MEETING OF THE BOARD OF DIRECTORS IN PUBLIC

Gateshead Health NHS Foundation Trust

Date: Tuesday 28th September 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 Gillian Findley. *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 July 2021** To be agreed as an accurate record	Agree	Enclosure 4
5.	09:35 am	**Matters Arising/Action Log**	Update	Enclosure 5
6.	09:40 am	**Patient & Staff Story** To receive a presentation from: • Ward 11 Patient & Family Experience	Assurance	Enclosure 6
		ITEMS FOR DECISION		
7.	09:50 am	**Standing Financial Instructions & Delegation of Powers** To approve the proposed amendment, presented by the Company Secretary	Approval	Enclosure 7
8.	09:55 am	**Calendar of Board Meetings** To approve the meeting dates for Quarter 4 2021/22 and 2022/23, presented by the Company Secretary	Approval	Enclosure 8
9.	10:00 am	**Winter Plan** To approve the plan, presented by the Chief Operating Officer	Approval	Enclosure 9
		ITEMS FOR ASSURANCE		
10.	10:15 am	**Assurance from Board Committees** i. Finance and Performance Committee – 27th July, 25th August, & 27th September 2021 (verbal) ii. Audit Committee – 2nd September 2021 iii. Quality Governance Committee – 21st July & 21st September 2021 (verbal) iv. Digital Committee – 16th August 2021 v. HR Committee - 14th September 2021	Assurance	Enclosure 10
11.	10:40 am	**Chief Executive's Update Report** To receive a briefing report from the Acting Chief Executive	Assurance	Presentation

12.	10:50 am	**Governance Reports** i. **Corporate Objective Delivery** ii. **Board Assurance Framework 2021/22** iii. **Organisational Risk Register** To receive the reports presented by the Company Secretary (BAF) and Chief Nurse (ORR)	Assurance	Enclosure 12
13.	11:00 am	**SIRO Report and Digital Update** To receive the report, presented by the Chief Digital Information Officer	Assurance	Enclosure 13
14.	11:10 am	**EPRR Core Standards Self-Assessment & Assurance Report** To receive the report presented by the Chief Operating Officer	Assurance	Enclosure 14
15.	11:20 am	**COVID Update** To receive an update, presented by the Medical Director	Assurance	Verbal
16.	11:25 am	**Finance Update** To receive the report, presented by the Group Director of Finance	Assurance	Enclosure 16
17.	11:35 am	**Integrated Oversight Report** To receive the report, presented by the Chief Operating Officer	Assurance	Enclosure 17
18.	11:45 am	**Learning from Deaths Report** To receive the report, presented by the Medical Director	Assurance	Enclosure 18
19.	11:50 am	**Nurse Staffing Exception Report** To receive the routine report presented by the Chief Nurse	Assurance	Enclosure 19
20.	11:55 am	**Healthcare Associated Infections** To receive the report presented by the Medical Director	Assurance	Enclosure 20
21.	12:00 pm	**WRES and WDES Report** To receive the report for information presented, by the Director of People and OD	Assurance	Enclosure 21
		ITEMS FOR INFORMATION		
22.	12:10 pm	**Cycle of Business** To receive the cycle of business outlining forthcoming items for consideration by the Board, presented by the Company Secretary	Information	Enclosure 22
23.	12:20 pm	**Questions from Governors in Attendance** To receive any questions from governors in attendance		Verbal
24.	12:30 pm	**Date and Time of the next Meeting** The next scheduled meeting of the Board of Directors to be held in public will be 24th November 2021 at 9:30 am		Verbal
25.	12:30 pm	**Chair Declares the Meeting Closed**		Verbal
26.	12:30 pm	**Exclusion of the Press and Public** To resolve to exclude the press and public from the remainder of the meeting, due to the confidential nature of the business to be discussed		Verbal

Gateshead Health
NHS Foundation Trust

Report Cover Sheet

Agenda Item: 2

Purpose of Report	Decision: ☒	Discussion: ☐	Assurance: ☐	Information: ☐
Report Title:	Declaration of interest			
Name of Meeting:	Board of Directors – Part 1			
Date of Meeting:	28 September 2021			
Author:	Jennifer Boyle, Company Secretary			
Executive Lead:	Jacqueline Bilcliff, Chief Executive			
Report presented by:	Jennifer Boyle, Company Secretary			
Executive Summary:	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. 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. Gillian Findley, Chief Nurse, joined the Board of Directors on 16 August 2021. Assurance can be provided that Gillian Findley completed both the declaration of interests and fit and proper person declaration on 26 July 2021 prior to commencing in post. No interests have been declared and Gillian Findley confirmed compliance and understanding of the fit and proper person requirements.			
Recommended actions for Board/Committee)	The Board is requested to: • Approve the inclusion of Gillian Findley's nil return in the Board's register of interests. • 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: **(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					
Links to Risks (identify significant risks and DATIX reference)	No risks identified in respect of the declaration process.					
People and OD Implications:	None					
Links to CQC KLOE	Caring ☐	Responsive ☐	Well-led ☒	Effective ☐	Safe ☐	
Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)	**Obj.1** ☐	The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance between working life and personal commitments				
	Obj. 2 ☐	All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers				
	Obj. 3 ☐	Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve				

Trust Board

Minutes of a meeting of the Board of Directors held at 9.30 am on Wednesday 28h July 2021, via Microsoft Teams

Gateshead Health NHS Foundation Trust

Present:	
Mrs A Marshall	Chair
Mrs J Baxter	Chief Operating Officer/Interim Chief Nurse
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 K Mackenzie	Acting Group Director of Finance
Mr A Moffat	Non-Executive Director
Mrs H Parker	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
Rev G Rowlands	Chaplain/Freedom to Speak Up Guardian (21/119)
Ms D Waites	Corporate Services Assistant
Governors and Members of the Public:	
Mr J Bedlington	Public Governor – Central
Mrs J Coleman	Staff Governor
Mr S Connolly	Staff Governor
Mr A Dougal	Public Governor - Eastern
Reverend J Gill	Public Governor – Western
Mrs K Marley	Staff Governor
Mr G Riddell	Public Governor - Western
Mr J Stephens	Public Governor - Central
Mrs K Tanriverdi	Public Governor – Central
	3 x members of the public
Apologies:	
Cllr M Gannon	Non-Executive Director
Mrs A Maskery	Interim Company Secretary
Mrs Y Ormston	Chief Executive

Agenda Item	Discussion and Action Points	Action By
21/111	**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 Anna Stabler to her first meeting following her recent appointment as Non-Executive Director, from 1st July 2021. She also welcomed the Trust's Governors and members of the public. Mrs Marshall encouraged the Board to be mindful of the current operational pressures being experienced by the Trust's staff and the importance of ensuring that they are fully supported and looked after during this time.	
21/112	**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.	
21/113	**APOLOGIES FOR ABSENCE:** Apologies were received from Cllr M Gannon and Mrs Y Ormston.	
21/114	**MINUTES OF THE PREVIOUS MEETING:** The minutes of the meeting of the Board of Directors held on Wednesday 26th May 2021 were approved as a correct record following a minor amendment in relation to the Quality Governance Committee Board Assurance Report which referred to Duty of Candour compliance. It was noted that the Trust was partially compliant.	
21/115	**MATTERS ARISING FROM THE MINUTES:** The Board Action Plan was updated accordingly to reflect matters arising from the minutes.	
21/116	**PATIENT & STAFF STORY:** Miss J Boyle, Company Secretary, presented the virtual patient story which showed Mr Matt Stewart leaving the Critical Care Unit. She highlighted that Mr Stewart had spent 156 days as an in-patient with Covid on the critical care unit before spending 18 days on a respiratory ward. Upon discharge he achieved his goal of walking out of the hospital unaided.	

Agenda Item	Discussion and Action Points	Action By
	The Board agreed that this was demonstrative of the quality of care Mr Stewart had received and was an uplifting story for all.	
21/117	**DECLARATIONS OF INTEREST:** Miss J Boyle, Company Secretary, presented the Declaration of Board Members' Interests and the Fit and Proper Persons Declaration for Mrs Anna Stabler, Non-Executive Director, who joined the Board on 1st July 2021. Miss Boyle reminded the Board that 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. 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. Assurance can be provided that Mrs Anna Stabler completed both the declaration of interests and fit and proper person declaration on 14th May 2021 prior to commencing in post. No interests have been declared and Mrs Anna Stabler confirmed compliance and understanding of the fit and proper person requirements. **RESOLVED:** i) to approve the inclusion of Anna Stabler'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.	
21/118	**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 29th June 2021 and 27th July 2021 (verbal). He reported that discussions mainly took place in relation to forecasting, spend and funding as well as supporting the recovery programme. There were no matters for escalation however he highlighted the following key points:	

Agenda Item	Discussion and Action Points	Action By
	• Finance Report – this showed a small increase in the surplus and the Committee were assured that current uncertainties in future funding were being factored into forecasting and budgeting as much as possible. • Elective Recovery Fund (ERF) – the Committee advised a challenge in relation to the receipt of ERF due to Covid pressures on the region and a change in target. Following a query from Mrs Marshall, Mrs K Mackenzie reported that ERF is earned on a monthly basis, so the Trust would receive some income for any months where the region had achieved its target so far. • Capital Programme / Capital Departmental Expenditure Limit (CDEL) – the Committee was assured regarding the current plan but expressed concern about the future requirements, particular given the relatively small CDEL. • H2 plan presentation – the Trust is currently awaiting details from NHS England and Improvement (NHSE&I) but this is not expected until the Autumn, leaving significant uncertainties. Ongoing work is being undertaken by the Finance team in relation to estimated spending profiles and forecasting. • The Financial and Accountability Framework was in place prior to pandemic and the plan is to reintroduce this, although further work is required to ensure that this is timed appropriately given the current organisational pressures. • Integrated Oversight Report – the Committee received a detailed exception report outlining the action being taken in relation to echocardiology. The Committee concluded that good progress was being made in this area, but there remains significant longer-term challenges. The significant challenges in relation to the increase in Covid cases and sickness absence were acknowledged, noting that the impact on performance would be seen in future iterations of the report. • Supply Procurement – good assurance was received and it was noted that Internal Audit will be reporting on this area as part of the audit plan. **Audit Committee** Mr A Moffat provided the assurance report for the Committee meetings held on 3rd June 2021 and 1st July 2021. There was one matter for escalation from the meeting on 1st July in relation to Medical Devices training and it was reported that the implementation date had slipped a number of times due to system improvement. A business case is awaiting approval however concerns were raised around the impact of this delay on the quality of the service as well as patient safety. Mr A Robson, Managing Director for QEF, reported that an e-learning management system was being procured and roll out is expected to take place next month. A	AR

Agenda Item	Discussion and Action Points	Action By
	recruitment advert for a training post has also gone live therefore an update on progress will be provided at the next Board meeting. Mrs J Baxter, Chief Operating Officer and Interim Chief Nurse, provided further assurances in relation to patient safety work and reported that there was a robust process being undertaken to ensure information on training was being collated and monitored. Mr Moffat highlighted other key points including: • The Counter Fraud Annual Work Plan for 2021/22 was approved by the Committee • Third Party Expenditure Review – further work to be undertaken by Group Finance in conjunction with QEF to provide additional assurance. • Internal Audit Progress Report - the Committee noted that there are 36 audits for 2021/22 and that 10 are in progress. • Ernst & Young Final Audit Results Report - the Committee noted the remuneration pension disclosures issue which led to the delay in the audit submission of the Trust's annual accounts. **Quality Governance Committee** Mr D Shilton provided the assurance report for the Committee meetings held on 23rd June 2021 & 21st July 2021 (verbal). There were no matters for escalation however he highlighted the following key points: • Medical Examiner Programme presentation – no areas of concern were identified. • Infection Prevention and Control (IPC) BAF - good assurance was provided overall and mitigating actions acknowledged around fit testing. • Integrated Oversight Report – it was noted that the Duty of Candour process is being reviewed. • Care Quality Commission (CQC) action plan – the Committee received partial assurance on progress and gaps in assurance remain relating to Sunniside, Chlorclean and Control of Substances Hazardous to Health (COSHH) therefore reports will be brought back in September. The mixed sex accommodation issue will be resolved following completion of the capital work. • Nurse staffing – partial compliance was received due to pandemic staffing levels. • Strategic Safeguarding Group - partial assurance was agreed due to the current operational pressures. • Older Person's Mental Health Report – a detailed report provided the Committee with a high level of compliance. • Maternity Assurance Report/Birth Rate Plus Report – a	

Agenda Item	Discussion and Action Points	Action By
	requirement to increase central funding for midwives and business case may be required. A risk was acknowledged that other maternity units will be looking to recruit at same time. • Pressure Damage Action Plan – this addressed some of the concerns previously raised and a full update report will be received by the Committee in September 2021. Mrs A Marshall felt that it would be beneficial to invite some of the matron staff to discuss how the staffing system has been managed during the pandemic and Mrs L Crichton-Jones felt that it was important to thank all staff for their continued efforts during these challenging times. **Digital Committee** Mr A Moffat provided the assurance report for the Committee meeting held on 21st June 2021. Mr Moffat reminded the Board that at the last meeting, the Digital Committee escalated its concern that the organisation may be unable to meet the requirements of the NHS Data Security & Protection Toolkit (DS&PT) by 30 June 2021 which required the level of Information Governance training to be at least 95%. As a result of action taken by the Senior Management Team, an improved percentage of 93% was reported to the Committee on 21 June 2021 which was increased to 96% by 30 June 2021, thereby achieving compliance the DS&PT standard. Mr Moffat also highlighted the following key points: • Strategic objectives – they were agreed and mapped to the Digital Strategy • Digital Roadmaps – no significant delivery risks were highlighted other than resource and supply issues • Digital Key Performance Indicators (KPIs) – partial assurance was provided due to delays in the roll out. Mrs J Bilcliff, Acting Chief Executive, reported that this is moving forward following discussion with Mr N Black, Chief Digital & Information Officer. **HR Committee** Dr R Bonnington provided the assurance report for the Committee meeting held on 13th July 2021. She reported that there were no matters for escalation however highlighted that the current meeting schedule has been revised to enable increased alignment to Board meetings. She highlighted the following key points: • A lot of work has been taking place across the People agenda and the Committee was reasonably assured. • Health and Well Being – staffing challenges were acknowledged due to increased absences, mental health issues and annual leave.	JMB

Agenda Item	Discussion and Action Points	Action By
	• Freedom to Speak Up (FTSU) – positive actions were being undertaken however some capacity challenges and a decrease in some staff survey indicators were noted. A deep dive exercise is to be undertaken for FTSU and Equality, Diversity and Inclusion (EDI). • External reviews and actions – this would be discussed in more detail in Part 2 of the Board. • Risks were highlighted in relation to increasing staff absences and challenges in completion of staff appraisals and core skills training. Mrs A Stabler, Non-Executive Director, felt that the information prepared for the Committee provided significant assurances. Mrs Marshall agreed that it was clear that a lot of work was ongoing and queried whether the team had sufficient capacity to be able to deliver on all workstreams. Mrs L Crichton-Jones, Executive Director for People & OD, highlighted that there were capacity risks in relation to leadership development training and the Executive Management Team have recently approved a business case to provide additional capacity. Once this is implemented, focus can then be given to providing business units with increased support around leadership and management. Discussion also took place around the increase in staff absences due to mental health issues and Mrs Crichton-Jones highlighted that this was a national trend representing the difficult circumstances being experienced by staff during the pandemic. She reported that additional occupational health and counselling support was being provided. Mrs Marshall thanked the Committee Chairs for their reports and felt that these would set the scene for the Board for the rest of meeting. After consideration, it was: **RESOLVED:** to receive the reports for assurance	
21/119	**FREEDOM TO SPEAK UP GUARDIAN REPORT:** Rev G Rowlands, Chaplain and Freedom to Speak Up Guardian (FTSUG), provided an update on the activity and recommendations from the Trust's FTSUG from April 2020 to April 2021. Rev Rowlands informed the Board that the FTSUG currently reports directly to the Chief Executive and Executive Director of People and OD (on an interim basis). In addition, Mrs Hilary Parker has recently	

Agenda Item	Discussion and Action Points	Action By
	taken up the Non-Executive Director lead for this area of work and regular meetings are scheduled as an opportunity to maintain oversight on FTSU work and scope further actions to continue to drive improvements and best practice throughout the Trust. Consideration is also being given to increasing the capacity for champions and ambassadors across the organisation over various specialties and departments as well as the implementation of a robust training programme. The Trust is the third best rated trust in the North East and Cumbria and following analysis of the results of the most recent NHS staff survey by the National Guardian's Office in May 2021, the Trust was identified to have continued to record a high FTSU index score for 2020, however the score is on a slightly downwards trajectory and Rev Rowlands highlighted some of the work underway to bring additional focus to this work within his presentation. It was suggested that it would be beneficial to arrange a session at one of the future Board Strategy Sessions to allow further discussions to take place along with the expected launch of the follow-up training for Trust Boards. Mrs L Crichton-Jones highlighted that one of the recommendations from the Well-Led Governance Review was to receive reports from the FTSUG twice yearly and the next report will highlight work carried out for 2021/22 Quarters 1 and 2. She also reported that there are plans to re-energise the Just Culture campaign therefore it is important to increase the number of champions across the Trust and felt that it would be beneficial to ensure representation from the Staff Networks to represent the diversity of the organisation. Following a query from Mr A Moffat, Non-Executive Director, regarding the number of cases categorised under harassment and bullying, Mrs J Bilcliff, Acting Chief Executive, reported that this categorised is determined by the National Guardian's Office and includes a broad range of issues which are triangulated with other sources of information. Assurance was given that it is not therefore an indicator of a systemic bullying and harassment culture. Rev Rowlands informed the Board that some concerns are reported anonymously which makes it challenging to always share learning and feedback with the individuals. Mrs A Stabler, Non-Executive Director, felt that it would be beneficial to share reports more widely to encourage staff to speak up without remaining anonymous and Rev Rowlands explained that departmental feedback is carried out and Mrs L Crichton-Jones also highlighted that other actions are being undertaken around increased communications, including screensavers and social media. Rev Rowlands reported that a new category had recently been added	JenB

Agenda Item	Discussion and Action Points	Action By
	to the National Guardian's Office categorisations in relation to staff safety and he was pleased to report that there were no Personal Protective Equipment (PPE) concerns reported by Trust staff. After further discussion, it was: **RESOLVED:** to receive the report for assurance. Rev G Rowlands left the meeting.	
21/120	**IMPROVING OUR PEOPLE PRACTICES UPDATE:** Mrs L Crichton-Jones, Executive Director of People and OD, provided an updated position in response to the NHSE&I Learning Lessons to Improve our People Practices recommendations which were presented to the Board in March 2021. She reminded the Board that following the completion of a self-assessment, the Trust was rated as Amber across all seven recommendations. Mrs Crichton-Jones highlighted that this position remains unchanged however a number of actions have been taken and implemented with immediate effect. Those not yet fully implemented are ongoing and it is anticipated that the majority of these will be completed by the end of September 2021. Regular meetings are in place to review progress against the recommendations and a working group will be formed to further agree and progress the actions and recommendations. A business case has also been recently approved to purchase an employee relations case management system which is expected to be in place by the end of September 2021. The Board were assured that processes are in place and being worked through. Mrs Marshall particularly highlighted the Board's support in providing health and welfare checks for people involved in investigation and disciplinary procedures. Following a query from Mr D Shilton, Non-Executive Director, regarding serious investigations being treated as a "never event", Mrs Crichton-Jones explained that these are not reported in the same way as a medical never event and is part of the national guidance. After consideration, it was: **RESOLVED:** to receive the report for assurance and note the current position, actions and next steps.	

Agenda Item	Discussion and Action Points	Action By
21/121	**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 the Trust is dealing with a further wave of covid and currently has 61 patients in hospital with 10 in critical care and 6 receiving ventilation. Escalation measures have been applied across the Trust and covid wards have been re-opened. The Trust is also experiencing increased emergency admissions and therefore some elective work has been stood down to release staff to support critical care and base wards. Pressures are being seen across the region however Mr Beeby highlighted that it is being reported that community rates are reducing therefore it is expected that numbers will also come down within the hospital over time. Mr Beeby emphasised that the workforce has responded very well in response to covid over the last 18 months and are highly admired for efforts undertaken. There are also additional staff pressures relating to self-isolation requirements. Mrs Marshall highlighted that the government has recently introduced a scheme to allow key workers to isolate at work however Mr Beeby reported that this has had little impact within the Trust. Mrs A Stabler, Non-Executive Director, queried the vaccine uptake rates amongst staff and Mr Beeby confirmed that there had been a good uptake to the vaccination programme however some staff had decided not to participate. He confirmed that there was further work to do to promote the programme and explained that staff risk assessments were being renewed. Mrs Crichton-Jones reported that there was approximately 90% uptake of the vaccine and 90% compliance with risk assessments. Mr Beeby referred to the recent guidance for the NHS which enabled isolating staff to come back to work in certain circumstances. He clarified that the Trust was only using this as a last resort, adopting a cautious approach. After further discussion, it was: **RESOLVED:** to receive the update for assurance	
21/122	**FINANCE UPDATE:** Mrs K Mackenzie, Acting Group Director of Finance, provided the Board with a summary of performance as at 30th June 2021 (Month 3) for the Group (inclusive of Trust and QE Facilities, excluding Charitable Funds).	

Agenda Item	Discussion and Action Points	Action By
	The Trust has reported an actual surplus of £0.182m for the month of June and a year to date surplus of £0.482m prior to the adjustment for donated assets and a surplus of £0.574m after the adjustment for donated assets. Mrs Mackenzie drew attention to the Cost Reduction Programme section of the report and explained that there was now an efficiency requirement included within financial plans to achieve the required breakeven position therefore it is imperative that the Trust continues to identify recurring schemes via the Transformation Programme. She also explained that a letter has been received from Julian Kelly (Chief Financial Officer, NHSE&I) and Pauline Philip (National Director of Emergency & Elective Care) which has advised that the thresholds for achieving the Elective Recovery Fund (ERF) are being raised, with a backdated impact, becoming effective from the 1st July 2021. Early discussions and calculations across the ICS Director of Finance Network indicate that it is therefore unlikely that any organisations in the ICS will be able to access ERF funding from 1st July 2021. However, any costs committed in respect of delivery of the Elective Recovery Framework will continue. Following a query from Mr A Moffat, Non-Executive Director, regarding the implications of this, Mrs Mackenzie agreed to discuss in further detail outside of the meeting. After consideration, it was: **RESOLVED:** to receive the report for assurance	KMac
21/123	**INTEGRATED OVERSIGHT REPORT:** Mrs J Baxter, Chief Operating Officer, presented the Integrated Oversight Report (IOR) for July 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. She highlighted that an error had been identified on the cover sheet in relation to patient safety alerts and reported that not all of the alerts were completed within the timeframe and there is currently one outstanding. This will be updated following the meeting. The Trust has continued with the elective recovery plans whilst ensuring a greater focus on staff wellbeing for this reporting period however increasing volumes of covid admissions and rising cases in hospital coupled with the impact of test and trace on staff absences are proving extremely challenging. Mrs Baxter drew attention to the	DW

Agenda Item	Discussion and Action Points	Action By
	areas of focus and risk and highlighted that whilst cancer referrals remain a prioritisation, the Trust's recovery programme is currently at risk. The Trust has not reported a never event since October 2020 and has the lowest volume of 52 week waiters within the ICS. Following a query from Mrs A Stabler, Non-Executive Director, regarding the review process of 52 week waiters, Mrs Baxter explained that each case is reviewed by a clinician and a risk assessment completed. Mrs Stabler felt that it would useful to present a paper at a future Quality Governance Committee to provide further detail and Mrs Baxter will ensure this is completed. Following further discussion and consideration, it was: **RESOLVED:** i) to receive the IQPR for July 2021 ii) to seek further information and test robustness of plans as is required, allowing judgement regarding levels of assurance for future levels of operational performance.	JMB
21/124	**HEALTHCARE ASSOCIATED INFECTIONS (HCAI):** Mr A Beeby, Medical Director and Joint Director of Infection Prevention and Control, provided an update to the Board on the current HCAI performance for the Trust. He reported that the mandatory reporting objectives for 2021/22 have not yet been published by NHSE&I however the Trust continues to adopt the national aspiration of attaining a zero tolerance approach to all avoidable infections and will set internal reduction objectives for all mandatory reportable organisms. Statistical Process Control (SPC) charts have been introduced as a way of monitoring infection rates and identifying where there is special cause variation requiring further work. Mr Beeby reminded the Board that the prominent area of focus has been Covid-19 and in Quarter 1, there have been no outbreaks reported. After consideration, it was: **RESOLVED:** to receive the report for assurance	
21/125	**QUESTIONS FROM GOVERNORS IN ATTENDANCE:** Mr J Bedlington queried whether financial support was being provided for the extra work completed in relation to Covid rates and Mrs K	

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	Mackenzie, Acting Group Director of Finance, explained that the Trust was being funded for work completed under the block contract and additional funding which was provided last year has been built into this year's financial framework.	
21/126	**DATE AND TIME OF THE NEXT MEETING:** **RESOLVED:** that the next meeting of the Board of Directors will be held at 9:30 am on Tuesday 28th September 2021 via Microsoft Teams	
21/127	**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
21/13	31/01/2021	Mortality Report – NEQOS session re. HSMR. Schedule in for future Board Strategy Session	30/09/2021	JenB	Took place on 13 September 2021
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 – JMB to discuss with GF and report back to next Board
21/48	31/03/2021	EPRR Assurance – six monthly reports going forward	30/09/2021	JMB	Next report due September 2021 (on agenda)
21/118	28/07/2021	Audit Committee Assurance Report – matter for escalation re. medical devices. Progress report to be provided at next Board meeting.	30/09/2021	AR	Assurance provided at the Audit Committee meeting in September 21 and further assurance to be provided at the December 21 meeting.
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	JMB	
21/119	28/07/2021	FTSU report – to arrange a session at one of the future Board Strategy Sessions.	30/09/2021	JenB	Provisional date identified for this Board strategy session in October 21.
21/122	28/07/2021	Finance update – to discuss the implications of thresholds for achieving the ERF in further detail outside of the meeting	30/09/2021	Kmac/AMo	
21/123	28/07/2021	IQPR – to update cover sheet re. patient safety alerts	31/07/2021	DW	Completed
21/123	28/07/2021	IQPR – to provide further detail re. 52 week waiters process to QGC	30/09/2021	JMB	To be presented at QGC September meeting (on QGC agenda)

Gateshead Health
NHS Foundation Trust

Report Cover Sheet

Agenda Item: 6

Purpose of Report	Decision: ☐	Discussion: ☒	Assurance: ☒	Information: ☐
Report Title:	Ward 11 – Patient and Family Experience			
Name of Meeting:	Board of Directors			
Date of Meeting:	28 September 2021			
Author:	Jennifer Boyle, Company Secretary			
Executive Lead:	Gillian Findley, Chief Nurse			
Report presented by:	Jennifer Boyle, Company Secretary			
Executive Summary:	On 25 August a letter was received from the family of patient who had sadly passed away on Ward 11 earlier in the month. The letter is appended to this report and demonstrates the impact colleagues on Ward 11 had on both the patient and his family. The staff showed great care and compassion to the patient and his family, and the letter clearly demonstrates the comfort that this has brought to the family. The feedback has been shared with Ward 11 and we express our sincere thank you to the family of the patient for sharing their experience and feedback with the Board of Directors.			
Recommended actions for Board/Committee)	The Board of Directors is requested to read the letter kindly sent by the patient's family and be assured that great care and compassion was demonstrated by dedicated colleagues on Ward 11.			

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	
Links to Risks (identify significant risks and DATIX reference)	None	
People and OD Implications:	This letter demonstrates an excellent example of colleagues living the Trust's values.	

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

Ward 11 – Patient and Family Experience

22 August 2021

Dear Yvonne Ormston

On behalf of my family, I wish to express our sincere thanks to the staff of Ward 11 at the Queen Elizabeth Hospital.

My dad was transferred to Ward 11 a few days before his death on 15th August.

After a telephone call on the 14th August from one of the ward team, we were given permission as a family to visit without restriction and our dad was moved to a single room to allow us privacy. He was obviously unwell and the staff were giving us the opportunity to be with him.

We visited late on the 14th, meeting a ward sister Sam, who explained the situation and what had been put in place for dad's comfort and care.

We were later to learn that this kind nurse had spent time with dad during the night and had assisted him to write a short letter to his wife and loved ones.

We returned on the morning of the 15th, after a phone call from dad stating he wished to go home. He was unhappy in the single room, missing the comfort of being with others and did not like the size of the single room.

After speaking with the staff, he was transferred back to the bay, at his request, and we started the process of planning his return home.

We left, leaving him happy in the bay.

He had a later visit that day from his family and he remained content and well cared for,

Unfortunately dad's condition deteriorated later that evening and I received a phone call to that effect. This deterioration was so quick that we received a subsequent call a few moments later to say he had passed away. Both calls were compassionate and professional. Myself and my sister went to the ward later that evening as we wished to see dad, and to thank the staff.

