of >52 week waiters in ICP
- The last benchmarked UEC activity places the Trust 11th of 139 providers (September data)
- In September SDEC reviewed 590 patients – of which 85.1% were discharged on the same day
- Trust has achieved the faster cancer diagnostic standard, and narrowly missed the 2 week wait standard

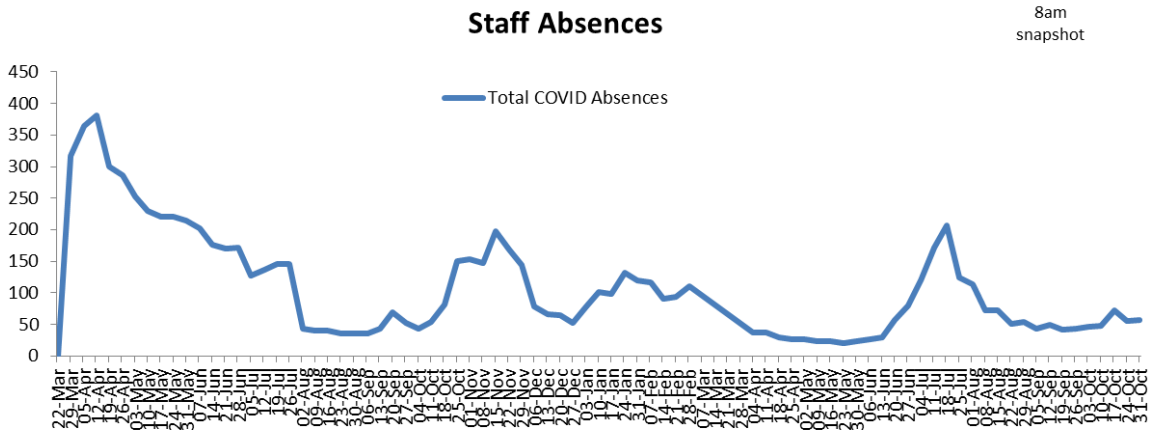
Areas of focus & risk include:

- ED pressures continue with a number of metrics (shadow monitoring) triggering concern
- HSMR – Position remains unchanged due to delay in national data from NHS Digital. Trust remains at 'More deaths than expected' in reporting period.
- Echocardiography slight increase in activity in October with additional capacity from November.
- Traditional Access targets (A&E, RTT, Diagnostics, Cancer)
- Sickness, core training and staff appraisal continue to underperform
- Volume of incomplete pathways increased in September 21
- Maternity indicators : Smoking at time of delivery, proportion of ladies breast feeding at discharge and the pre-term birthrates

Covid-19: Statistical Update

The level of Covid-19 patients in the hospital is starting show a slight upward kink during the 4th wave. The Trust has treated more than 2,350 patients.
The blue line in chart (1) below indicates the start of the 4th wave in the hospital. This pattern is indicative across the NENC ICS patch. COVID positive patients are currently being treated according to NHSI/E, PHE guidelines. The Trust has mobilised a clinical model to accommodate COVID patient care safely. The staff absences on chart (2) demonstrate the impact of track and trace and increase in COVID cases on staff absence. (Admin, clerical and nursing only).

1



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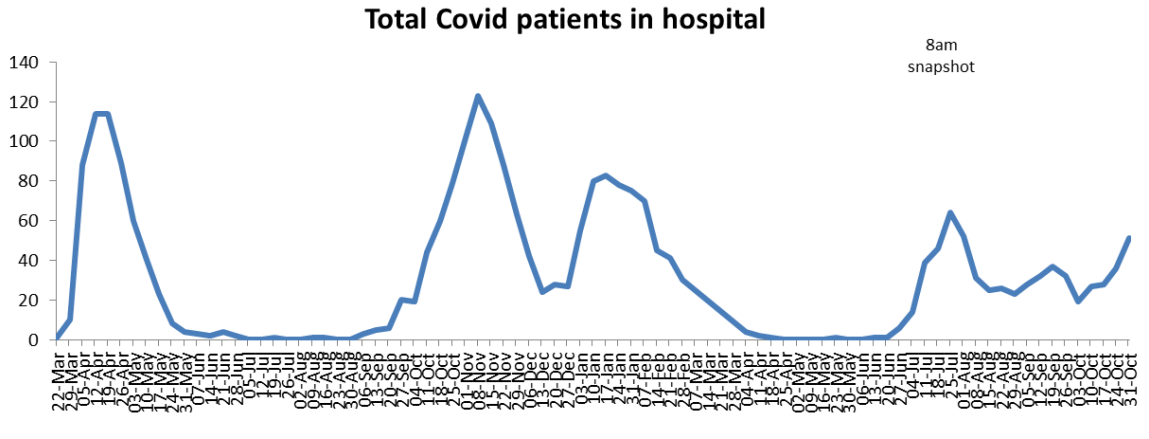
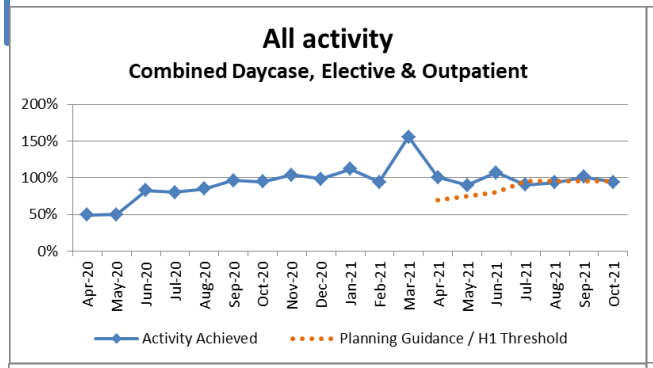
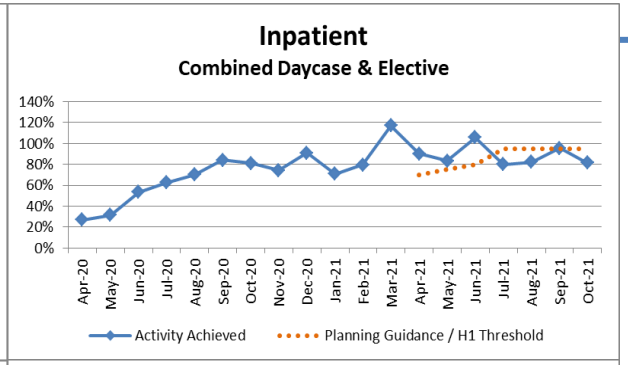


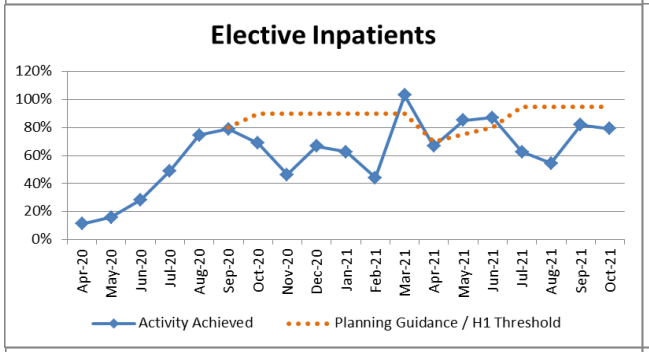
H2 Activity & Recovery

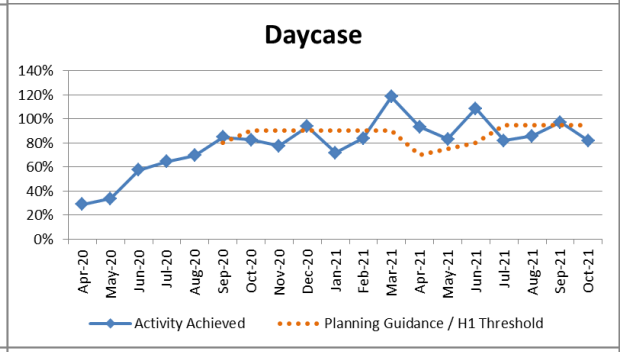
Gateshead Health NHS Foundation Trust

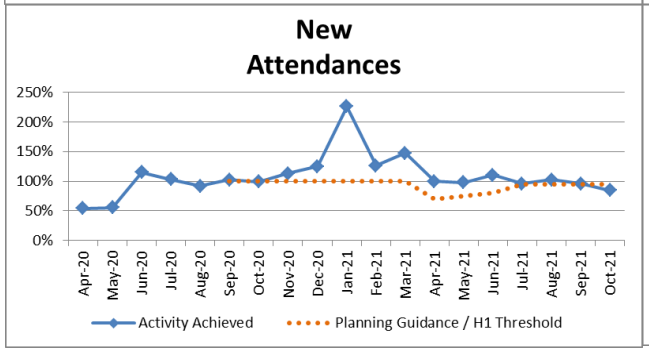
H1 Planning guidance had stated Trusts should meet the following activity (value) thresholds as a minimum:
70% April, 75% May, 80% June, 95% from July onwards.
H2 expectation is to maximise elective activity and eliminate waits of over 104 weeks, taking full advantage of opportunities to transform the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

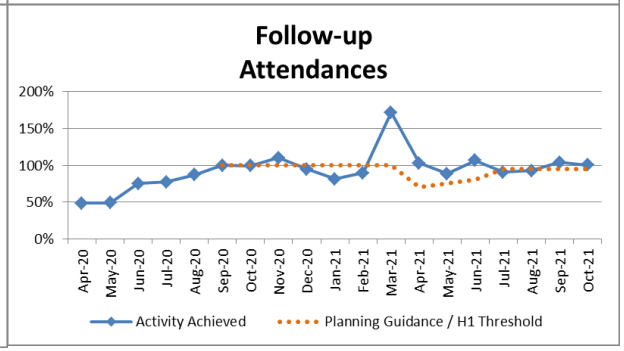












Commentary for October 2021

Combined activity (indicative) **October 94%**

October (Indicative) Activity:

- **Day cases 82%**
- **Elective overnights 79%**
- **Outpatients 94%**

This is a positive achievement on activity delivered in July and August where levels were circa 89%.

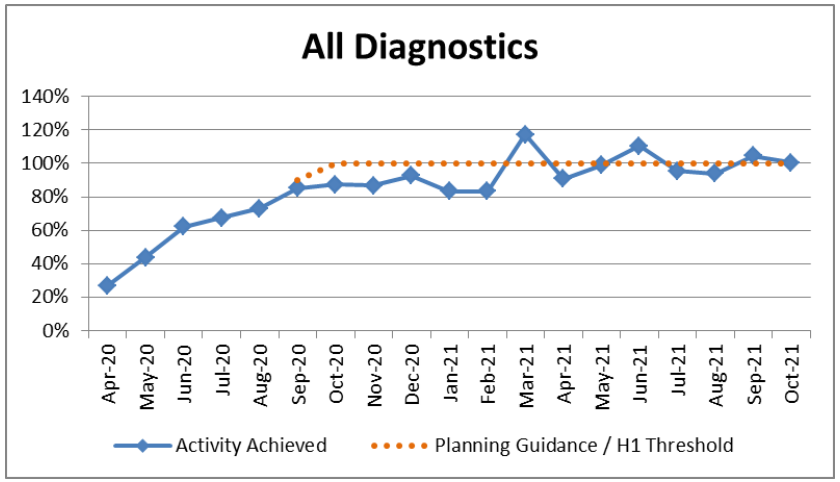
Other key requirements:
25% of Outpatient appointments to be virtual and PIFU activity to achieve 1.5% of all outpatients by December 21 and 2% by March 2022.

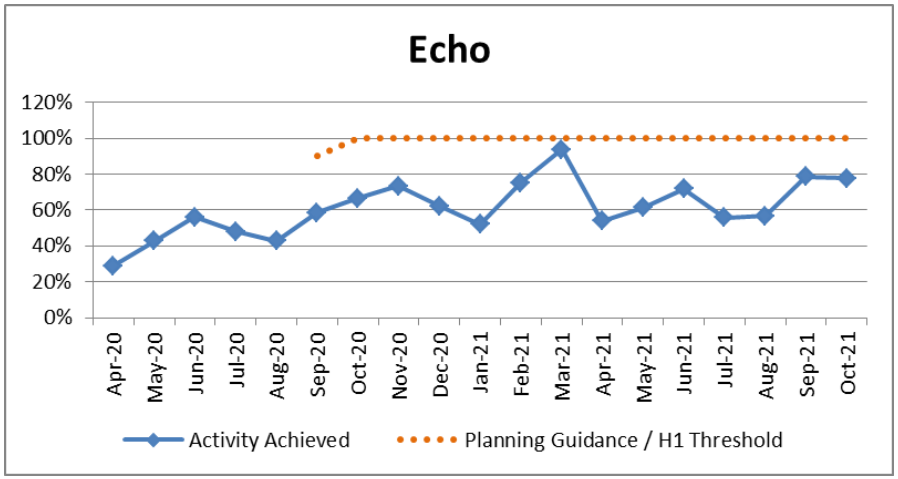
The Trust is reporting 25% of all outpatient attendances conducted remotely & approximately 1.6% of all OP recorded as Patient Initiated follow-up activities recorded in the 5 specialties Respiratory medicine, Rheumatology, cardiology, Gastroenterology and Trauma & Orthopaedics

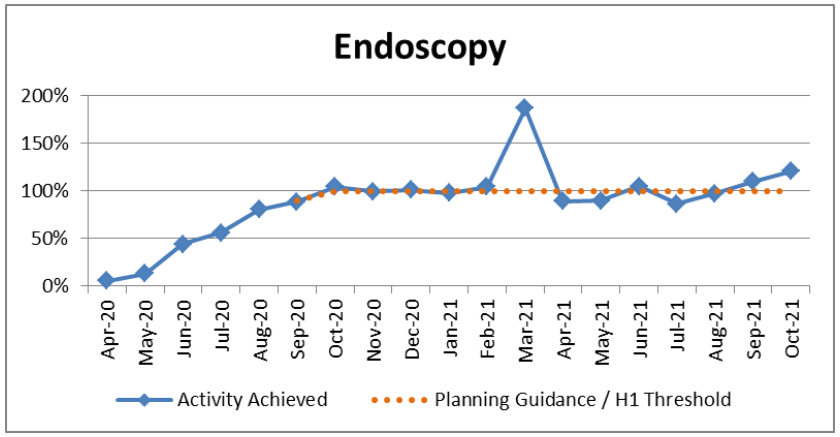
H2 Activity & Recovery

Gateshead Health NHS Foundation Trust

Whilst there are no specific planning thresholds for diagnostic delivery, Trusts are expected to deliver as much as they can to support elective recovery. **All Diagnostics**: **Activity at 105% Endoscopy: Activity at 109% Echocardiology: Activity 79%**
Pressures continue in echocardiography – activity delivered in October 78% of same period in 19/20 : Number of waiters> 6 weeks 81.39% of echocardiography waiters.







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

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

- Echocardiography accounts for 85.7% of the diagnostic waiters > 6 weeks with 81.3% of the echocardiography tests waiting longer than 6 weeks.
- Audiology accounts for 11.9% of the diagnostic waiters over 6 weeks with 43% of the audiology patients waiting longer than 6 weeks.
- Urodynamics percentage of over 6 week waiters are increasing although remain small volumes.

KLOE Summary

Responsive

A&E: October 21 Performance against the 4 hour standard 75.83%. Footfall through A&E has increased in October and is on average 77 attendances per day more than last year (37.6% increase), although activity remains below pre-covid levels. The latest national benchmarking data (September) places the Trust at 11th of 139 Type 1 providers. The Trust reported 87 30-60 minute and 54 over 60 minute ambulance delays in October.