The staff on duty were so considerate. They spent time with us explaining events. They made sure that we were aware of the letter dad had stored on his mobile phone. Without this, we would have been non the wiser and would be unaware of those words of comfort.

During our visits and phone calls, dad told us that the staff were great. He was aware of and commented on how hard they all worked and he was grateful for all their help and support.

When we mentioned this to the staff they told us that our dad was a gentleman.

Having been a ward manager in the NHS myself for some decades, I consider myself a good judge of what good nursing care should be and I cannot fault the care, treatment and understanding that my dad received on this ward.

Particular thanks go to the night staff on duty on 14 and 15 August. Thank you Sam (I hope we recall her name correctly). You will never know the comfort we feel at being able to read that last letter, and knowing you took the time to sit with dad and assist him with this. It means so much.

Thank you to the lovely nurse with the dark and red hair who ensured that we knew the letter was on his phone. We will forever be grateful to you for this and also for your sensitivity.

Thank you to all the staff, keep doing a wonderful job and be proud of the standard of care you deliver.

Written on behalf of all of the family.

Gateshead Health
NHS Foundation Trust

Report Cover Sheet

Agenda Item: 7

Purpose of Report	Decision: ☒	Discussion: ☐	Assurance: ☐	Information: ☐
Report Title:	Standing Financial Instructions (SFIs) and Delegation of Powers			
Name of Meeting:	Board of Directors – Part 1			
Date of Meeting:	28 September 2021			
Author:	Jennifer Boyle, Company Secretary			
Executive Lead:	Kris Mackenzie, Acting Director of Finance			
Report presented by:	Jennifer Boyle, Company Secretary			
Executive Summary:	An amendment has been made which replaces Schedule 1 of the Public Contracts Regulations 2015 with Schedule 1 of the Public Procurement Amendment Regulations 2021. This means 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. The Trust's finance team have proposed an amendment to the Standing Financial Instructions and Scheme of Delegation to reflect the new legislation. The proposed amendments are appended to this cover sheet for review. The Audit Committee reviewed the proposed amendments at its meeting on 2 September 2021 and recommend them to the Board of Directors.			
Recommended actions for Board/Committee)	The Board of Directors is requested to review and approve the proposed amendments, being mindful of the recommendation of the Audit Committee.			
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:	A lower financial threshold means a potentially greater volume of formal tendering is required.	
Links to Risks (identify significant risks and DATIX reference)	No specific risks identified in relation to this change in legislation.	
People and OD Implications:	None	

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

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

Appendix – Proposed Changes

Standing Financial Instructions (amendment shown in blue)

21.2 **Legislation and Guidance Governing Public Procurement**

The Trust shall comply with the Public Contracts Regulations 2015 (including future amendments), and all relevant EU Directives. Such legislation shall be incorporated into the Trust's Standing Orders and SFI's.

Scheme of Delegation (amendments shown in red)

DELEGATED AREA	SPECIFICS/ VALUES	AUTHORITY DELEGATED TO	NOTES
3.2 Capital Individual Capital Project Land transactions	Within capital project budgetary limit Over capital budgetary limit (by scheme) All	Delegated to QEF nominated estates officer or for ICT projects named individuals authorised by Capital Planning Group To be approved by Capital Steering Group and ratified by DF&I Trust Board	
4. Quotation and Tendering Recorded on the Tender registered held in the Procurement Department **4.1 Expenditure**	From £1,000 to £9,999 From £10,000 up to £49,999 From £50,000 up to ~~EU Limit~~Sterling thresholds (UK procurement threshold) £122,976 (as of 16/8/2021 ~~164,176 (as at 30/9/2016)~~ ~~Over EU Limit (as at 30/9/2016 £164,176)~~	2 verbal quotes 3 quotations (electronic) Formal tender process (electronic) advertised on Contract finder Subject to ~~EU tender process (electronic)~~ Public Procurement Process	All elements of expenditure refer to the cumulative cost over the whole life of the contract, and all limits are exclusive of VAT.

Gateshead Health
NHS Foundation Trust

Report Cover Sheet

Agenda Item: 8

Purpose of Report	**Decision:** ☒	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☐
Report Title:	Calendar of Board Meetings			
Name of Meeting:	Board of Directors			
Date of Meeting:	Tuesday 28th September 2021			
Author:	Diane Waites, Corporate Services Assistant			
Executive Lead:	Jackie Bilcliff, Acting Chief Executive			
Report presented by:	Jennifer Boyle, Company Secretary			
Executive Summary:	To inform the Board of the planned Board meeting dates for Quarter 4 2021/22 and 2022/23.			
Recommended actions for Board/Committee)	The Board is asked to approve and receive the dates of the Board of Directors' meetings to be held in 2022/23			
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			
Links to Risks (identify significant risks and DATIX reference)	None			
People and OD Implications:	None			

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

Gateshead Health NHS Foundation Trust

Board of Directors' Meetings Quarter 4 2021/22 and 2022/23

During 2022/23 The Board of Directors will hold 9 public meetings including the Annual General Meeting.

Date	**Time**	**Venue**
26 January 2022	9.30am	Room 3 Trust HQ
30 March 2022	9.30am	Room 3 Trust HQ
25 May 2022	9.30am	Room 3 Trust HQ
27 July 2022	9.30am	Room 3 Trust HQ
27 September 2022 (Tuesday)	9.30am	Room 3 Trust HQ
28 September 2022 Annual General Meeting	9.30am	Lecture Theatre
30 November 2022	9.30am	Room 3 Trust HQ
25 January 2023	9.30am	Room 3 Trust HQ
29 March 2023	9.30am	Room 3 Trust HQ

Gateshead Health
NHS Foundation Trust

Report Cover Sheet

Agenda Item: 9

Purpose of Report	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☒
Report Title:	Draft Winter Plan 2021/22 Assurance Report			
Name of Meeting:	Trust Board			
Date of Meeting:	28th September 2021			
Author	Tom Knox			
Executive Lead	**Joanne Baxter**			
Report presented by	**Joanne Baxter**			
Executive Summary	**This report asks the Board to consider that:** • The Trust has been through a period of change and has been faced with the many challenges of responding to reoccurring waves of Co-vid-19 • Planning for the challenges of Winter are an on-going and dynamic process and this plan will evolve to meet demand • Despite the success of the Covid-19 vaccine rollout, winter 2021/22 is predicted to be particularly challenging as the NHS manages Covid-19 alongside other winter viruses • This increase in demand for services will increase pressure on bed capacity, staffing and an already pressurised system as services try to recover activity that has been affected by the pandemic • The Trust are collectively focused on reducing impacts and providing mitigation to ensure our patients continue to receive safe, effective care and a positive patient experience • Staffing shortages, and in particular nurse staffing vacancies, have modified our planning with incremental steps established in our initial winter ward allocation until able to provide robust and safe staffing levels • As a Trust we recognise that our winter planning must ensure we avoid admissions, reduce length of stay and improve our ability to ensure timely discharges			

	• The Trust has co-operated and collaborated with system partners via the Regional Chief Operating Officer Group, Urgent & Emergency Care Network, the ICS , ICP and the Gateshead Care System					
Recommended actions for Board/Committee)	Executive are asked to review the Winter Plan and to consider if it provides reasonable assurance to support the work of the Trust during the Winter period 2021-22.					
Trust Aims that the report relates to: (Including reference to any specific risk)	**Aim 1** ☒	We will provide consistently high quality care in all our services				
	Aim 2 ☐	We will be a great organisation to work in				
	Aim 3 ☒	We will deliver value for money and strengthen delivery of our clinical services				
	Aim 4 ☒	We will work with our partners to help make Gateshead a place where everyone thrives				
	Aim 5 ☐	We will use our expertise to provide specialist services beyond Gateshead				
Financial Implications:	Funding has been identified from current streams to ensure appropriate resources are made available to support required work-streams					
Links to Risks (identify significant risks and DATIX reference)	The plan acts as mitigation for the series of identified risks on the Trust risk registers linked to winter pressures					
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

Winter Plan 2021/22

September 2021

Version 1

CONTENTS **Page No.**

APPENDICES

1. Introduction

1.1 Historically, the impacts of winter on the population served by the Trust, our local communities and the NHS are well known:

- Increased fractures due to slips, trips and falls
- Increase in respiratory viruses including influenza and respiratory syncytial virus (RSV)
- Increased emergency admissions as a result of the deterioration of chronic health problem
- Increased staff sickness absences
- Potential transport difficulties

During the Covid-19 pandemic there has been a notable reduction in other respiratory viral infections such as influenza and RSV. As a result the population, and in particular young children, have not previously been exposed to these common circulating viruses.

As lockdowns ease and life begins to get back to normal the co-circulation of Covid-19 and other respiratory viruses is expected in the UK this winter.

Despite the success of the Covid-19 vaccine rollout, winter 2021/22 is predicted to be particularly challenging as the NHS manages Covid-19 alongside other winter viruses. This increase in demand for services will increase pressure on an already pressurised system as services try to recover activity that has been affected by the pandemic.

1.2 All of these factors affect the Trust's ability to deliver a high quality service over the winter months. Robust planning and forecasting is therefore required in order to reduce the likely impacts and to provide mitigation to ensure our patients continue to receive safe, effective care and a positive patient experience.

- Winter 2021/22 is made more complex by a continuing need to respond to and recover from Covid-19 waves alongside the added requirement of managing a likely challenging flu season.
- The Trust provides a range of services including Acute Medical and Surgical specialities, Urgent and Emergency Care provision, Diagnostic and Screening services, Older Persons Mental Health services consisting of inpatient beds, community and day care services and a wide range of Community Services. It is important our Winter Plan is robust and provides resilience in all services to ensure the pressures that winter brings are managed appropriately.

1.3 In the last 12 to 18 months, The Trust has taken a number of steps to improve **overall resilience.** The Trust has:

- Revised its senior management structure to strengthen its operational capacity and coordination
- Appointed a Chief Operating Officer and established four Director of Operations
- Created a Head of Emergency Preparedness, Resilience and Response (EPRR) role and supporting EPRR & Business Continuity Manager and Site Resilience Team Manager roles to enhance resilience, patient flow and escalation

- Clarified the roles of senior medical, nursing and service managers in managing winter pressures to be more in line with best practice
- Reviewed and updated the related policies and procedures relating to bed and site management along with ensuring on-call requirements meet the needs set out within the NHS England EPRR core standards
- Revised operational policies and procedures for patient flow, discharge, length of stay, bed management, escalation, and capacity in the hospital out of hours and at weekends.
- Is working to ensure the proactive use of IT and live performance dashboards in real time to support bed and site management and decision making, ensuring forecasting drives planning assumptions
- Improved management of surges in demand with NEAS and other partners through working more collaboratively at the point of call.
- Creation of a Trust Incident Response Plan with supporting action cards to inform decision making at Operational, Tactical and Strategic levels
- Revised the Trust OPEL escalation procedures and multi-agency response arrangements

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

- The North East and North Cumbria Emergency Care Network
- The Local Area A&E Delivery Board
- To the COO Group for use by the Integrated Care System

1.5 To manage winter pressures the Trust works with health and care partners in Gateshead through the Gateshead System Group (all partners) and Gateshead Care Partnership (Providers)

1.6 This partnership working emphasises the importance of:

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

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

- Transforming Urgent and Emergency Care Services, Safe, Faster, Better (2015)
- Good Practice Guide, focus on patient flow (2017)
- Safer Patient Flow Bundle
- Hospital Discharge Service Requirements (NHS England 2020)
- Outbreak Management Policy (IC24)
- Heath and Social Care Act

1.8 It also relates to other associated documents such as:

- The Trust's Outbreak Plan
- OPEL escalation Plan
- Bed management policy
- Incident Response Plan
- Flu Pandemic Plan
- Flu Plan
- Adverse Weather Plan
- Discharge Policy
- Opening a ward procedure
- Individual Business Continuity plans

2. Covid-19- Organisational Learning

2.1 Points of learning from Covid-19 have included:

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

Further shared learning can be identified via this link:

https://www.nhsemployers.org/case-studies/covid-19-shared-learning-nhs-trusts

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

2.3 The number of peak cases in Hospital is demonstrated in the table below:

Covid Wave	No:	Date
Wave 1	Peak: 124	(09/04/2020)
Wave 2	Peak: 141	(09/11/2020)
Wave 3	Peak : 91	(22/1/2021)
Wave 4	Peak: 66	(26/07/2021)

2.4 Staffing availability was also affected as in line with national guidance staff shielded. At the highest point we had 266 staff, approximately 63% of sickness absence were absent due to Covid-19.

2.5 The number of staff COVID absences is demonstrated in the table below:

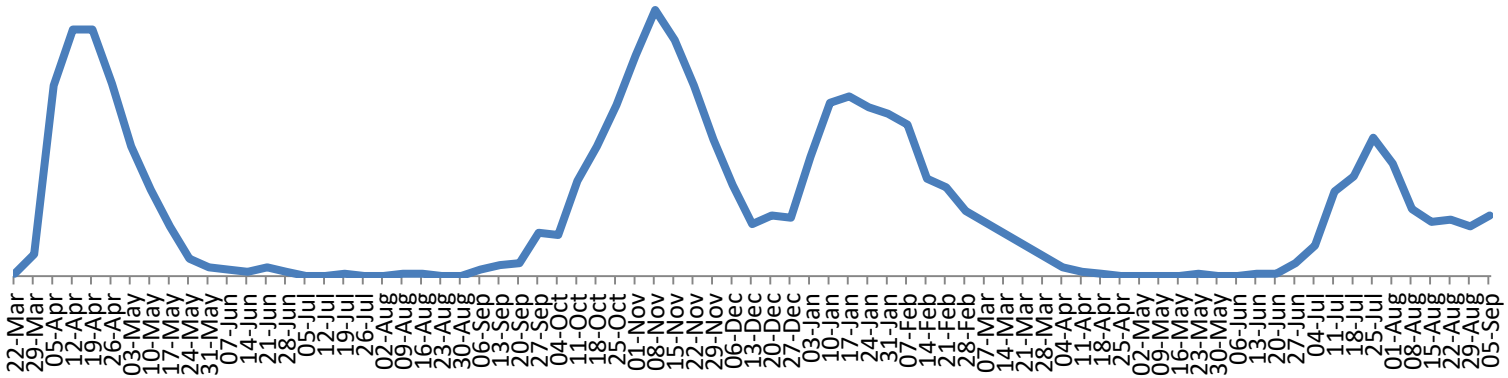
Covid Wave	No:	Date:	% of sickness absence
Wave 1	Peak: 266*	(15/05/2020)	**63% of sickness absence**
Wave 2	Peak: 237	(17/11/2020)	**56% of sickness absence**
Wave 3	Peak: 142	(22/1/2021)	**51% of sickness absence**
Wave 4	Peak: 243	(15/07/2021)	**53% of sickness absence**

*Retrospective information was provided internally for COVID SITREP but could not re report nationally as no resubmissions allowed. Original runs of data were based on recorded staffing absence as on day extracted.

2.6 The graphs overleaf provide a snapshot of the total covid patients in hospital and breakdown of staff absences.

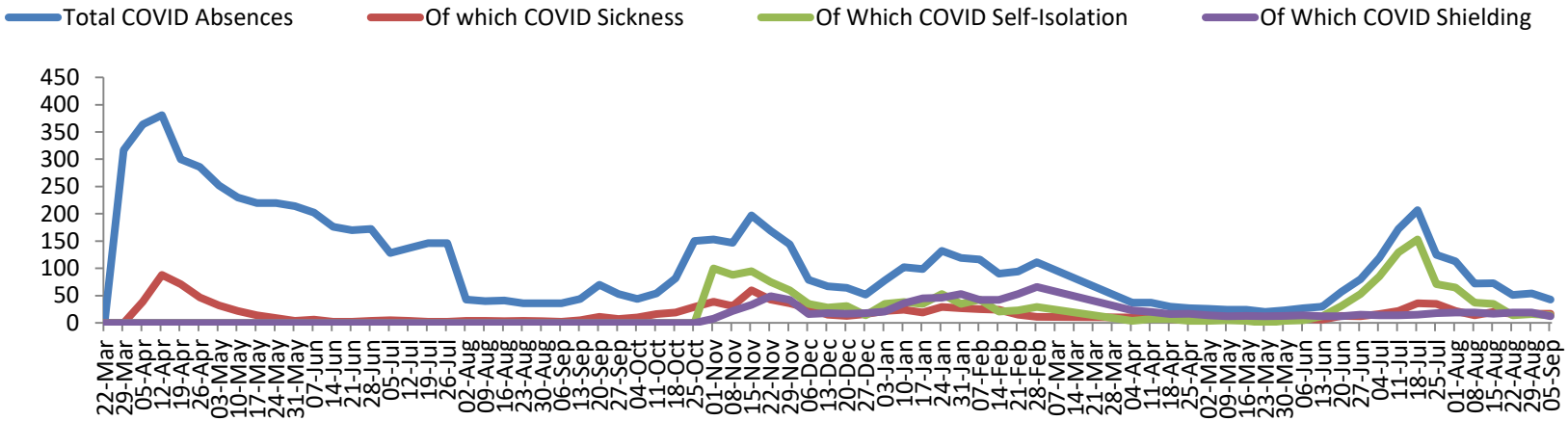
Total Covid patients in hospital

8am snapshot



Staff Absences

8am snapshot



2.7 The Trust reviewed its Command Control and Coordination (C3) arrangements in November 2020 and introduced a revised and robust Trust structure to manage Covid-19 response and to deal with day to day escalation and impact management at operational, tactical and strategic levels This structure was supported by a number of support cells providing key information to facilitate informed decision-making.

2.8 To facilitate a robust Covid-19 response and to build-in capacity for core business the trust took a number of steps:

- Increased critical care capacity to 41 beds and redeployed staff
- Suspended elective surgery
- Created Covid and non Covid areas
- Suspended routine Community Services
- Carried out estates work to increase capacity for oxygen supply and therapy
- Implemented revised discharge arrangements
- Revision to whole estate to ensure services were safe, this involved moving a number of services within the Trust acute and community sites.

2.9 The Trust support cells instigated internally and externally were;

- Clinical Advisory Group
- Outbreak/Infection Prevention Control
- Workforce Cell
- Primary Care including supporting GP 'hot sites'
- Outbreak Control, led by the Director of Public Health.

2.10 These cells were stood up as required in response to the different COVID 19 waves and stood down when no longer required.

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

- The need to be able to respond quickly to increasing numbers of Covid presentations including the reallocation of wards and rapid discharge of patients
- The need to deploy staff and resources quickly in response to evolving situations
- Keeping staff safe, healthy and well both physically and psychologically
- Supporting flexible working
- Risk assessing staff and particularly our BAME staff
- Adopting new ways of working including remote consultations via Attend Anywhere as an example
- Growing our workforce including via training for specific areas such as critical care
- Working collaboratively across our locality of Gateshead but also more broadly in our Integrated Care Partnership (ICP) and Integrated Care System (ICS)
- Protecting the most vulnerable people in our community from Covid
- Restoring our NHS services by accelerating transformation programmes
- Strengthening our leadership
- The need, with the CCG, Primary Care and Gateshead Council to support care homes with nursing capacity. Additional Community Nurse Practitioner support has been commissioned until January 2022 to support Care Homes. At the CCG's request in Phase 1 we intervened to keep a number of care homes open. There is

a need to ensure that our services are responsive to the challenges faced by Care Homes including outbreak control measures developed with GCP partners. This has been funded for 12 months.

- To adapt national guidance to local circumstances especially on testing regimes
- Increasing the frequency and detail of communications to staff
- With partners to ensure primary care continues to operate an accessible service
- We are working through these lessons with partners. Plans are in place and are being progressed for implementation.
- Ensure a whole system approach is utilised linking key professionals
- Daily pattern calls to support real time information and unified planning
- Mutual understanding of service or delivery pressures across all partners and the impact on others
- Mutual understanding and co-ordination of key messages going to staff- trying to pre-empt Q+A's across all partners
- Secondary, Primary and Social care to work in collaboration to provide resilience and support
- Co-location of rapid response services during critical times to share information and reduce duplication of effort
- The ability to be flexible in service delivery very quickly i.e. within hours
- The willingness of staff to help wherever they could to ensure patient care was not negatively affected
- Mutual aid and response when one are of service delivery at a system level was unable to deliver
- Co-ordination at a central level for direction and communication
- Resilience in many workforces was not enough at peak outbreak which did affect the quality of care delivered
- We are an integrated provider and community services were being asked to support in all directions so tough decisions had to be made
- Palliative and EOL care was a particular challenge as staff felt they did not the time to get to know their patients well enough prior to death
- Procurement/facilities and estates colleagues need to be an integral part of any planning processes going forward

2.12 We have learned the lessons of the earlier phases and have well tested Covid-19 systems and processes. This includes the use of testing for patients likely to be admitted for 24 hours or more. For winter 21/22 we have developed pathways for Covid-19 positive and Query Covid patients as part of our approach to bed management. Thresholds and trigger points to support escalation and de-escalation are detailed in our Covid escalation plan.

2.13 The Winter Plan 2021/22 is developed on planning assumptions from previous Co-vid-19 waves but acknowledges that recent numbers have exceeded predicted numbers and that the demand placed on our Trust by extra elective requirements and the anticipated increased impacts from FLU than those in winter 20/21 have to be considered.

2.14 Caveats to the Winter Plan linked to Covid-19 include:

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

3 Review of Winter 2020/21

3.1 Winter 2020/21 was one of the most challenging ever faced by the NHS, but 2021/22 is anticipated to be equally challenging if not more severe.

3.2 The key features were:

- The continued extensive challenges of the COVID 19 Pandemic
- Unprecedented reduction in staffing levels as a consequence
- A requirement to adjust all working practices to manage COVID 19 impacts

3.3 For the Trust this meant:

Average/Peak G&A Occupancy

- Wave 1: 71.7% (Peak 89.53% - 18/06/2020)
- Wave 2: 85.9%(Peak 98.8% - 05/10/2020)
- Wave 3 : 85.79% (Peak 95.0% - 15/03/21)
- Wave 4: 90.1% (Peak 97.6% - 25/07/2021)

- Staffing and budget pressures caused by the need to open beds over and above the winter plan.
- The Trust opened additional beds for a longer period than planned, with our winter wards on 10 and 12, remaining open to meet the extra and unpredictable demand.
- Levels of performance below the nationally mandated targets and the exceptional situation of a small number of breaches of 12 hour waiting times
- Poor patient experience
- Sustained stress on staff
- Requests to other Trusts for mutual help on more occasions
- Increased scrutiny by regulators and reporting to Trust Board

3.4 With the North ICP agreed ways of working, these additional pressures were experienced across the North East but particularly in some neighbouring Trusts. Consequently with surge calls across the region there was an unknown and therefore unplanned impact on increased activity in Gateshead which led to patients in ambulances being diverted to us and impacting on our ability to respond

3.5 Our experience of Winter 2020/21 highlighted:

- The need to work more closely at a senior level with ICP and ICS partners to plan for winter and in the day to day management of pressures –

- As a result there is now a regional Chief Operating Officer network and this is strengthened by the regional Urgent and Emergency Care Network which reports directly to the ICS.

- The need to strengthen our operational management of winter aligned with business continuity planning and emergency response and resilience (EPRR) –
  - Appointment of a Chief Operating Officer (Accountable Emergency Officer) and Head of EPRR, aligning the winter response through on-call, escalation and resilience planning

- The need to revise our structures and investing in operational capacity –
  - the appointment of the Operational Directors and Divisional Managers within the Medicine and Surgery Business Units

- Severe staffing pressures in the nursing and medical workforce need to be addressed –
  - Recruitment to nursing posts has been partially successful and refinement of services and the estate to make best use of medical teams and ensuring processes are lean. We have introduced new rota management systems and have introduced a robust On-call management framework and revised Incident Management Plan to strengthen our senior decision maker presence overnight and at weekends.

- Our new operating model takes into account recent bed-modelling and staffing. The enhanced Site Resilience Team proactively manage planning by:
  - Modelling from a number of scenarios taken from previous actual activity and that seen through different Phases of the Pandemic to ensure our staffing and bed capacity can flex to meet that demand as best possible.

- Managing extra beds safely and effectively through improved bed occupancy, reduced length of stay and better discharge processes –
  - Best practice relating to the above is being incorporated into our transformation programme and winter planning requirements

4 National Guidance and Good Practice

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

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

4.2 The good practice that we will implement is:

- Working collaboratively with partners in Social Care, Ambulance Services, Primary Care, the Voluntary Sector and Community Services to reduce avoidable presentations to A&E, admissions and re-admissions.

- Implement the Same Day Emergency Care requirements to safely avoid admissions for those with ambulatory conditions
- Further development/expansion of 'Talk before you Walk' to manage urgent activity more effectively
- Reducing length of stay by setting an expected date of discharge on the day of admission utilising model hospital benchmarked LOS data and one that the whole of the MDT work together on to realise
- Create discharge processes which aim to discharge 40% of patients scheduled to be discharged that day using criteria led discharge, discharge to assess and regular senior review
- Ensuring robust discharge transport arrangements are in place
- Closely and proactively monitoring and reviewing stranded, super stranded and DTOC
- Implement Red and Green Days approach
- Implement SAFER Care Bundle
- As part of discharge and caring for people at home, have Rapid Response health and care services available
- Implement new discharge requirements published August 2020 (updated February 2021) https://www.gov.uk/government/collections/hospital-discharge-service-guidance

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

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

5 Purpose of the Winter Plan

5.1 Taking into consideration the learning from previous winters and the COVID pandemic, this Winter Plan for 21/22 sets out the framework within which the operational processes will be implemented, and any surge in activity managed effectively. It does not however contain the detailed contingency plans (e.g. Incident Management Plan) or the related procedures that will be implemented over the winter period e.g. the Operational Pressures Escalation Plan (OPEL) and associated action cards and bed capacity management procedure as these plans are already in existence and fit for purpose.

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

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

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

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

6. Roles and Responsibilities

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

6.2 **Trust Board**

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

6.3 **Chief Executive**

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

6.4 **Chief Operating Officer**

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

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

6.5 Medical Director

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

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

The Medical Director will continue to provide visible professional leadership to medical colleagues, most specifically at times of increased pressure.

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

6.6 Director of Nursing

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

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

6.7 Managing Director QEF

Will ensure that:

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

6.8 Directors of Operations

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

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

6.9 Heads of Clinical Service

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

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

6.10 Divisional Managers (non-medical)

Divisional Managers will be responsible for ensuring their areas are staffed appropriately and escalate to the SLM when they have exhausted all possibilities within their remit or when forecasted staffing difficulties can be foreseen and remain unmitigated. They will proactively manage staff in relation to demand and acuity.

6.11 **Consultants**

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

6.12 **Clinical Leads**

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

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

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

6.13 Deputy Director of Nursing

The Deputy Director of Nursing will provide strategic oversite for all nursing resource and clinical and professional support to the Head of Nursing, Chief Matrons and Matrons, to ensure professional standards are maintained and clinical support is in place

6.14 Head of Nursing

The Head of Nursing will provide clinical and professional support in collaboration with the Chief Matron and Matrons to facilitate nursing resource to safely deliver the Winter Plan.

6.15 **Chief Matrons**

The Chief Matrons will provide support to the Matrons to effectively manage resources to deliver the winter plan.

Under the instruction of the Operations Director or Senior Manager on call the Chief Matrons are responsible for the opening and closing of beds to meet fluctuation in demand and monitor the quality of care and safety of patients in line with the opening of beds procedure.

One or both Chief Matrons will escalate to relevant managers any issues relating to the implementation of the plan and dial into the daily Site Resilience huddles (Mon-Fri), as well as providing leadership for the matrons. They will ensure that any risks to patient safety as a result of winter are identified and escalated appropriately and that minimum safe staffing levels are met.

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

6.16 Head of EPRR

- Ensure sit-rep reporting is communicated externally on behalf of the Chief Operating Officer
- Be the point of contact for NHSE/I winter command room and communications including surge
- Be the key contact for overall site resilience and surge management overseeing and monitoring of the winter plans, reporting to the Chief Operating Officer
- Be responsible for ensuring robust resilience is managed daily in relation to surges in activity along with daily management of the Site Resilience Team

6.17 **Divisional Managers**

Working to the Directors of Operations and in a triumvirate with the Clinical Head of Service and Chief Matron, the Divisional Managers will support the delivery of the winter plan and associated activities. With a focus on maintaining operational performance levels the Divisional Managers will work at tactical level to ensure patients are seen in the right place, at the right time, by the right team. They will escalate any concerns to the Director of Operations.

6.18 **Service Line Managers (SLMs)**

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

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

6.19 **Site Resilience Team Manager and Team**

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

6.20 EPRR & BC Manager

- To receive the cold weather alerts on behalf of the Trust and circulate as appropriate
- Deputise as appropriate for the Head of EPRR
- Manage the on-call rota ensuring appropriate cover is available at all levels and any gaps in the rota are filled

6.21 **Matrons/Community Team Leaders**

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

Identified Matron/Matrons will support the Registered Site Resilience Practitioner at site management meetings and monitor the quality of care and patient safety at ward and community level as reported in the daily shift reports. They will provide leadership to ward managers.

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

6.22 **Ward Managers**

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

6.23 **IPC and Microbiology**

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

7 Approach to Winter 2021/22

7.1 Over the last 18 months, services and the staff within them have been working in a very different way to pre-covid. At the beginning of 2020 the Trust commenced a comprehensive piece of work to determine the future operating model and clinically led estates strategy. This work was presented to the Trust Board in June and July 2021 when significant capital and revenue investment was made to ensure the QE is not only resilient but sustainable for the future.

7.2 Recognising that this winter is going to be particularly challenging the Trust has invested significantly to support a revised operating model in preparation. This includes changing urgent and emergency care pathways front of house. In the new model that went live on 20th September, same day emergency care is co-located with the emergency department within the emergency care centre (ECC) to ensure patients are seen in the right place at the right time with an emphasis on admission avoidance.

In addition, the emergency admissions unit has increased from 24 to 48 beds within ECC. Again the aim of this is to shorten pathways of care and avoid admissions where possible.

Where patients are admitted to a back of house ward, transformation programmes are looking at ward ways of working to reduce length of stay and improved discharge processes.

These changes are key components of the 2021/22 winter plan.

7.3 Within the new model a dedicated winter ward has been developed to manage surge and increase the number of general and acute beds available.

7.4 Due to national supply and workforce challenges in the building and construction industry the Trust will not be able to realise all of the capital elements of the new operating model for winter 2021/22. Operational teams are working hard to recruit to the workforce elements of the new operating model to ensure we have the resilience needed.

At the time of writing, it is apparent that despite best efforts of all of the teams, it is not going to be possible to open the winter ward (Ward 4) as initially planned in October 2021. Staffing shortages, and in particular nurse staffing vacancies, mean that we would be unable to provide a rota that complies with safe staffing levels.

We continue to run Wards 10 and 12 (our 2020/21 winter wards that should have closed in April 2021) on staff from across the organisation.

Until such time that we have established teams for wards 10 and 12 as part of the new operating model we are unable to safely staff an additional area (Ward 4). Recruitment to wards 10 and 12 is underway with expected start dates for qualified nursing staff in December 2021.

Until this time, we propose keeping Ward 4 closed and instead redirecting some of the nursing resource identified for winter to Clinical Support and Screening for them to increase Allied Health Professional support such as Physiotherapists, Occupational Therapists and Pharmacists to focus on admission avoidance front of house and early discharge back of house.

Table 9 on page 24 has been updated to reflect the new escalation plan.

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

8 Capacity and demand modelling

8.1 Prior to Covid-19 a detailed piece of work was completed by the Trust's Planning and Performance team to determine the number of beds required across the Trust. This work was presented to the Corporate Management Team (CMT) in March 2020. It included business as usual as well as winter peak. It determined bed numbers as follows:

Projected beds required to achieve 92% occupancy at Jan peak

	Medicine	Surgery	Trust
May-Oct	336	112	448
Jan peak	404	100	504
Change in beds at peak	68	-12	56

8.2 NB: proposal at the time was a reduction of 12 elective surgical beds at January peak. This needs to be reconsidered given the impact of Co-vid 19 on the surgical elective programme and recovery. Currently to deliver on the elective recovery plan, 112 surgical beds are required for the entire year although opportunities exist in terms of a further shift to day-case activity and reduction in length of stay that will allow further reduction to the surgical footprint to circa 102 beds in the medium term.

8.3 This work was refreshed in March 2021 when approximately the same number of beds were required; 335 for medicine in 'summer' and 397 in 'peak winter'.

9. Winter Phasing

Table 7 Bed Escalation Plan - Winter 2020/21 – (for comparison)

General and Acute Wards - Core Bed Stock	Core Bed Total	Business Unit	Specialties	Notes on winter plan	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
EAU	24	Medical	General Medicine	No change	24	24	24	24	24	24	24	24
Ward 1	24	Medical	General Medicine	No change	24	24	24	24	24	24	24	24
Ward 2	24	Medical	Short Stay Unit	No change	24	24	24	24	24	24	24	24
Ward 4	20	Medical	Stroke	Increases from 20 to 30 beds for 1st half of January	20	20	20	20	30	20	20	20
Ward 6	0	Medical/Surgical	Hospital to home	Decommissioned	0	0	0	0	0	0	0	0
Ward 8	21	Medical	Cardiology	No change	21	21	21	21	21	21	21	21
Ward 9	36	Medical	Respiratory	No change	36	36	36	36	36	36	36	36
Ward 10 (escalation)	0	Medical	Respiratory	12 beds to open from October onwards	0	12	12	12	12	12	12	12
Ward 11	25	Medical	Gastroenterology	No change	25	25	25	25	25	25	25	25
Ward 12 (Winter Ward)	0	Medical	General Medicine	16 beds to open October, 24 beds Nov-March, reduce to 16 beds for Easter	0	0	16	24	24	24	24	16
Ward 14	25	Medical	General Medicine	No change	25	25	25	25	25	25	25	25
Ward 14A	26	Surgical	Trauma & Orthopaedics	Reassign up to 16 beds to medicine for January & February	26	26	26	26	10	10	26	26
Ward 14A reassigned beds		Medical	General Medicine		0	0	0	0	16	16	0	0
Ward 21	28	Surgical	Gynae/Oncol	Reassign up to 18 beds to medicine for January & February	28	28	28	28	10	10	28	28
Ward 21 reassigned beds		Medical	General medicine		0	0	0	0	18	18	0	0
Ward 22	29	Medical	Geriatric Medicine	No change	29	29	29	29	29	29	29	29
Ward 23	24	Medical	Geriatric Medicine	No change	24	24	24	24	24	24	24	24
Ward 24	29	Medical	Geriatric Medicine	No change	29	29	29	29	29	29	29	29
Ward 25	30	Medical	Geriatric Medicine	No change	30	30	30	30	30	30	30	30
TCL1 Ward 26	24	Surgical	Trauma & Orthopaedics	No change	24	24	24	24	24	24	24	24
TCL2 Ward 27	30	Surgical	General Surgery	No change	30	30	30	30	30	30	30	30
St Bedes	10	Medical	Palliative Medicine	No change	10	10	10	10	10	10	10	10
Total	429											
Bed Stock Over night stay Total					**429**	**441**	**457**	**465**	**475**	**465**	**465**	**457**
				Medicine	321	333	349	357	401	391	357	349
				Surgery	108	108	108	108	74	74	108	108

Table 08 – Bed escalation plan – Winter 2021/22 (original plan)

General and Acute Wards - Core Bed Stock	Core Bed Total	Business Unit	Specialties	Notes on winter plan	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
Ward 1	24	Medical	EAU	No change	24	24	24	24	24	24	24	24
Ward 2	24	Medical	EAU	No change	24	24	24	24	24	24	24	24
Ward 3 / 4	0	Medical	Winter Ward	Winter ward (phased 15 + 10 + 14)	0	15	25	39	39	29	15	0
Ward 8	21	Medical	Cardiology	No change	21	21	21	21	21	21	21	21
Ward 9	24	Medical	Respiratory	No change	24	24	24	24	24	24	24	24
Ward 10	23	Medical	Respiratory / Gen Med	No change	23	23	23	23	23	23	23	23
Ward 11	25	Medical	Gastroenterology	No change	25	25	25	25	25	25	25	25
Ward 12	24	Medical	General Medicine	No change	24	24	24	24	24	24	24	24
Ward 14	22	Medical	CEV/ General Medicine	No change	22	22	22	22	22	22	22	22
JASRU	20	Medical	Stroke	No change	20	20	20	20	20	20	20	20
CEV on ward 27	6	Medical	CEV	No change	6	6	6	6	6	6	6	6
Ward 14A	24	Surgical	Trauma & Orthopaedics	Plus 2 escalation beds Dec and Jan	24	24	24	26	26	24	24	24
Ward 21	28	Surgical	Gynae/Oncol	No change	28	28	28	28	28	28	28	28
Ward 22	29	Medical	Geriatric Medicine	Plus 2 escalation beds Dec and Jan	29	29	29	31	31	29	29	29
Ward 23	24	Medical	Geriatric Medicine	No change	24	24	24	24	24	24	24	24
Ward 24	29	Medical	Geriatric Medicine	Plus 2 escalation beds Dec and Jan	29	29	29	31	31	29	29	29
Ward 25	30	Medical	Geriatric Medicine	Plus 3 escalation beds Dec and Jan	30	30	30	33	33	30	30	30
TCL1 Ward 26	24	Surgical	Trauma & Orthopaedics	No change	24	24	24	24	24	24	24	24
TCL2 Ward 27	24	Surgical	General Surgery	No change	24	24	24	24	24	24	24	24
St Bedes	10	Medical	Palliative Medicine	No change	10	10	10	10	10	10	10	10
	435											
Bed Stock Over night stay Total					435	450	460	483	483	464	450	435
				Medicine	335	350	360	381	381	364	350	335
				Surgery	100	100	100	102	102	100	100	100

Table 9 – Bed escalation plan – Winter2021/22 (Revised Sept 2021)

General and Acute Wards - Core Bed Stock	Core Bed Total	Business Unit	Specialties	Notes on winter plan	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
Ward 1	24	Medical	EAU	No change	24	24	24	24	24	24	24	24
Ward 2	24	Medical	EAU	No change	24	24	24	24	24	24	24	24
Ward 3 / 4	0	Medical	Winter Ward	Winter ward (phased 25 + 14)	0	0	0	25	39	29	15	0
Ward 8	21	Medical	Cardiology	No change	21	21	21	21	21	21	21	21
Ward 9	24	Medical	Respiratory	No change	24	24	24	24	24	24	24	24
Ward 10	23	Medical	Respiratory / Gen Med	No change	23	23	23	23	23	23	23	23
Ward 11	25	Medical	Gastroenterology	No change	25	25	25	25	25	25	25	25
Ward 12	24	Medical	General Medicine	No change	24	24	24	24	24	24	24	24
Ward 14	22	Medical	CEV/ General Medicine	No change	22	22	22	22	22	22	22	22
JASRU	20	Medical	Stroke	No change	20	20	20	20	20	20	20	20
CEV on ward 27	6	Medical	CEV	No change	6	6	6	6	6	6	6	6
Ward 14A	24	Surgical	Trauma & Orthopaedics	Plus 2 escalation beds Dec and Jan	24	24	24	26	26	24	24	24
Ward 21	28	Surgical	Gynae/Oncol	No change	28	28	28	28	28	28	28	28
Ward 22	29	Medical	Geriatric Medicine	Plus 2 escalation beds Dec and Jan	29	29	29	31	31	29	29	29
Ward 23	24	Medical	Geriatric Medicine	No change	24	24	24	24	24	24	24	24
Ward 24	29	Medical	Geriatric Medicine	Plus 2 escalation beds Dec and Jan	29	29	29	31	31	29	29	29
Ward 25	30	Medical	Geriatric Medicine	Plus 3 escalation beds Dec and Jan	30	30	30	33	33	30	30	30
TCL1 Ward 26	24	Surgical	Trauma & Orthopaedics	No change	24	24	24	24	24	24	24	24
TCL2 Ward 27	24	Surgical	General Surgery	No change	24	24	24	24	24	24	24	24
St Bedes	10	Medical	Palliative Medicine	No change	10	10	10	10	10	10	10	10
	435											
Bed Stock Over night stay Total					435	435	435	469	483	464	450	435
				Medicine	335	335	335	367	381	364	350	335
				Surgery	100	100	100	102	102	100	100	100

Maintaining Elective Recovery

9.1 The suspension of elective surgery during the pandemic has resulted in the Trust accumulating a significant backlog of elective cases with associated risk to patient safety due to lengthening delay to surgery. The North ICP recovery and accelerator programme has mandated that activity is maintained consistently over a 12-month period in order to reduce the unacceptable waiting times for our elective patients . All trusts must achieve their planned activity levels on a month-by-month basis otherwise the whole region will fail to achieve the target required to secure the financial incentive arrangements.

9.2 In previous years the QEH surgical winter plan has been based around a scheduled reduction in elective in-patient activity in order to free up bed capacity to support an increase in unscheduled activity. For winter 2021/22 in order to maintain our elective recovery trajectory it is essential that there is a plan in place to mitigate against the need to board medical patients into surgical beds and in doing so protect planned elective activity for as long as possible during the winter months.

9.3 Table 09 indicates a planned maximum bed capacity of 102 beds for surgery however this may be challenging to maintain during peak winter pressures and as such a plan has been developed to temporarily reconfigure the surgical bed footprint to maximise the capacity taking into account potential IPC challenges to the site and an escalation in unplanned activity.

Current Position

9.4 The existing orthopaedic elective Ward 26 is a 30 bedded ward with single en-suite rooms. Within the current configuration, the beds are not fully utilised within the orthopaedic function but are prevented from use by other patients due to the nature of mandatory ring fencing in line with BOAS and GIRFT requirements. Due to pathway changes and reduction in LOS, our current levels of elective inpatient orthopaedic activity does not require the full bed capacity within ward 26 and currently occupies a maximum of 14 beds at any one time with the remaining beds being utilised for patients who meet the appropriate boarding criteria. In reality this equates to a maximum of 24 beds out of 30 beds occupied at any one time.

9.5 The single bedded configuration makes the ward vulnerable at times of escalation in terms of an increase in site IPC challenges:

- Additional provision for CEV patients
- Isolation cubicles for flu
- Isolation cubicles for Covid-19
- Isolation cubicles for norovirus

Surgical Escalation Plan

9.6 The surgery winter escalation plan looks to reconfigure the current surgical footprint to maximise use of the existing bed base with the aim of supporting the delivery of in-patient elective activity for as long as possible during the winter period. When escalation necessitates this plan to be implemented the surgical footprint will be

reduced to 94 beds, however the configuration will be much more flexible and will provide some resilience to support ongoing delivery of elective activity.

9.7 Ward 21 is currently split into two halves. Gynaecological oncology patients occupy 16 beds within the ward footprint. The other half of the ward is currently occupied by yellow critical care (YCCD) and it is anticipated that it may be necessary for YCCD to remain on Ward 21 throughout the winter period. A proportion of the gynae oncology beds are frequently used for general surgery patients due to the fact that ward 27 is currently accommodating 6 clinically extremely vulnerable patients. The CEV patients will remain on Ward 27 until building work can commence on Wards 11 and 12 to accommodate these patients within the medicine bed base; however this work is unlikely to commence until spring 2022. The 6 beds on ward 27 have therefore been accounted for within the medicine winter plan.

9.8 The proposed surgical plan is to swap ward 26 team and activity with the ward 21 unit and in doing so this places the orthopaedic activity into a bed footprint which matches current demand. This enables the gynae-oncology team to move to the larger ward 26 facility, accommodating their patients within single en-suite rooms, and allowing the other beds within the ward to be used by other female surgical patients and doing so maximise occupancy the surgical bed footprint for surgical patients. The plan is as follows:

Ward 26 – female surgical

- 30 beds incorporating gynae-oncology
- Enables mix of surgery and appropriate female medical boarders (if required)
- Improved privacy / dignity for female patients
- Enables other surgical patients to be accommodated and improves flow from front of house
- No building or alteration work is needed.

-

Ward 21- elective inpatient orthopaedics

- 15 bedded ward
- Ring-fenced unit with strict no boarding policy.
- Requirements to comply with ring-fencing:

    1. Double doors between Yellow CCD and ward area remain closed at all times- consider emergency locking system
    2. Minor building work to create a sluice area.
    3. Relocation of clean utility within the YCCD side of the ward.

Ward 14A – Trauma Ward

- 24 beds on ward 14A to be ring-fenced for trauma patients only wherever possible to ensure appropriate capacity as ward 26 is not a suitable environment for elderly trauma patients – there will be no option to board trauma patients into 21.

Ward 27

- Remains as current model – 24 beds for general surgery emergency and elective surgical patient beds for CEV patients.

Use of the Independent Sector

9.9 QEH has been working in collaboration with other ICS partners throughout the pandemic to optimise the use of independent sector capacity. The national contract remains in place facilitate access to independent sector facilities, however the terms of the contract with individual providers are not as favourable compared with winter 20/21. This does constrain access primarily due to requirement of practicing rights for individual consultants. The Trust has access to Nuffield Hospital in Newcastle for a limited amount of elective orthopaedic work. However, this is focused on low acuity patients and at this point in time is suitable for only a small number of patients on the elective waiting list. It is anticipated that this resource will enable the Trust to continue with both day-case and inpatient elective work during periods of significant escalation.

Diagnostic

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

Service hours

- **CT and X-Ray** 24hrs 7 days a week
- **MRI** 8-8 7 days a week
- **US** 8-8 Monday to Friday and 8-4 on weekends
- **IR, VAT and nursing support** 9-5 Monday to Friday
- **Medical Physics** 9-5 Monday to Friday

General Operating Model

- Prioritise services based on staffing resources available and reflecting competing demands in the Department as defined in the Business Continuity Plan.
- Liaise with clinical specialties to agree priority work areas
- Implement rapid prioritisation of outpatient work across all modalities to ensure sufficient capacity for inpatient demand.
- Assess and cease non urgent scans to meet inpatient and ECC demands if necessary
- Maintain reporting turnaround times by increasing reporting capacity with outsourcing companies.
- Consultant on-call and duty-rotas will focus on urgent needs.
- Review the use of off-site facilities at Blaydon and Tranwell for CT, MRI, US and X-ray, which are routinely used for outpatients, to prioritise scans for vulnerable patients off site and free up capacity on site for inpatients
- Cross cover staffing between modalities to ensure priority scans are maintained eg theatres, 2 week waits, A&E etc.
- Ensure full staffing compliment going into winter period
- Maintain agreed patient flow throughout the department for covid/non covid patients

- Actively encourage all staff to have flu and booster covid jab when required.

Nursing and Vascular Access and Interventional Radiology Services

Prioritise

  - VAT and IR inpatient procedures to facilitate timely discharges, creating additional capacity for biopsies/drainages as required
  - nursing capacity to deliver prep and recovery for diagnostic procedures in CT such as VAT connections and contrast injections

- Forward plan to stand down routine work to release staff to support in ward areas/critical care
- Increase venous access support where appropriate to support ART teams, wards and patient discharge with CT, MRI and X-ray to ensure cover provided and support available
- Maintain current patient flow for COVID/non COVID and continue with Trust approved swabbing process for all procedures

Phlebotomy

9.11 The Phlebotomy Department will:

- Aim to deliver full services across wards and outpatient settings. The Department will complement the phlebotomy done by ward staff where urgent bloods are needed.
- extend working hours if needed / assist with trust demands e.g.- escalation wards
- Maintain good staffing levels through agreed annual leave cover and use of bank staff
- Prioritise staffing to support to pressure points in the Trust to and to assist in the delivery of escalation areas, testing etc.

Endoscopy Capacity

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

10. Flu planning

10.1 This year the Trust are looking to plan differently from the very successful campaigns that delivered Flu vaccinations to 80% of Trust staff for the last few years.

- The Flu campaign commences on 27th September 2021 until 31st January 2022
- The Flu Planning Group including a wide-range of representatives from across the Trust are currently meeting to consider a wider need to plan for delivery of a Covid booster to frontline healthcare workers
- The plan is to look to give the flu vaccine and Covid booster dose both at the same time
- A robust plan based upon the plan used for delivery of the Covid vaccinations is in place
- This includes:

- Use of a booking system where staff will attend pre-booked appointments
- Plans to use the Occupational Health Department as the base to deliver the vaccinations
- Utilising the volunteer vaccinators used for the Covid vaccines
- Planning is reliant on a consistent supply of relevant vaccines to meet planned demand
- Trust staff, including some senior nurses, will be required to coordinate the clinics, supported by the booking team, Pharmacy, Communications, IT, HCAs and admin.
- Staff can continue to inform the Trust they've received the Flu or booster vaccine at a pharmacy/GP surgery/ supermarket

- A full communications plan has been developed and will be implemented by the Communications Team, commencing 2 weeks preceding the campaign/delivery
- Staff incentives will again be considered for teams achieving over 80%
- Level of uptake will be shared with all staff via QE Weekly/Screensavers/Flu page
- Business Units/Service Lines will be informed of their current level of uptake, and senior teams asked to engage/encourage/communicate key messages

11. Workforce Plan

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

11.2 Nurse staffing has been extremely challenging throughout the last 18 months due to additional pressures in the system created by the Covid pandemic. Nurse staffing has been reviewed this year in-line with the new operating model. The key initiatives to support winter pressures are recruitment into new ward establishments, mobilisation wherever possible, of all non-ward based nurses, review of our specialist nursing resources and local agreement to use agency/ NHS professionals (NHSP).

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

- Clinical senior nurse leadership.
- Nurse recruitment realigned to the new operating model.
- A continuation of the Trainee Nurse Associates programme.
- Real time staff monitoring through electronic systems, capturing acuity and staffing resource.
- Flexible working initiatives.
- Practice Development support.

11.4 The governance and delivery of the nursing winter staffing plan will be led implemented and monitored by the Chief Matron/Matrons in the acute setting and the Clinical Lead for community services.

Specialist Nurse Supporting Winter Pressures 2021

11.5 Historically, over the winter period qualified nurses and healthcare assistants from across the organisation are redeployed to support winter teams, to ensure safe

staffing levels are met and high quality, safe, effective care can be delivered. This year this deployment model has been used much earlier with wards initially used for winter retained to support capacity with extra demands placed on staffing resources by the pressures of Co-vid response and Trust recovery. The Winter Plan has been developed to ensure that there is a consistent approach to the utilisation of specialist nurses from across the Trust. The key focus has been to initially deploy staff into wards 10 and 12 with an intention to deploy staff to Ward 4 in December when increased staffing levels will allow us to ensure we maintain patient safety.

11.6 From mid-September 2021 specialist nurses will be required to spend time in their areas to ensure familiarity within the clinical environment, supported by the practice development team so they can refresh their clinical skills and systems knowledge and training. Thereafter they will deployed into clinical practice, predominantly supporting ward 10 and ward 12 and then incrementally ward 4, to further support the winter plan.

11.7 Specialist nurses will continue to contribute to the core nursing team on the ward, delivering the fundamentals of care and also utilising their specialist knowledge, skills and experience, to support patient safety and promote a positive patient experience. Working in the ward environment will enable specialist nurses to support the Health and Well-being agenda, sharing their expertise as well as offering professional leadership, clinical supervision and pastoral support to newly qualified and existing staff. This year, more than ever, we recognise that all staff are tired and depleted from the continual demands of a global pandemic.

11.8 Learning from winter 2020, listening to staff feedback and noting our organisational learning from covid, the Trust has based winter planning on the changing risk landscape. The Trust has adopted a flexible and dynamic approach to staffing requiring a strategic-led and collaborative approach to ensure we make informed decisions on risk, allowing safe and effective deployment of staff across the trust and in particular from our key business units. This will continue to require a collective trust-wide effort to ensure capacity and managed demand.

11.9 The fundamental areas of practice they can also contribute to are;

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

11.10 Each registrant /practitioner needs to ensure they are up to date with core skills, basic life support, managing deteriorating patient skills and patient moving and handling. This will be supported by the practice development team.

11.11 SN will be aligned to ward 4 or ward 12. A fair and equitable approach within the size of teams -for example x1 WTE from a team of 5 (equating to x5 shifts per week) further agreed between themselves and their line manager.

11.12 The business unit lead will collate SN availability and share this with the matron and ward manager who will collate the off duty on Health roster.

11.13 The matron for winter together with a designated NS lead for winter to manage and monitor planned release and actual attendance. The Chief Matron and matrons will need to work closely with the SN lead, SNs, matrons and service line managers to support their release.

11.14 SN nurses will be required to commence their shift at the standard start time for the area and where possible support 7 day cover.

11.15 The Matron for winter will record any non -attendance or issues and escalate these to the matrons, service line managers and chief matron.

11.17 The Chief Matron/ matrons will attend the winter resilience meeting and report any issues regarding SN allocations and actions taken.

Business unit Leads for SN Staffing :

Business Unit	Lead	Ext	Bleep	e-mail
Medicine	Michael Shaw	3676	3124	Michael.shaw7@nhs.net
Ward 4 winter	Susie Chrystal			susie.chrystal@nhs.net
Surgery	Caroline Lane	3535	2677	caroline.lane@nhs.net
Clinical Support	Debbie Wright			Debbie.wright6@nhs.net
Nursing Directorate	Dawn Orr Yvonne Tamburro Janet Thompson		-	yvonne.tamburro@nhs.net Karen.roberts@nhs.net
Medical or surgical matrons can be contacted via VOCERA on 6391				

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

- Phase 1 : Ward 3 / 4 opens 25 beds in December
- Phase 2 : Ward 3 / 4 opens a further 14 beds in January (39 beds in total – ward fully open)
- Wards 22, 24 and 25 have capacity to open escalation beds in day rooms in December and January (7 beds in total)
- Wards 22, 24 and 25 have capacity to open sit out chairs in day rooms in December and January (3 chairs in total)
- Phase 4 : Ward 3 / 4 closes 10 beds in mid-February taking the ward to 29 beds in total
- Phase 5 : Ward 3 / 4 closes remaining 24 beds end March 2022.
- Ward 4 closed.
- End of winter escalation.

Easter falls 15 – 18th April 2022. If in place the Ward 4 escalation area will impact on planned Scheme 3 works.

Ward 4 winter planning

As explained in section 7.4 above, due to nurse staffing shortages it has been necessary to amend the plans for Ward 4 over winter. Ward 4 can open to 39 beds incrementally as safe staffing allows, starting with 25 beds in December and expanding up to 14 beds in January.

The safe staffing plan has been faced by a number of operational pressures and continued demand from covid activity has impacted the plan with staff usually identified to support winter planning, already deployed to meet current challenges.

The safe staffing plan continues to be facilitated by matrons and SLMs working with their teams to identify the release of qualified staff with the right skills and experience, further strengthened by the SN workforce, bank and agency staff.

There is a recruitment plan for qualified and HCA staff and the leadership team have already been recruited at matron and band 7.

The nurse staffing establishment requirements are tabled below and made up of Registered Nurses and Health Care Assistants. The initial Ward 4 staffing requirements are tabled overleaf for information:

Ward 4 - Leadership plan

This includes a x1 Band 8a Winter Matron, x1 Band 7 Ward manager and x4 Band 6 Deputy ward managers to create the senior nurse leadership team. The Matron is responsible for quality and safety with operational and performance oversight. The matron is further supported by the Chief Matron and Service Line Manager. A ward manager has already been appointed from internal interview and the appointments of deputy ward managers are scheduled for mid-September.

Ward 4 senior nurse team will provide operational leadership over a 7 day period.

Quality impact Assessment: Ward 4

This year the nurse staffing plan faces increased significant pressure requiring dynamic management of staff absence through Test and Trace/ self-isolation rules and Covid activity.

The matrons have worked together and with their ward managers and SN teams to coordinate the release of skilled staff to support the nurse staffing plan, identifying staff with the right skills to be deployed appropriately to the right place. The SN teams form the support that frontline teams need through winter pressures and the focus this year is on supporting ward 4 and ward 12 as it embeds an established team in the new operating model.

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

Ward teams are expected to work within their establishments to manage effective safer staffing. Where there are any acute sudden shortfalls, the matrons will support the ward managers with their planned rosters to facilitate safe staffing. There is functionality within the health roster system to send shifts directly to bank rather than via the bank team.

Community Staffing

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

The transformation work has enabled community to embed the right skills right time right place principles into all the community teams however ongoing monitoring and review is needed as the discharge to assess model and changes to CHC funding and packages of care have impact on the demand for community intervention.

This needs to be done in parallel with the acute staffing rota's and in conjunction with local partners eg LA and Primary Care. There will need to be investment to deliver the expectations of primary care in terms of both flu vaccination and any anticipated COVID 19 additional vaccinations which may be required for cohorts 1-4 Flu vaccines for housebound over 50's and CEV patients. It has been confirmed that due to the schedules for vaccine release, it is unlikely these will be able to be delivered concurrently.

In order to fully implement the discharge to assess model work has been undertaken to look at further assessments being undertaken in the Community by Therapies staff and the introduction of discharge co-ordinators to support this. The DLN team will continue to work 8am until 8pm 7 days a week to continue to early supported discharge model implemented during Covid. They will be supported by the Trusted Assessor function within the Rapid Response team at quieter times.

12. Medical cover

12.1 The new operating model agreed by the Board includes the provision of additional medical staff (Consultant and Junior) within Medicine to ensure the delivery of safe, high quality care across the inpatient wards.

Senior Medical Consultant Cover

a) The pathways of care and ward arrangement detailed in the new operating model aim to increase admission avoidance and improve efficiency with medical patients on medical wards to enable surgical activity to continue throughout the winter period. The practice of ad hoc boarding should be by exception in extreme surge. Additional Consultant posts have been accounted for front and back of house as part of the new operating model and winter.
b) Additional senior medical cover will also be provided over known periods of peak demand in ECC. These dates are typically the weekends immediately after Christmas and following the New Year.

c) Other periods of high demand are known to fluctuate, therefore operational teams will seek additional senior medical cover as and when necessary to ensure the safety of patients and quality of care provided.