RTT: September 21 Performance against the 18 week standard is at 79.06% with an increase of patients on the RTT waiting list from 9,422 to 9,912, with a decrease to 29 patients waiting over 52 weeks.

Cancer: 2ww The Trust position against the 2 week wait target in October was 92.2% just below the 93% standard . In October this year 1340 Two week wait referrals were received which shows an increase of 15.3% in comparison to the same period last year and up by 25.2% on the same period in 2019. Breast service referrals remain high with 789 referrals in October.

Cancer: 62 day treatments The Trusts position against the 62 day standard showed a decrease in performance for September reporting performance at 63.43% with Breast, Haematology, Lung and Upper GI above the performance standard of over 85%.

Gynaeoncology, Lower GI, and Urology were unable to achieve the standard with all reporting performance at or below 25%.

Diagnostics: The Trust failed the diagnostic standard in September reporting a slight improvement to 66.57% of patients seen with 6 weeks of referral. Echocardiography continues to be the main challenge at 18.61% however audiology and Urodynamics are also below 62% and highlighted as areas of concern.

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

Cancelled elective operations within 24 hours not readmitted within 28 days One cancelled operation in October.

KLOE Summary

Safe

Total number of Trust reportable SI's are included as a request to review the trend – this indicator is not triggering concern
No maternity **Serious Incidents** reported in October
There are currently no open patient safety alerts
The latest **Never Event** was observed in October 2020

Effective

The Trust **Hospital Standardised Mortality Ratio** (HSMR) remains unchanged from the previous reported position due to a delay in the national data . It currently shows more deaths than expected for this indicator. This follows several consecutive months of reduction and two consecutive periods of Deaths as expected.

Well Led

Core training performance remains broadly the same from 69.7.in July, and 70.2 in August and September.
Appraisals decreased from 67.3% in July to 65.6% in August and 62.1% In September
Sickness Absence rates deteriorated from 5.6% in August to 5.8% in September.

Caring

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

Maternity

Includes a sub-set of indicators taken from the maternity dashboard. Smoking at time of delivery, Breast feeding at time of discharge and local rates of pre-term births are currently triggering concern.

Operational Measures

Gateshead Health NHS Foundation Trust

This table shows a summary of Access standards, and expands on data demonstrated in the Single Oversight Framework to include measures of interest as part of Phase 3 monitoring.
A pass or X indicates our performance against the current period for against a performance measure. A variation flag indicates the trend for this measure and the assurance indicator represents of this process in in control.

(This data represents final - validated performance position and will therefore contain different reporting periods for different standards & measures)

Pefromance Measure	RO	Last Period		This Period		This Period Status	Variation	Assurance	Target (where applicable) or trajectory	Target type
Referral to treatment within 18 weeks	JBa	79.7%	Aug-21	79.1%	Sep-21	✗	H	F	92%	National
Referral to treatment Total Incomplete waiters	JBa	9422	Aug-21	9912	Sep-21				8,590	Activity and recovery monitoring
Referral to Treatment >52 week waiters	JBa	44	Aug-21	29	Sep-21				0	Activity and recovery monitoring
A&E seen within 4 hours	JBa	83.1%	Sep-21	75.3%	Oct-21	✗	L	?	95%	National
A&E attendances	JBa	8355	Sep-21	8699	Oct-21		H		10,268	Activity and recovery monitoring
Handover delays 30-60 minutes	JBa	36	Sep-21	87	Oct-21		H		0	National
Handover delays >60 minutes	JBa	18	Sep-21	54	Oct-21		H		0	National
Bed Occupancy	JBa	91.9%	Sep-21	94.4%	Oct-21		H		92%	National
Cancer 2 ww - first seen	JBa	92.8%	Sep-21	92.2%	Oct-21	✗		?	93%	National
Cancer 2ww to treatment within 62 days	JBa	78.3%	Aug-21	63.4%	Sep-21	✗		?	85%	National
Cancer 62 day treatment screening	JBa	91.0%	Aug-21	83.1%	Sep-21	✓	H	?	90%	National
Cancer waits over 104 days (all pathways)	JBa	43	Aug-21	38	Sep-21		L	F	0	Local monitoring
Diagnostic waits % within 6 weeks	JBa	65.8%	Aug-21	65.2%	Sep-21	✗	H	F	99%	National
Diagnostic waiters	JBa	6137	Aug-21	6230	Sep-21					National
Endoscopy waiters (subset of the above)	JBa	415	Aug-21	383	Sep-21					National

Integrated Oversight Report –Summary Indicators

	Measure	Latest period		Target	Latest 12 months	Variation	Assurance	Comment
EFFECTIVE	Hospital Standardised Mortality Ratio	110.44	Jul 20 -Jun 21			H		No update currently available on the previous figure (due mid October) The Trust is demonstrating 'More Deaths than Expected' for the most recent available period. The HSMR had recently fallen to deaths within the expected range for two periods however has it has increased in the latest figures available.
RESPONSIVE	UEC maximum waiting time of four hours from arrival to admission/transfer/discharge	75.3%	Oct-21	95%	85.8%	L	?	Below target since August 2020. Special Cause Variation (concern) in July and August and October 2021.
	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway	79.1%	Sep-21	92%	77.5%	H	F	Special variation (improvement) from October 2020, performance below target since January 2020.
	Number of patients on an incomplete pathway	9912	Sep-21			H		Special cause variation (Concern). General upward trend displayed with trigger in September 2021.
	Cancer 2ww compliance	92.2%	Oct-21	93%	81.3%		?	Compliance achieved in March 2021 and just below target in september and October 2021. Common cause variation.
	Cancer 2ww ENCB compliance	96.2%	Oct-21	93%	96.8%		?	Special cause variation for May and June 2020
	Cancer 28 day compliance	79.9%	Sep-21	75%	75.4%	H	?	Target achieved in for the last eight consecutive months. Special cause variation (improvement) observed from February 2021.
	Cancer 28 day exhibited compliance	100.0%	Sep-21	75%	84.0%		?	Below target in October 2020 and January 2021.
	Cancer 28 day screening compliance	53.2%	Sep-21	75%	58.9%		?	Target achieved in May 2021 however performance below target for four consecutive months.
	Cancer 31 day compliance	90.1%	Sep-21	96%	97.7%		?	Target achieved in August 2021 hoewever the September figures is triggering special cause variation concern with performance at 90.1%
	Cancer 31 day subsequent drugs compliance	100.0%	Sep-21	98%	99.3%		?	Target achieved in September 2021. Common cause variation observed.
	Cancer 31 day subsequent surgery compliance	93.3%	Sep-21	94%	95.7%		?	Performance slightly under target in September 2021, common cause variation
	All cancers - maximum 62-day wait for first treatment from urgent GP referral for suspected cancer	63.4%	Sep-21	85%	68.7%		?	Common cause variation. Target not achieved in the last 18 months
	All cancers - maximum 62-day wait for first treatment from NHS cancer screening service referrals	83.1%	Sep-21	90%	90.0%	H	?	Target not achieved in September 2021. Special cause variation (improvement) identified from October 2020 to date.
	Maximum 6-week wait for diagnostic procedures	65.2%	Sep-21	99%	67.5%	H	F	Special cause variation (Improvement) from December 2020 with 10 consecutive points above the mean, performance below target since March 2020
WELL-LED	Staff sickness	5.8%	Sep-21	4%	5.2%		?	September 2021 above target. Target achieved 2 out of 18 months
	Appraisals	62.1%	Sep-21	85%	63.7%		F	Common cause variation currenlty displayed with special cause variation Januuary and F ebruary 2021. Thuis indicator consistently performs below the target.
	Core Training	70.2%	Sep-21	85%	72.6%	L	F	Special cause variation - concern. Recent performance below 18 month mean for the last 8 months. 6 consecitive months below the lower process limit. This indicator consistently performs below the 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.

Integrated Oversight Report

NHS Gateshead Health NHS Foundation Trust

Responsive

	Measure	Latest period		Target	Latest 12 months	Variation	Assurance	Comment
RESPONSIVE	UEC maximum waiting time of four hours from arrival to admission/transfer/discharge	75.3%	Oct-21	95%	85.8%	L	?	Below target since August 2020. Special Cause Variation (concern) in July and August and October 2021.
	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway	79.1%	Sep-21	92%	77.5%	H	F	Special variation (improvement) from October 2020, performance below target since January 2020.
	Number of patients on an incomplete pathway	9912	Sep-21			H		Special cause variation (Concern). General upward trend displayed with trigger in September 2021.
	Number of patients waiting 52 weeks or more on an incomplete pathway	29	Sep-21					Special cause variation between October 2020 and April 2021. Common cause variation currently displayed as the number of patients waiting 52 weeks returned below the 18 month mean from May 2021.
	Maximum 6-week wait for diagnostic procedures	65.2%	Sep-21	99%	67.5%	H	F	Special cause variation (Improvement) from December 2020 with 10 consecutive points above the mean, performance below target since March 2020
	Duty of Candour - Verbal Compliance	88.4%	Oct-21					Duty of Candour verbal compliance showing common cause varaition.
	Formal Complaints	23	Oct-21		268			Clinical Treatment (13) Patient Care (3) Privacy, Dignity & wellbeing (including patients' property & expenses) (3) Communications (2) Values & Behaviours (Staff) (1) Admissions, discharge & Transfers (1)
	Informal complaints	51	Oct-21		539			
	Compliments	63	Oct-21		489	H		

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Integrated Oversight Report

Gateshead Health NHS Foundation Trust

Responsive

	Measure	Latest period		Target	Latest 12 months	Variation	Assurance	Comment
RESPONSIVE	Cancer 2ww compliance	92.2%	Oct-21	93%	81.3%			Compliance achieved in March 2021 and just below target in september and October 2021. Common cause variation.
	Cancer 2ww ENCB compliance	96.2%	Oct-21	93%	96.8%			Special cause variation for May and June 2020
	Cancer 28 day compliance	79.9%	Sep-21	75%	75.4%	H		Target achieved in for the last eight consecutive months. Special cause variation (improvement) observed from February 2021.
	Cancer 28 day exhibited compliance	100.0%	Sep-21	75%	84.0%			Below target in October 2020 and January 2021.
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	All cancers - maximum 62-day wait for first treatment from urgent GP referral for suspected cancer	63.4%	Sep-21	85%	68.7%			Common cause variation. Target not achieved in the last 18 months
	All cancers - maximum 62-day wait for first treatment from NHS cancer screening service referrals	83.1%	Sep-21	90%	90.0%	H		Target not achieved in September 2021. Special cause variation (improvement) identified from October 2020 to date.
	Cancer 62 day upgrade compliance	33.3%	Sep-21	94%	47.3%			

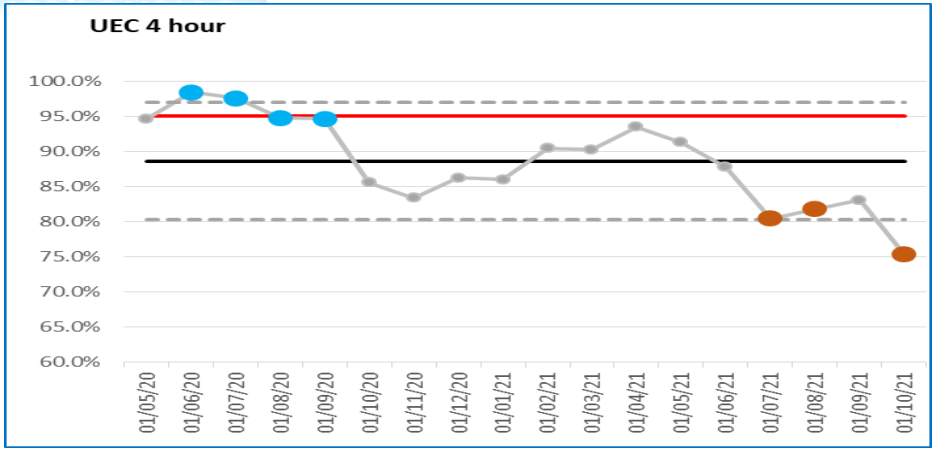
Variation & Assurance : Indicators that do not include a symbol for variation and /or assurance are either not appropriate for measuring by SPC charting or are not measured against a target.

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

Gateshead Health NHS Foundation Trust

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

Responsive



Quality Access & Outcomes	Requirement	Target	April	May	June	July	August	September	October
UEC Shadow Performance Measures	95 % Target	95%	93.45%	91.30%	87.78%	80.69%	81.78%	83.08%	75.32%
	QEH ED Total Attendances		7390	7790	8394	8115	7998	8355	8699
	(Activity levels 2019/20)		10268	10636	10350	10987	10740	10621	10731
	Activity as proportion of base year		72%	73%	81%	74%	74%	79%	81%
	Type 1 Attendances		4951	5205	5556	5555	5404	5614	6132
	Type 3 Attendances		2439	2585	2838	2560	2594	2741	2567
	No Attendances Assessed within 15 mins		2352	2310	2895	2883	2593	3241	3642
	Attendances Assessed within 15 minutes		5038	5480	5499	5232	5405	5114	5057
	Percentage Assessed within 15 minutes		68.17%	70.35%	65.51%	64.47%	67.58%	61.21%	58.13%
	30 minute Ambulance Breaches		2	4	22	55	34	36	87
	Total patients spending > 12hrs in Dept.		4	6	5	52	81	32	211
	No of patients with TCI > 12 hours		0	0	0	0	5	0	0
	Average Time in Dept - Non-Admitted		132	130	135	147	145	142	160
	Average Time in Dept - Admitted		243	264	293	363	354	339	417
SDEC	% of 0 LOS Admission as proportion of total NEL Activity		21.47%	22.40%	20.81%	19.97%	19.13%	34.45%	37.04%

Situation – 4 hour target at 75.32%

Key factors driving performance are increases in attendances – Overall activity is at 81% of pre-covid levels, footfall and patient numbers increased in October with daily attendances average 77 more than October 2019 (37.6%).

Assessment

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

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

Actions

- Continued focus on hospital flow & embedding the New Operating Model
- Talk before you Walk & Telephone triage for Urgent Treatment Centre continue
- Blaydon UTC reopening to walk in minor injuries on the 21st November 2021
- ED streaming provisional go live 6th December 2021
- Nerve Centre go-live 6th December 2021
- Access to POC testing to allow streaming of patients direct to surgical wards
- Alignment of workforce to staffing at peak times – (Job Plan Review)
- Review data capture and ECDS Submission to be compliant with H2 requirements
- Review of speciality pathways & streaming patients front house
- External Flow Coaching programmes: SDEC & EAU
- Review ward ways of working and BI to support flow
- Discharge workshop to review ward & Board rounds earlier in the day
- External ECIST support to commence in November
- A regional review of UEC is underway, as ED presentations across the region are increasing and pressure across primary care is evident.