Junior Medical Cover

The medical staffing manager will work with the relevant SLM to resolve any gaps in staffing for the Medical Business Unit and escalate any issues as appropriate.

MBU have increased the JCF pool of staff in medicine;

a) Wards 9 and 10 – An additional three Junior Clinical Fellow posts added to the Ward 9 and 10 respiratory team to enable cover across the whole floor and support safe staffing in and out of hours.
b) Ward 12 – an additional Junior Clinical Fellow post added to the Ward 12 team to enable cover across the ward and support safe staffing in and out of hours.
c) Ward 4 – 6 additional Junior Clinical Fellow posts to cover Winter escalation on Ward 4 and to support any sickness to ensure safe staffing numbers.
d) Ward 14- an additional 2 Junior Clinical Fellows added to the Ward 14 team, including the care of Clinically Extremely Vulnerable patients.
e) Ward 8- an additional 2 Junior Clinical Fellows added to the Ward 8 team to support safe staffing in and out of hours.
f) Care of the Elderly (COTE) Wards (22,23,24 and 25)- an additional Junior Clinical Fellow post added to the COTE team to enable cover across the wards and support safe staffing in and out of hours.
g) The uplift in junior medical cover for patients has been modelled on the Medical bed numbers specified in the New Operational Estates Model.
h) Additional ad hoc shifts are likely to be required for annual leave and sickness absence.

13. Therapy cover

13.1 The current Physiotherapy and Occupational Therapy workforce will continue to deliver a service over 7 days to manage referrals from across the Trust. Due to funded staffing establishments weekend cover is reduced and proved urgent assessments and interventions only. The services continue to work with the Business Units to deliver transformational change, which may provide additional opportunities to support new workforce models and patient pathways to reduce length of stay. Any requirement for Physiotherapy staff to support enhanced respiratory provision or Critical Care over the Winter period will significantly reduce capacity back of house to deliver timely discharges. The service will explore opportunities to over recruit newly registered staff as the services recruit new graduates in August/ September.

13.2 Physiotherapy has extended its twilight service until 8pm across all specialties. This service provides an opportunity to support the assessment and discharge of patients up to 8.00pm both Front and Back of House. Two advance practitioner posts work front of house to support rapid assessment/management and discharge of patients. One post supports Medicine and Elderly pathways and the second post works in ED supporting the management of patients presenting with MSK conditions.

13.3 The Occupational Therapy Service has realigned its workforce to manage the needs of patients in those areas demonstrating high clinical demand in areas which have not historically had dedicated support. Service delivery supports both Back and Front of House delivery.

13.4 Work is ongoing within the Discharge improvement Programme to agree an appropriate D2A model. This requires agreement from system partners for a new model of delivery. To support this work it is proposed to over recruit 2 physiotherapists and 2 occupational therapists for patients on pathways 1 – 3 and form part of an integrated team who will embed the discharge to assess principles. This work will be overseen by the Discharge Improvement Group and the Flow Programme Board.

14. Pharmacy Cover

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

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

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

Pharmacy Cover

Scheme	Dates	Actions	Implications	Resource
Extended 7 day Pharmacy Services	Continuous	In-Patient Pharmacy Weekend Opening Times: Saturday: 09:00 – 17:00 *(previously 09:00 – 14:30)* Sunday: 09:00 – 17:00 *(previously 13:00 – 16:00)* Weekend Clinical Pharmacy Weekend Omnicell® Automated Drug Cabinet refills and ward top ups	Access to medicines from Pharmacy, and the availability of dispensing of discharges over a longer timescale at weekends. Quick and accurate medicines reconciliation and support with prescribing. Clinical Pharmacy support beyond EAU. The ability to refill Omnicell® Automated Drug Cabinets in high use areas across the weekend, where appropriate.	Within current budget
Clinical Pharmacy Technician Weekend Support	Continuous	Following pilot Jan-21 and Feb-21 implement long-term. Clinical Technician support Pharmacist Independent Prescribers at Weekends with Medicines Reconciliation – Sat and Sun.	Maximise Medicines Reconciliation Rate GIRFT NB: This will be to undertake Med Rec on EAU Only.	Within current budget
QEF Dispensary Saturday am opening *Formal request has been made to QEF*	Permanent [If approved]	Extend Opening Hours of QEF Dispensary to Saturday am 08:30 – 13:00	OP Dispensary available for dispensing IVF scripts to relieve pressure on IP Pharmacy; Sell OTC medicines direct to patients (A & E workstream?), dispense A & E prescriptions and support any OP clinics flexed into Sat am.	Requires extra funding circa. £15,000 per annum
Weekday Late Shift Flexibility	January and February 2022	Increase dispensary staff capacity to manage peaks in activity	To help manage surges in discharge prescriptions	Within current budget
Extra Clinical Pharmacy Technician Support to Anticoagulant Service and Meds Reconciliation	1 Nov 2021 – 31 Mar 2022	Extend hours of part-time Clinical Pharmacy Technicians	Clinical Pharmacist resource released from Anticoagulant Service/Meds Rec to support extra medical in-patient workload	Within current budget
COVID-19 vaccine clinic (Pending)	September 2021 to January 2022	Pharmacist and pharmacy technician to be allocated to make up COVID-19 vaccines in the booster clinics scheduled for Sept-21 and Jan-22	Vaccines to be made up into syringes within the vaccine clinic	Within current budget Back fill staff with Bank cover where needed.

15 Facilities Team

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

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

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

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

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

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

16 Community

16.1 The following are the initiatives and service changes that will be in place to support system pressures during winter 2021/22.

- Mobile devices are now in use by most clinical teams. The use of such devices and access to live clinical records in the patient home will as has been shown enhance patient safety and team efficiency and responsiveness.
- Community services are in the second year of delivering the Hospice at Home service. This is now fully staffed. The team support timely discharge and /or step up support for palliative patients. The impact over winter should be specifically the support this service can provide in timely discharge for patients at the end of life which has been problematic in past winters.
- Rapid Response service has been working more closely with GP OOH service as well as NEAS and this is to continue with the aim to enhance clinical decision making and expand out of hospital care and treatment to avoid more efficiently hospital attendances and admissions.
- Frailty Nurses will work FoH as well as with new/developing SDEC pathways particularly related to falls.
- 7 day–a-week therapy-cover in community to continue into winter.
- Falls car to continue into winter months ongoing discussions with CCG regarding funding and model
- Community service staff input and support increased to cover across all PICs to support LA staff.
- Discharge team offer support working hours, 8am-8pm, 7 days;
- Community services manage wound care clinics Monday to Friday for ambulatory patients, previously seen by primary care available over 3 sites. We are currently also working on developing a weekend clinic. This will ensure no patents unnecessarily attend ED for routine dressing changes.
- Immunisation programme of house bound and care home patients against Influenza and any COVID 19 top up vaccinations to be carried as per plan in negotiation with CCG and primary care once the vaccine is available. In conjunction with a COVID booster.
- For this winter community services have extended health care provision across all elderly care homes in Gateshead until the end of January 2022. The CNPs have been key to supporting the care homes and providing daily contact to help problem solve as well as clinically supporting residents care plans and the GP link on ward rounds.
- Locality MDTs working in the main virtually have been implemented across all 5 locality areas by winter. These MDTs include health and care staff from the trust and LA as well as primary care colleagues. The aim is to reduce admissions and LoS with better coordinated support within the community.
- Adult Speech and Language Team will prioritise patients due to their clinical need with the potential of flexing the team to support prompt discharge where appropriate in line with SLT clinical standards

17 Discharge

17.1 The Trust has been working towards a home first principle in line with national guidance. There are ongoing challenges in sourcing packages of home based social care within Gateshead at present. Therefore patients are being offered an alternative out of hospital placement. Guidance was expected on 16 September as to the ongoing funding regime which will underpin this. At present four weeks care is provided free of charge to individuals leaving hospital.

17.2 In line with established principals:

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

17.3 The Flow Programme Board has been working throughout the year to identify support which would enable discharge to happen more smoothly, Additional Therapy resource to reach out into the Community and dedicated discharge co-ordinators are proposed for the wards.

18 Collaborative Operational Planning

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

19 Transformation Portfolio

19.1 The Trust had previously launched a Transformation Portfolio of work which was paused due to the Pandemic. As the trust continues to manage the response to Covid-19 as well as returning services and activity to a new normal, the trust has identified key improvement areas to focus on building on the clinical model recently approved at Trust Board.

19.2 The trust aims to sustain improvements made as part of the response to Covid 19 which includes (but not exhaustive of) the following:

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

19.3 The specific Transformational Programmes to support winter are as follows:

- **Unscheduled Care** – SDEC, Urgent and Emergency Care Pathways, integrated approach to discharge, ward ways of working, ward rounds and board rounds to facilitate decision making for timely and safe discharge and admission avoidance
- **Elective and Planned Care Recovery** – Capacity and Demand, Productive Theatres, Performance Improvement, Diagnostics and Model Hospital

19.4 Key enabling programmes and activities will include

- New Operating Model
- Digital Transformation – to support new ways of working
- Education & Training and Future Workforce Development - to include Health Roster, Job Planning, Medical Staff Solutions for rostering and advanced roles
- Leadership Development - building on the corporate Vision, values and behaviours, Goals & Performance.
- Continuous Improvement methodology to support change
- Benefits Management and Realisation

20 Financial plan

20.1 The total estimated cost of the winter plan as outlined in this document is £2.101m (full costing Appendix 3). The comparable costs for last year were £2.214m. Therefore, the anticipated costs for this year's plan represent an reduction in plan of £0.113m in comparison. .

20.2 It is difficult to unpick the true costs of winter due to the covid pandemic and the trust's response including the post covid operating framework which has seen a significant reconfiguration of the bed base and an associated increase in staffing costs.

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

21. Operational Management and Escalation arrangements

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

21.2 To proactively manage capacity and demand a series of Site Resilience Huddles are held daily to manage impacts, demand and surge. The escalation framework incorporates the OPEL triggers and provides the Trust with Operational, Tactical and Strategic coordination and direction to manage demand and a safe and timely patient journey.

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

21.4 A single email and telephone contact point is in place:

Email: england.cne-winter@nhs.net
Phone: 01138251405

22. Organisational on-call arrangements

22.1 Out of hours on-call arrangements have been reviewed in line with the EPRR Core standards and the Trust On-Call and Command, Control and Coordination (C3) structures put in place. This will ensure the continued use of a robust escalation model deployed during COVID 19 waves and in response to Trust impacts to bring Operational, Tactical and Strategic on call managers and directors together to manage surge and provide clear Trust direction. The Site Resilience Huddles held a number of times daily will ensure hands-on operational day to day site management incorporating escalation plans and OPEL levels and appropriate actions cards specific to role.

22.2 Awareness raising/training sessions took place for the on-call management teams in October 2020 and will be delivered in September 2021. Multi-agency Teams calls will once again be used to facilitate internal and external calls for those responsible for proactively managing the Winter Plan to support the whole patient pathway from admission avoidance through to discharge.

23 Adverse weather plan

23.1 Gritting and snow ploughing

Please note:

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

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

For Winter 2021/22, the following arrangements have been put in place; please refer to Adverse Weather Plan.

23.2 Winter Team

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

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

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

23.3 Queen Elizabeth Hospital

Main Circulation Roads & Car Parks

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

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

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

Footpaths

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

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

Car Parks

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

23.4 Bensham Hospital

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

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

23.5 Moss Heaps Car Park

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

23.6 **Key Contacts**

Name	**Contact**
Coatsworth Landscapes	Mobile: 07710 804752 (Priority 1) Mobile: 07710 804280 (Priority 2) Office: 01670 825335
Gateshead Council (During daytime hours 0700-2130 Mon – Fri) After 21.30pm the nigh-shift is the POC. Duty Highways Manager Brian Drummond, Highways Manager	 Tel. 0191 433 7411 Matty Lindsay or Tel. 0191 433 7415/7965 Brian Drummand Mobile: 07849 304 528 Mobile: 07771 972999
QEF On-Call Estates Officer	Contact via QEH switchboard

24 Transport/Estates

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

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

25 Management of Outpatient Department

25.1 The Outpatient Department will maintain the delivery of outpatient clinic facilities, within available resources, to meet the needs of the clinical specialties. This will be achieved by the following:

- Proactively manage available clinic capacity to ensure best use of available resource.
- During inclement weather/staff shortages, liaise with clinical service leads regarding flexibility for consolidating clinics to the main site to flex staff usage.
- Liaise with leads from all 9 sites of delivery, during periods of site escalation, to determine staffing requirements, necessity and alternative options for cover.
- Review clinic numbers and flex staff to support multiple clinics in the event of low Outpatient staffing numbers.
- Assess and prioritise availability of offsite clinic provision at Blaydon Primary Care Centre for vulnerable patients/additional capacity/flexibility.
- In the event clinics have to be cancelled at short notice due to Outpatient nursing staff shortages or site unavailability, liaise with specialty admin teams and clinical leads to ensure they are able to contact patients quickly to re-book appointments and prioritise patients depending upon clinical need.

25.2 In the event that outpatient clinics are de-escalated or stood down to prioritise staff elsewhere in the Trust to support the Medical or Surgical Business Units, the Outpatient Department will:

- Allocate appropriately risk assessed nursing staff to support wards to mitigate staffing shortages and site pressures.
- Work with clinical service leads to support additional clinics/ re- provision of clinics due to site pressures.
- Within resource capabilities, flexibly support evening and weekend/adhoc clinics to maintain priority clinics such as 2 week wait clinics and waiting list demands/cancellations due to site pressures.

26 Pathology demand from increasing winter illness

26.1 Pathology planning for winter pressures include:

- The laboratory has procured a stock of Covid/Flu multiplex assays to provide rapid Covid/flu testing for patients presenting with respiratory symptoms over the winter season. The turnaround time on this test is 60 minutes and will be available 24/7. This is in addition to the standard Covid test for all admissions.

- Point of care services are available in acute locations to provide blood gas analysis including in A/E and EAU, there is a laboratory back up service in place.
- A point of care device for Full Blood Count is also available in A/E
- The main laboratory equipment has sufficient capacity to service the additional demand from increasing winter illness.

27 IPC

27.1 2020 and 2021 have been dominated by the COVID-19 pandemic. The IPC team and Microbiologists are involved in the interpretation and dissemination of the guidance issued from national bodies, including Public Health England and NHS England/Improvement. This supports operational effectiveness within this organisation and the wider healthcare community.

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

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

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

27.5 During the winter months there is an increase in the seasonally related infections conditions of influenza and Norovirus. In addition the COVID-19 pandemic remains a priority. Therefore winter 2021/22 will potentially create a unique combination of infectious conditions that will require the ability to respond adopting a cohesive and collaborative approach.

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

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

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

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

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

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

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

28 Communications strategy

Internal communications

28.1 The final winter plan will be cascaded through the internal communications channel as well online resources updated on the intranet.

External communications

28.2 We are part of the regional **#DoYourBit** campaign which encourages people to take responsibility to protect themselves, each other and their communities and focusing on messages around our recovery, flu vaccinations, surge plans and staying well over winter. The campaign, which is led by the regional communications network, includes shared content which can be used across multiple channels, region-wide media and advertising buy which enables us to amplify messages but also localise options where we need to.

29 Risk Assessment

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

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

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

Proposed Nurse Staffing Plan

RN Planned	Position	From :	Ward 12 winter Staffing Names	RN Actual	Notes: Move from	Backfill of NWBN
Band 8a	Matron	Gen Medicine Winter Lead	TBC	1.0	MED	
Band 7	Ward Manager	TBC	TBC	1.0	MED	
Band 6	Deputy Sister x2	TBC	Interviews 18.09.20	1.0	MED	
		TBC		1.0	SURG	
Band 5 14.62	RN5/6	TBC	18.09.20	1.0	MED	
	RN5	4*	confirmed	1.0	MED	
	RN5	4*	confirmed	1.0	MED	
	RN5	4*	confirmed	0.64	MED	
	RN5	8	confirmed	1.0	MED	
	RN5	9	TBC	1.0	MED	
	RN5	14a	TBC	1.0	SURG	
	RN5	26	TBC	1.0	SURG	
	RN5	27	confirmed	1.0	SURG	
	RN5	C support	TBC – ward 10	1.0	C support	
	RN5	C support	TBC	1.0	C support	
	RN5	NWBN	TBC	To call each shift	Discharge Team	
	RN5	NWBN	TBC	To call each shift	Dietetics / C support	
Total						
17.62WTE				14.64 WTE		

Winter Plan – Medicine

Winter Ward 21-22 Costing

Heading	Grade	WTE	Oct21 - Mar22 £
Ward Manager	Band 7	1.00	25,599
Senior Sister	Band 6	4.00	99,620
Staff Nurse	Band 5	24.22	517,186
Healthcare Assistant	Band 2	22.50	348,774
Housekeeper	Band 2	1.80	21,210
Ward Clerk (Admin)	Band 2	1.00	11,783
Staff Nurse for 22,24,25	Band 5	11.83	200,648
Healthcare Assistant for 22,24,25	Band 2	7.25	85,428
Matron	Band 8	1.00	28,713
Junior staffing	CT1	4.00	96,756
Registrar		2.00	61,634
Consultant		2.00	117,183
Subtotal Pay		**82.60**	**1,614,534**
Non Pay			60,000
Total Cost		**82.60**	**1,674,534**

Non Medicine Business Unit Costings

Business Unit	Scheme	From	WTE	Cost
Community	Flu/COVID vaccine delivery	J. Clark		£30,000
	Community Therapies support		0.20	£11,000
	2 Hour response			£205,000
	B7 In care homes continuation		0.00	£30,000
	Call back service		3.00	£55,225
Surgery	Ward 14A Non Pay	Last years Plan		£13,671
	Ward 21 Non Pay			£14,723
	Additional Bank Spend (increased wi			£36,761
CSS	Physiotherapy Support	Last years Plan	1.50	£23,667
	Pharmacy - Dispensary Support		0.40	£6,338
TOTAL			5.10	426,386

Notes

Pay scales effective from April 2021

NI and Superannuation all at 2021-22 rates

All posts costed at top of scale / point of employee if known

Assumed member of staff paying superannuation

Gateshead Health
NHS Foundation Trust

Assurance Report

Agenda Item: 10i

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	Finance and Performance Committee – 27.07.2021			
Name of Meeting:	Trust Board			
Date of Meeting:	28.09.2021			
Author:	Mrs K Mackenzie and Mrs D Renwick			
Executive Lead:	Mrs K Mackenzie and Mrs J Baxter			
Report presented by:	Mr M Robson, Chair of Committee			
Matters to be escalated to the Board:	Nothing to escalate			
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	<u>Financial Revenue Report – Month 3</u> The Financial Revenue Report for Month 3 was received showing a small surplus. The Committee noted that there is an underlying surplus, and that plans are being collated in respect of utilising this balanced against the lack of clarity on H2 funding envelopes. <u>H2 Plan 2021/22</u> The Committee received a presentation and noted that partial assurance was received in respect of the work being undertaken internally to the Trust whilst being limited by timelines for national planning guidance publication. <u>Capital Plan Update</u> The Committee received a paper which outlines that the Trust has an approved CDEL of £9.723m. The Committee noted partial assurance as there are robust plans in place, however there is some external uncertainty around further funding. <u>Integrated Oversight Report</u> The Committee noted partial assurance as short term actions and longer terms risks are not fully assured. <u>Board Assurance Framework (BAF)</u> The Board Assurance Framework was updated accordingly. <u>Supply Procurement Committee Summary Table</u> The Committee received this for assurance and will await			

	the internal audit report with interest. <u>Audit One Reports – Risk Based Audit of Procurement</u> The Committee received this for information. <u>Finance and Performance Committee Work Plan 2021/22</u> The Committee received this for information. <u>Accountability Framework</u> The Committee noted partial assurance as there is a process in place and a plan is required for introduction. <u>Transformation</u> This feeds back to the Finance Committee but reports to the Transformation Board – there is a gap in the process.					
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:	Workforce issues across the Organisation due to Track and Trace.					
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: 10i

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	Finance and Performance Committee – 25.08.2021			
Name of Meeting:	Trust Board			
Date of Meeting:	28.09.2021			
Author:	Mrs K Mackenzie and Mrs D Renwick			
Executive Lead:	Mrs K Mackenzie and Mrs J Baxter			
Report presented by:	Mr M Robson, Chair of Committee			
Matters to be escalated to the Board:	Nothing to escalate to Board.			
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	<u>Financial Revenue Report – Month 4</u> The Financial Revenue Report for Month 4 was received and it was noted that income from the Elective Recovery Framework is slightly higher than planned. No further income associated with the ERF is anticipated from July 2021. The Trust has an underlying surplus and has an opportunity to utilise some of this to make improvements to the quality of patient care and patient experience as well as support the health and well-being of staff. <u>H2 Plan 2021/22</u> The Committee received a verbal update noting that the Trust is expecting the Planning Guidance on 16th September 2021. H1 allocations are likely to be rolled forward, but uncertainty continues. <u>Integrated Oversight Report</u> The Committee noted partial assurance. Risks remain in relation to the impact of cancelling the non-urgent elective work and echocardiology. It was noted that the lack of back of house beds is the main cause of the breaches. <u>Cost Collection Output Report</u> The Committee received the above report for assurance noting the key areas highlighted in the paper. All areas identified for focus will be triangulated in conjunction with the ongoing Model Hospital work.			

	Review of Objectives The Committee reviewed the objectives in detail and noted that clarity is needed in relation to what objectives sit with each Committee and the format of the report. 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						
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:	Workforce issues across the Organisation due to Track and Trace.					
Links to CQC KLOE	Caring ☒	Responsive ☒	Well-led ☒	Effective ☒	Safe ☒	
Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)	**Obj.1** ☐	The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance between working life and personal commitments				
	Obj. 2 ☐	All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers				
	Obj. 3 ☐	Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve				

Gateshead Health
NHS Foundation Trust

Assurance Report

Agenda Item: 10ii

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	Audit Committee – 02/09/21			
Name of Meeting:	Board of Directors			
Date of Meeting:	28 September 2021			
Author:	Mr A Moffat, Chair of the Audit Committee Mrs K Mackenzie, Acting Group Director of Finance			
Executive Lead:	Mrs K Mackenzie, Acting Group Director of Finance			
Report presented by:	Mr A Moffat, Chair of the Audit Committee			
Matters to be escalated to the Board of Directors:	No specific matters to escalate to the Board for further action.			
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	A summary of assurances, gaps and agreed actions for each of the core agenda items is outlined below. **<u>Freedom to Speak Up (FTSU)</u>** Assurances were received regarding: • Regular meetings occurring between the Guardian and Board Leads. • FTSU reports now being received directly by the Board. A number of work-streams are ongoing and the Committee was assured of the following progress: • Further development of the FTSU reports to focus on themes and learnings. • Recruitment of FTSU champions in operational business units. **<u>Audit Committee Dates 2022/23</u>** The Committee approved the draft meeting dates, noting that those meetings relating to the year-end reporting may require amendment. **<u>Losses and Special Payments</u>** The Committee approved the report, noting there were no significant issues or anomalies to highlight. **<u>Risk Management Policy</u>** The Committee acknowledged the significant amount of work undertaken in this area.			

	Positive assurances were received regarding the policy addressing external peer review recommendations. Training on risk management would need to be revised in line with the Patient Safety Assessment Framework when published. The Committee ratified the policy, noting the plans to develop the risk management strategy, which it is anticipated will likely lead to policy revisions in the near future. **Counter Fraud Update Reports** Positive assurance was received regarding the preventative activity undertaken. Concerns were raised regarding the length of time taken by external profession registration bodies to close investigations, although this is out-with the control of the Trust and / or Counter Fraud. Only one area was rated as red within the report and assurances were received that this was due to lack of provision of external training on a new NHS Counter Fraud Authority risk assessment methodology. Positive assurances were received regarding the robustness of the application of the previous methodology by the team. The Committee requested further streamlining of Counter Fraud reports and consistency of format with AuditOne reports where possible. The Audit Committee approved the Counter Fraud annual report. **Internal Audit Update Reports** Two audits were finalised in the period: • Data Security and Protection (DSP) Toolkit (2020/21 follow-up review) – where moderate assurance was concluded as being provided. • Medical devices training (2019/20 report follow up) – limited assurance was again the outcome of the Medical Devices training follow-up audit. It was noted that some progress has now been made in implementing historic recommendations. It was acknowledged that Internal Audit are currently behind plan, but assurances were received that additional Trust resources are now in place. The Committee approved the inclusion of four Technology Risk and Assurance (TRA) audits into the plan. It was agreed that the CQC process audit would be deferred until Quarter 4 to provide the incoming Chief Nurse with an opportunity to implement planned actions. The Group Audit Manager agreed to share findings from the preliminary work conducted to-date to ensure actions address already identified issues. It was agreed that to ensure appropriate escalation of

<table>
<tr><td></td><td colspan="6">overdue actions, the escalation officer for each action would be an Executive Director.
The Committee expressed concern regarding the slippages on audit action implementation. It was agreed that the Acting Group Director of Finance and Company Secretary would review the current internal processes.
Audit Committee members set a clear expectation that this would be a future item for escalation to the Board should improvements not be evident.

<u>Executive Risk Management Group</u>
The report provided an appropriate level of positive assurance regarding the work of this new Group.

<u>Proposed Change to the Standing Financial Instructions and Scheme of Delegation</u>
The Committee supported the proposed change in relation to procurement limits and would be recommending the approval of the amendments to the Board (see separate item on the Board's agenda).</td></tr>
<tr><td>Recommended actions for the Board of Directors</td><td colspan="6">The Board is requested to take assurance from the work of the Committee and note the assurances, actions and decisions of the Committee in framing related items on the Board agenda.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:
(Including reference to any specific risk)</td><td>Aim 1
☒</td><td colspan="5">We will continuously improve the quality and safety of our services for our patients</td></tr>
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<tr><td>Aim 5
☐</td><td colspan="5">We will develop and expand our services within and beyond Gateshead</td></tr>
<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">There are no significant risks on Datix relating to the business conducted at this meeting.</td></tr>
<tr><td>People and OD Implications:</td><td colspan="6">None to note.</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>Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)</td><td>Obj.1
☐</td><td colspan="5">The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance between working life and personal commitments</td></tr>
</table>

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

Gateshead Health
NHS Foundation Trust

Assurance Report

Agenda Item: 10iii

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☒
Committee Reporting Assurance:	Quality Governance Committee – 21 July 2021			
Name of Meeting:	Trust Board			
Date of Meeting:	28 September 2021			
Author:	Dave Shilton, Non-Executive Director			
Executive Lead:	Joanne Baxter, Chief Operating Officer			
Report presented by:	Dave Shilton, Non-Executive Director			
Matters to be escalated to the Board:	None			
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	The Quality Governance Committee met on the 21 July 2021. The key agenda items discussed were as follows;- **<u>Items for Decision</u>** <u>Integrated Impact Assessment Policy and Procedure</u> The Committee agreed this was a robust policy and ratified the document. Assurance on the delivery of this will be received by the Committee on a quarterly basis. **<u>Item for Discussion</u>** None discussed. **<u>Items received for Assurance</u>** <u>Integrated Oversight Report</u> Full assurance received. The Committee acknowledged the ongoing development of the report and noted the level of assurance it provided. It was advised that as the Safeguarding committee had moved to quarterly that safeguarding metrics will look be included in future reports to provide that ongoing assurance on a monthly basis. An assurance report would be provided to the committee going forward from safety and risk and safeguarding groups. Work ongoing to align all assurance Committee reports to ensure the triangulation of data for the same time period.			

	The Committee noted that performance targets were not being achieved, however received good assurance that recovery plans were in place. <u>Assurances from Strategic Safeguarding Group</u> The Committee noted that compliance was low in safeguarding training, however, were assured that appropriate safeguarding referrals continued to be completed by all staff. The Committee were assured that work is underway to look at the cohort of staff trained in level 3 and staff training will then be prioritised and that e-learning had been developed to support delivery. The Committee agreed a level of partial assurance as due to the current operational pressures; training issues will not be resolved in the short term. <u>Maternity Assurance Report</u> No assurance received. This item has been deferred to the August Committee. <u>Older Persons Mental Health Integrated Report</u> The Committee acknowledged the ongoing estates issues on the Cragside new build, however received good assurance robust plans have been put in place to mitigate against mixed sex accommodation and other issues identified by the CQC <u>Birth Rate Plus</u> The Committee received assurance that the bid external funding had been awarded for 5.3WTE staff, however risk noted that didn't received total bid for 9WTE staff. The Committee acknowledged the increased rates of equity in births and received assurance that robust processes were in place to review still births. The Committee received full assurance for the report, however agreed that they would like to ensure the business case which us currently in development be finalised asap and submitted through the BC process for the staff for the staffing levels needed in the service with details of current staff retention plans. <u>Clinical Audit Annual Report</u> The Committee noted a good level of assurance for this report and noted the high level of compliance against national audits undertaken.