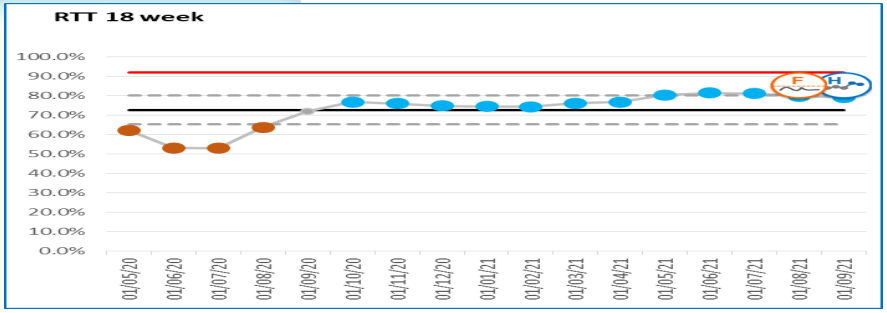
Recommendation

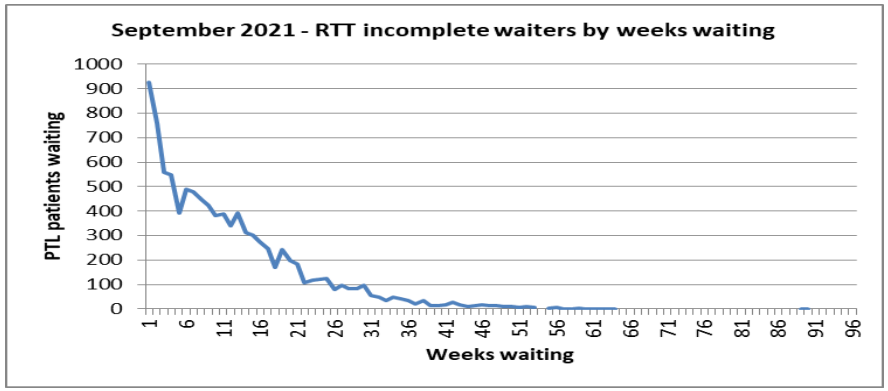
Finance & Performance Committee to receive updates from service.

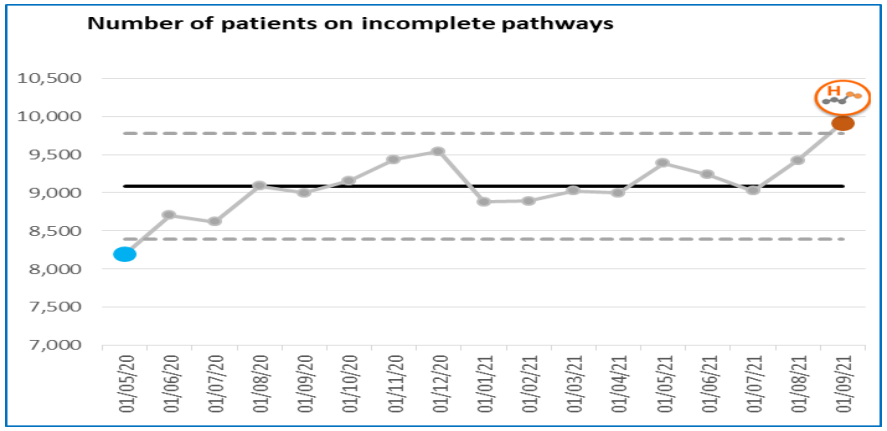
Report by exception: Responsive – Spotlight Maximum time of 18 weeks from point of referral to treatment (RTT) 92%

NHS Gateshead Health NHS Foundation Trust

Responsive







Situation

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

The Trust is making excellent progress in reducing the backlog of long waiters – reporting no over 104 week waiters and have reduced the back-log of over 52 week waiters down to 29 in September. There is an emerging risk from onward referrals of long waiters received from the Independent sector. A meeting is in train to review processes and gain transparency across the pathways.

The Elective Programme Board continues to provide leadership and oversight on all stages of treatment in RTT: Outpatients, diagnostics and inpatients.
The priority for the Trust is to make sure all patients have TCI dates and to limit cancellations where possible, whilst prioritising out P2's and cancer patients. Clinical prioritisation is ongoing and centralised scheduling supports reducing long waiters and booking patients in clinical priority then longest waits.

Areas of risk continue to be workforce staffing in theatres and reduced staffing across a number of surgical specialties. Agency staffing and WLI continue to support areas of workforce pressures.

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

Actions

- Business Units are working towards achieving the expectations in the planning submission Weekly prioritisation of available capacity.
- Principles of Maximising Day case potential & working through additional capacity plans to deliver the gateway criteria at ICP/ICS levels.
- Plans to deliver zero >52 week waiters by end of the financial year.
- Technical validation of the waiting list to be repeated to understand patients' treatment options and refresh those choosing to delay treatment but remain on the waiting list.
- External support to review waiting lists validation completed mid August in support of baselining validation capacity and supporting with the additional weekly waiting list requirements in support of gateway criterion and elective recovery.
- Treatment cancellations by priority type are now sit-rep reportable.

Recommendation

Finance & Performance Committee are to note that the above plans remain in place whilst current COVID levels are maintained The focus in H2 will be on backlog reduction and maintaining September 2021 waiting lists levels.

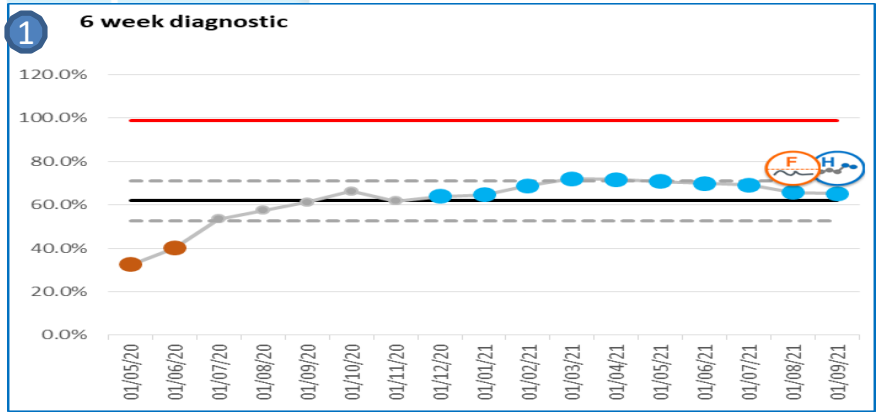
Report by exception: Responsive – Maximum 6-week wait for diagnostic procedures

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

Gateshead Health NHS Foundation Trust

Responsive

1



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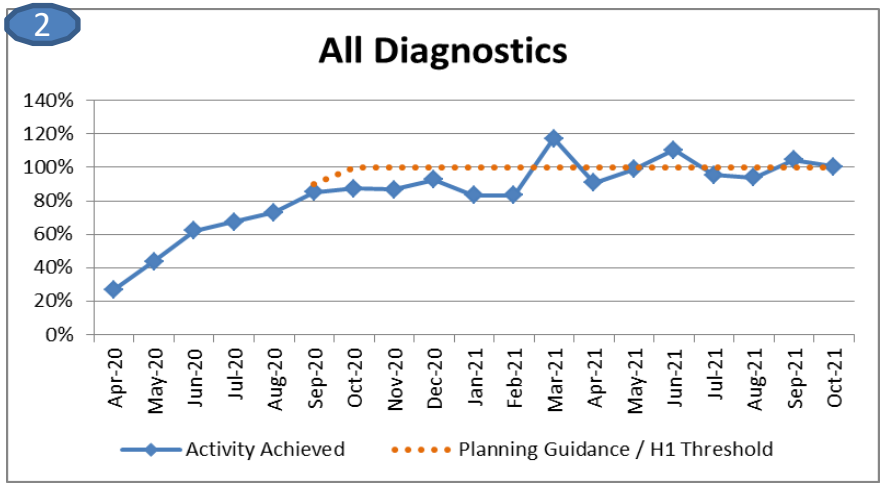

Background

1. 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.
2. Displays the % activity delivered as a proportion of 2019.20 baselines

Assessment

Recovery plans are in place to re-instate additional capacity, Echocardiography still remains a particular area of concern accounting for 85.7% of the patients waiting over 6 weeks – and current performance at 18.7% of patients waiting within 6 weeks. Activity levels for echocardiography rose slightly in September and remain below Pre-COVID 2019/20 levels: 54% in April, 61% in May, 72% in June , 56% in July , 57% in August and 79% in September.

Increasing referrals in Audiology are also impacting on waiting times with (56%) waiting less than 6 weeks. Capacity is now being reviewed on a weekly basis, along with service reprovision.

Waiting times for urodynamics are at 62% withing 6 weeks. Workforce pressures and gaps continue across the services. Gynaecology are preparing a business case for additional nursing staff and in Urology current workforce gaps and availability of clinics are being reviewd.

Actions

- Echocardiography action plan includes estates work for additional room and also using external resource to meet the capacity gap
- Backlog recovery of all long waits – March 22.
- Weekly management of audiology referrals.
- Follow-up action plans in support of recovery for urodynamics and audiology

Recommendation

Detailed discussion and scrutiny at Finance & Performance Committee

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

Gateshead Health NHS Foundation Trust

Responsive

1. Distribution of waiting times for routine patients
2. Distribution of waiting times for urgent patients
3. Distribution of waiting times for planned patients

Key: Light Blue indicates within 6 weeks and dark blue indicates patients waiting over 6 weeks

Whilst recovery has begun, for the reporting month of October activity delivery has not consistently been at predicted volume levels and compliance with the 6 week target has deteriorated further from 20.4% to 18.61% . Supplementary weekly data (charts 4 and 5) demonstrate the total waiters with the recovery trajectory and delivered activity levels.

Additional resources, kit and staffing have been deployed from an alternative source after the original supplier failed to deliver planned activity levels.

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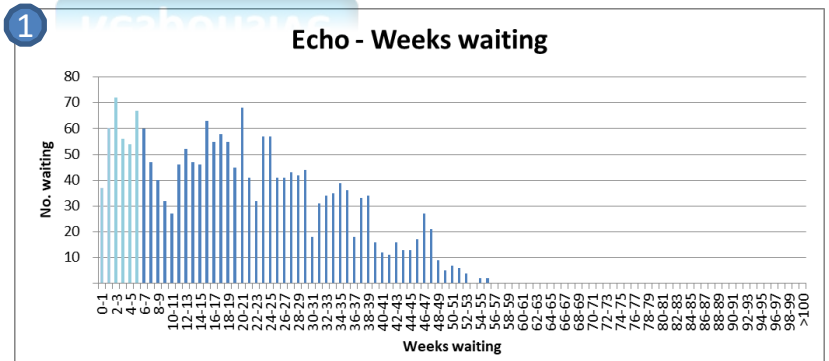

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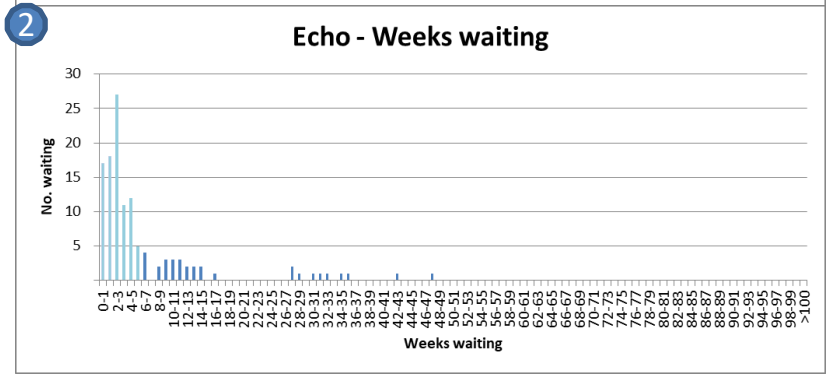

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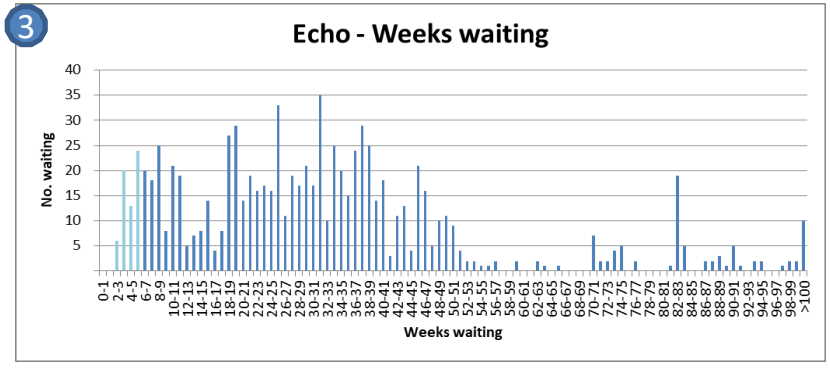

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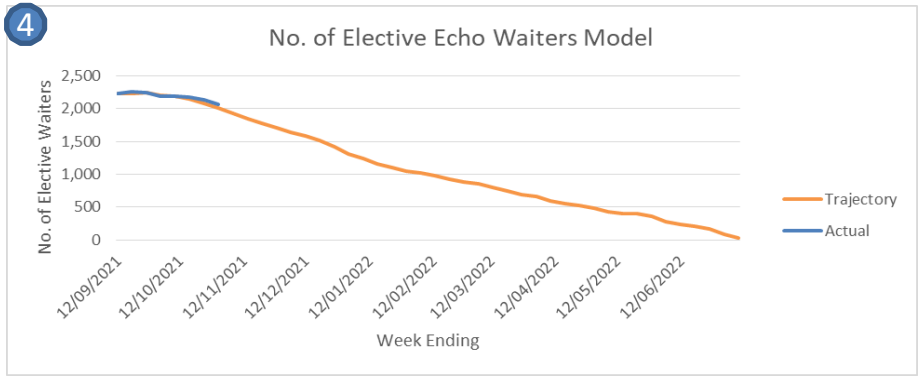

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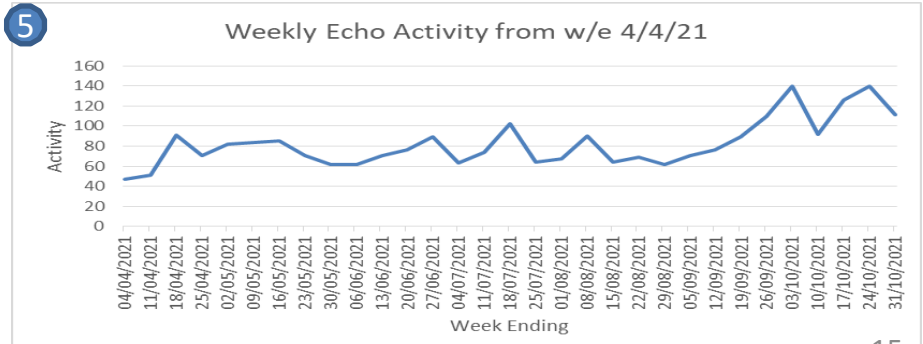

Report by exception: Responsive – Cancer Standards Summary

Gateshead Health NHS Foundation Trust

Responsive

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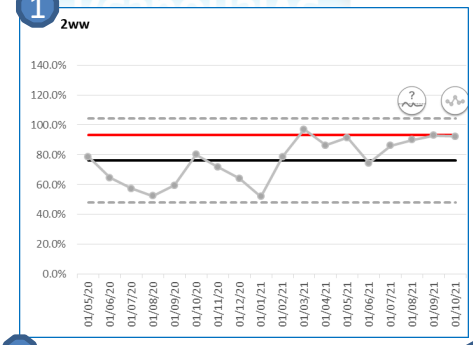

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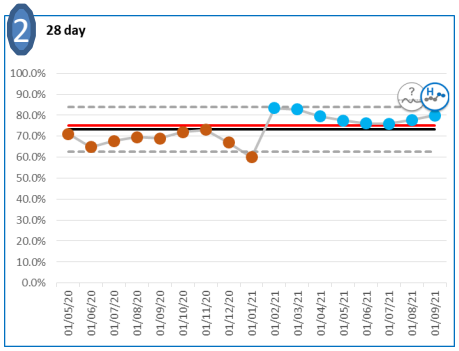