	NICE Guidance Annual Report The Committee noted a good level of assurance for this report and noted the high level of compliance. Pressure Damage Action Plan The Committee received a good assurance that a robust action plan had been implemented, however agreed that tighter timescales were required against the plan. A full pressure damage update report will be received by the Committee in September 2021. IPC Board Assurance Framework To Committee perceived good assurance that 9 out of the 10 KLOE's were Green with 1 Amber. Ongoing issues with mask fitting continues to cause concern; however, work is ongoing to look at how this can be managed.				
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 - Fit testing (as above) - Risk areas were increase in falls and pressure area damage - SI Performance - risks remain around timeliness of investigations and closing out actions - Maternity Estate (as above) - Health and Safety Annual Report (as above)				
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: 10iv

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	Digital Committee – 16 August 2021			
Name of Meeting:	Trust Board			
Date of Meeting:	28th September 2021			
Author:	Andrea Adams, Head of Digital Transformation and Assurance			
Executive Lead:	Jackie Bilcliff, Acting Chief Executive			
Report presented by:	Andrew Moffat, Chair of Committee			
Matters to be escalated to the Board:	To ensure the organisation continues to be compliant with the requirements of the NHS Data Security & Protection Toolkit (DS&PT) the level of Information Governance training must be at least 95% by 30 June 2022. As at 30 June 2021 – 95.54% compliance was reported. Pressures were also noted on digital resource capacity and supplier delivery concerns. A re-prioritisation exercise is due to take place at the end of August 21, the outcome of this will be reported through the Digital Transformation Group for discussion and any further escalations will be presented at the October Digital Committee.			
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	A status update report was presented to demonstrate alignment from the digital portfolio through to the digital elements of the Trust Strategic Aims and Objectives. The report provides assurance by monitoring both the delivery of new digital capabilities and also how the digital aspect will be measured. Partial assurance gained due to the need to formulate a plan to shorten the potential 8 month delay to the Windip migration. Digital Strategy and Transformation Roadmap Tracker and GDEFF milestones identified one red RAG area surrounding the migration of legacy records from Windip into Docstore. Pressures were also noted on digital resource capacity and supplier delivery concerns. Partial assurance gained due to the need to expand commentary and narrative on the tracker and to undertake a prioritisation review of the digital portfolio to help ease the capacity issues.			

	Digital KPIs were further expanded to include Cyber Security alongside updated Information Governance and Clinical Coding KPI's as presented at the previous meeting. Successes included IG training level hitting the 95% target and the committee were pleased to see the addition of further KPI's. Additional KPIs around IT will be added for the next meeting in October. Partial assurance was gained due to the KPI document still being in development and an action to consider presenting the data in a different format from the SPC chart for certain KPI's that would benefit. Audit reports covering NHS Data Security & Protection Toolkit (DSPT) interim and final audit report, Clinical Systems Management and Nervecentre System Security were discussed. Assurance was provided that the issues flagged in the initial DSPT audit report were fully addressed and overall outcome from AuditOne was substantial. Clinical Systems Management was marked reasonable and Nervecentre assurance was good. Partial assurance was gained overall by the committee as further information on cyber essentials and cyber essentials plus was requested and also any outstanding actions on previous audits was requested to be presented at the next committee meeting. Work will begin to discuss an outline approach to Workforce Digital Adoption. This will be planned in collaboration with People and OD leadership and management to ensure the plan fits with other workforce initiatives. This work will act as a key enabler to the digital transformation agenda within the Trust as well as underpinning the digital elements of the Trust's strategic aims and objectives. Risks were reviewed both from an operational and portfolio perspective, a more tailored risk log will be presented to the next digital committee including only those risks that may affect the delivery of the strategic aims and objectives that the Digital Committee oversee. The minutes of the Digital Committee's sub committees (the Digital Assurance Group and Digital Transformation Group) were reviewed and noted. There were no formal items of escalation at this point.	
Recommended actions for Board	Accept the assurances provided in the report, ensure the increase in uptake of mandatory Information Governance training.	
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)	Risks 2929 - There is a risk of disrupted or delayed implementation of the Trusts digital strategic objectives - due to lack of digital resource, clinical resource, reprioritisation of workload (e.g. pandemic), supplier failure, financial constraints - resulting in failure to achieve the desired outcomes.	
People and OD Implications:	Workforce implications within the Digital Team and the wider Trust.	

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: 10v

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	Human Resources Committee – 14 September 2021			
Name of Meeting:	Trust Board			
Date of Meeting:	28th September 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 Human Resources Committee met on 14 September 2021. The key agenda items discussed were as follows: <u>Update Report from POD Portfolio Board</u> The Committee were partially assured and noted the progress that has been made. Members were reminded of the operational context in which the POD directorate have been functioning over the past couple of months with the key areas of focus being identified as the Delivering Excellence in People Practices restructure and responding to wave 4 Covid pressures. <u>People Plan Operational Guidance</u> The Committee were partially assured and noted that there are 13 priorities for 21/22 with 5 being achieved, 7 where action has been taken and on track to achieve and 1 where no action has been taken/progress made to date, that relating to trust wide workforce planning. Pressure arising from capacity to progress work continues in the team. It was confirmed that key actions and next steps will be incorporated into the overall People Plan Action Plan and POD directorate actions, a People Plan dashboard will be developed. Implementation of the new directorate structure will begin in October. Oversight of all progress will be retained via the POD Portfolio Board. <u>WRES 2020-21</u> The Committee were partially assured and noted the			

	ongoing work and progress made to date, recognising that a lot more progress still needs to be made in this important area of work. The BAME Network has particularly asked to see improvements in relation to recruitment and retention by way of continuing work to overhaul recruitment practices. Concerns were raised in relation to the numbers of staff experiencing harassment and bullying. <u>WDES 2020-21</u> The Committee were partially assured and noted the ongoing work and progress made to date, recognising that a lot more progress still needs to be made in this important area of work. The Committee discussed the report in detail. Comments from the Disability Group have been reflected and the work will feed into the People and OD Board Human Rights and EDI programme board. <u>Gender Pay Gap Reporting 2020-21</u> The Committee were fully assured and noted the reduction in the mean average pay gap and discussed the actions identified within the paper. The Committee asked that this work be further explored and developed with the Women's Network. <u>Integrated Oversight Report People & OD Metrics</u> The Committee were partially assured. A detailed discussed took place regarding the current context and 'as is' relating to this work. The size of the task to improve people metrics is significant and the progress to date was noted, along with the aspirations for future metrics reports. Focus was given to recovery plans for core skills and appraisal work and this has been discussed by Execs and SMT. Business Units have been asked to develop plans to meet the required standards of compliance by March 22. A review of core skills is at an early stage. A fifth POD service review has been Commissioned within Learning and Development. Discussion also took place relating to what appears to be higher levels of turnover in surgery and medicine relating to the first few years of service and a deep dive will be undertaken to better understand this. No metrics relating to recruitment nor employee relations were provided due to the current lack of e based systems and this will be rectified with the introduction of new systems TRAC and Selenity.

	<u>Protecting and Understanding the Health and Wellbeing of Our Staff</u> The Committee were partially assured and discussed the report in detail and noted that there will be Health and Wellbeing questions included in this year's staff survey. Events took place for Appreciation August for all staff. <u>Develop a Leadership and OD Strategy for the Trust</u> The Committee received partially assurance. It was confirmed that the first Board has been set up and Mrs J Baxter is the SRO. <u>Strategic Workforce Planning</u> The Committee were partially assured and noted that the round table event with Whole Systems Partnership to scope our priorities for workforce planning with internal stakeholders is being reset for the end of September, the July meeting having been cancelled due to covid pressures. The Workforce Supply Task and Finish Group has been established which will look at Nursing supply in the first instance. Clear actions are in place. <u>People Quality, Performance and Governance</u> The Committee noted that the Learning and Development Review has been commissioned. The report has amber and green ratings. The risk scores will be reviewed. <u>POD Service Review Outcomes</u> The Committee were partially assured and they previously received presentations on the outcomes of the four independent reviews which have taken place and received an update report on progress since the last meeting. The priority actions from each review have been the focus of activity within the teams, however in terms of risk and assurance specific emphasis has been placed on the Resourcing and Occupational Health priority actions which are progressing in a timely manner with regular oversight from the senior POD team. The Recruitment Team have made significant progress with the audit of files for the last year and the level of risk has significantly reduced due to audit findings. As a result, the committee will receive a further update in the January meeting. A report will be presented at the Quality Governance Committee which details the key findings. <u>Guardian of Safe Working Annual Report 2021-22</u> The Committee were fully assured and the report was presented for the Committees assurance and information.

<table>
<tr><td></td><td colspan="2">The ongoing work was noted and further work to be done in relation to revising work schedules.

<u>Quality Assurance of Medical Appraisal Revalidation Report 2020-21</u>
The Committee were fully assured and confirmed that some appraisal work has been undertaken during the Pandemic and that staff will be validated on time.

<u>People & OD Organisational Risk Register</u>
The Committee noted three risks which were in relation to Supply, Leadership and Health and Wellbeing. The current controls on the Risk Register will be updated for the next Committee.

The following items were received for information -
ADQM Results and Outcomes 2020-21
HR Policies – Policy Schedule Update</td></tr>
<tr><td>Recommended actions for Board</td><td colspan="2">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="2"></td></tr>
<tr><td>Links to Risks (identify significant risks and DATIX reference)</td><td colspan="2">• 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="2">As set out</td></tr>
<tr><td>Links to CQC KLOE</td><td colspan="2"><table><tr><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
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		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

Report Cover Sheet

Agenda Item: 12i

Purpose of Report	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
Report Title:	Corporate Objective Delivery			
Name of Meeting:	Board of Directors			
Date of Meeting:	28 September 2021			
Author:	Kirsty Roberton, Deputy Director of Corporate Services and Transformation Jennifer Boyle, Company Secretary			
Executive Lead:	Jacqueline Bilcliff, Acting Chief Executive			
Report presented by:	Jennifer Boyle, Company Secretary			
Executive Summary:	In March 2021 the Board of Directors agreed 5 strategic aims, supported by objectives. The Board agreed that 15 of these objectives would be designated as priority objectives. This paper seeks to provide assurance over the delivery of the 15 priority objectives, noting that Board committees have received more detailed assurance reports. In summary, it is recognised that the Trust experienced significant operational pressures during the summer, and as such work on some of the priority objectives was paused to refocus resource. This paper provides assurance that progress has been made towards the delivery of the Board priorities, recognising that some risks to delivery have been identified in some areas. Reporting on objective achievement is new and continues to develop. Future reporting to Board is therefore anticipated to provide more detailed and measurable assurance reporting.			
Recommended actions for Board/Committee)	The Board is requested to review the report and be assured that whilst there have been operational challenges impacting upon the delivery of the Board priorities, progress has been made against each of the 15 objectives.			
Trust Strategic Aims that the report relates to: **(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 directly – although individual objectives may require investment (e.g. maternity staffing business case).	
Links to Risks (identify significant risks and DATIX reference)	2868 – risk of a further wave of COVID-19 impacting upon the capacity to deliver on corporate objectives and priorities (linked on the BAF to strategic aim 3).	
People and OD Implications:	A number of the priority areas require focussed resource, but plans are being made to ensure that there is the capacity to deliver. An example here would be the People and Organisational Development business unit consultation and restructure.	

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
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Corporate Objective Delivery

1. Executive Summary

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

The strategic aims are aligned to the Board committees for monitoring purposes.

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

This paper seeks to provide a summary position against each strategic aim. It is noted that the further wave of the pandemic over the summer months impacted on the ability of the senior leadership team to progress with a number of priorities. There was a need to reprioritise resource and workstreams to focus on the delivery of operational services.

In addition, the process for seeking assurance over the achievement of the strategic aims at Board committees is new and continues to embed. As such this Board report is a high-level summary of progress, with more detailed and measurable reporting anticipated for the next Board assurance report.

This report focusses on the delivery of the 15 priority objectives.

In respect of **Strategic Aim 1** (we will continuously improve the quality and safety of our services for our patients) progress has been made in implementing the recommendations from the Ockenden Review, recognising there is further work planned. Good progress has been made in respect of Covid mortality reviews and the use of digital imaging.

Work on the CQC route map to outstanding was paused during the operational pressures but has now restarted with leadership from the Chief Nurse.

In respect of **Strategic Aim 2** (we will be a great organisation with a highly engaged workforce) a lot of progress has been made in respect of protecting and understanding the health and wellbeing of our staff, with this objective proceeding to plan within agreed tolerances.

Strategic workforce planning is proceeding to plan, but with some issues and risks to flag, which are primarily in relation to capacity. Assurance can be provided that the Trust is recommencing its engagement with an external partner in this area, which will assist in making further progress. Work also continues to develop accurate and insightful workforce metrics, recognising there is still a lot to achieve in this area.

The development of a leadership and organisational development (OD) strategy is also proceeding to plan with some identified risks. This area was impacted by the latest wave of the pandemic, with workstreams such as the development of the new vision paused. A leadership and OD group has been established to provide greater oversight of this objective and work is now also recommencing in respect of Just Culture.

In respect of **Strategic Aim 3** (we will enhance our productivity and efficiency to make the best use of our resources) work has continued to be undertaken on the development of revenue and capital plans despite H2 requirements not being published. Internal draft budgets have been developed and there are plans to gradually re-introduce the financial accountability framework.

In relation to the delivery of the transformation programme, the new operational model is proceeding with the first operational moves taking place in September 21. Change programmes in elective and planned care and unscheduled care are underway as part of operational recovery and will support the delivery of the benefits outlined in the New Operating Model Business Case.

In respect of **Strategic Aim 4** (we will be an effective partner and be ambitious in our commitment to improving health outcomes) work has been progressed towards the establishment of an acute tobacco dependency service. This is now an active physician within the Trust and a recent bid was made for the service.

The Trust continues to work collaboratively with all partners as part of the Gateshead Place and through the Alliance agreement. The Trust is developing its relationships with key partners such as Gateshead College and Gateshead Citizen's Advice Bureau.

In respect of **Strategic Aim 5** (we will develop and expand our services within and beyond Gateshead) a bid was prepared for the community diagnostic hub. Work also continues to expand the pathology services through the use of innovation, and the Board received further insight into this in September 21.

QE Facilities is almost at the go-live stage for the manufacture of FFP3 masks, with testing and certification steps underway. QE Facilities has also expanded the use of the warehouse facility in Washington, with further options planned.

In summary, progress has been made towards the achievement of the Board priority objectives, recognising that this has been constrained by operational pressures.

2. Introduction

In March 2021 the Board agreed 5 strategic aims for 2021/22. Each strategic aim has an Executive Director lead and comprises of a number of objectives. At its meeting in March 2021 the Board identified 15 priority objectives.

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

	Strategic Aim	Number of Board priority objectives	Executive Director Leads	Board Committee
1	We will continuously improve the quality and safety of our services for our patients.	4	Chief Nurse & Medical Director	Quality Governance Committee & Digital Committee

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

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

The reporting of corporate objectives at Board committee level is still embedding and the ability to progress with the delivery of objectives has also been impacted by the significant operational pressures faced by the Trust over the summer months.

As such this Board report is a high-level summary of progress, with more detailed and measurable reporting anticipated for the next Board assurance report.

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

Progress against this aim and associated objectives was reviewed at the Quality Governance Committee in September 21 and the Digital Committee in August 21.

It is recognised that work to support the delivery of a number of the objectives was paused as the Trust refocussed its attention of addressing the latest wave of the pandemic during the summer months.

Assurance over the progress over the delivery of this strategic aim is therefore more limited than envisaged by the timescales originally agreed. Assurance can be provided that paused work is now being restarted.

In respect of the priority objective to implement the recommendations of the Ockenden report on maternity services, this is partially complete. The Quality Governance Committee received an assurance report that highlighted areas for further focus. A business case has been developed by the Head of Midwifery to address the staffing shortfalls identified.

There is a priority objective regarding understanding the effects of Covid on mortality, with the aim to identify learning. Good progress has been made in this area and the Board recently received a presentation on mortality by the North East Quality Observatory Service (NEQOS). This

provided insight and assurance regarding the mortality rates. The Mortality Council continues to review deaths in hospital and the Trust engages a medical examiner to review deaths for learning.

A further priority objective is to maximise the use of digital imaging technology to digitise all imaging. Good progress has been made in moving cardiology imaging to be fully digital, with testing complete and about to go live. In respect of clinical photography, this is subject to business case approval, with a go live planned for January 2022.

The final priority objective for Strategic Aim 1 relates to the development of a route map to take the Trust towards an 'outstanding' rating for CQC. The timescale for completion of this objective is September 2022. This work has been paused to focus on the pandemic response, but assurance monitoring audits have now restarted and the new Chief Nurse will be leading this work.

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

The HR Committee has been receiving update reports on the three priority objectives within this strategic aim.

In respect of the priority objective regarding protecting and understanding the health and wellbeing of our staff, this is proceeding to plan within agreed tolerances. A health and wellbeing dashboard is in place with weekly reviews. The Trust's health and wellbeing programme has been rebranded and relaunched. Health and wellbeing check-ins with staff are continuing to be progressed and further questions around health and wellbeing have been added to the staff survey to provide greater insight into this area. The recent #AppreciationAugust initiative was well received and work continues to plan for vaccination boosters and new requirements for care home staff vaccinations.

In terms of strategic workforce planning, this is proceeding to plan, but with some issues and risks to delivery. Operational pressures impacted on the planned start date for engaging with an external partner to support the development and delivery of strategic workforce planning. This workstream is planned to recommence in September 2021. In addition the structure of the corporate business unit has been subject to a recent consultation – revised structures should provide greater capacity to focus on key priority areas. Work is also planned to improve workforce data and metrics in the Trust, although there remains a significant amount of work to do to complete this sub-objective.

A further Board priority is the development of a leadership and organisational development (OD) strategy for the Trust. This priority is proceeding to plan, but with some issues and risks to delivery. A new Leadership and OD Group has been established to provide increased oversight and assurance in this area, with the first meeting planned for September. A new management development framework has been created, with a view to launching the programme in October / November 21. Work on the development of the new vision was paused to focus on the pandemic response, with a plan to restart this imminently. Similarly, the work on the development of a Just Culture was paused, but has now recommenced.

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

The Finance and Performance Committee seeks assurance over the delivery of 2 Board priorities in relation to Strategic Aim 3.

The first of the priority objectives relates to the development of an approved capital and revenue plan. The H1 revenue plan was presented and approved by the Board. Whilst H2 guidance remained unpublished, the Committee was provided with assurance that the Trust continues to undertake work internally to plan for this, with the development of draft expenditure plans and divisional budgets. The concept of a financial accountability framework will be introduced in a phased approach to support managers to monitor and manage their budgets effectively. The capital plan was presented to the June Committee meeting and detailed quarterly reports are now in place.

The second priority objective relates to the delivery of the operational transformation programme to improve productivity and efficiency of service delivery and recovery post-Covid. The new operational model business case and implementation plans were supported by the Board at its July 21 meeting. Detailed delivery plans are under development and project timescales being agreed. The first operational moves took place earlier this month. Change programmes in respect of elective and planned care and unscheduled care are underway as part of operational recovery and will support the delivery of the benefits outlined in the New Operating Model Business Case.

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

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

The first of the priority objectives relates to the establishment of an acute tobacco dependency service. This is now an active physician within the Trust working with partners to achieve this objective. The outcome of a recent service bid is awaited.

The second priority objective is to work collaboratively with all partners as part of the Gateshead Place and through the Alliance agreement. Work continues with all partners including health and local authority partners, specifically around the Integrated Care System (ICS) design and the model of place-based decision-making. Other key workstreams include developing further collaborative working with key partners including Gateshead College and the Citizen's Advice Bureau.

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

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

The first priority relates to the development of a bid for a community diagnostic hub, which is being progressed.

The second priority relates to the continued development of our pathology offer using innovation and technology. This area is being progressed and the Board approved plans in relation to this at its meeting in September 21.

The third priority relates to the manufacture of FFP3 masks for NHS and commercial markets. There was delays experienced due to delivery and Covid restrictions and therefore the original timescale for implementation was not achievable. The machine is now in situ with the testing undertaken during August. Certification is expected shortly and staff recruitment was due for completion in September.

The fourth priority relates to utilising the warehouse facility at Washington to provide efficient commercial use of the building. The training facility is complete and now in use. Pharmacy approval was granted in August 21 and elements of the warehouse are now being let to external partners. Further options for the usage of the warehouse are under review.

3. Recommendation

The Board is requested to review the report and be assured that whilst there have been operational challenges impacting upon the delivery of the Board priorities, progress has been made against each of the 15 objectives.

Gateshead Health
NHS Foundation Trust

Report Cover Sheet

Agenda Item: 12ii

Purpose of Report	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
Report Title:	Board Assurance Framework 2021/22			
Name of Meeting:	Board of Directors			
Date of Meeting:	28 September 2021			
Author:	Jennifer Boyle, Company Secretary			
Executive Lead:	Gillian Findley, Chief Nurse			
Report presented by:	Jennifer Boyle, Company Secretary			
Executive Summary:	The Board Assurance Framework (BAF) has been reviewed by Board committees and updated at each meeting. For each strategic aim the overall assurance rating has been maintained at **partially assured**. Whilst overall ratings have not changed, there have been movements in individual assurance ratings and new assurance ratings assigned as the committees have considered new reports. This demonstrates that the BAF is being used as an active assurance tool at Board committee meetings.			
Recommended actions for Board/Committee)	The Board is requested to: • Review the latest full position of the Board Assurance Framework; • Be assured that this has been subject to review and update as part of each Board committee meeting; and • Be assured that whilst overall ratings remain at **partial assurance**, this report evidences that active updates are being made to the BAF to reflect new and changed assurance levels.			
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 directly	
Links to Risks (identify significant risks and DATIX reference)	BAF risks are reflected on the Organisational Risk Register which provides more detail on how these risks are being managed.	
People and OD Implications:	None directly	

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

Board Assurance Framework 2021/22

1. Executive Summary

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

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

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

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

The full Board Assurance Framework is appended to the report, but this executive summary highlights the pertinent points from the BAF for each strategic aim.

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

Aim No.	**April 2021**	**May 2021**	**June 2021**	**July 2021**	**Aug 2021**	**Sept 2021**
1 Quality Governance Committee						TBC
2 Human Resources Committee	N/A	N/A	N/A			
3 Finance and Performance Committee						TBC
4 Quality Governance Committee						
5 Finance and Performance Committee	N/A		N/A			TBC
Digital Committee		N/A		N/A		N/A

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

The Board Assurance Framework extract for this Strategic Aim is rated as **partial assurance** overall as at July '21 (the August '21 Quality Governance Committee meeting was cancelled due to operational pressures). Whilst this is consistent with the previous month there was one area where assurance ratings had improved.

The rating for the Integrated Oversight Report increased from **partial assurance** to **full assurance**. This is reflective of the continued development of this report as an assurance tool for quality governance reporting. Good assurance was received over the Trust's recovery plans.

The assurance level for the Strategic Safeguarding Group report reduced from **full assurance** to **partial assurance**. This reflected the training compliance levels, with a further update on this expected in October '21.

In July '21 the Committee received the annual review of the clinical audit programme. As this demonstrated a high level of compliance against national audits, this was rated as **fully assured**. Similarly the NICE (National Institute of Clinical Excellence) Guidance Annual Report also demonstrated a high level of compliance and a rating of **fully assured** was given.

The BAF correlates with the corporate objectives reporting paper on the Board's agenda, reflecting that more work is planned to provide a higher level of assurance regarding the Trust's Care Quality Commission (CQC) action plan and route map to outstanding, which are reflected as **partially assured**.

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

The BAF extract for this Strategic Aim is rated as **partial assurance** overall as at September '21. Whilst the overall rating remained consistent with the previous review in July '21, a number of new reports were considered and rated.

The Committee received an update from the newly formed People and Organisational Development Portfolio Board. This was rated as **partially assured**, recognising that some workstreams are still being established.

The Committee considered the Guardian of Safe Working Annual Report, which was rated as **fully assured**, reflecting the positive assurances outlined within the report on safe working for junior doctors. The Committee rated both the Revalidation and Annual Deans' Quality Meeting (ADQM) annual report as **fully assured** reflecting the levels of compliance the reports demonstrated.

The Committee received annual reports on the Workforce Race Equality Standard (WRES) and Workforce Race Disability Standard (WDES). Both reports demonstrated that a significant amount of work has been undertaken over the last year, but reflected that there is still much work to do across the Trust collectively in respect of both standards. The **partial assurance** rating for both reports reflects this.

The Integrated Oversight Report and People and Organisational Development (OD) Metrics Report maintained their **partial assurance** ratings. This reflects ongoing work to improve the accuracy of employee relations and recruitment data. The Committee also requested a breakdown of training compliance to strengthen the insight provided in this area.

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

The BAF extract for this Strategic Aim is rated as partially assured as at August ’21, which is consistent with the previous month. Since the BAF extract was last presented to Board (the June ’21 extract), a number of new reports have been considered.

Whilst the H2 planning guidance remained unpublished, the Committee received an update on the Trust’s preparation for H2. This was rated as **partially assured**, reflecting that H2 guidance and announcements of further capital awards is awaited, but noting the Trust was continuing to develop its own draft budgets in anticipation. Linked to this the Committee received an update on the plans to reintroduce an accountability framework in shadow format. This was rated as **partial assurance** reflecting that this would be an effective control and assurance measure once launched in shadow format the Autumn.

The Supply and Procurement Committee update report was rated as **fully assured**, reflecting the inclusion of new data which provided the Committee with greater assurance over this area.

The Committee received a report on the delivery of the corporate objectives. The Committee rated this as **not assured**, reflecting that further clarity on objective mapping and the report format was required.

The rating for the Integrated Oversight Report remained as **partially assured**, but it should be noted that the Committee received a deep dive on echocardiology, as requested. Due to the challenges faced by the service a further assurance report was requested for September ’21.

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

This Strategic Aim is aligned to the Quality Governance Committee. The Committee was due to consider the assurance reports aligned to the strategic aim in its August ’21 meeting, but this was stood down to refocus on the response to operational pressures.

An update will be provided during the next BAF update to the Board of Directors in January 2022.

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

This Strategic Aim is aligned to the Finance and Performance Committee. The BAF extract is rated as **partially assured** as at August ’21, which is consistent with the previous month. Since the BAF extract was last presented to Board (the June ’21 extract), one new report was presented which aligned to this strategic aim.

This is the same report on corporate objective achievement that the Committee received in respect of Strategic Aim 3. As such the rating of **not assured** was provided, reflecting that further work is required on the format of the report.

Digital Committee

The Digital Committee monitors a BAF extract which covers a number of objectives across Strategic Aims 1, 2 and 3 (the detail of which can be seen on the BAF itself). A rating of **partially**

assured was maintained at the August ’21 meeting. This was consistent with the previous meeting in June ’21.

A new report was received on corporate objective achievement. This provided a comprehensive overview of the progress made towards each mapped objective. A rating of **partial assurance** was awarded reflecting that further assurance was requested regarding Windip decommissioning, given its completion rate of 10%.

The rating for the Strategy and Transformation Roadmap and Global Digital Exemplar Milestones was reduced from **fully assured** to **partially assured**. Whilst good progress was still being maintained this was reflective of the need to review some of the delivery dates for the programme and include more accompanying narrative for actions with imminent due dates.

Progress had been made in respect of expanding the key performance indicators (KPIs) included in the Service KPIs report. The rating of **partial assurance** was maintained to reflect that further indicators on IT service provision will be included in the report next month, along with reflections on the format of some of the charts, following feedback from the Committee.

2. Recommendations

The Board is requested to:

- Review the latest full position of the Board Assurance Framework;
- Be assured that this has been subject to review and update as part of each Board committee meeting; and
- Be assured that whilst overall ratings remain at **partial assurance**, this report evidences that active updates are being made to the BAF to reflect new and changed assurance levels.