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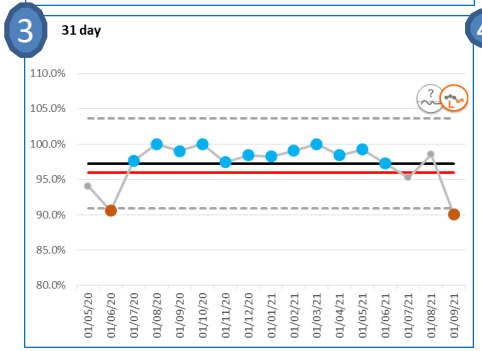

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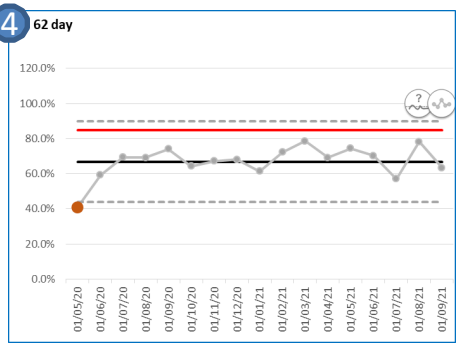

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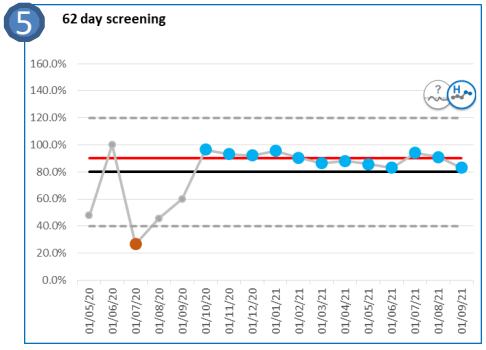

Commentary

1. 2 Week Waits - 92.2% Despite October's performance being just below the 93% threshold there has been a recent improvement in performance. Haematology Gynaecology, Lower GI & testicular cancers were all within the 93% target.
There were pressures in October in Breast lung, Upper GI and urology.
Reduced capacity related to ongoing infection control requirements and workforce issues are the main contributory pressures in all services

2. 28 Day Faster Diagnostics September: 79.68% The target was achieved in the last eight consecutive months identifying special cause variation for improvement. This measure will replace the 2 Week wait in the new system oversight framework.

3. 31 Day Diagnostic Standard – performance at 90% is caused by the increase in gynae-oncology patients requiring surgical intervention within Gateshead. However, despite a drop in performance the team continued to see a high number of patients with 141 patients being seen in September which is the highest number seen since June (146).

4. 62 Day Treatment September: 63.4% Whilst the national target is set at 85%, the planning guidance recognises the challenges faced by the NHS and has set a recovery trajectory based on the volume of patients waiting over 62 days. The Trust at the end of September reported 63 patients waiting over 62 days.

The number of long waits (> 104 days) on a 62 day (2ww) pathway at the end of September was 10 patients (38 on all pathways).
The Trust is currently supporting the provision of gynaecology oncology services across the ICS & is now treating more patients from South of the ICS, which is currently adding to the volume of long waiters.

5. 62 Day Screening September: 83.1% The performance has dropped below the 90% standard.

Actions
Ongoing weekly liaison and collaboration within ICP at Cancer hub meeting to highlight concerns, delays in treatment pathways across shared pathways.
Ongoing discussion with NCA in relation to financial support to develop innovative ways of working with particular focus on challenged pathways
Weekly PTL meetings being developed within all tumour sites with representation from SLM's, admin and cancer tracking teams
Cancer recovery meeting established with a planned focus on improving performance against CWT standards which will provide a monthly feedback to elective recovery board.

Integrated Oversight Report

NHS Gateshead Health NHS Foundation Trust

Safe

	Measure	Latest period		Target	Latest 12 months	Variation	Assurance	Comment
SAFE	Occurrence of any Never Event	0	Oct-21	0	0		?	1 never event in October 2020
	Emergency c-section rate	14.4%	Oct-21		13.9%			
	Venous thromboembolism (VTE) risk assessment	98.9%	Oct-21	95%	98.8%		P	Common cause variation and consistently achieved target
	C difficile actual	5	Oct-21		34			
	Clostridium difficile - infection rate	37.69	Oct-21		23.37			
	Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	0	Apr - Mar 21/22	0	0			
	P. aeruginosa bacteraemia infection rate	0.0	Oct-21		18.5			
	Klebsiella spp: bacteraemia infection rate	37.7	Oct-21		35.4			
	COVID Hospital-Onset Indeterminate Healthcare-Associated	7	Oct-21					
	COVID Hospital-Onset Probable Healthcare-Associated	2	Oct-21					
	COVID Hospital-Onset Definite Healthcare-Associated	3	Oct-21					

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Integrated Oversight Report

Gateshead Health NHS Foundation Trust

Safe

	Measure	Latest period		Target	Latest 12 months	Variation	Assurance	Comment
SAFE	Medication errors per 1000 FCEs	8,2	Oct-21		8.7			Common cause variation
	Patient Falls per 1000 bed days	8.0	Oct-21		10.0			Common cause variation
	Trust Acquired Pressure Damage per 1000 bed days (Category 2 and above)	2.5	Oct-21		2.9	L		Special cause variation for improvement - seven conscutive points below the 18 month mean
	Potential under-reporting of patient safety incidents	38.7	Oct-21		40.9			Common cause variation
	Serious Incidents reported to StEIS	8	Oct-21		75			Common cause variation
	Patient Safety Alerts not completed by deadline	0	Oct-21	0			?	Previous patient safety alert now closed - NatPSA/2020/008/NHSPS Deterioration due to rapid offload of pleural effusion fluid from chest drains
	Escherichia Coli (E. coli) bacteraemia bloodstream infection (BSI) rate	105.5	Oct-21		161.2			
	Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemia infection rate	7.5	Sep-21		11.8			
	Care hours per patient day	7.91	Sep-21					

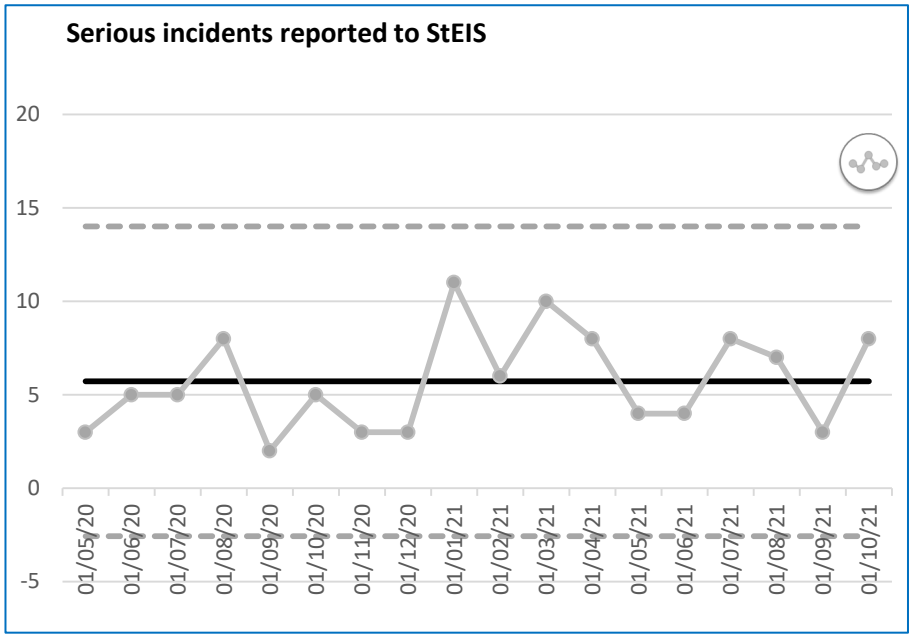
Variation & Assurance : Indicators that do not include a symbol for variation and /or assurance are either not appropriate for measuring by SPC charting or are not measured against a target.

Report by Exception Integrated Oversight Report

Gateshead Health NHS Foundation Trust

Safe

Serious Incidents reported to StEIS



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

This indicator is included as trending information only – there is no trigger raising a cause for concern, and is included at the request of the Board for information only.

There we 8 Serious incidents reported in October 2021:
The themes of those incidents are listed below:

2 x Deterioration of patient to Category 3 during trust care (Moderate harm)
2 x Diagnosis - delay / failure (Death / Catastrophic)
1 x Fall from height – chair (Severe harm)
1 x Discharge – inappropriate (Severe Harm)
1 x Ambulance black breach (Death / Catastrophic)
1 x Diagnosis – incorrect (Severe Harm)

Integrated Oversight Report

NHS Gateshead Health NHS Foundation Trust

Effective

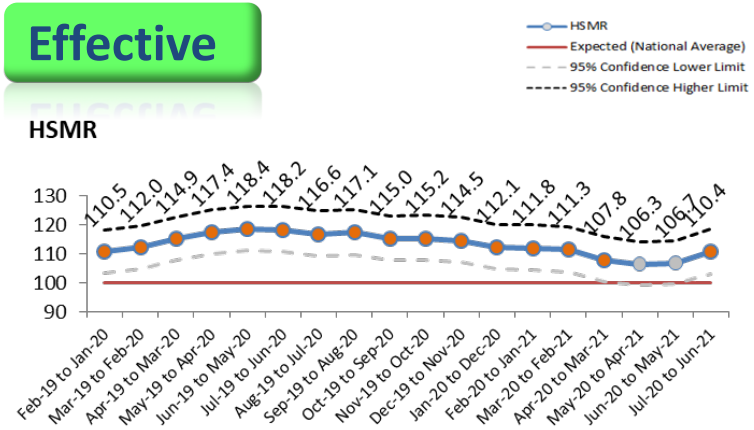
	Measure	Latest period		Target	Latest 12 months	Variation	Assurance	Comment
EFFECTIVE	Summary Hospital level Mortality Indicator	1.02	Jun 20 -May-21					12 month figure, The Trust has a banding of 'As expected' for the most recent available 12 month period.
	Hospital Standardised Mortality Ratio	110.44	Jul 20 -Jun 21					No update currently available on the previous figure (due mid October) The Trust is demonstrating 'More Deaths than Expected' for the most recent available period. The HSMR had recently fallen to deaths within the expected range for two periods however has it has increased in the latest figures available.
	Crude Mortality - Inpatient Deaths	100	Oct-21		1156			
	Crude Mortality - Covid Deaths	12	Oct-21		243			
	Mortality Review Compliance	57.4%	Oct 20 - Sep 21					
	Potentially Avoidable Deaths (%/#)	0.0% (0)	Oct 20 - Sep 21					
	Mortality Review Compliance - Learning Disability Deaths	84.2% (0)	Oct 20 - Sep 21					
	Potentially Avoidable Deaths - Learning Disability Deaths (%/#)	0.0% (0)	Oct 20 - Sep 21					
	Long Length of Stay Patients	47.6	Oct-21		46.5			
	Readmissions within 30 days	10.8%	May-21		10.5%			
	Pre procedure elective bed days	0.24	Oct-21		0.30			

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.

Report by exception: Effective – Hospital Standardised Mortality Ratio

Gateshead Health NHS Foundation Trust

Effective



Mortality Review

Period: October 2020 – September 2021

	Deaths in period	Deaths reviewed	%	Hogan 1	Hogan 2	Hogan 3	Hogan 4	Hogan 5	Hogan 6	Potentially Avoidable Deaths
All Deaths	1215	698	57.4%	93.0%	6.4%	0.6%	0.0%	0.0%	0.0%	0.0% (0)
Learning Disability Deaths	19	16*	84.2%	86.5%	6.3%	6.3%	0.0%	0.0%	0.0%	0.0% (0)

*15 Learning disability deaths reviewed overall of which 11 reviewed at level 2 mortality council. No cases highlighted as potentially avoidable

Alert	CCS Diagnostic Group	Period	Expected Deaths	Observed Deaths	Obs -Exp	Score	% Reviewed (where death within Trust)	% Definitely not preventable	% NCEPOD Good Practice
HSMR	Pneumonia	Apr-20 to Mar-21	117	154	37	131	51.9%	98.8%	85.0%
SHMI	Cancer of Bladder	Mar-20 to Feb-21	3	9 (6 in hospital)	6	326	83.3%	100%	66.7%*
HSMR CUSUM	Pneumonia	Mar-21	13	18	5	5.2	38.9%	100%	100%
HSMR CUSUM	Congestive heart failure; non hypertensive	Mar-21	4	7	3	4.7	57.1%	100%	100%
HSMR CUSUM	Peritonitis and intestinal abscess	Feb-21	0.8	1	0.2	3.46	100%	100%	100%

*1 figure relates to one case, no GP summary or death certificate in notes

Situation – Due to technical changes in the indicator by NHS digital there is a delay in the national HSMR data and an update on this indicator is currently unavailable The Trust is demonstrating 'More Deaths than Expected' for the most recent available period. The HSMR had recently fallen to deaths within the expected range for two periods however has it has increased in the latest figures available. Tony Roberts, NEQOS, presented the findings of their review to the Trust Board and explained difficulties and inherent flaws in HSMR especially with the Covid pandemic. The Board were reassured that looking at other measures (ME work, Mortality reviews, SI's) was a better way to understand mortality and look for learning / identify problems

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

Assessment - Mortality indicators show the Trust deaths relative to the expected deaths per the statistical models for HSMR and SHMI. The HSMR is showing 'More Deaths than Expected whereas the SHMI is showing deaths are within the expected range.

From October 2020 to September there were 1215 deaths; 698 have been reviewed (57.4%). Of these 93% were recorded as definitely not preventable (Hogan1). All cases scoring more than Hogan 1 are subject to a review at Mortality Council, the majority of these cases are also patient safety incidents and would go through the Trusts Serious Incident Panel.

In terms of national alerts received for diagnosis groups, 98.8 %- 100% of deaths from reviewed cases were deemed to be definitely not preventable. The SHMI remains as 'as expected'. A six monthly learning from deaths report will be presented to the Quality Governance Committee in September 2021, this provides full details of the mortality work.

The mortality models are influenced by a trust's coding, in particular the Primary diagnosis, also the Secondary and Palliative Care coding (for the HSMR). The models have different exclusion criteria for COVID-19 diagnosed patients. Following an external review by the North East Quality Observatory (NEQOS) in December 2020 looking at data back to 2016, a number of metrics were analysed and triangulated including number of patient safety incidents including serious incidents and mortality reviews, no specific cause for the high HSMR, or concern about quality of care, was 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. This indicator may continue to flag for sometime. Mortality review data for the last 12 months demonstrates that 93.5% of deaths reviewed were definitely not preventable.

Actions –

- Explore the use of HIE to ensure all comorbidities are captured more efficiently in the initial clerking document in order to be coded appropriately, lead for Great North Care Record, he is going to take it back to the HIE – completed full access to HIE is available
- Review the admission document to ensure all differential diagnoses can be added and coded appropriately has this been done – this is to be discussed at the Mortality & Morbidity Steering Group in July 2021 – this meeting was stood down therefore item has been rolled over to September 2021 – completed.

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

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	76.1%	Oct-21		83.6%			FFT in inpatient areas was launched in May 2021 using text messaging. Reporting by cards is also available by exception. The service for outpatient clinics went liver towards the back of October 2021. Discussion with Maternity services to decide the most appropriate method of collection.
	Inpatient & day case scores from Friends & Family Test - % positive	94.2%	Oct-21		98.0%			
	Maternity scores from Friends & Family Test - % positive	91.7%	Oct-21		97.5%			
	Outpatient scores from Friends & Family Test - % positive	94.2%	Oct-21		99.0%			
	Community scores from Friends & Family Test - % positive	-	Oct-21		100.0%			
	Mental Health scores from Friends & Family Test - % positive	-	Oct-21		100.0%			
	Written Complaints rate per 1000 WTE	5.3	Sep-21					

Well Led

	Measure	Latest period		Target	Latest 12 months	Variation	Assurance	Comment
WELL-LED	Staff sickness	5.8%	Sep-21	4%	5.2%			September 2021 above target. Target achieved 2 out of 18 months
	Staff turnover	1.3%	Sep-21		1.3%			Special cause variation - concern for August 2020
	Appraisals	62.1%	Sep-21	85%	63.7%			Common cause variation currenlty displayed with special cause variation Janvuary and F ebruary 2021. Thuis indicator consistently performs below the target.
	Core Training	70.2%	Sep-21	85%	72.6%			Special cause variation - concern. Recent performance below 18 month mean for the last 8 months. 6 consecitive months below the lower process limit. This indicator consistently performs below the target.
	Data Quality Maturity Index (DQMI) - MHSDS dataset score	85.7%	Jul-21		89.0%			

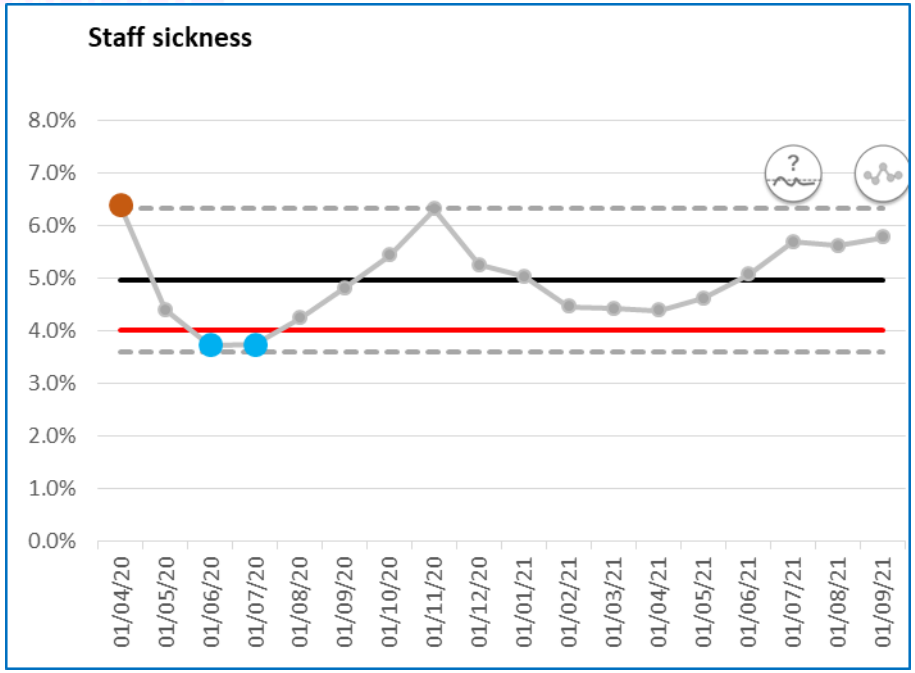
Variation & Assurance : Indicators that do not include a symbol for variation and /or assurance are either not appropriate for measuring by SPC charting or are not measured against a target.

Report by exception: Well led – Sickness Absence

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

Gateshead Health NHS Foundation Trust

Well Led



Combined impact analysis

Financial impact
Increased staff sickness is expensive for the Trust in terms of loss of productivity and associated backfill costs.

Quality impact
No direct quality impact yet identified.

Workforce impact
Less workforce available.

Operational performance impact
No direct operational performance impact identified.

Situation Common cause variation displayed
The target has been achieved in two of the last 18 months (June 2020 and July 2020) . Current performance of 5.8% represents a fail of the Trust target.

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

Assessment
Whilst we have seen a small decrease in sickness absence levels we continue to see a fail against the Trust target. Over the summer months the trust continued to experience significant operational pressures linked to patient acuity, at a time of higher levels of annual leave. We recognise that staff are working extremely hard, very flexibly, with frequent additional bank shifts to provide staffing in key areas, such as COTE.

Actions
The Workforce Cell continues to urgently review the effectiveness of actions to support staff who may be experiencing the effects of tiredness, burn-out, and ward moves. 70 HCA's have been appointed and will fill posts across COTE and the Nurse Bank, and recruitment campaigns are underway to staff the new operating model. To support the effective management of staff who are currently absent from work, regular sickness absence meetings/clinics are held with managers, with support and advice provided by HR. Additional HR Administrator support has been introduced into Medicine and Surgery to support those line managers who are experiencing particular pressures. This should enable more timely and appropriate interventions to enable staff to return to work sooner, and ultimately reduce sickness absence. OH referral capacity was unavoidably reduced summer holiday period, but now offers appointments in line with internal KPI's.

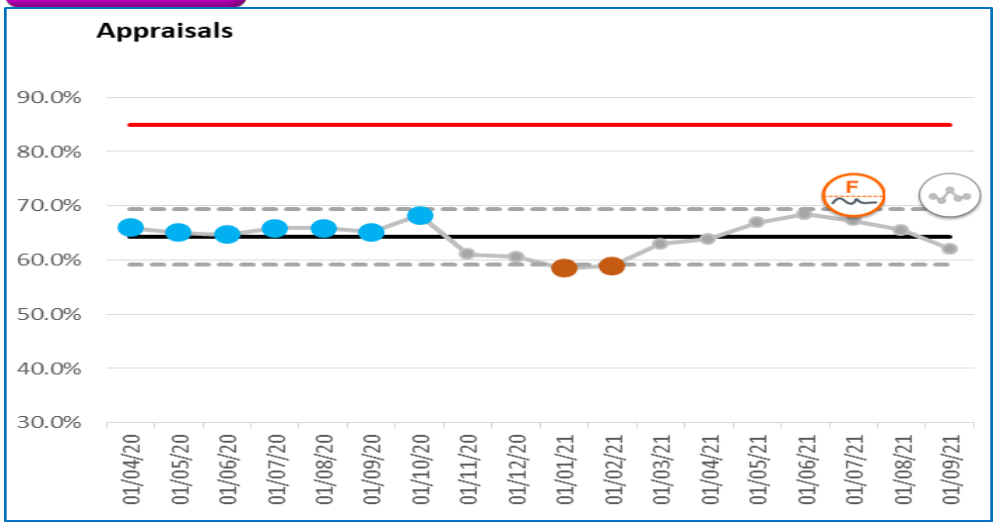
Recommendation
Review, management and oversight at Senior Leadership Team and continued management by operational teams.

Report by exception: Well led – Appraisals

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

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 the 85% target, with this target not being achieved during the past 18 months.
Special cause variation (low) is observed between January and February 2021.

Background

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

Assessment

Compliance rates are monitored via ESR and reported to business units as part of the suite of workforce metrics that are produced. Current compliance is 60.4% against an 85% target, which represents a slight decrease since August. This reflects the pressures services and staff were under over the last quarter, namely the 4th wave of COVID-19 during July and August.

Actions

Whilst decisions to defer appraisal until a time when a more meaningful conversation can be held is sometimes necessary, it should always be reviewed. POD continue reporting monthly to line managers, with the aim of reducing the volume of information, and include additional data about appraisals due in the next 90 days. The aim is to encourage managers to make realistic plans for the coming months. Work continues to provide support by updating ESR on behalf of managers and the new Education, Learning & Development Group, which has now been established, will oversee a wider review of the process.

Recommendation

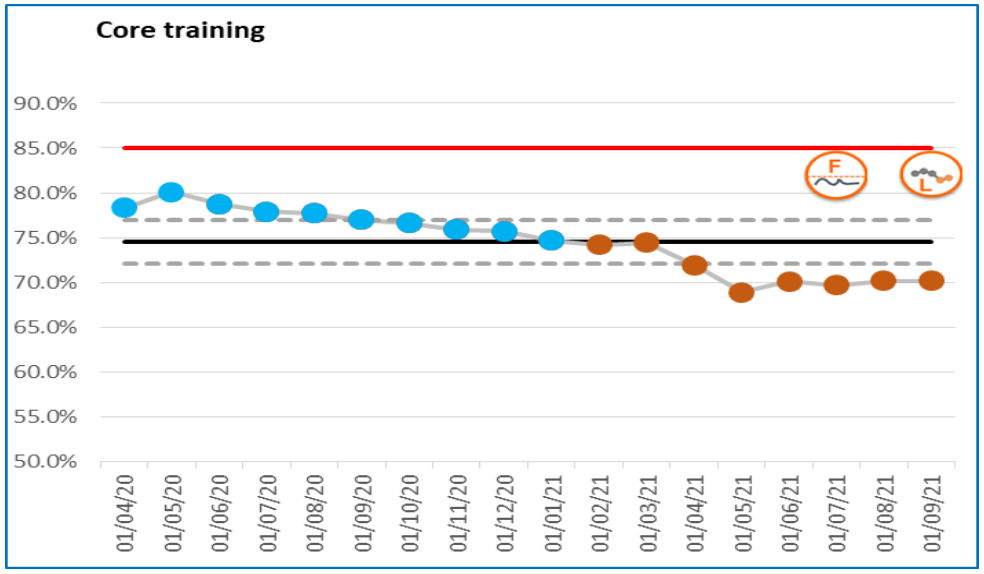
Review, management and oversight at Senior Leadership Team and continued management by operational teams.

Report by exception: Well led – Core training

Gateshead Health NHS Foundation Trust

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

Well Led



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.

Situation
A shift in core skills compliance is observed from February 2021 with special cause variation (low) triggering for the last eight months and. 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. However the need to respond to the significant demands on staff and services as a result of the pandemic and recovery, has meant this was not as high a priority in some services. In addition it was necessary to cancel a number of taught core skills courses; capacity on taught courses is still reduced as a result of social distancing measures; and difficulties to source other suitable accommodation. This inevitably affects capacity to improve certain core skills performance.

Assessment
Current compliance is at 70.2% against an 85% target, no change from increase 70.2 in August.

Actions
A core skills review is currently underway, led by the L&D Manager and will result in greater clarity re: requirements, increased focus on national packages, agreed processes for statutory training requests, improved ESR functionality and improved access via the ESR App. This project will be overseen by the newly formed Education, Learning & Development Group and will include BU recovery planning in partnership with POD Leads.

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

Integrated Oversight Report

Gateshead Health NHS Foundation Trust

Maternity

	Measure	Latest period		Target	Latest 12 months	Variation	Assurance	Comment
MATERNITY	Total births	167	Oct-21	166	1779		?	
	C-section rate	31.1%	Oct-21	<30%	29.2%		?	
	Smoking at time of delivery	12.2%	Oct-21	6%	13.3%		?	
	Breastfeeding at discharge	21.0%	Oct-21	66.2%	37.6%		F	Consistent failure of target.
	Admitted directly to NNU (>37 weeks)	3.3%	Oct-21	<6%	2.7%		?	
	Pre term birth rate <36+6 weeks	7.8%	Oct-21	<6%	7.3%		?	

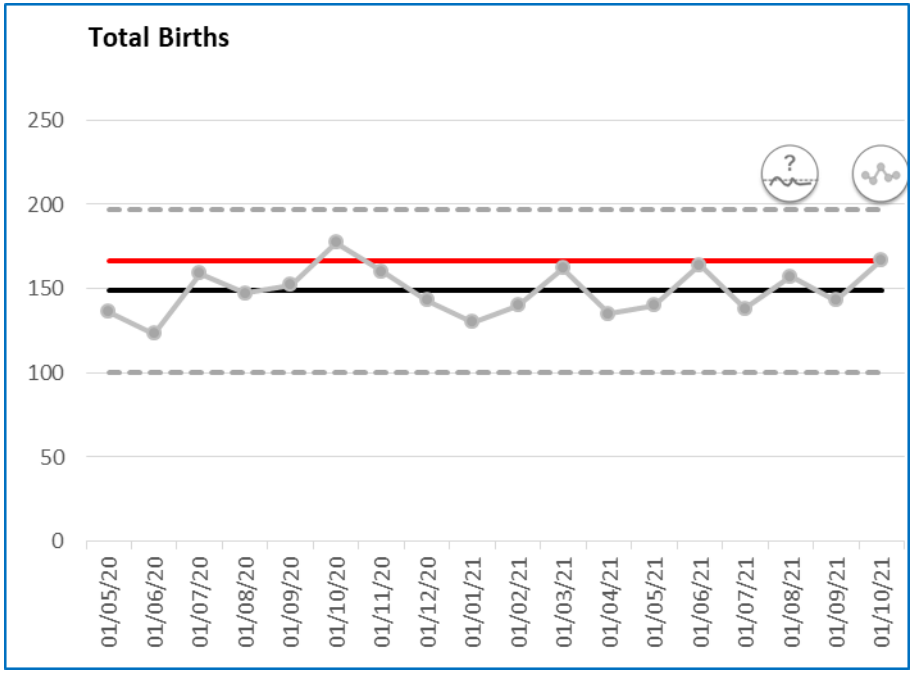
Variation & Assurance : Indicators that do not include a symbol for variation and/or assurance are either not appropriate for measuring by SPC charting or are not measured against a target.

Report by exception: Maternity – Total births

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

Gateshead Health NHS Foundation Trust

Maternity



Combined impact analysis

Financial impact

Quality impact

Workforce impact

Operational performance impact

Situation Common cause variation displayed
167 births in October represents activity or birth rates within expected range. Activity has been over the target threshold twice in the last 18 months.

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

Assessment
The variation in total number of births shows common cause variation and does not indicate a sustained increase in births. A full review of Midwifery staffing has been performed and indicates that staffing levels need to increase as the acuity of mothers has increased.

Actions
The acuity of mothers is recorded on a four hourly basis on the delivery suite and postnatal ward. This is reviewed daily and weekly and informs the HOM staffing review and report to the Chief Nurse.

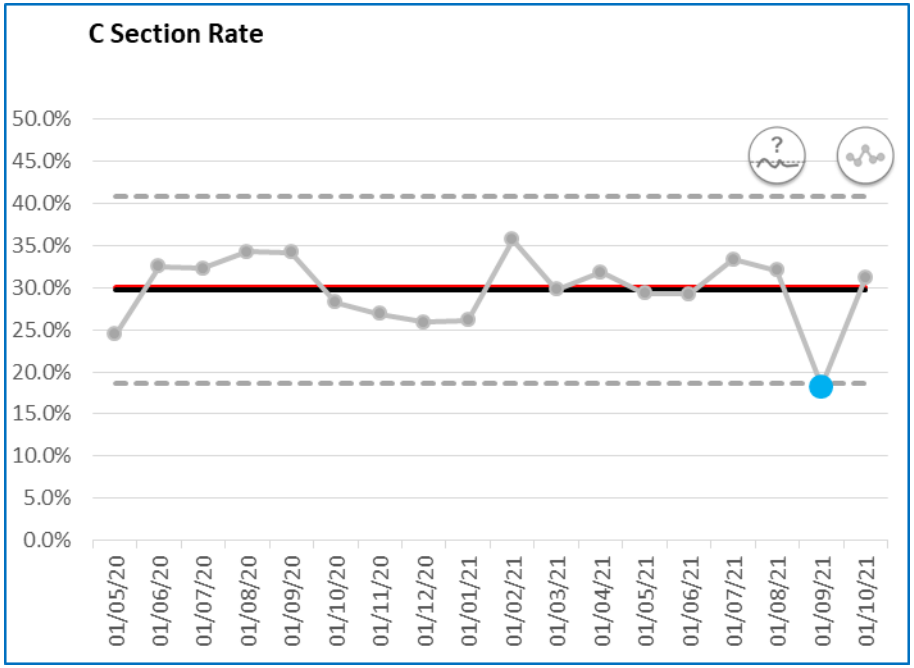
Recommendation
Maternity service is out to recruitment at this point to increase midwifery staffing levels.