Strategic Aim 1 - We will continuously improve the quality and safety of our services for our patients. Enabling Strategy: Quality Strategy Monitoring Board Committee: **Quality Governance Committee – updated from July '21 meeting** Lead Director: Medical Director and Chief Nurse					**Committee date** **July 2021**	**Apr 21**	**May 21**	**Jun 21**	**July 21**	**Aug 21**	**Sep 21**	**Oct 21**	**Nov 21**	**Dec 21**	**Jan 22**	**Feb 22**	**Mar 22**
					Assurance Level (document updated to)												
Key	**No assurances due**	*N/A*	**Gaps in assurance and no plans in place to address**	***Not assured***	**Gaps in assurance but clear plans in place to address**				***Partially assured***		**No gaps in assurance**				***Fully assured***		

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

Priority Objective	**Risks which may prevent the achievement of the strategic aim and priority objective**	**Reports the Committee receives across the year providing assurance that strategic aims and objectives are being delivered and risks mitigated. (Controls)** *(I- internal/ E – External)*	**Identified gaps in controls – gaps within the reports that are therefore not a full control or report doesn't exist currently**	**Actions needed to address gaps in controls**	**Date action to be completed by; and who is responsible**	**Assurances gained during the committees business – assurances received from the controls**	**Gaps in assurances it is felt that there are key items missing from the report (control) to provide assurance**	**Actions to address gaps in assurance**	**Date action to be completed by and who is responsible**	**Assurance rating received this period** *Not assured* *Partially assured* *Fully assured*
Priority Obj 1.1 Implementation of the recommendations of the Ockenden report on	2879 - There are risks relating to the trusts Maternity estate that have the potential to impact on the delivery of safe maternity services and the ability to satisfactorily address requirements (HSIB/ Ockenden/ Continuing Care/ Birthrate Plus). (Current score 15) Also impacted by Finance (2874/2873), Workforce (2764) and Future pandemic activity (2868)	Integrated Oversight Report (IOR Dashboard going forward) (monthly) (I)	(June review) Maternity reporting requirements not included	(June review) Add into IOR – below maternity assurance report until addressed.	Head of Midwifery	(July 21) IOR provided good assurance and noted that this report is in development. Received good assurance that performance recovery plans are in place. Pressure damage action plan - The Committee received a good assurance that a robust action plan had been implemented, however agreed that tighter timescales were required against the plan.	20/21 BAF CF – Complaint processes (May 21) Falls and Pressure damage quality priorities (July 21) PD Plan – tighter timescales & update required.	20/21 BAF CF – report updating findings and actions from complaints process review (May 21) Plans for improvement to be submitted to committee (July 21) A full pressure damage update report will be received by the Committee in September 2021.	Sept 21 Chief Nurse Sept21 Chief Nurse Sept 21 Chief Nurse	**Fully Assured**
		Maternity assurance report (monthly)				(June 21) A report on the maternity incentive scheme provided assurance over the 10 safety actions (fully assured) (July 21) Item deferred to the next Committee.				**Fully Assured**
Priority Objective 1.3 Understand the effects of Covid on mortality and look for learning Maternity Services	2868 - Risk of a further wave (s) of Covid -19 and increased demand. (current score 12) (also on Aim 3)	Birth Rate Plus				The Committee received full assurance for the report, however agreed that they would like to receive the business case which is currently in development for the staffing levels needed in the service with details of current staff retention plans.	Business case	Completed business case to be brought to Committee	TBC	**Fully Assured**

Priority Objective	Risks which may prevent the achievement of the strategic aim and priority objective	Reports the Committee receives across the year providing assurance that strategic aims and objectives are being delivered and risks mitigated. (Controls) *(I- internal/ E – External)*	Identified gaps in controls – gaps within the reports that are therefore not a full control or report doesn't exist currently	Actions needed to address gaps in controls	Date action to be completed by; and who is responsible	Assurances gained during the committees business – assurances received from the controls	Gaps in assurances it is felt that there are key items missing from the report (control) to provide assurance	Actions to address gaps in assurance	Date action to be completed by and who is responsible	Assurance rating received this period *Not assured* *Partially assured* *Fully assured*
Priority Objective 1.10 Develop route map to CQC Outstanding **Other Objectives** 1.2 Develop clinically led Estates Strategy 1.7 Deliver National Patient Safety Strategy 1.8 Accreditation of Nursing & Midwifery Excellence Programme 1.9 Develop and delivery trusts quality strategy and quality accounts	2779 - If we do not have a clear plan and capacity within the organisation to ensure compliance with CQC fundamental standards, we may be unable to achieve an outstanding rating (Current score 12) Also impacted by Finance (2874/2873), Workforce (2764) and Future pandemic activity (2868)	Objectives delivery report (quarterly July, Oct, Jan)								
		Draft Quality Report proposals 22/23 (Jan & Mar 22) (I)								
		Quality Objectives 21/22 (date to be determined)								
		Quality priorities quarterly update (quarterly Jun, Sep, Dec, Mar) (I)				(Apr 21) FLO update – good assurance over the positive impact this service has for families. (G) September paper removed.	20/21 BAF CF -Staff attending human factors training low	20/21 BAF CF - Update on numbers trained in next report	Sept 21	**Partially Assured**
		Quality Strategy close out report 21/22 quality report (May 21) (I)								
		Final Quality Report 21/22 (June 21) (I)				(June 21) Assurance provided over the progress and work completed on Quality Priorities, with particular recognition of volunteers and patient experience. Clear quality priorities going forward. (Fully Assured)				**Fully Assured**
		FLO Annual Report (Oct 21) (I)								
		Annual review of the quality of training (TBD) (I)								
		Learning from deaths annual report (Aug 21) (I)								
		Learning from deaths outcome report (6-monthly April & Oct 21) (I)					20/21 BAF CF -Mortality and Morbidity outlier (Apr 21) Learning from covid deaths	20/21 BAF CF – Deep dive review reported back. NEQOS review report. (Apr 21) Findings and outcomes of review into Covid deaths	Sept 21 Medical Director Sept 21 Medical Director	

Priority Objective	Risks which may prevent the achievement of the strategic aim and priority objective	Reports the Committee receives across the year providing assurance that strategic aims and objectives are being delivered and risks mitigated. (Controls) *(I- internal/ E – External)*	Identified gaps in controls – gaps within the reports that are therefore not a full control or report doesn't exist currently	Actions needed to address gaps in controls	Date action to be completed by; and who is responsible	Assurances gained during the committees business – assurances received from the controls	Gaps in assurances it is felt that there are key items missing from the report (control) to provide assurance	Actions to address gaps in assurance	Date action to be completed by and who is responsible	Assurance rating received this period *Not assured Partially assured Fully assured*
		Medical Examiner Update (Jun 21)				(June 21) A presentation from the Lead Medical Examiner updating and providing assurance on the processes established.	(Jun 21) multiple policies for review and learning from deaths, investigation, SI, complaints and claims. (Jun 21) No formal feedback processes in place from families (at present) or established for consultants/ Junior doctors involved. (Jun 21) learning not fully captured and shared.	(Jun 21) Committee update on alignment of policies. (Jun 21) Update on formal feedback processes established, and feedback to date. (Jun 21) Update on the review into how learning shared	Mar 22 Medical Director/ Chief Nurse / Lead ME Dec 21 Lead ME Dec 21 Lead ME	**Partially Assured**
		R&D Annual Report/ Research Plan 21/22 (Nov 21(TBD)) (I)								
		Nursing Excellence Programme Board update (6 monthly) (Nov)								
		IPC Annual Report (Aug 21) (I)								
		IPC BAF (monthly) (I)				(July 21) Good assurance received in relation to the 9 out of 10 green KLOE's with one remaining amber.	(July 21) Ongoing issues with mask fitting continue but work is ongoing to look at how this can be managed.			**Fully Assured**
		(Annual Learning report (Aug 21) (I)				Deferred to Oct Committee				
		Safeguarding annual report (Aug 21) (I)								
		Assurances from Strategic Safeguarding Group (quarterly A/J/O/J) (I) (note current meetings bi-monthly but proposal to change.				(July 21) Assured that safeguarding referrals continue to be made however noted that training compliance levels are low.				**Partially Assured**
		Older Persons Mental Health Integrated report (July 21)				The Committee acknowledged the ongoing estates issues on the Cragside new build, however				**Fully Assured**

Priority Objective	Risks which may prevent the achievement of the strategic aim and priority objective	Reports the Committee receives across the year providing assurance that strategic aims and objectives are being delivered and risks mitigated. (Controls) *(I- internal/ E – External)*	Identified gaps in controls – gaps within the reports that are therefore not a full control or report doesn't exist currently	Actions needed to address gaps in controls	Date action to be completed by; and who is responsible	Assurances gained during the committees business – assurances received from the controls	Gaps in assurances it is felt that there are key items missing from the report (control) to provide assurance	Actions to address gaps in assurance	Date action to be completed by and who is responsible	Assurance rating received this period *Not assured* *Partially assured* *Fully assured*
						received good assurance robust plans have been put in place to mitigate against mixed sex accommodation				
		Patient Experience annual report (Jul 21) (I)				Deferred to Committee				
		QIA CIP Report (6-monthly Sep 21 & Mar 22) (I)				Removed from Agenda				
		Learning Disabilities Annual report (Nov 21) (I)								
		Cancer services Annual report (June 21) (I)				(June 21) received for information				
		Route map to outstanding	(Initial review) Not yet developed	(Initial review) Route map in development	Sept 21 Chief Nurse	(Apr 21) CQC action plan reasonable assurance over must do actions (A)	(Initial review) Have not yet undertaken gap analysis against CQC fundamental standards 20/21 BAF CF – CQC inpatient survey 2019 – actions required and no action plan	(Initial review) Gap analysis and action plan to be developed 20/21 BAF CF – Action plan to be received	Sept 21 Chief Nurse Dec 21 COO	**Partially Assured**
		CQC Action plan update (bi-monthly, A, J, A, O, D, F)				(June 21) Full CQC action plan presented proving assurance on progress but still some actions to complete. Report also received from QEF re Chlorclean and COSHH as requested to provide further clarity on this aspect. (Partially Assured)	(June 21) Full assurance over the completion of actions in relation to hazardous substances.	(June 21) Aim to complete and report back to committee.	Sept 21	**Partially Assured**
		CQC Insights report (quarterly) (E)								
		CQC MH Update report (6 monthly (sept/ march) (I)								
		F2SU Guardian Update (2x year) (Jun/ Dec 21) (I)				(June 21)F2SU Guardian updated the committee on activity and provided some assurance on the comparative position of the Trust, however a risk reflected from staff survey	20/21 BAF CF – No F2SU Guardian Strategy (June 21) Current governance reporting to be reviewed in line with	20/21 BAF CF – F2SU Guardian Strategy to be presented to Committee. (June 21) Agreed governance reporting to be fed	Oct 21 Dec 21 F2SU Guardian	**Partially Assured**

Priority Objective	Risks which may prevent the achievement of the strategic aim and priority objective	Reports the Committee receives across the year providing assurance that strategic aims and objectives are being delivered and risks mitigated. (Controls) *(I- internal/ E – External)*	Identified gaps in controls – gaps within the reports that are therefore not a full control or report doesn't exist currently	Actions needed to address gaps in controls	Date action to be completed by; and who is responsible	Assurances gained during the committees business – assurances received from the controls	Gaps in assurances it is felt that there are key items missing from the report (control) to provide assurance	Actions to address gaps in assurance	Date action to be completed by and who is responsible	Assurance rating received this period *Not assured Partially assured Fully assured*
						where the % on the question regarding staff feeling they can speak up had reduced (albeit still above average). Possible change in governance reporting as the recently complete well led review suggested reporting directly to Board. (Partially Assured)	well led feedback.	back to Committee.		
		Nursing, Midwifery & AHP Strategy (Sept/Oct 21) (I) & Annual review of delivery								
		Inpatient Survey (Aug 21)								
		Annual report on Health & equalities outcomes								
		SI Report (quarterly M, A, N, F)				(May 21) SI performance report – robust assurance re compliance with reporting SIs in timescales and learning from investigations (G)				**Fully Assured**
		Safer Staffing Report (monthly)				(June 21) Report covering a 3 month period presented, providing only partial assurance. Challenges with data due to staffing movements and changes to bed base which are not reflected in the current reporting requirements. Some management actions to improve data capture to provide improved management data were discussed.				**Partially Assured**
		Annual review of clinical audit programme (July 21) (I)				(July 2021) Good level of assurance received noting the high level of compliance against national audits undertaken.				**Fully assured**

Priority Objective	Risks which may prevent the achievement of the strategic aim and priority objective	Reports the Committee receives across the year providing assurance that strategic aims and objectives are being delivered and risks mitigated. (Controls) *(I- internal/ E – External)*	Identified gaps in controls – gaps within the reports that are therefore not a full control or report doesn't exist currently	Actions needed to address gaps in controls	Date action to be completed by; and who is responsible	Assurances gained during the committees business – assurances received from the controls	Gaps in assurances it is felt that there are key items missing from the report (control) to provide assurance	Actions to address gaps in assurance	Date action to be completed by and who is responsible	Assurance rating received this period *Not assured* *Partially assured* *Fully assured*
		Clinical Audit Plan Delivery progress update (Nov 21) (I)								
		Proposed Clinical Audit Plan 22/23 (March 22) (I)								
		NICE Guidance Annual Report (July)				The Committee noted a good level of assurance for this report and noted the high level of compliance.				**Fully assured**
		Pharmacy report (TBD) (I)								
		H&S Annual Report (May 21) (I)				(May 21) H&S Annual report – good assurance	(May 21) Lots of information – more regular reporting/ possibly metrics	(May 21) added to COB and BAF shown below – once assurance in place move this to Fully Assured	Sept 21	**Partially Assured**
		H&S Quarterly Report (Quarterly Aug, Nov, Feb) (I)	(May 21) Report does not yet exist	(May 21) Develop report	Aug 21 MD QEF					
		Internal Audits/ External Reviews (where applicable) (E)	(Initial review) Ockenden Compliance Report –- Reporting not yet in place	(Initial review) Develop reporting mechanism.	July 21 Head of Midwifery	(May 21) Maternity review action plan update – robust assurance received. (A) re risks relating to estate.				**Partially Assured**
		Policy Progress report (quarterly ~~M~~, A, N, F)/ Policy Updates (monthly as required) (I)								
		Reg 28 (if required)								

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

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Priority Objective	**Risks which may prevent the achievement of the strategic aim and priority objective**	**Reports the Committee receives across the year providing assurance that strategic aims and objectives are being delivered and risks mitigated. (Controls)** *(I- internal/ E – External)*	**Identified gaps in controls – gaps within the reports that are therefore not a full control or report doesn't exist currently**	**Actions needed to address gaps in controls**	**Date action to be completed by; and who is responsible**	**Assurances gained during the committees business – assurances received from the controls**	**Gaps in assurances it is felt that there are key items missing from the report (control) to provide assurance**	**Actions to address gaps in assurance**	**Date action to be completed by and who is responsible**	**Assurance rating received this period** *Not assured* *Partially assured* *Fully assured*
Priority Objective 2.1 Establish a post Covid health and wellbeing programme to incorporate; The development of a HWB strategy, the roll out of HWB conversations, the continuing arrangement for a Trust Testing Track & Trace & vaccine service and a review of the trust occupational health service **Priority Objective 2.3** Develop a Trust wide approach to strategic workforce planning **Priority objective 2.4** Develop a leadership and OD Strategy with clear outcomes **Other Objectives** 2.2 Continue to	2759: Risk that we are not able to appropriately support the health and wellbeing needs of our workforce (12) 2764 - Risk of not having the right people in right place at the right time with the right skills (16) 2765: No Leadership and OD strategy in place across the trust resulting in failure to support our workforce (16)	People and OD Strategy Items								
		Update report from POD Portfolio Board (each meeting)				(Sept 21) The Committee highlighted the work ongoing and the challenges. It was reflected that a number of workstreams are still developing (education, training, leadership and OD) and therefore the report could not provide significant assurance in these areas.	(Sept 21) Limited assurance over the workstreams referenced.	(Sept 21) Provide an update on these workstreams and their progress as part of the next report.	Nov 21 Lisa Crichton-Jones	**Partially assured**
		People Plan 20-21 Update (Jul, Nov, Mar)								
		People Plan Operational Guidance/Updates (May, Sep, Jan)				(Sept 21) 13 priorities, 5 have been achieved, 7 are on track and 1 red which is in relation to workforce planning. Work will improve with restructure and capacity.	(Sept 21) No specific gap or corresponding action – rating is reflective of the progress made, but understanding the constraints here and the benefits that increased capacity will bring	(Sept 21) No specific action to bring back to the Committee – increased capacity will support increased progress. Next update due in Jan 22	Jan 22 Lisa Crichton-Jones	**Partially assured**
		People and OD Strategy (Jan 22)								
		Strategic Theme: Protect and Understand the Health and Well-being of our Staff								
		Update on Delivery of Strategic Objective (2.1)	-	-.	-	(Sept 21) Significant amount of work undertaken but noted that there are still red and amber areas to work on.	(Sept 21) The red areas are in relation to data, metrics and implications with the Digital Strategy on the Strategic Workforce Plan.	(Sept 21) Work is ongoing and the regular progress reports will provide assurance over progress or addition emerging risks	Nov 21 Lisa Crichton-Jones	**Partially assured**
		Guardian of Safe Working Report (July,	None			(Sept 21) Report deferred to next meeting	None			**Fully assured**

Priority Objective	Risks which may prevent the achievement of the strategic aim and priority objective	Reports the Committee receives across the year providing assurance that strategic aims and objectives are being delivered and risks mitigated. (Controls) *(I- internal/ E – External)*	Identified gaps in controls – gaps within the reports that are therefore not a full control or report doesn't exist currently	Actions needed to address gaps in controls	Date action to be completed by; and who is responsible	Assurances gained during the committees business – assurances received from the controls	Gaps in assurances it is felt that there are key items missing from the report (control) to provide assurance	Actions to address gaps in assurance	Date action to be completed by and who is responsible	Assurance rating received this period *Not assured Partially assured Fully assured*
learn and improve on the challenges in response to Covid 2.5 Strengthen approaches to people related quality, performance and governance measures 2.6 Increase the number of non clinical staff who are working flexibly **Objectives enabled by Digital** 2.7 Develop digital skills programmes to enable staff to exploit the technology they have 2.8 Design user technology around them, reducing the number of devices they have 2.9 Improve service desk response		Sep, Nov, Jan)								
		Guardian of Safe Working Annual Report (Sept 21)				(Sept 21) Good overview received and exceptional work has taken place by the Junior Doctors through the Covid Pandemic.				**Fully assured**
		Strategic theme: Develop a Leadership and OD Strategy for the Trust								
		Update on Delivery of Strategic Objective (2.4) (each meeting)				(Sept 21) Significant amount of work undertaken but noted that there are still red and amber areas to work on.	(Sept 21) The red areas are in relation to data, metrics and implications with the Digital Strategy on the Strategic Workforce Plan.	(Sept 21) Work is ongoing and the regular progress reports will provide assurance over progress or addition emerging risks	Nov 21 Lisa Crichton-Jones	**Partially assured**
		NHS Staff survey results (annual – May)								
		NHS staff survey & action plan (July)	None			(July 21) Overall steering group and individual BU and corporate directorates action plans presented, 7 areas had action plans, although 3 needed to clarify timescales 2 areas where no action plan currently in place.	(July 21) Actions plans needed for 2 areas.	(July 21) Action plans for 2 areas to be developed	Nov 21	**Partially assured**
		EDI Annual Update (WRES/WDES Annual reports 2022 and EDS2 update (TBD), Equality Report) (July)				(July 21) Report presented analysis as to current position and the key areas of focus. 10 priority areas. (Sept 21) Confirmation received that timescales have ben updated to reflect achievable delivery	(July 21) Timescales may not be realistic (Sept 21) Assured that action now completed.	(July 21) Review and update timescales to reflect achievable delivery. (Sept 21) Assured that action now completed.	Sept 21 Action complete	**Partially assured**
		Workforce Race Equality Standard (WRES) (Annual – Sep)				(Sept 21) Work ongoing and recognition was received in relation to ongoing work with the BAME Network. Whilst a lot of progress had	(Sept 21) No specific gaps, as gaps covered within the action plan – rating reflects the scale of the task still ahead in achieving compliance	-	-	**Partially assured**

Priority Objective	Risks which may prevent the achievement of the strategic aim and priority objective	Reports the Committee receives across the year providing assurance that strategic aims and objectives are being delivered and risks mitigated. (Controls) *(I- internal/ E – External)*	Identified gaps in controls – gaps within the reports that are therefore not a full control or report doesn't exist currently	Actions needed to address gaps in controls	Date action to be completed by; and who is responsible	Assurances gained during the committees business – assurances received from the controls	Gaps in assurances it is felt that there are key items missing from the report (control) to provide assurance	Actions to address gaps in assurance	Date action to be completed by and who is responsible	Assurance rating received this period *Not assured* *Partially assured* *Fully assured*
						been made, the Committee reflected that there was still a significant amount of work to complete, guided by the comprehensive action plan	with the standard.			
		Workforce Disability Equality Standard (WDES) (Annual – Sep)				(Sept 21) Plan in place for work going forward and there are 10 standards. Whilst a lot of progress had been made, the Committee reflected that there was still a significant amount of work to complete, guided by the comprehensive action plan	(Sept 21) No specific gaps, as gaps covered within the action plan – rating reflects the scale of the task still ahead in achieving compliance with the standard.	-	-	**Partially assured**
		Equality Delivery System (EDS2)								
		Freedom to Speak Up Report (6 monthly – July, Jan)	None			(July 21) Detailed report on activity for prior year. Increase in concerns raised within the year. Work to raise awareness of F2SU guardian underway. Key risks – FTSU deteriorating trend. Workplan being developed.				**Partially assured**
		Library Quality Assurance Self-Assessment (Annual – Sept)				(Sept 21) Item deferred.				
		Senior Management & Board Visibility (Annual – Nov)								
		Strategic theme: Strategic Workforce planning								
		Update on Delivery of Strategic Objectives (2.3) (each meeting)				(Sept 21) Significant amount of work undertaken but noted that there are still red and amber areas to work on.	(Sept 21) The red areas are in relation to data, metrics and implications with the Digital Strategy on the Strategic Workforce Plan.	(Sept 21) Work is ongoing and the regular progress reports will provide assurance over progress or addition emerging risks	Nov 21 Lisa Crichton-Jones	**Partially assured**
		Revalidation Report (Annual – Sep)				(Sept 21) Good assurance over compliance provided-	-	-	-	**Fully assured**

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						no specific gaps identified.				
		Public Sector Apprenticeship Target (Annual- Sep)								
		GMC Survey Results & Action Plan (Annual – Sep)								
		ADQM Results and Outcome (Annual)				(Sept 21) Noted good assurance and for information. Learners are happy with the environment.				**Fully assured**
		ADQM Self-Assessment report (Annual- Nov)								
		Strategic theme: People Quality, Performance & Governance								
		Update on Delivery of Strategic Objective (2.5)(each meeting)				(Sept 21) Significant amount of work undertaken but noted that there are still red and amber areas to work on.	(Sept 21) The red areas are in relation to data, metrics and implications with the Digital Strategy on the Strategic Workforce Plan.	(Sept 21) Work is ongoing and the regular progress reports will provide assurance over progress or addition emerging risks	Nov 21 Lisa Crichton-Jones	**Partially assured**
		POD Service Review Outcomes (Jul, Sept, Nov, Mar)				(Sept 21) Good level of assurance received noting the ongoing work.	(Sept 21) Further work has been Commissioned for a review on Learning and Development.	(Sept 21) Actions from the review.	Nov 21 Lisa Crichton-Jones	**Partially assured**
		Integrated Oversight Report (each meeting) People and OD Metrics (each meeting)	Breakdown of training compliance not included in the report	Include more granular data once external review is complete in Oct 21		(Sept 21) Work continues to ensure that report includes consistent and accurate data.	(Sept 21) employee relations and recruitment metrics still has data accuracy issues which are being addressed through the service review actions	(Sept 21) continue to implement actions from service reviews to obtain accurate and reliable data to include in the report	Mar 22 Lisa Crichton-Jones	**Partially assured**
		HR Policies - Schedule Update and Any for Approval (each meeting)				(Sept 21) Report presented covering policy position. Demonstrates progress is being made in respect of overdue policies. Plans in place to address these.	(Sept 21) – no addition actions required – work continues.			**Partially assured**

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		Audit reports (as & when – list in rows below)								
		Disciplinary Policy Audit report (July 21)				(July 21) Reasonable assurance, 7 actions to be delivered, on track.	(July 21) No method to get update on delivery of actions	(July 21) Report back to committee re delivery of actions	Nov 21	**Partially assured**
		Covid 19 risk assessment audit report (July 21)				(July 21) Good assurance, 5 minor remedial actions, on track to deliver.	(July 21) No method to get update on delivery of actions	(July 21) Report back to committee re delivery of actions	Nov 21	**Partially assured**
		Gender Pay Gap Reporting (usually March – c/f sept)				(Sept 21) Good assurance level received and good action plan.				**Fully assured**
		CQUIN Review/ Plan (TBD)								
		Staff Side Insights (Nov)								
		Clinical Excellence Annual Report (Jan)								
		Other Themes and items								
		Continue to Lead and Improve on Challenges in Response to Covid (e-rostering) (2.2)								
		Supporting the Workforce with Tools/Skills knowledge (link to Digital) (2.6, 2.7, 2.8, 2.9)								
		Governance & Assurance								
		Terms of Reference Review (Annual review - Sep)				(Sept 21) Terms of Reference agreed by the Chair and Executive of the Committee.				**Fully assured**
		HRC Effectiveness Review (Annual review - Sep)				(Sept 21) item deferred to the year-end to ensure it is more meaningful given the Committee is undergoing a period of change				

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

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Priority Objective	**Risks which may prevent the achievement of the strategic aim and priority objective**	**Reports the Committee receives across the year providing assurance that strategic aims and objectives are being delivered and risks mitigated. (Controls)** *(I- internal/ E – External)*	**Identified gaps in controls – gaps within the reports that are therefore not a full control or report doesn't exist currently**	**Actions needed to address gaps in controls**	**Date action to be completed by; and who is responsible**	**Assurances gained during the committees business – assurances received from the controls**	**Gaps in assurances it is felt that there are key items missing from the report (control) to provide assurance**	**Actions to address gaps in assurance**	**Date action to be completed by and who is responsible**	**Assurance rating received this period** *Not assured* *Partially assured* *Fully assured*
Priority Obj 3.4 Develop an approved capital and revenue plan. (and perform within) **Priority Obj. 3.8** Deliver the Operational transformation programme to improve productivity and efficiency of service delivery and recovery post Covid **Other Objectives** 3.5 accountability framework 3.6 delivery of transformation plan 3.7 costing strategy 3.9 SMART corporate reporting framework 3.10 capital funding to support estates strategy 3.11 Review and Establish Charity Strategy (sits under	2874 Risk that we are unable to formulate (and deliver) a coherent financial plan due to the uncertainty surrounding the financial framework (16) 2873 Risk that the Trust is unable to form a suitable capital plan and programme due to reduced levels of CDEL available (16) 2868 - Risk of a further wave (s) of Covid -19 and increase in demand (12) Also impacted by Workforce (2764)	Financial revenue report (Monthly) (I) (Obj 3.4, Risk 2874)	(Aug 21) Still requires divisional level run rate reporting.	(Jul 21) Transformation Board reporting to the Committee to recommence when the Transformation Board is reinstated	Revised date – September 21 DoF September 21 DDoCS&T	(Aug-21) Partial assurance was received. Discussed revenue and capital in detail noting that there are plans in place. Transformation Board will be reinstated from end of September.		(Aug-21) High level run rates discussed. Noted that there are gaps with the Divisional Revenue run rate but that plans are in place.	Revised date – September 21 DoF	**Partially Assured**
		H1 Plan update (April 21) (Obj 3.4, Risk 2874)	none	none		(Apr 21) Comprehensive update re H1 planning. (G)	none	none		**Fully Assured**
		H2 Plan 21/22 (July 2021) (I) (Obj 3.4, Risk 2874)	No identified gaps in the report			(Aug 21) Partial assurance was received. The Committee noted that work is ongoing and that the guidance will be received on 16th September 2021.	No specific gaps within the Trust's control here – national guidance awaited in order to progress	(Aug-21) Work ongoing and there will be a report at the Committee once the guidance is received.	September 21	**Partially assured**
		Accountability Framework (July) (Obj 3.5)				(Aug-21) Partial assurance was received and it was confirmed that the framework would be reintroduced in shadow form from October.	(Jul 21) Accountability Framework has not been relaunched yet due to operational pressures.	(Jul 21) Agree a launch date which is realistic and achievable. (Aug 21) Will be presented at the September Board	September 21 DoF	**Partially Assured**

Priority Objective	Risks which may prevent the achievement of the strategic aim and priority objective	Reports the Committee receives across the year providing assurance that strategic aims and objectives are being delivered and risks mitigated. (Controls) *(I- internal/ E – External)*	Identified gaps in controls – gaps within the reports that are therefore not a full control or report doesn't exist currently	Actions needed to address gaps in controls	Date action to be completed by; and who is responsible	Assurances gained during the committees business – assurances received from the controls	Gaps in assurances it is felt that there are key items missing from the report (control) to provide assurance	Actions to address gaps in assurance	Date action to be completed by and who is responsible	Assurance rating received this period *Not assured Partially assured Fully assured*
the remit of the Charitable Funds Committee)								for reintroduction in shadow form from October.		
		Supply & Procurement Committee Update (Monthly) (I) (Obj 3.4, 3.8, Risk 2874)				(July 21) Good assurance was received particularly in relation to the inclusion of a new graph indicating the number and value of reports discussed at the meeting. Internal audit will be reviewing the process but currently fully assured from the information provided. (Aug 21) Deferred to next Committee.				**Fully assured**
		Budget Setting 22/23 (Feb 22) (Obj 3.4, Risk 2874)								
		Capital Plan Update (Bi monthly from Jun 2021) (I) (Obj 3.4, 3.10, risk 2873)				(Aug-21) Partial assurance received and discussed in detail within the revenue report.	(Aug-21)No specific gaps within the Trust's control here – future national guidance and direction may impact.	(Aug-21) Waiting for H2 guidance and announcements of further capital awards.		**Partially Assured**
		Internal Audit reports received (E)				(July 21) Good level of assurance was received on the Risk Based Audit of Procurement Report.				
		Policy Updates (monthly as required) (I)				(July 21) To be discussed at a forthcoming meeting.				