Report by exception: Maternity – C section rate

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

Gateshead Health NHS Foundation Trust

Maternity



Combined impact analysis

Financial impact

Quality impact

Workforce impact

Operational performance impact

Situation Common cause variation is displayed. In September 2021 the Trust experienced a significantly low C section rate. Current performance of 31.1% is just above the set standard of 30% – although the rate is still within the upper control limits.

Background

The target for combined emergency and elective LSCS levels has been agreed by the NE &Y Regional Perinatal Quality Oversight Group as 13% for Elective LSCS and 17% for Emergency LSCS, combined limit at 30%.

Assessment

The elective LSCS rate was low in September 7.04% and in October was 11.27% which is an increase and combined with higher emergency LSCS rate in October at 14.37% has led to the increase. There was also a higher number of births.

Actions

LSCS and Emergency LSCS rate monitored monthly and triangulated with other indicators such as term admissions and post-partum haemorrhage to identify and quality or performance issues.

Recommendation

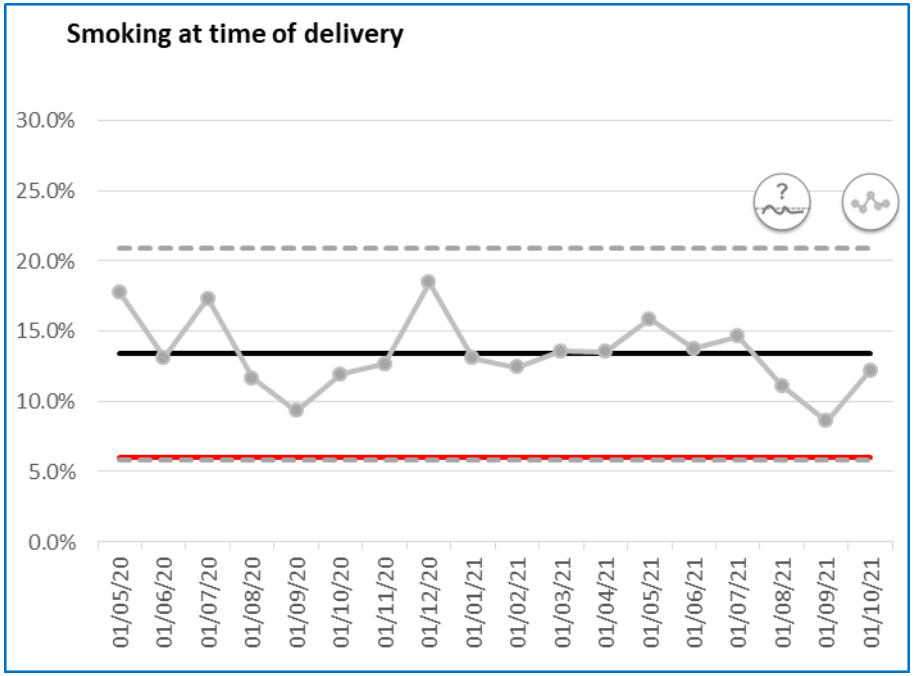
Assessed as common cause variation.

Report by exception: Maternity – Smoking at time of delivery

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

NHS Gateshead Health NHS Foundation Trust

Maternity



Combined impact analysis

Financial impact

Quality impact

Workforce impact

Operational performance impact

Situation Common cause variation is displayed
The target has not been achieved in the last 18 months
Current performance of 12.2% is above the Trust target.

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

Working with Trust Smoke Free leads to develop robust referral and support smoking cessation pathway for our maternity service users and their families.
Funding for this has been agreed from the Maternity Transformation leads and matched by the ICS.

Assessment
Working towards compliance with Saving Babies Lives Care bundle and compliance with MIS year 4 which includes access to smoking referral pathways and improved training and dedicated smoking cessation leads.
Actions
Monthly reporting of Co monitoring. Appointment of PH leads and smoking cessation Band 3 in process.

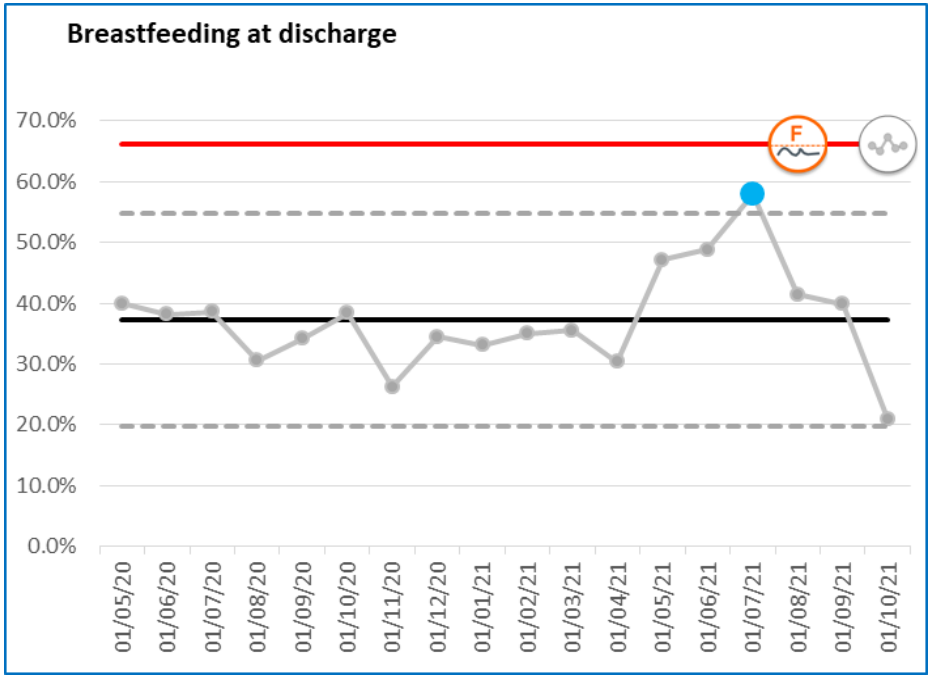
Recommendation
PH plans in place to address KPI's

Report by exception: Maternity – Breastfeeding at discharge

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

NHS Gateshead Health NHS Foundation Trust

Maternity



Combined impact analysis

Financial impact

Quality impact

Workforce impact

Operational performance impact

Situation

Better Births (2016), the Maternity Transformation Programme and the NHS Long Term Plan (2019) highlight the importance and benefits of breastfeeding. It is widely recognised that improving the UK's breastfeeding rates would have a profoundly positive impact on short and long-term health of babies and mothers and give all children the best start in life. There is a regional breastfeeding target to achieve of 72% by 2025, currently the department are working to a rate of 66.25%.

From April 21 to July 21 the Trust was demonstrating a positive trend. However, The target has not been achieved in the last 18 months . Current performance of 21.0% represents a decline in Trust performance against this target.

Background

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

100% of units at UNICEF level 2 by 2020

100% of units at UNICEF level 3 by 2025

Breastfeeding rates greater or equivalent to England by 2025

Assessment

Gateshead Health NHS Foundation trust is accredited at Level 1 and is eligible for Level 2 support: accreditation assessment costs and additional support. We have begun the accreditation process with a view of all services achieving full accreditation by March 2024.

Current breastfeeding initiation rate of 67.5% for 2021 (Jan-Oct).

October initiation rate 67% and discharge rate 20.96% . This could be because of covid and some staffing support issues we have had on the ward.

Actions

Project Lead in post and attended full 5 day NHS Long Term Plan UNICEF training in September 2021.

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

Recommendation

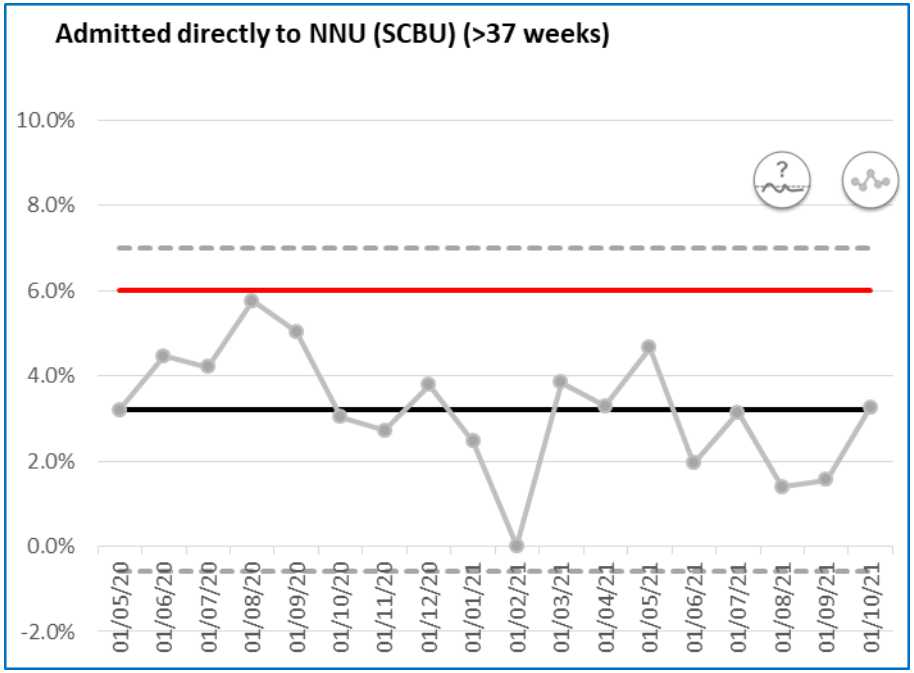
Head of Midwifery proposes to QGC to review the targets in the clinical dashboard parameters for breast feeding at discharge as this will not be the same rate as initiation, based upon a drop off rate at discharge from hospital as 10% or less as there will always be some mothers do not continue to fully breast feed. A full review of target indicators will be part of Maternity Sub group reporting.

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

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

NHS Gateshead Health NHS Foundation Trust

Maternity



Combined impact analysis

Financial impact

Quality impact

Workforce impact

Operational performance impact

Situation Common cause variation displayed
The target has been achieved for every month in the last 18 months

Current performance of 2.7% represents an achievement of the Trust target.

Background
We introduce our Transitional care model in 2019. This enables babies who would have once been admitted to SCBU to remain with their mothers and be supported on the postnatal ward with input from the Neonatal nurse practitioners and maternity support workers.

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

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

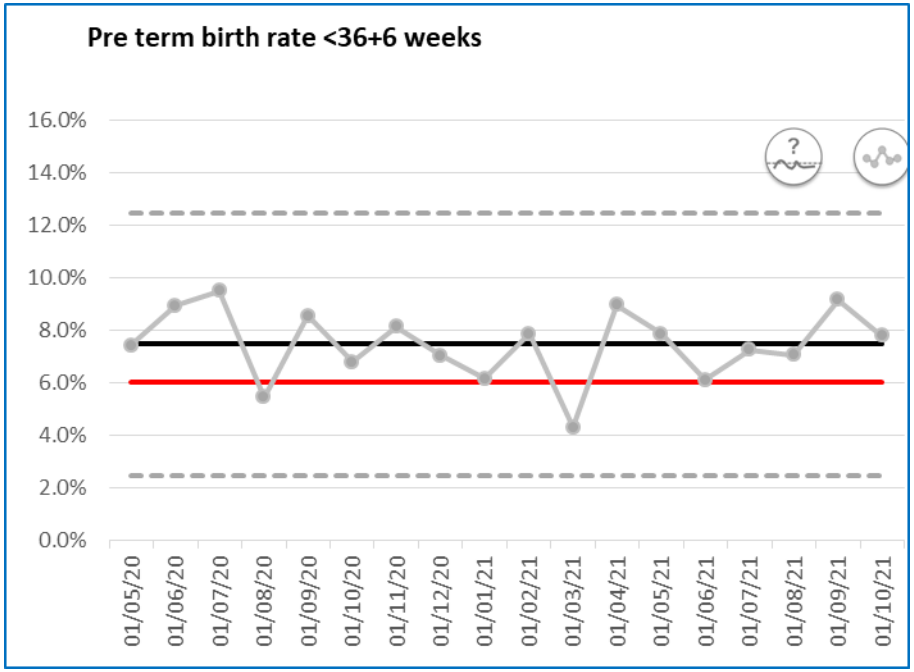
Recommendation

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

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

Gateshead Health NHS Foundation Trust

Maternity



Combined impact analysis

Financial impact

Quality impact

Workforce impact

Operational performance impact

Situation Common cause variation displayed
The target has been achieved in two of the last 18 months
Current performance of 9.15% represents a fail of the Trust target.

Background

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

Assessment

Data capture of any pre-term births (definition; delivery prior to 37 weeks gestation**)**

Actions
Engagement with regional preterm birth network including allocated funding to provide specialist pre-term birth clinic – metrics to be reported to NENC LMS
Engagement with MatNeoSIP national pre-term birth optimisation pathway
Implementation of saving Babies Lives v2 care bundle (element 5 relates to preterm birth)

Recommendation

Continue to engage & monitor outcomes following full implementation of these work streams

Appendices

The following items can be located in the Convene reading rooms

Benchmarking

Reporting Changes

Introduction to SPC

Benchmarking

Latest Benchmarking Summary

Indicator	QEH Performance	View	Position
A&E 4 hour waiting time target	83.4%	September	11th / 139 All NHS Providers
Latest weekly PTL: patients waiting > 104 weeks	0	w/e 24th October	Joint 1st / 8 Providers in ICS
Latest weekly PTL: patients waiting > 52 weeks	23	w/e 24th October	1st / 8 Providers in ICS
Latest weekly PTL: patients waiting > 62 days for cancer treatment	59	w/e 24th October	2nd / 8 Providers in ICS
62 day backlog as % of waiting list 739	7.4%	w/e 24th October	76 (top 20 under NHSE/I scrutiny)

Benchmarking – UEC – all activity

The table below presents the September position for UEC (All activity) against the 4 hour standard.
The latest national benchmarking data places the Trust at 11th of 139 Type 1 providers and 2nd within the local Trusts with no local Trust reaching the 95% standard in September 2021.
Benchmarking data for October – unavailable

	April	May	June	July	August	September
Gateshead	93.5%	91.3%	87.8%	80.4%	81.8%	83.4%
Newcastle	92.4%	92.0%	89.8%	86.7%	85.6%	81.6%
Durham & Darlington	88.0%	83.9%	80.8%	74.4%	73.6%	71.1%
South Tyneside & Sunderland	89.8%	88.0%	84.4%	78.4%	81.5%	79.9%
Northumbria	95.6%	95.8%	95.0%	92.7%	92.7%	90.6%
	April	**May**	**June**	**July**	**August**	**September**
National rank out of 139 type 1 providers	12th	16th	17th	33rd	21st	11th
						2nd in region

Reporting

Changes in Corporate Reporting

The plan is to develop a single report which furnishes all Committees: **Integrated Oversight Report** (IOR) with appropriate deep dive information being presented only at the relevant committee for assurance. As we haven't automated the reporting function yet, there will be some cross over (duplication) reporting whilst we sign off the reporting elements with the relevant Committees. Where there is duplication, this will be highlighted in the IOR.