Priority Objective	Risks which may prevent the achievement of the strategic aim and priority objective	Reports the Committee receives across the year providing assurance that strategic aims and objectives are being delivered and risks mitigated. (Controls) *(I- internal/ E – External)*	Identified gaps in controls – gaps within the reports that are therefore not a full control or report doesn't exist currently	Actions needed to address gaps in controls	Date action to be completed by; and who is responsible	Assurances gained during the committees business – assurances received from the controls	Gaps in assurances it is felt that there are key items missing from the report (control) to provide assurance	Actions to address gaps in assurance	Date action to be completed by and who is responsible	Assurance rating received this period *Not assured* *Partially assured* *Fully assured*
		Integrated Oversight Report (IOR) (Monthly) (I)	(April - CF) IOR still under development not yet reporting all key performance metrics	(April - CF) Continue to develop the IOR to incorporate all metrics – in the interim provide additional assurance reports where necessary	Ongoing development COO	(Aug-21) Partial assurance was received. The report was accepted and a detailed discussion took place in relation to actions that the Trust are undertaken.	(Aug-21) More detail to be provided at the next Committee in relation to progress with Echocardiology.	(Aug-21) Further assurance required in relation to the issues raised in the report.	Sept 21 COO	**Partially Assured**
		Objectives delivery report(quarterly)	(April - CF) Report on these not yet in place	(April - CF) Objective report to be developed and be submitted to July Committee (July 21) – report deferred to August meeting.	September2021 DoF COO	(Aug-21) The Committee were not assured as clarify is needed in relation to the objectives, which Committee they sit under and the format of the report.	(Aug-21) Format to be looked at and the objectives need to be clear as to which Committee they sit with.	(Aug-21) Format of the report to be discussed outside of the meeting.		**Not assured**

Strategic Aim 4 - We will be an effective partner and be ambitious in our commitment to improving health outcomes Enabling Strategy: Partnership/Corporate Monitoring Board Committee: **Quality Governance Committee – updated from July '21 meeting** Lead Director: Chief Executive/ Medical Director					**Committee date June 2021**	**Apr 21**	**May 21**	**Jun 21**	**July 21**	**Aug 21**	**Sep 21**	**Oct 21**	**Nov 21**	**Dec 21**	**Jan 22**	**Feb 22**	**Mar 22**
					Assurance Level (document updated to)												
Key	**No assurances due**	***N/A***	**Gaps in assurance and no plans in place to address**	***Not assured***	**Gaps in assurance but clear plans in place to address**				***Partially assured***		**No gaps in assurance**				***Fully assured***		

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Priority Objective	**Risks which may prevent the achievement of the strategic aim and priority objective**	**Reports the Committee receives across the year providing assurance that strategic aims and objectives are being delivered and risks mitigated. (Controls)** *(I- internal/ E – External)*	**Identified gaps in controls – gaps within the reports that are therefore not a full control or report doesn't exist currently**	**Actions needed to address gaps in controls**	**Date action to be completed by; and who is responsible**	**Assurances gained during the committees business – assurances received from the controls**	**Gaps in assurances it is felt that there are key items missing from the report (control) to provide assurance**	**Actions to address gaps in assurance**	**Date action to be completed by and who is responsible**	**Assurance rating received this period** *Not assured* *Partially assured* *Fully assured*
Priority Objective 4.3 / **4.4** Strong partner working at Place, ICP, ICS levels and beyond to manage population health and tackle health inequalities. **Priority Objective 4.1** Establish an Acute Tobacco Dependency Service (based on the CURE model - full implementation) **Other objectives** **4.2 –** Target the public health inequalities with partners across Gateshead at Place **4.5 -** Assess value (deteriorated, maintained, improved) through application of costing strategy	2880 - Risk that Place/ICS/ICP strategy and plans do not fully align with our objectives and aspirations to tackle health inequalities. (current score 9) Also impacted by Finance (2874/2873), Workforce (2764) and Future pandemic activity (2868)	Objectives delivery report (quarterly ~~A~~ S, O, D,)	(Initial review) We don't have a regular update on plans and activity at Place/ ICS/ ICP	(Initial review) Develop reporting to provide regular update on plans and activity at Place/ICS and ICP level highlighting where this is aligned to our objectives and benefits, or where not aligned how this impacts on them.	TBD					**N/A**
		Population health management reporting	(Initial review) Population health statistics not received	(Initial review) Reporting to be established						**N/A**

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

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Board Priority Objective Other Committee Objectives	**Risks which may prevent the achievement of the strategic aim and priority objective**	**Reports the Committee receives across the year providing assurance that strategic aims and objectives are being delivered and risks mitigated. (Controls)**	**Identified gaps in controls – gaps within the reports that are therefore not a full control or report doesn't exist currently**	**Actions needed to address gaps in controls**	**Date action to be completed by; and who is responsible**	**Assurances gained during the committees business – assurances received from the controls**	**Gaps in assurances it is felt that there are key items missing from the report (control) to provide assurance**	**Actions to address gaps in assurance**	**Date action to be completed by and who is responsible**	**Assurance rating received this period** *Not assured* *Partially assured* *Fully assured*
Priority Obj. 5.3 Prepare a bid for Community Diagnostic Hub for North ICP **Priority Obj. 5.5** Continue to further develop our pathology offer using innovation and technology **Priority Obj. 5.6 & 5.7** Optimise Commercial Opportunities. **Other Objectives** 5.1 Specialist breast service 5.2 tertiary gynae oncology service 5.4 Surgery Centre for Excellence 5.8 Expand wholesale pharmacy drugs Expand NE transport hub	2882 - Risk of commercial market climate changes, due to political, environmental or other factors, affecting the ability to maximise opportunities. (6) Also impacted by Finance (2874/2873), and Workforce (2764)	Objectives delivery report(quarterly)	(April - CF) Report on these not yet in place	(April - CF) Objective report to be developed and be submitted to July Committee (July 21) – report deferred to August meeting.	August 2021 DoF COO	(Aug-21) The Committee were not assured as clarify is needed in relation to the objectives, which Committee they sit under and the format of the report.	(Aug-21) Format to be looked at and the objectives need to be clear as to which Committee they sit with.	(Aug-21) Format of the report to be discussed outside of the meeting.		**Not assured**
		QE Facilities update (6 monthly May/ Nov)	None	None		(May 21) Positive assurance received and contribution at Group level. Risks relating to market and trading anomalies caused by the pandemic. Ensure that as a Group we do not lose sight of the VAT issues if regulations were to change. Possibility of looking at CF donation with any profit elements. (G)				**Fully Assured**

Digital objectives – Aim 1, Aim 3 and enabling for Aim 2. Enabling Strategy: Digital Strategy Monitoring Board Committee: **Digital Committee – updated from August 2021 meeting** Lead Director: Medical Director and Chief Information Officer					**Committee date** **Bi Monthly meeting cycle**	**Apr 21**	**May 21**	**Jun 21**	**July 21**	**Aug 21**	**Sep 21**	**Oct 21**	**Nov 21**	**Dec 21**	**Jan 22**	**Feb 22**	**Mar 22**
					Assurance Level												
Key	**No assurances due**	*N/A*	**Gaps in assurance and no plans in place to address**	***Not assured***	**Gaps in assurance but clear plans in place to address**			***Partially assured***			**No gaps in assurance**				***Fully assured***		

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Priority Obj 1.6 Maximise the use of Carestream to digitise all imaging **Other Digital Objectives** **Aim 1** 1.4 - Maximise the use of Nervecentre to improve patient care 1.5 Maximise the use of DocStore to digitise legacy paper used by clinicians **Aim 2** 2.6 Increase the number of non-clinical staff who are working flexibly 2.7 Develop digital skills programmes to enable staff to exploit the technology they have 2.8 Design user technology around them, reducing the number of devices they have	The risks to delivery of the objectives are included on Datix – Risks 2929 There is a risk of disrupted or delayed implementation of the Trusts digital strategic objectives - due to lack of digital resource, clinical resource, reprioritisation of workload (e.g. pandemic), supplier failure, financial constraints - resulting in failure to achieve the desired outcomes.	Strategic Aims & Objectives – allocated to Digital Committee				(Aug 21) Assurance report received and noted. Mitigation being planned by DTG.	(Aug 21) Windip decommissioning only at 10% completion rate	(Aug 21) Update on Windip decommissioning required at next meeting	Andrea Adams Oct 21	***Partially assured***
		Strategy and transformation roadmap (each mtg) Global Digital Exemplar milestones (each mtg)	(Aug 21) No narrative to accompany those actions with imminent due dates – difficult to determine if date will be met	(Aug 21) When due dates are imminent, the report requires narrative to provide context and assurance over likely completion	Andrea Adams Oct 21	(Aug 21) No significant delivery risks, some slippage due to supplier issues, mitigation being planned by DTG.	(Aug 21) It was identified that the programme was ambitious with no flexibility on completion dates	(Aug 21) Review dates to ensure they are realistic timescales and reflect this in the next report	Andrea Adams Oct 21	***Partially assured***
		Service key performance indicators (each mtg)	(Aug 21) Format of some charts was not considered to be most conducive for understanding performance.	(Aug 21) Review format of charts (e.g. SPC charts) and make necessary amendments for the next meeting	Andrea Adams Oct 21	(Aug 21) Report covering expanded KPIs.	(Aug 21) KPIs to be produced for IT service Provision for October meeting	(Aug 21) Develop KPIs for meeting and ensure target dates are clearly displayed	Oct 21 CIO	**Partially Assured**
		Data Security Protection toolkit (Apr, Aug)				(Aug 21) Report covering DSPT Audits received and noted. 96% achieved for the toolkit.	(Aug 21) Cyber essentials accreditation not yet due	(Aug 21) Submit cyber essentials in December and report back to Committee	Andrea Adams Dec 21	**Partially Assured**
		SIRO Annual report (Apr)				(Apr 21) Report submitted based on national template.				**Fully Assured**

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2.9 Improve service desk response **Aim 3** 3.1 Replace the ward dashboards to support more efficient patient flow 3.2 Implement 3 robotic process automations to remove repetitive tasks 3.3 Utilise non-face-to-face outpatient consultation as the first choice						Top 3 risks identified to be monitored through DSP Toolkit. No update due				
		Clinical Safety Assurance (Jun, Dec)				(Jun 21) Fully trained clinical safety officers in place, need executive lead. Not fully complaint with requirements, although action plan in place. No update due				**Partially Assured**
		Policy Updates – (annual plan Apr, Oct)				(Apr 21) 21/22 annual plan for review of all digital policies and procedures approved. No update due				**Fully Assured**
		Audit One Reports (Apr, Aug, Dec) *Need to add audit reports – e.g. clinical systems management*	(Aug 21) Report doesn't include outstanding actions and recommendations	(Aug 21) Devise a method to enable assurance over outstanding actions to be gained	Nick Black Andrea Adams Oct 21	(Aug 21) Report covering all Audits since April received and noted. Annual Audit plan approved.				**Partially Assured**
		Clinical Systems Management Audit Report				(Aug 21) Committee assured by report and management responses to recommendations				**Fully Assured**
		NerveCentre System Security Audit Report				(Aug 21) Committee assured by report and management responses to recommendations				**Fully Assured**
		TRA Audit Needs Assessment Audit Report				(Aug 21) Committee assured by report and management responses to recommendations				**Fully Assured**
		Digital strategy (Jun, Dec)				(Jun 21) Verbal update, Digital Strategy approved in Dec 20 still valid. Awaiting organisational strategy completion to enable review of Digital strategy to				**Fully Assured**

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

Gateshead Health
NHS Foundation Trust

Report Cover Sheet

Agenda Item: 12iii

Purpose of Report	Decision: ☐	Discussion: ☒	Assurance: ☐	Information: ☐
Report Title:	**Organisational Risk Register**			
Name of Meeting:	Board of Directors			
Date of Meeting:	23rd September 2021			
Author	Kendra Marley, Corporate Risk Manager			
Executive Lead	**Gill Findley, Chief Nurse**			
Report presented by	**Gill Findley, Chief Nurse**			
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.			
Recommended actions for Board/Committee)	The group are asked to: • Review and approve the changes to the Organisational Risk Register. • Review the risks and actions with a view to identifying any action or follow up required.			
Trust Aims that the report relates to: **(Including reference to any specific risk)**	**Aim 1** ☒	We will provide consistently high quality care in all our services		
	Aim 2 ☒	We will be a great organisation to work in		
	Aim 3 ☒	We will deliver value for money and strengthen delivery of our clinical services		
	Aim 4 ☒	We will work with our partners to help make Gateshead a place where everyone thrives		
	Aim 5 ☒	We will use our expertise to provide specialist services beyond Gateshead		

Financial Implications:	Not directly				
Links to Risks (identify significant risks and DATIX reference)	Risk Management Processes				
People and OD Implications:	Not directly				
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

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 19th July (when last report for July meeting was extracted) to 14th September (extraction date for this report).

Organisational Risk Register - Movements

There have been no movements on to or removal from the organisational risk register, with the register remaining at 12 risks, of which 10 are BAF risks, and 6 are at 15+.

There have been no changes in current risk scores for any risks in the period, however 2 actions have been completed on risks 2779 and 2868 and are shown (shaded) within the risk register on the accompanying report.

All risks are up to date, and there are no actions overdue.

The accompanying 15+ report highlights 3 new 15+ risks for consideration for addition to the ORR, 1 is recommended for addition. Please refer to 15+ report paper for details.

Recommendations

The group are asked to:

- Review the risks and actions with a view to identifying any action or follow up required.

Organisational Risk Register Report

19-Jul-2021 to 14-Sep-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 (16)

Wellbeing - 1

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

Business Continuity - 1

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

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. (16)

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 - 1

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)

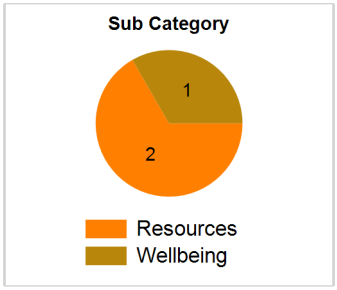
CEOL2 2880 - Risk that Place/ICS/ICP strategy and plans do not fully align with our objectives and aspirations to tackle health inequalities. (9)

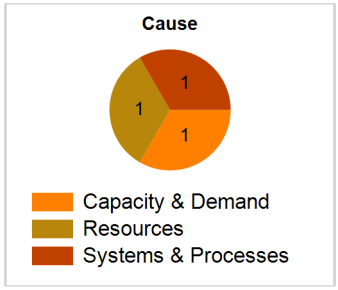
Organisational Risk Register Report

19-Jul-2021 to 14-Sep-2021

Gateshead Health NHS Foundation Trust

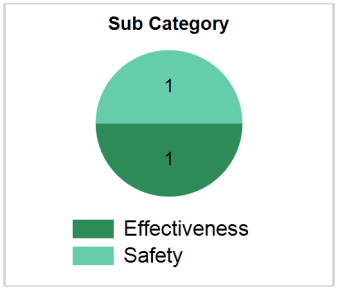
People & Resources

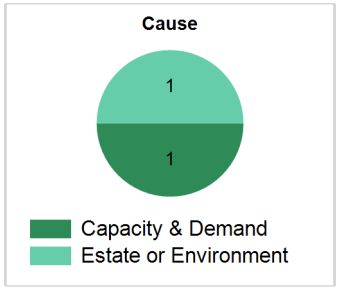




Risk Sub Cat	Risk Cause	No. Risks
Resources	Resources	1
	Systems & Processes	1
Wellbeing	Capacity & Demand	1

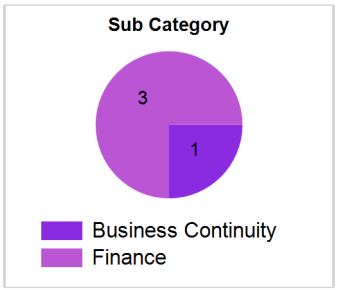
Quality Outcomes

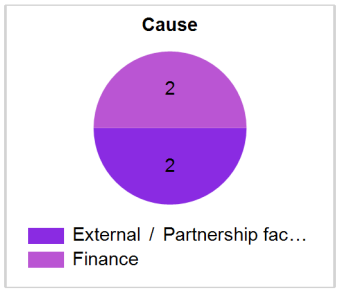




Risk Sub Cat	Risk Cause	No. Risks
Effectiveness	Capacity & Demand	1
Safety	Estate or Environment	1

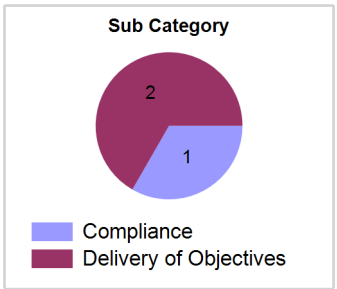
Finance & Efficiency

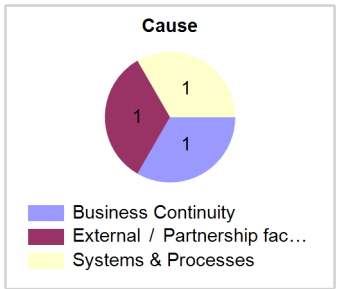




Risk Sub Cat	Risk Cause	No. Risks
Business Continuity	External / Partnership factors	1
Finance	External / Partnership factors	1
	Finance	2

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

19-Jul-2021 to 14-Sep-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	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR
2764 17/11/2020 Natasha Botto People and OD Workforce Development 30/09/2021 BAF HRC ORG	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. 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 to progress	16	Work to be scoped and future resource identified. Consider how workforce development group can be combined with Educuation, Training Group	Natasha Botto 29/10/2021 Laura Farrington (Completed 30/08/2021)	8
2765 17/11/2020 Laura Farrington People and OD Workforce Development 30/09/2021 BAF HRC ORG	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 draft. Vision work currently underway. Focus group arranged with those who attended the joint Just Culture training within NEAS in 2019.	16	Estabish a leadership and OD programme board	Natasha Botto 30/09/2021	8
2869 27/04/2021 Helen Routh Chief Operating Officer Chief Operating Officer 10/10/2021 ORG	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

Organisational Risk Register Report

19-Jul-2021 to 14-Sep-2021

Business Intelligence

Gateshead Health NHS Foundation Trust

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR
2873 30/04/2021 Kris MacKenzie Finance Finance 15/10/2021 BAF FPC ORG	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	16			8
2874 30/04/2021 Kris MacKenzie Finance Finance 29/10/2021 BAF FPC ORG	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
2879 29/04/2021 Joanne Baxter Chief Operating Officer Chief Operating Officer 30/09/2021 BAF ORG QGC	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 Deliver the full project plan for a new maternity build in collabaration with QEF	Kate Hewitson 29/10/2021 Joanne Baxter 20/10/2022	10

Organisational Risk Register Report

19-Jul-2021 to 14-Sep-2021

Business Intelligence

NHS Gateshead Health NHS Foundation Trust

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR
2759 16/11/2020 Amanda Venner People and OD Human Resources 04/10/2021 BAF HRC ORG	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	HWB strategy to be developed	Amanda Venner 30/09/2021	8
					OH review needed focussing on capacity and psychological support offer	Rebekah Coombes 30/09/2021	
					More sophistocated workforce metrics needed	Rebekah Coombes 30/09/2021	
					Improved alignment with ICS	Lisa Crichton-Jones 30/09/2021	
2779 01/07/2020 Andrea Tweddell Nursing, Midwifery & Quality Quality Governance 23/09/2021 BAF ORG QGC	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	Andrea Tweddell 30/09/2021	6
					Develop a route map to Outstanding	Andrea Tweddell 29/10/2021	
					Ensure the CQC action plan is regulalry reviewed as BU meetings and Executive team	Andrea Tweddell (Completed 26/08/2021)	

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR
2868 27/04/2021 Joanne Baxter Chief Operating Officer Chief Operating Officer 29/10/2021 BAF EPRR FPC ORG QGC	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
1636 10/11/2014 Derek Prudhoe 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	Jon Potts 30/11/2021	5
					Develop comprehensive Cyber KPIs & IT Security Assurance Report	Dianne Ridsdale 31/12/2021	
					Complete Cyber Essential Plus Accreditation	Jon Potts 31/12/2021	
2880 30/04/2021 Mr Andrew Beeby Chief Executive Office Medical Directorate 30/11/2021 BAF ORG QGC	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 30/09/2021	6

Organisational Risk Register Report

19-Jul-2021 to 14-Sep-2021

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register	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	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
							12

Changes in CRR - Current/Managed Risks

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

Risks Moved to Managed in Period

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

Risks Closed in Period

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

Risks Added in Period

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

Risks Removed in Period

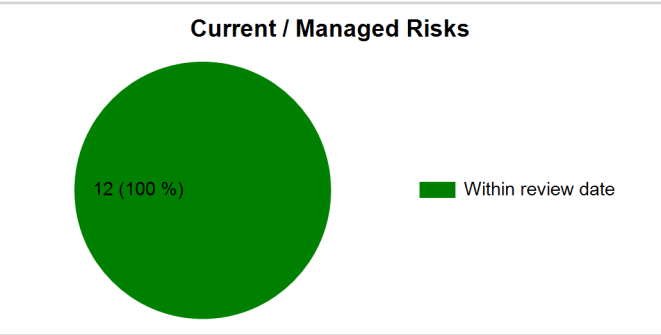
Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note / Date Removed from ORR
								0

Organisational Risk Register Report

19-Jul-2021 to 14-Sep-2021

Gateshead Health NHS Foundation Trust

Risk Review Compliance



Risk Action Compliance

Movements in CRR

					CRR											
BU	Service Line	Department	ID	Risk Description	Oct-2020	Nov-2020	Dec-2020	Jan-2021	Feb-2021	Mar-2021	Apr-2021	May-2021	Jun-2021	Jul-2021	Aug-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
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
			2869	Unintended harm to patients, due to the impact of reduced services, delayed treatment and pathway starts							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
			2882	Risk of commercial market climate changes, affecting the ability to maximise oppo								6	6	6	6	6
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

Organisational Risk Register Report

19-Jul-2021 to 14-Sep-2021

Gateshead Health NHS Foundation Trust

					CRR											
BU	Service Line	Department	ID	Risk Description	Oct-2020	Nov-2020	Dec-2020	Jan-2021	Feb-2021	Mar-2021	Apr-2021	May-2021	Jun-2021	Jul-2021	Aug-2021	Today
Finance	Finance	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
Information	IT	IT	1636	UCRF R01/R03/R20/R23 - Malware such as Ransomware Compromising Unpatched Endpoints, Servers and Equipment	8	8	8	8	8	8	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
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	9	16	16	16	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	20	16	16	16	16	16
		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	25	16	16	16	16	16

Risks Overdue

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

Actions Overdue

Risk ID / Date Identified	Risk Description	IRR	Current Controls	CRR	Action	Action Owner	TRR

Organisational Risk Register Report

19-Jul-2021 to 14-Sep-2021

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

Gateshead Health
NHS Foundation Trust

Report Cover Sheet

Agenda Item:

Purpose of Report	**Decision:** ☒	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☐	
Report Title:	Digital Update				
Name of Meeting:	Board of Directors – Part 1				
Date of Meeting:	28 September 2021				
Author:	Nick Black, Chief Digital Information Officer				
Executive Lead:	**Jackie Bilcliff, Acting Chief Executive**				
Report presented by:					
Executive Summary:	This paper gives the Trust Board an update on the digital strategy in the Trust, the planned clinical systems options appraisal and the new national strategic direction being driven by NHSx. The paper also details a few of the key achievements over the last 6 months – clinically and operationally; together with sharing some of the assurances that have been provided to the Digital Committee.				
Recommended actions for Board/Committee)	Accept the report and support the ongoing assurance through the Digital Committee				
Trust Strategic Aims that the report relates to: **(Including reference to any specific risk)**	**Aim 1** ☒	We will continuously improve the quality and safety of our services for our patients			
	Aim 2 ☒	We will be a great organisation with a highly engaged workforce			
	Aim 3 ☒	We will enhance our productivity and efficiency to make the best use of resources			
	Aim 4 ☒	We will be an effective partner and be ambitious in our commitment to improving health outcomes			
	Aim 5 ☒	We will develop and expand our services within and beyond Gateshead			
Financial Implications:	No additional financial implications				
Links to Risks (identify significant risks and DATIX reference)	All digital risks				
People and OD Implications:	Impact on all patients and staff				
Links to CQC KLOE	Caring ☒	Responsive ☒	Well-led ☒	Effective ☒	Safe ☒

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

1. Digital Governance

The Digital Committee first met in October 2020 and since April has continued to meet bi-monthly.

The key responsibilities of the Committee are to:

- Seek assurance over the delivery of the digital strategy and roadmap
- Seek assurance over performance against core digital KPIs
- Seek assurance over compliance with core data and digital standards
- Seek assurance over the clinical safety of digital services
- Seek assurance over the delivery of corporate objectives mapped to the Committee and the effective management of those risks which may threaten the achievement of these objectives

The Digital Committee has two groups reporting in; the Digital Transformation Group with responsibility for digital strategy and managing all digitally enabled transformation/change; and the Digital Assurance Group with responsibility for managing existing systems, records, infrastructure and digital services.

2. Digital Transformation Group (Strategy)

In October 2020, the Digital Committee reviewed and approved the Digital Strategy previously agreed at CMT in April 2019. It was recognised that the strategy would need to be updated in line with the review of the overall Trust strategy. Fundamental to the overall Trust Digital Strategy is the clinical systems strategy.

The current clinical systems strategy was originally set in April 2010 with an outline business case that was agreed at Trust Board – which led to SystemC Medway (now Careflow) being selected as the most economically advantageous service, and subsequently implemented. The selection of SystemC was to implement a core PAS, with some clinical functionality, tightly integrated to best of breed departmental systems.

The Global Digital Exemplar Fast Follower programme (January 2018) driven by clinical priorities and funding levels, continued this best of breed strategic direction; seeking to continue to exploit the current market leading departmental systems to improve the digitisation of the Trust. The GDE is due to be formally accredited over the coming months to demonstrate the progress that we have achieved. Through the implementation, the 'best of breed' approach has brought systems that are well-liked by clinical and operational staff, however it has created a slightly 'disjointed' way of working – that SystemC have been unable to address.

In parallel to this digital maturation, there is around three years left on our core clinical system contracts, giving us an ideal checkpoint to review our future plans. To clarify these plans, we are planning to bring in external support to develop a full options appraisal – including full stakeholder engagement, review of existing capability and a wider review of the capability in the market. This options appraisal will be reported to Digital Committee for review.

2.1 National Strategic Update

During the pandemic we have seen incredible examples of the way digital has transformed the delivery of care. The opportunity now is for the health and care sector to apply such approaches with increased urgency and consistency to both our long-term challenges and the immediate tasks of recovering from the pandemic.

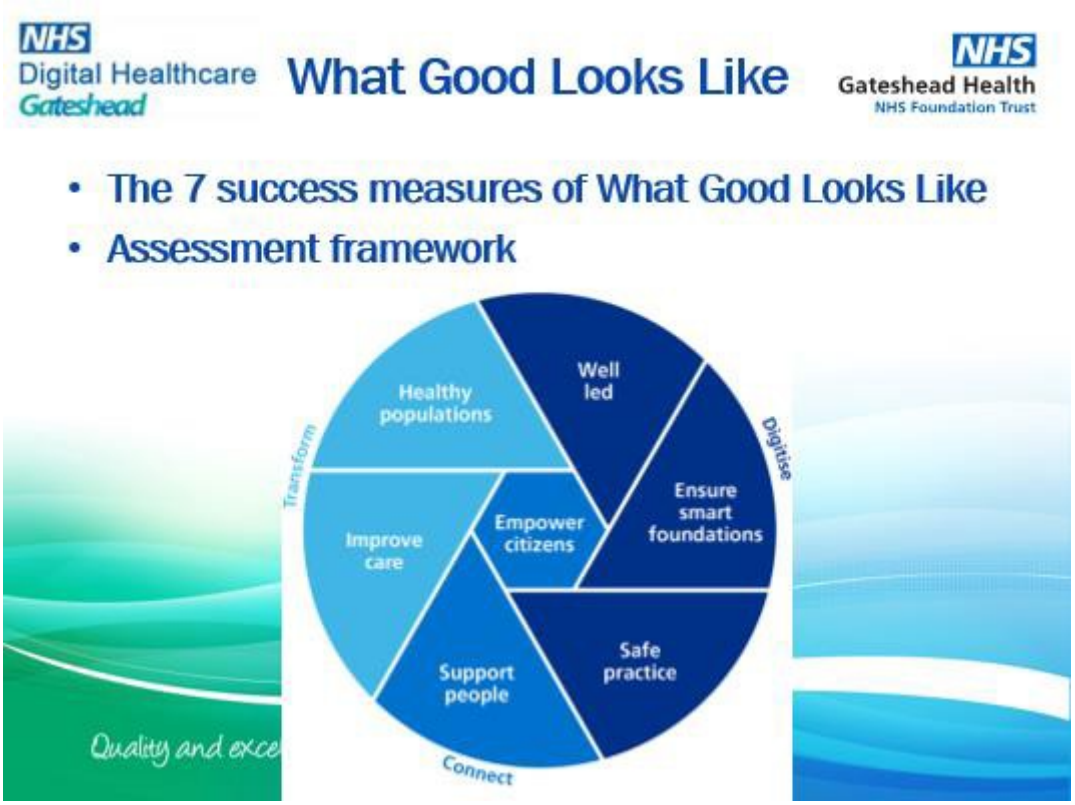
The strategy for technology in health and care is to digitise services, connect them to support integration and, through these foundations, enable service transformation. The NHS Long Term Plan committed to digitise the entire NHS by 2024.