- Ultimate Plan is to have a golden reporting thread from Ward to Board accompanied by assurance 'spot lights' reporting when required.
- There are known developmental and reporting gaps – this is a work in progress.
- A steering group will manage resource implications (i) development work (ii) capacity to develop (iii) training programme with support from external sources.

The plans is to use our data more intelligently: Using the CQC's key lines of enquiry (KLOE) as the basic structure, providing the outline framework. The CQC domains are colour coded, Responsive (blue), Safety (yellow), Caring (purple), Effective (green), Well led (pink).

We have included a wider set of metrics to support of better decision making and getting a wider view on what's happening in the hospital e.g. activity measures as we recover from C-19, as activity drives performance, and additional ICP benchmarking data.

The reporting strategy includes moving to (statistical process control) SPC charts to study how a system / process or metric changes over time. By using these charts, we can then understand where the focus of work needs to be concentrated in order to make a difference. This is part of NHSI/E drive 'making data count ' moving away from comparing fixed points, moving into understanding variation into taking the most appropriate action. Dr Don Berwick, CEO IHI 'plotting measurements over time is the most powerful thing we have in system learning. Changing our reporting will show us when a situation is deteriorating, improving, delivering a standard or target and whether a process is reliable & in control. The following section includes a narrative in support of reading the report.

Integrated Oversight Report

Introduction and SPC

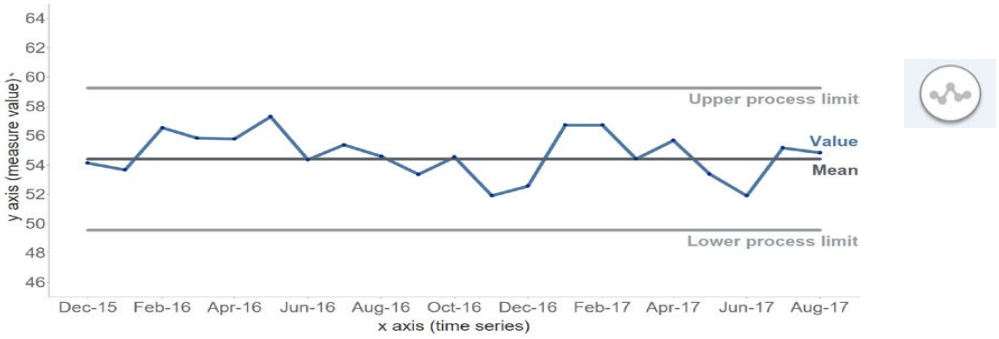
Gateshead Health NHS Foundation Trust

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'.

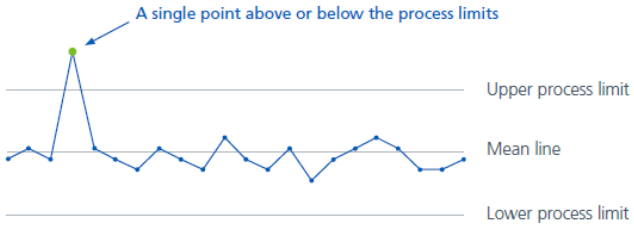
Integrated Oversight Report

Using SPC to identify special cause variation

Gateshead Health NHS Foundation Trust

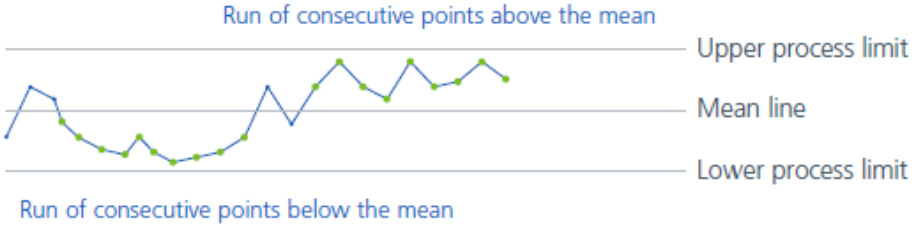
A single point outside the control limits

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.



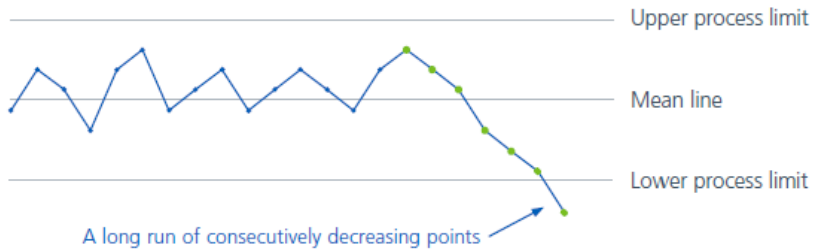
Consecutive points above or below the mean line

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.



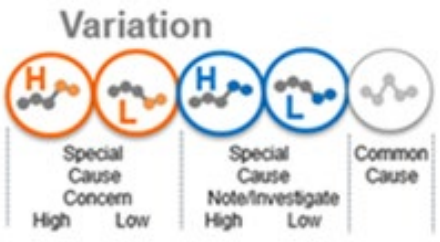
Integrated Oversight Report

How we use statistical process control in this report

Gateshead Health NHS Foundation Trust

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.

Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 15

Report Title:	Nurse Staffing Exception Report – September and October 2021			
Name of Meeting:	Trust Board			
Date of Meeting:	24 November 2021			
Author:	Dr Karen Roberts, Deputy Director of Nursing, Midwifery and Quality Laura Edgar, Lead Nurse Healthroster			
Executive Sponsor:	Gill Findley, Chief Nurse and Professional Lead for Midwifery and AHPs			
Report presented by:	Gill Findley, Chief Nurse and Professional Lead for Midwifery and AHPs			
Purpose of Report	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☒
	To brief the Trust Board on the levels of Registered Nursing staff funded and actual in line with national reporting requirements outlined in the National Quality Board "Safe Sustainable and Productive Staffing Guidance".			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	N/A			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	• This report provides information relating to ward staffing levels (planned against actual) and details of the actions taken to address any shortfalls. • September and October continued with significant staffing challenges following on from August 2021 as the Trust managed the COVID-19 activity that impacted on staffing resource and the clinical operating model. • Wards where staffing fell below 75% of the funded establishment are shown within the paper. Actions taken are documented. Assurance that the escalation process is operating as expected is provided and all staffing Datix reports have been reviewed and no patient harm identified.			

<table>
<tr><td></td><td colspan="5">• Operational issues are being addressed on a daily basis by the site resilience team and the Chief Matrons. A task and finish group is operating to look at longer term recruitment and recording of staffing issues.</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="5">The Board are asked to receive the report for assurance and note the work being undertaken to address the shortfalls in staffing.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="4">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☐</td><td colspan="4">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td colspan="4">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☐</td><td colspan="4">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☐</td><td colspan="4">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="5">Board priority 2.3 - Develop a Trust-wide approach to strategic workforce planning</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☒</td><td>Effective
☒</td><td>Safe
☒</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td colspan="5"></td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☒</td><td>Not applicable
☐</td></tr>
</table>

Gateshead Health NHS Foundation Trust

Nursing and Midwifery Staffing Exception Report

September / October 2021

1. Introduction

This report is to provide assurance to the Board that staffing establishments are being monitored on a shift-to-shift basis. The Board will receive bi-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 September and October2021.

2. Staffing

The actual ward staffing against the budgeted establishments for September and October are presented in Tables 1 and 2. All in-patient wards are presented within this report in appendix 1, broken down into each ward areas staffing. 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 September 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 (%)**
83.2%	92.6%	96.1%	95.9%

Table 2: Whole Trust wards staffing October 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 (%)**
86.5%	95.5%	89.0%	97.5%

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

Exceptions:

The guidance on safe staffing requires that the Board will be advised of those wards where staffing capacity and capability frequently falls short of what is planned, the reasons why, any impact on quality and the actions taken to address gaps in staffing. In terms of exception reporting, Gateshead Health NHS Foundation Trust reports to the Board if the planned staffing in any area drops below 75%.

Contextual information and actions taken

Wards 14, 26 and 8 have been affected by higher levels of sickness absence during the month of September which would correlate with the increased community rates of Covid. JASRU and ward 8 have supported wards 11 and 12 with 1.0 wte and 2.0 wte registered nurses retrospectively. Ward 26 flexed beds during the month of September (15-24) and had a period of closure for deep cleaning in readiness for re-commencing elective activity, with staff supporting escalation areas during these times, reflective in the low fill rates for September. Ward 22 currently has 6.0 wte qualified vacancies, 3 of which have been appointed to but not yet in post. Ward 12 demonstrates low fill rates in the month of September. A short term internal staffing plan has been created until staff are substantively recruited due to the operational pressures within the organisation. There is an ongoing staffing review and recruitment programme to staff ward 12.

The exceptions to report for September are as below:

September 2021	
Qualified Nurse Days	**%**
Ward 12	67.9%
Ward 14 Medicine	72.8%
Ward 14A Trauma	70.0%
Ward 22	60.4%
Ward 23	74.1%
Ward 24	68.1%
Ward 25	65.6%
Ward 26	48.1%
Ward 27	70.3%
Ward 8	59.0%
JASRU	64.5%
Qualified Nurse Nights	**%**
Ward 10	69.1%
Healthcare Assistant Days	**%**
Ward 12	35.5%
Ward 21	74.1%
Ward 26	66.0%
Ward 8	72.4%
Healthcare Assistant Nights	**%**
Ward 12	66.4%
Ward 22	65.8%
Ward 26	65.0%
JASRU	74.2%

In September the Trust worked to the agreed clinical COVID model which meant at times some wards listed above had lower patient occupancy and staff were redeployed appropriately to areas with the greatest clinical need. This accounts for the low average fill rates for Wards 26 and 27. Throughout September, areas of deficit were escalated as per staffing policy and mitigations were put in place by the Matron teams using professional judgement as to the acuity and demand in each area which included:

- Redeployments of Registered Nurses and HealthCare assistants on a daily and at times hourly basis between wards according to patient acuity and demand.
- Mobilisation of part of the non-ward based nurse workforce away from normal duties to support areas most in need of support as detailed in the Trust's winter surge plans.

Work is continuing with the Matrons and the People and Organisational Development team to address the sickness levels within the divisions and to recruit to any vacancies.

October 2021	
Qualified Nurse Days	**%**
JASRU	61.2%
Maternity	128.2%
Ward 8	56.6%
Ward 9	133.4%
Ward 14A	73.0%
Ward 25	57.6%
Ward 26	55.9%
Qualified Nurse Nights	**%**
ECC Ward 1	68.5%
ECC Ward 2	57.8%
Healthcare Assistant Days	**%**
Critical Care	68.4%
Ward 22	72.9%
Ward 23	129.4%
Ward 25	74.9%
Healthcare Assistant Nights	**%**
Cragside Court	132.7%
ECC Ward 1	74.4%
JASRU	65.2%
Sunniside Unit	149.1%
Ward 22	74.5%

JASRU and ward 8 continue to support ward 12 with 1.0 wte and 2.0 wte registered nurses retrospectively. Ward 26 flexed beds during the month of October (15-24) and had a period of closure for deep cleaning in readiness for the move with ward 21. During this time staff supported other areas, reflective in the low fill rates for October to the areas of greatest clinical need. Ward 22 currently has 6.0 wte unqualified vacancies, 3 of which have been appointed to but not yet in post. Ward 25 currently have 5.48 wte qualified vacancies and 4.37 wte unqualified vacancies, 3.0 wte unqualified are awaiting start dates.
Emergency Care Centre 01 and 02 report low fill rates for qualified nights in October. The establishment supports 1:4 nurse ratio, however currently staffed at 1:6. Vacant posts have been recruited to, staff awaiting start dates. There will a rapid review of establishment within wards 1 and 2. Ward 12 continues with ongoing recruitment to the area. Ward 9 report a higher fill rate for qualified staff in October due to supporting ward 10 and the Respiratory Support unit.

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. A report is generated on a monthly basis and discussed at the Nursing and Midwifery Professional Forum. This report helps identify areas where nurse staffing may have fallen below planned levels and what actions were taken to manage the situation.

There were 26 staffing incidents in September and 11 within October, reflective of the slightly improved fill rates between both months. Of the identified staffing incidents within September and October, there were no patient harms relating to staffing incidences.

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

5. Governance

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

6. Conclusion

This paper provides an exception report for nursing and midwifery staffing in September and October 2021.

7. Recommendations

The Board is asked to receive this report for assurance.

Gill Findley
Chief Nurse & Professional Lead for Midwifery and AHP's

Appendix 1 – Table 3: Ward by Ward staffing September 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	85.5%	95.5%	143.7%	128.7%	526	3.9	4.1	8.0
Ward 2 - SSU	104.3%	209.9%	125.7%	142.7%	570	3.9	4.2	8.1
Ward 8	59.0%	72.4%	90.8%	105.3%	597	3.0	2.6	5.6
Ward 9	113.9%	122.5%	83.5%	93.4%	684	2.9	2.9	5.8
Ward 10	-	-	-	-	-	-	-	-
Ward 11	77.1%	91.7%	113.3%	112.2%	592	3.1	3.3	6.5
Ward 12	67.9%	35.5%	106.2%	66.4%	582	2.9	1.6	4.4
Ward 14 Medicine	72.8%	101.4%	103.9%	105.8%	599	2.9	3.2	6.1
Ward 14A	70.0%	122.0%	102.0%	91.2%	667	2.9	3.7	6.6
Ward 21	92.3%	74.1%	98.6%	92.1%	406	4.2	2.8	7.0
Ward 22	60.4%	82.2%	102.0%	65.8%	751	2.2	2.7	4.9
Ward 23	74.1%	104.0%	103.3%	95.0%	668	2.4	3.4	5.8
Ward 24	68.1%	91.4%	104.0%	85.6%	803	2.2	3.0	5.2

	Day		Night		Care Hours Per Patient Per Day (CHPPD)			
Ward	Average fill rate - nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative patient count over the month	Registered midwives / nurses	Care Staff	Overall
Ward 25	65.6%	80.0%	101.9%	80.7%	856	2.0	2.5	4.5
Ward 26	48.1%	66.0%	80.5%	65.0%	328	4.1	4.8	8.8
Ward 27	70.3%	94.4%	104.3%	95.6%	854	2.2	2.5	4.8
Cragside Court	83.7%	92.2%	76.1%	114.6%	199	8.1	9.2	17.3
Critical Care	83.9%	93.8%	75.0%	119.5%	265	25.2	4.8	29.9
EAU	-	-	-	-	-	-	-	-
JASRU	64.5%	75.5%	98.5%	74.2%	520	3.0	3.7	6.7
Maternity	133.1%	134.6%	94.0%	95.6%	506	14.2	6.1	20.3
Paediatrics	122.6%	96.7%	108.9%	-	69	34.2	9.4	43.6
SCBU	80.1%	101.0%	100.0%	99.9%	137	11.2	4.4	15.6
St Bedes	96.8%	89.9%	101.4%	94.3%	222	6.8	4.8	11.6
Sunniside	103.8%	75.3%	95.9%	181.3%	220	7.3	6.7	14.1

Appendix 2 – Table 4: Ward by Ward staffing October 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 - ECC	78.0%	112.2%	68.5%	74.4%	638	5.7	3.6	9.3
Ward 2 - ECC	82.1%	115.6%	57.8%	124.6%	647	5.4	4.6	9.9
Ward 8	56.6%	81.1%	100.4%	114.4%	631	2.9	2.8	5.7
Ward 9	70.8%	91.3%	91.6%	95.9%	730	3.2	2.6	5.8
Ward 10	85.0%	113.9%	75.9%	110.8%	653	2.8	3.2	5.9
Ward 11	82.1%	97.4%	106.9%	111.4%	610	3.2	3.5	6.7
Ward 12	52.7%	82.7%	99.5%	94.4%	654	2.8	2.4	5.2
Ward 14 Medicine	87.1%	79.0%	100.8%	102.1%	650	3.0	2.6	5.6
Ward 14A	73.0%	100.4%	101.8%	94.1%	734	2.8	3.1	5.9
Ward 21	109.0%	83.5%	95.4%	101.9%	324	6.1	4.0	10.1
Ward 22	63.0%	61.5%	102.0%	74.5%	717	2.9	2.8	5.7
Ward 23	83.4%	129.4%	99.9%	101.4%	715	2.4	3.9	6.4
Ward 24	59.3%	84.8%	100.5%	89.8%	854	2.3	3.1	5.5

	Day		Night		Care Hours Per Patient Per Day (CHPPD)			
Ward	**Average fill rate - nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Cumulative patient count over the month**	**Registered midwives / nurses**	**Care Staff**	**Overall**
Ward 25	57.6%	63.6%	105.7%	82.2%	892	2.2	2.4	4.6
Ward 26	55.9%	75.4%	87.8%	100.5%	557	2.8	3.6	6.5
Ward 27	84.5%	97.9%	105.0%	92.3%	816	2.8	2.8	5.6
Cragside Court	78.5%	94.7%	93.9%	132.2%	271	6.3	7.5	13.8
Critical Care	78.1%	68.4%	91.0%	97.3%	277	25.7	3.6	29.3
JASRU	61.2%	78.1%	98.4%	65.2%	590	2.7	3.3	6.0
Maternity	128.2%	123.3%	88.5%	96.5%	616	12.3	4.9	17.2
Paediatrics	122.2%	123.9%	106.3%		104	23.2	6.8	29.9
SCBU	91.5%	110.8%	97.7%	100.9%	237	7.2	2.7	9.9
St Bedes	96.3%	101.5%	93.1%	109.2%	281	5.3	4.5	9.8
Sunniside	100.3%	75.6%	91.8%	149.1%	171	9.4	8.4	17.7

Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 16

Report Title:	QE Facilities 6 Monthly Update			
Name of Meeting:	Board of Directors			
Date of Meeting:	24 November 2021			
Author:	Anthony Robson, Managing Director QE Facilities			
Executive Sponsor:	Anthony Robson, Managing Director QE Facilities			
Report presented by:	Anthony Robson, Managing Director QE Facilities			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☒
	This report sets out a brief update for the last 6 months with examples of what the company has delivered and moving towards our current activity.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☒ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	-			

Key issues:
Briefly outline what the top 3-5 key points are from the paper in bullet point format
 	
Consider key implications e.g.
• *Finance*
• *Patient outcomes / experience*
• *Quality and safety*
• *People and organisational development*
• *Governance and legal*
• *Equality, diversity and inclusion*
	• Positive developments have been made in relation to a number of aspects of the business, including:
	  • Launch of the mobile vaccination unit
	  • New Patient Transport Services contracts secured
	  • Improved commercial usage of Spire House
	  • Continued progress in the mark manufacturing
	  • Progress in relation to the estate and property strategy
	  • Good progress with the company restructure
	  • Becoming a fully accredited Real Living Wage organisation			

Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Board is requested to receive the report for assurance and information.			

Trust Strategic Aims that the report relates to:	**Aim 1** ☒	We will continuously improve the quality and safety of our services for our patients			
	Aim 2 ☒	We will be a great organisation with a highly engaged workforce			
	Aim 3 ☒	We will enhance our productivity and efficiency to make the best use of resources			
	Aim 4 ☒	We will be an effective partner and be ambitious in our commitment to improving health outcomes			
	Aim 5 ☒	We will develop and expand our services within and beyond Gateshead			
Trust corporate objectives that the report relates to:	5.6 – manufacture FFP3 masks 5.7 – maximise use of the warehouse to provide efficient commercial use of the building 5.8 – expand the business of wholesale pharmacy drugs 5.9 – develop and expand the North East transport hub				
Links to CQC KLOE	Caring ☐	Responsive ☒	Well-led ☒	Effective ☒	Safe ☒
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks and DATIX reference)	No direct risks				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

QEF UPDATE

This report sets out a brief update on a range of issues that are being progressed or have emerged since the last Board update.

- **Covid-19**

  Difficult weeks continue in the FT with numbers of Covid cases rising and the track and trace affect staff reaching high levels once again. Bed numbers were at capacity across last week and pressures on emergency care remain at a high level.

- **Transport**

  Great news as our new mobile vaccination unit arrived at the Metro Centre, Gateshead. Working with Newcastle Hospitals QEF have delivered a fully fitted out vehicle with driver in record time. Well done to our Procurement team and Transport team for pulling this off!

  We continue to tender for work in Shropshire and Manchester awaiting responses.

  We have successfully contracted with Newcastle Hospitals to provide PTS services at the RVI and Freeman hospitals with NEAS also requiring additional services as pressures increase in the locality.

- **Spire House Washington**

  A small commercial research company has taken space at Spire House with a 12-month rolling lease. This has now been followed by a national company who requires warehouse and distribution to trunking centres for furniture suppliers. This has commenced in November and is in full operation.
  We are also pleased to announce a 12 months booking for seminar training and physical outdoor HAZMAT training for NEAS. Our canopy used for ambulance washing is ideal for this venture and is proving the perfect facility.

  Spire House now has a full time reception facility staffed by the team at Washington.

- **PPE Mask manufacturing**

  The mask machine has now CE certification and BSI are concluding the UKCA certification with imminent results. BSI have agreed a joint publicity project with the certification showing the strength of the British manufacturing industry and the UKCA mark.

  Problems with the headband module on the machine have been highlighted and German engineers are concluding re-engineering of the headband weld.

  We are working with the University of Southampton on face fitting for BAME and other staff with data from over 70,000 mask fittings. This is an initiative with the government and is funded by a grant to the University.

  We have spoken to members of the business community in Hong Kong via the British Consulate about our mask and the certification. The anti-viral layer is an innovation made by C-Polar a Hong Kong company with sponsorship and endorsement from several leading medical faculties including John Hopkins and Harvard medical school. C-Polar have requested a co-patent with QEF over the mask which will allow the product to be protected and then opens up the export markets for the future.

  Our talks with Steripack Ireland Ltd continue with NDA's exchanged as we look at business continuity being serviced via a second site manufacturing facility for our mask (under licence).

  We continue to improve the materials being manufactured in the UK as our Don & Low meltblown material has passed all checks and is now a component part of the mask.

- **Post Covid Estate and Property Strategy**

  QEF is working with the FT to provide a consolidated response to the return of business as usual to the site. We have identified staff working from home and plans to repatriate some of those staff to new accommodation on site and off site. We are now talking to the Local Authority to explore accommodation for administrative staff at the civic centre in Gateshead.

  We have worked out a solution for the Finance team in the FT who are returning to work at BGH freeing up space on the QEH site. We have live projects with the HR team and the IT team. QEF Finance have relocated and a planned return to office plan is in place to include hybrid working.

- **QEF Restructure & related issues.**

  The company restructure is detailed within the HR report today but is well advanced and has been carried out with due diligence and promptness. The structure will redefine the management structure and make us more responsive to our customers and patients. I would like to thank Iain Rae who has worked extremely hard on this to progress so quickly.

The relaunch of our company values is happening this month and will coincide with Portering services on site being taken over by Transport which is now running the service on the QEH site.

Our new associate directors are now being appointed and so far we welcome John Welsh and Paul Bowmaker to the Board and congratulate them both on their new roles and service to the organisation.

We expect to advertise more roles this week and have the replacement Head of Procurement interviews being arranged following the retirement of Mick Lloyd. We thank Mick for his service to QEF since inception and wish him a very happy retirement.

- **Real Living Wage**

Our acceptance by the Living Wage commission was made last week and we are now a fully accredited Real Living Wage organisation. In April 2016 the government introduced a higher minimum wage rate for all staff over 25 years of age inspired by the Living Wage campaign - even calling it the 'national living wage'.

However, this wage is not calculated according to what employees and their families need to live. Instead, it is based on a target to reach 66% of median earnings by 2024. Under current forecasts this means a rise to £10.50 per hour by 2024 and from 2021 was adjusted to include those over 23 years old. The government minimum takes into account what is affordable for businesses.

The real Living Wage rates are higher because they are independently-calculated based on what people need to get by. QEF have made this commitment to our staff to ensure they earn a wage that meets the costs of living, not just the government minimum wage. It is part of our ongoing commitment to social value and we will encourage all of our sub contractors to pledge that they will ensure their workforce are being paid accordingly.

- **Dementia Matters**

We are having discussions with Dementia Matters (Bev Reid) a local charity (turnover circa £1m) who require advice and services on their Bradbury site in Brunswick, Newcastle. This will include Transport (PTS) services, buildings maintenance, grounds and gardens work and cleaning services. A site visit and discussion are taking place next week.

- **Newcastle Clinic – TSS**

The day care facility has been delayed by building works but is hoping to go-live before Christmas when we will deliver pharmaceutical, facilities and estate services for NHS patients.

- **Green Apple Award**

QE Facilities won a prestigious International Green Apple Environment Award in 2020 for environmental best practice, which was finally awarded this month due to delays.

The Green Apple Environment Awards were established in 1994 as an annual campaign to recognise, reward and promote environmental best practice. The win comes as the NHS becomes the world's first national health system to commit to become 'carbon net zero'.

QE Facilities are passionate about our continual responsibilities in reducing the impact on the environment. We have implemented energy efficient schemes to deliver significant reductions in carbon emissions, achieving a 34% reduction. Further work has since been undertaken as we continue to work hard to meet the NHS Net Zero targets.

The Board is asked to note progress on the issues above.

Anthony J Robson
Managing Director

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

	Lead	Type of item	Public/Private	Sep-21	October 21 (extra Board)	Nov-21	Jan-22	Mar-22	May-22 (Ex)	May-22	Jul-22	Sep-22	Nov-22	Jan-23	Mar-23
Standing Items			Part 1 & Part 2												
Apologies	Chair	Standing Item	Part 1 & Part 2	√		√	√	√	√	√	√	√	√	√	√
Declaration of interests	Chair	Standing Item	Part 1 & Part 2	√		√	√	√	√	√	√	√	√	√	√
Minutes	Chair	Standing Item	Part 1 & Part 2	√		√	√	√		√	√	√	√	√	√
Action log	Chair	Standing Item	Part 1 & Part 2	√		√	√	√		√	√	√	√	√	√
Matters arising	Chair	Standing Item	Part 1 & Part 2	√		√	√	√		√	√	√	√	√	√
Chief Executive's Update Report	Chief Executive	Standing Item	Part 1 & Part 2	√		√	√	√		√	√	√	√	√	√
Cycle of Business	Company Secretary	Standing Item	Part 1 & Part 2	√		√	√	√	√	√	√	√	√	√	√
Patient & Staff Story	Company Secretary	Standing Item	Part 1	√		√	√	√		√	√	√	√	√	√
Questions from Governors	Chair	Standing Item	Part 1	√		√	√	√		√	√	√	√	√	√
Items for Decision			Part 1 & Part 2												
Annual Declarations of Interest	Company Secretary	Item for Decision	Part 1					√							√
Trust Strategic Aims & Objectives	Chief Executive	Item for Decision	Part 1					√							√
Board Assurance Framework - approval of closing and opening position	Company Secretary	Item for Decision	Part 1					√							√
Standing Financial Instructions & Delegation of Powers	Company Secretary / Group Director of Finance	Item for Decision	Part 1	√			√					√			
Calendar of Board Meetings	Company Secretary	Item for Decision	Part 1	√								√			
Winter Plan	Chief Operating Officer	Item for Decision	Part 1	√								√			
Constitution and Standing Orders - annual review	Company Secretary	Item for Decision	Part 1				√								
Board Committee Terms of Reference - Ratification	Company Secretary	Item for Decision	Part 1			√	√								
Board Committee Annual Reviews of Effectiveness and Terms of Reference Update	Company Secretary	Item for Decision	Part 1							√					
Items for Assurance			Part 1 & Part 2												
Board Committee Assurance Reports	Committee Chairs	Item for Assurance	Part 1	√		√	√	√		√	√	√	√	√	√
Corporate Objective Delivery	Company Secretary	Item for Assurance	Part 1	√			√	√		√		√		√	
Board Assurance Framework	Company Secretary	Item for Assurance	Part 1	√			√			√		√		√	
Organisational Risk Register	Chief Nurse	Item for Assurance	Part 1	√		√	√	√		√	√	√	√	√	√
Annual Staff Survey Results	Exec Director of People & OD	Item for Assurance	Part 1					√							√
Covid Update	Medical Director	Item for Assurance	Part 1	√		√	√	√		√	√	√	√	√	√
Finance Report	Group Director of Finance	Item for Assurance	Part 1 & Part 2	√		√	√	√		√	√	√	√	√	√
Integrated Oversight Report	Chief Operating Officer	Item for Assurance	Part 1	√		√	√	√		√	√	√	√	√	√
Nurse Staffing Exception Report	Chief Nurse	Item for Assurance	Part 1	√		√	√	√		√	√	√	√	√	√
Nurse Staffing Annual Capacity & Capability Report	Chief Nurse	Item for Assurance	Part 1				√							√	
Learning from Deaths (quarterly - dates to be confirmed)	Medical Director	Item for Assurance	Part 1	√											
SIRO Report & Digital Update	Group Director of Finance	Item for Assurance	Part 1	√				√				√			√
EPRR Core Standards Self-Assessment Report	Chief Operating Officer	Item for Assurance	Part 1	√								√			
EPRR Assurance Report	Chief Operating Officer	Item for Assurance	Part 1	√				√				√			√
CNST Maternity Compliance Report	Medical Director	Item for Assurance	Part 1							√					
Sustainable Development Management Plan	QEF Managing Director	Item for Assurance	Part 1							√					
QEF 6 monthly update report	QEF Managing Director	Item for Assurance	Part 1			√				√			√		
Freedom to Speak Up Guardian Report	Exec Director of People & OD	Item for Assurance	Part 1				√				√			√	
Improving People Practices Update	Exec Director of People & OD	Item for Assurance	Part 1				√				√			√	
WRES and WDES Report	Exec Director of People & OD	Item for Assurance	Part 1	√				√				√			√
Mortality Report	Medical Director	Item for Assurance	Part 1	√				√				√			√
Quality Accounts Priorities 6 monthly update	Chief Nurse	Item for Assurance	Part 1			√							√		
People's Plan Briefing (dependent upon national publication)	Exec Director of People & OD	Item for Assurance	Part 1												
Items for Information			Part 1 & Part 2												
Ad Hoc Items (i.e. items emerging during the year)			Part 1 & Part 2												