2.1.1 What Good Looks Like

NHSX has published a set of guidelines (What Good Looks Like framework - NHSX) (31 August) so that Integrated Care Systems (ICSs) and individual health and care organisations know what is expected for them to meet the goal of fully digitised and connected services and the local capabilities that need to be in place to support transformation.

What Good Looks Like sets out a common vision for good digital practice to empower frontline leaders to accelerate digital transformation in their organisations. Going forward, the programme will provide a comprehensive and practical set of tools, guidelines and best practices for NHS leaders to achieve meaningful digital transformation. The What Good Looks Like guidance has seven success measures that frontline NHS systems and organisations across England should aim to reach, and it was included in the 2021 to 2022 Operational Planning and Contracting Guidance, and the ICS Design Framework. The ICS has asked each Trust to undertake a self-assessment against

the criteria to get an understating of the current level of digitisation across the ICS, prior to the more formal national assessment.



2.1.2 Digital Clinical Safety Strategy

The Digital Clinical Safety Strategy - NHSX is a joint publication (17 September) between NHSX, NHS Digital and NHS England and NHS Improvement. It is an addendum to the NHS Patient Safety Strategy, outlining the case for improved digital clinical safety across health and social care.

The aim of the strategy is twofold.

- To improve the safety of digital technologies in health and care, now and in the future.
- To identify, and promote the use of, digital technologies as solutions to patient safety challenges.

In other words, digital clinical safety is about making sure the technologies used in health and care are safe, and then using those technologies to improve patient safety.

This strategy will be reviewed alongside our approach to Clinical Safety to ensure it is firmly embedded in the safety procedures in the Trust.

3. Digital Delivery and Assurance

3.1 Digital Clinical Delivery

The slide below pulls out the highlights of the Digital Clinical Delivery over the last 6 months, together with a couple of key deliverables in the next few months.

- The Nervecentre upgrade provided the functionality to implement Sepsis and the data flows to develop digital whiteboards that give a single view of Careflow and Nervecentre data on one screen. The nursing/AHP assessments continue to being rolled out across the Trust, with business change continuing to ensure we switch off the paper collection following go live.
- The core focus of the Nervecentre work for many months has been the implementation into UCC – due to go live in November. This will enable the continuity of care with the digital record flowing onto the wards – rather that the current paper records.
- Careflow bed management has enabled improved visibility and flow of patients through the wards. The planned upgrade in October enables key functionality required for our GDE accreditation, that streamlines some of the clinical application switching that is currently required.
- Cardiology imaging is now implemented into Carestream – meaning we have opened a closed clinical record – ensuring it is accessible site wide and eventually across the ICS.
- Clinical noting also continues to expand across the clinical services, with the focus now moving onto ensuring that the patient outcomes and follow up are captured digitally at the point of care – to ensure the waiting list management is accurate.
- The patient engagement portal is due to go live in January 2022 with Gateshead joining soon after, enabling letter sharing and direct interaction with patients (saving postage)

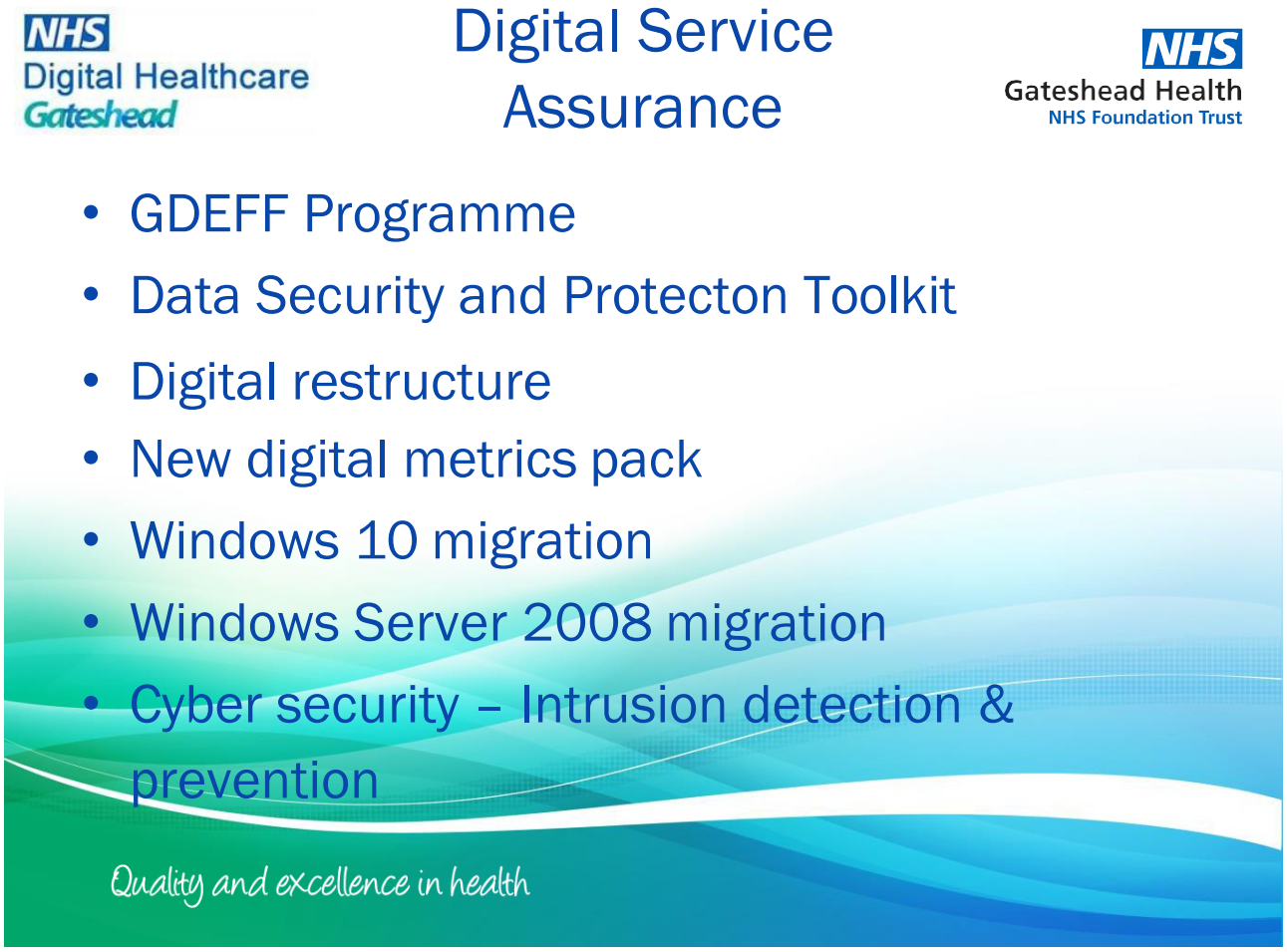
3.2 Digital Operations Delivery

The slide below pulls out the highlights of the Digital Operations Delivery.

- Teams continues to be the place to have meetings, and despite the occasional national connection issues has fundamentally changed how the Trust operates and enable the new ways of working.
- The Office365 project is well underway with personal folders and shared drives beginning to be migrated into the cloud – again enabling flexible working.
- Device replacements and upgrades have continued site wide to improve and standardise the hardware in use
- Operational dashboards and site reporting – the Covid bed status and site management reporting continue to be used regularly, but the focus is now on the wider performance requirements. We are working with North Tees to see if we can mirror their dashboarding capability over the coming months.
- Attend Anywhere – the regionally funded video consultation system contract runs until March 2022. There is work at ICS level to standardise solutions, but due to the lack of progress we are reviewing which solution fits our needs best.
- Royal Free Robotic Process Automation – Our first automation in the booking team went live as planned in April, delivering significant time savings; further work is underway on a number of processes to ensure the benefits in the business case have been delivered. The team are actively on the look out for new opportunities.
- The trust has implemented an RFID tracking system to enable active asset management, initially for medical devices but will be expanded to encompass digital devices too.

3.3 Digital Service Assurance

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



- GDEFF Programme – the contractual end point remains in November 2021 with full accreditation to be completed by March 2022 – risks to delivery are monitored through Digital Transformation Group and Digital Committee. The key risk currently flagged (and being managed) is the risk of disrupted or delayed implementation of digital strategic objectives – primarily due to internal resource and reprioritisation pressures; and some external supplier issues.
- The DSP toolkit requirements for 2021/22 were submitted and audited in June 2021 – meeting all requirements. The last remaining element – the Information Governance training metric that routinely concerns the Trust passed the 95% mandated target during June.
- The Digital restructure is now complete and the settling in period has led to several vacancies that are actively being recruited to. The programme of underpinning OD work to improve the culture within digital teams is leading to a real customer focus and making significant improvements in enabling the teams to work more collaboratively.
- The Digital Committee is now receiving a pack of digital metrics to provide assurance on the services that operate. These metrics continue to develop as data becomes available and priorities change.
- 99.8% of desktop devices are now on Windows10 – the remaining 8 are supporting critical systems so require careful migration
- 79% of Windows servers are on Server 2012 or above.
- Intrusion detection and prevention – this is a requirement for GDE and Cyber Essentials Plus and is on track to be delivered in October.

4. Summary

This paper gives the Trust Board an update on the digital strategy in the Trust, the planned clinical systems options appraisal and the new national strategic direction being driven by NHSx.

The paper also details a few of the key achievements over the last 6 months – clinically and operationally; together with sharing some of the assurances that have been provided to the Digital Committee.

Recommendations

Trust Board is requested to:

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

Nick Black, Chief Digital Information Officer

Gateshead Health
NHS Foundation Trust

Report Cover Sheet

Agenda Item: 14

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Report Title:	Emergency Preparedness Resilience & Response (EPRR) Assurance Report			
Name of Meeting:	Board of Directors			
Date of Meeting:	Tuesday 28th September 2021			
Author	Tom Knox			
Executive Lead	**Joanne Baxter**			
Report presented by	**Joanne Baxter**			
Executive Summary	**This report asks the board to consider that:** • The Trust has been through a period of change and has been faced with the many challenges of responding to reoccurring waves of Co-vid-19 • NHS England (NHSE) have removed a small number of standards to recognise this context and accommodate this year's assurance process • A single Site Resilience Team is currently being formed to enhance Trust resilience and a new EPRR Team has been put in place in Autumn 2020 with a specific responsibility for delivery of EPRR standards • A review of the EPRR core standards and all associated plans has been undertaken and the Trust's current compliance is **78.2%** which provides an overall grading of **Partial compliance** • The Trust are fully compliant with **36** of **46** standards • The Trust is partially compliant with the further **10** standards or **21.7%** • We are non-compliant with none of the standards • The report documents the specific actions the Trust are taking to address outstanding issues and provides an indicative timeline on when they will be achieved • Consultation has taken place with NHSE/I EPRR regionally and our intended planning and self-assessment approach was ratified			

Recommended actions for Board/Committee)	Endorsement of the current self-assessment and work programme	
Trust Aims that the report relates to: (Including reference to any specific risk)	**Aim 1** ☒	We will provide consistently high quality care in all our services
	Aim 2 ☐	We will be a great organisation to work in
	Aim 3 ☒	We will deliver value for money and strengthen delivery of our clinical services
	Aim 4 ☒	We will work with our partners to help make Gateshead a place where everyone thrives
	Aim 5 ☐	We will use our expertise to provide specialist services beyond Gateshead
Financial Implications:	Funding has been identified from current streams to establish Site Resilience/EPRR re-structure	
Links to Risks (identify significant risks and DATIX reference)	Assessment of Trust position against EPRR Standards	
People and OD Implications:	Current re-structure of EPRR and Site Resilience	

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

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

EPRR Assurance Statement 2021

1. Introduction and context

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

The EPRR assurance process is based on the NHS England Core Standards for EPRR.

As a result of the events of 2020 these standards did not receive their regular tri-annual review and, as a consequence, not all standards may reflect current best practice.

NHS England (NHSE) have removed a small number of standards to accommodate this year's assurance process with a full review to be completed in future years. This report is based upon the adapted standards.

Organisations were asked to undertake a self-assessment against individual core standards relevant to their organisation type and rate their compliance for each.

This assessment does not replace the Trust's statutory responsibility to be compliant with the full set of standards applicable to the Trust, but in recognising the demands over the last 18 months, NHSE will not be seeking to obtain assurance on compliance against a number of previously issued standards.

Organisational assurance rating

The overall EPRR assurance rating is based on the percentage of core standards the organisation can self-assess as f**ully compliant**.

This is explained in more detail below:

Organisational rating	Criteria
Fully compliant	The organisation if fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial compliance	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial compliance	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non- compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

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

1) That EPRR assurance action plans have been reviewed in order to improve the level of compliance against 2021-22 EPRR Assurance Core Standards, and where non-compliance was reported as part of the overall assurance rating, that an updated and reviewed assurance level is provided with an ongoing action plan.

A GHFT Action Plan is attached to this document detailing the core standards and the Trust's current compliance setting out actions and time-line to identify additional work to enhance Trust resilience.

2. Assurance Elements

2.1 EPRR Core Standards and Action Plan review

A review of the EPRR core standards and the associated plan has been undertaken and the overall level of compliance within the Trust has currently been assessed as **Partial Compliance**.

The Trust has been through a rapid period of change and has been faced with the many challenges of responding to reoccurring waves of Co-vid-19. Simultaneously, a new EPRR team has been put in place with specific responsibility for delivery of EPRR standards.

In support of overall Trust resilience the Site Resilience Team (SRT) has also recently been established, bringing together the Patent-flow Team and Acute Response Team (ART) to form a single team to facilitate and enhance Trust resilience.

It is acknowledged that although many positive steps forward have recently been taken, some standards will continue to require further review and enhancement.

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

NEW ASSESSMENT

Core Standards (As at 06/09/2021)	Total standards applicable	Fully compliant	Partially compliant	Non compliant
1. Governance	5	5	0	0
2. Duty to risk assess	2	2	0	0
3. Duty to maintain plans	9	6	3	0
4. Command and control	1	1	0	0
5. Training and exercising	-	-	-	-
6. Response	5	5	0	0
7. Warning and informing	3	3	0	0
8. Cooperation	2	1	1	0
9. Business Continuity	7	7	0	0
10. CBRN	12	6	6	0
Total	**46**	**36**	**10**	**0**

The trust's current compliance is **78.2%** which provides a rating of **Partial compliance.**

The current action plan is provided at Appendix A.

2.2 EPRR Assurance Statement and work-plan for 2021-22

The following section provides a summary of key areas within the standards and progress made by GHNFT since the last assessment:

- A review and re-structure of the Trust Resilience Group and Strategic EPRR Committee has taken place in 2021 and terms of reference clarified and confirmed.
- A number of the EPRR standards have been recently assessed and have received sign-off at the Trust EPRR committee.
- The launch of the restructured Site Resilience Team in July 2021 has provided further enhance levels of resilience, collaborative working and compliance and ensure standards are improved as actions are progressed.
- The appointment of an EPRR Coordinator and Administration Assistant to support the EPRR Team

Domain 1 – Governance

- A Non-Executive Director has been recently appointed for EPRR to support the Accountable Emergency Officer [AEO]
- The Trust EPRR Policy Statement has been revised to provide an overview of governance, roles and responsibilities and a trust commitment to emergency planning, business continuity, training, exercising and debriefing
- A trust Incident Response Policy to provide an assessment of roles and resources, organisational structure charts and internal governance structures
- A continuous improvement process as standard, with scrutiny of internal debriefing across the trust

Domain 2 – Duty to risk assess

- A specific EPRR Risk Register with an overview of identified EPRR Risks reported quarterly to EPRR Committee to provide risk mitigation assurance
- Direct participation in the Northumbria LRF Risk Assessment Working Group reviewing community and national risks

Domain 3 – Duty to maintain plans

- Development of a new Trust Incident Response Plan providing clear, robust, response arrangements for Business Continuity, Critical or Major Incidents. This has been endorsed by the AEO, EPRR Committee and Trust Resilience Group.
- A programme of training and exercising to test Trust response plans with Identified time-line for training and exercising to mitigate key risks

- Review of all emergency plans and action cards to assess trust capabilities, scheduled within the EPRR team work-plan for 2021-22

Domain 4 – Command and Control

- Implementation of updated Trust On-Call management protocols and revised Incident Response Plan [July 2021] supported by the new On-Call Handbook [September 2021]
- Clarity on requirements, responsibilities and expectations for 24 hour Trust On-Call rota and resilience at strategic, tactical and operational levels
- Introduction and embedding of consistent Command, Control and Coordination (C3) escalation arrangements for business continuity, critical or major incidents
- On-going review of current practice to ensure flexibility in management of organisational pressures and capability, competence and capacity of On-call rotas to support out of hours

Although currently compliant the following areas require further development to ensure:

Domain 6 – Response

- A regular programme of training and exercising to include testing of ICC (Incident Command Centre) set-up
- A full review and refresh of Business Continuity Plans
- Review of all staff action cards to align to new Incident Response Plan and support staff development with programme of training and exercising

Domain 7 – Warning and Informing

- An internal review of communications with a refreshed overall EPRR communications strategy for the trust to include incident response

Domain 8 – Cooperation

- A review of internal mutual aid provision, aligned to the Incident Response Plan and accompanied by a staff programme of training and exercising, developed to test and validate updated plans
- The current version of the Trust Information Sharing Protocol is outdated and a review is currently ongoing with Northumbria LRF partners to update in line with General Data Protection Regulations (GDPR)

Domain 9 – Business Continuity

- A full review and refresh of the Trust Business Continuity Management System (BCMS) including policy statement, individual plans and learning from audit
- A work programme and timeline within the EPRR team work-plan for 2021-22

Domain 10 – CBRN

- A full review and refresh of the CBRN Plan to include staffing requirements and skill assessment and organisational training building on previous organisational learning

- Development of a work programme and timeline to achieve this within the EPRR team work-plan for 2021-22

3. Conclusion

The EPRR Team have continued to use the EPRR standards as a benchmark for progress and to identify organisational learning embedded via EPRR action plans.

The Trust EPRR response to COVID-19 has supported the safety and well-being of our patients and staff despite experiencing so many challenges through a period of on-going change and transition.

This report is provided for consideration and as an assurance that tangible progress has been made with EPRR standards during the reporting period for 2021-22.

Tom Knox
Head of Emergency Preparedness Resilience and Response
GHFT

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be	Action to be taken	Lead	Timescale	Comments
Domain 1 - Governance											
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Y	• Name and role of appointed individual	Jo Baxter as Chief Operating Officer [COO] is the executive board level member that is the identified **Accountable Emergency Officer [AEO]** for Gateshead Health NHS Foundation Trust. Anna Stabler is the **non-executive board member** that is identified to support the AEO in this role.	Fully compliant	No action at this time	EPRR Team with AEO/COO	Currently in place	✓ **Change to compliant**
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Y	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	The trust's revised **EPRR Policy statement [OP89]** provides an overview of governance, roles and responsiblities and a trust commitment to emergency planning, business continuity, training, exercising and debrief. The trust's revised **Incident Response Policy** has been reviewed to supersede the Major Incident Policy (November 2020) that provides the framework, roles, responsibilities with resources as to how the trust responds to an incident - copy available on request Both policies have a review schedule and version control; unambiguous terminology; clear responsibilities for update, review and testing; and include references to other sources of information and supporting documentation.	Fully compliant	No action at this time	EPRR Team with AEO/COO	Currently in place	Within EPRR Team work-plan for 2021-22
3	Governance	EPRR board reports	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process.	Y	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board	The EPRR portfolio area reports in the trust Executive Risk Management Group which reports to the **trust Executive Board**. Update reports to the group are scheduled every **6 months** and are presented by the AEO. A previous **Trust Board** update was presented on 31 March 2021 with a further update to be presented on 28 September 2021 - copies available on request The reports include an overview the organisation's compliance to the NHS England Core Standards; lessons identified from any incidents and/or exercises; any incidents experienced by the organisation and any training and exercises undertaken by the organisation - copies available on request	Fully compliant	No action at this time	EPRR Team with AEO/COO	Currently in place	Within EPRR Team work-plan for 2021-22
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Y	• EPRR Policy identifies resources required to fulfill EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group	The trust's revised **EPRR Policy statement [OP89]** provides an overview of governance, roles and responsiblities and a trust commitment to to emergency planning, business continuity management, risk, training and exercising identified learning and debrief. The **Incident Response Policy** was signed off by the trust EPRR Committee [delegated responsibilty on behalf of the Trust Board] in June 2021 which provides an assessment of roles and resources, the organisation structure chart and internal governance structure - copy available on request A new **EPRR Team** was appointed in October and December 2020 respectively so new EPRR workplan developed to take into account of NHS Core Standards requirements and organisation trust priorities. Further team members are to join September/October 2021 to enable a full team complement.	Fully compliant	No action at this time	EPRR Team with AEO/COO	Currently in place	✓ **Change to compliant**
6	Governance	Continuous improvement process	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Y	• Process explicitly described within the EPRR policy statement	The trust EPRR Team are **structured debrief trained** and utilise NE **LRF Debrief Protocol** for current debriefing which is demonstrated in the Incident Response Policy (November 2020) and Incident Response Plan (July 2021) - copies available on request	Fully compliant	Although compliant with the standard, further internal work will be undertaken to increase the staffing capacity of internal debriefing across the trust	EPRR & BC Manager and EPRR Coordinator	31 January 2022	✓ **Change to compliant**
Domain 2 - Duty to risk assess											
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register	EPRR risks are regularly reviewed, considered on a quarterly basis and recorded on the **trust's Risk Register** - this is reported to the Executive Risk Management Group and trust Executive Board by exception. A specific **EPRR Risk Register** with an overview of EPRR Risks is produced on a regular basis for any risks identified so there is relevant assurances over delivery of actions to mitigate risks within the governance arrangements The trust are a standing member and participant in the **Northumbria LRF Risk Assessment Working Group** which looks at the community and national risk registers.	Fully compliant	No action at this time	EPRR Team with trust Corporate Risk Manager and Chair of LRF Risk Working Group	Currently in place	✓ **Change to compliant**
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Y	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	As above all EPRR risks are included on the trust's Risk Register. The process for risk management follows the **trust's Risk Management Policy [RM01]** and the EPPR Portfolio is referenced within this along with trust's revised **EPRR Policy statement [OP89]** - copies available on request.	Fully compliant	No action at this time	EPRR Team with trust Corporate Risk Manager	Currently in place	Within EPRR Team work-plan for 2021-22
Domain 3 - Duty to maintain plans											
11	Duty to maintain plans	Critical incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The trust's revised **Incident Response Plan (July 2021)** is in line with current practice of a **Critical Incident** as defined within the EPRR Framework; in line with risk assessment; signed off by the AEO and EPRR Committee; has been shared appropriately and outlines any equipment requirements. This will be supported by Action Cards - copy available on request	Partially compliant	The current staff Action Cards require review and updating to align to new Incident Response Plan A staff programme of training and exercising is required and will be developed to test the trust response to a critical incident	EPRR & BC Manager and EPRR Coordinator	30 June 2022	Within EPRR Team work-plan for 2021-22
12	Duty to maintain plans	Major incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The trust has a current **MAJAX Plan [SOP-QE-EPRR-04]** which has been previously tested and exercised with staff on a regular basis however not for the last 18 months or so - copy available on request. This will be superceded by the trust's revised **Incident Response Plan (July 2021)** that is in line with current practice of a **Major Incident** as defined within the EPRR Framework; in line with risk assessment; signed off by the AEO and EPRR Committee; has been shared appropriately and outlines any equipment requirements. This will be supported by Action Cards - copy available on request	Fully compliant	Current MAJAX Plan and staff Action Cards require updating to align to new Incident Response Plan A staff programme of training and exercising is required and will be developed to test the trust response to a major incident	EPRR & BC Manager and EPRR Coordinator	30 June 2022	Within EPRR Team work-plan for 2021-22
13	Duty to maintain plans	Heatwave	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heatwave on the population the organisation serves and its staff.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The trust has a **Adverse Weather Emergency Preparedness Pla**n that includes a **Heatwave plan**. This has been developed in line with current national practice; in line with risk assessment; signed off; shared appropriately; outlines any equipment required and provides specific departmental action cards - copy available on request	Fully compliant	The current trust Heatwave plan and staff Action Cards require review and updating A staff programme of training and exercising is required and will be developed to test and validate the updated plan	EPRR & BC Manager and EPRR Coordinator	31 May 2022	Within EPRR Team work-plan for 2021-22
14	Duty to maintain plans	Cold weather	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The trust has a **Adverse Weather Emergency Preparedness Pla**n that includes a **Cold weather plan**. This has been developed in line with current national practice; in line with risk assessment; signed off; shared appropriately; outlines any equipment required and provides specific departmental action cards - copy available on request	Fully compliant	The current trust Cold weather plan and staff Action Cards require review and updating A staff programme of training and exercising is required and will be developed to test and validate the updated plan	EPRR & BC Manager and EPRR Coordinator	31 October 2021	Within EPRR Team work-plan for 2021-22
18	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level 3 ITU capacity for 96 hours (for those with level 3 ITU bed).	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The trust has a **Mass Casualty Plan** that is in line with current practice; in line with risk assessment; previous signed off from the EPRR Committee; has been shared appropriately and outlines any equipment requirements. This has been reviewed, tested and used in previous exercising. This will be included in the suite of plans that will support the trust's revised Incident Response Plan (July 2021)	Partially compliant	The current Mass Casualty plan and staff Action Cards require review and updating, and aligned to the Incident Response Plan A staff programme of training and exercising is required and will be developed to test and validate the updated plan	EPRR & BC Manager and EPRR Coordinator	31 August 2021	Within EPRR Team work-plan for 2021-22
19	Duty to maintain plans	Mass Casualty - patient identification	The organisation has arrangements to ensure a safe identification system for unidentified patients in an emergency/mass casualty incident. This system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The trust has a **Patient Identification Policy [RM40]** which includes the use of specific wrist bands, and pre-printed folders using a unique name, date of birth, gender which allows the patient to be registered as quickly as possible which then gives prompt access to systems, tests and treatment e.g. blood etc. - copy is available on request	Fully compliant	No action at this time	EPRR Team and relevant teams	Currently in place	Within EPRR Team work-plan for 2021-22
20	Duty to maintain plans	Shelter and evacuation	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements for shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The trust has a **Hospital Evacuation and Sheltering Pla**n in place to evacuate ward and areas as necessary that have been previous used and tested - copy available on request	Partially compliant	The current Evaluation and Shelter plan and staff Action Cards require review and updating, and aligned to the Incident Response Plan A staff programme of training and exercising is required and will be developed to test and validate the updated plan	EPRR & BC Manager and EPRR Coordinator, and relavant teams	30 April 2022	Within EPRR Team work-plan for 2021-22
21	Duty to maintain plans	Lockdown	In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust has a **Lockdown Procedure** that is reviewed regularly and updated accordingly. A lockdown risk profile will be produced by the Local Security Management Specialist and the Health and Safety/Risk Management Team to make sure that any assessment made on the Trust's ability to lockdown is accurate and achievable in line with the security management guidance - a copy is available on request	Fully compliant	To be reviewed in September 2021	QEF Head of Security and relevant teams	30 September 2021	✓ **Change to compliant**
22	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has effective arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Guidance and arrangements is included within the **Incident Response Plan (**July 2021) to manage and respond to 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site - copy available on request.	Fully compliant	The plan and staff Action Cards require updating A staff programme of training and exercising is required and will be developed to test and validate the Incident Response Plan	EPRR & BC Manager and EPRR Coordinator	30 June 2022	Within EPRR Team work-plan for 2021-22

Domain 4 - Command and control											
24	**Command and control**	**On-call mechanism**	A resilient and dedicated EPRR on-call mechanism is in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond to or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Include 24 hour arrangements for alerting managers and other key staff.	The trust's **On-Call mechanism** is explicitly described within the revised **Incident Response Plan** [July 2021] and within a specific trust **draft On-Call Handbook** [August 2021] developed for the On-Call Team. Within this the On-Call Standards and expectations are set out which includes the 24 hours arrangements for alerting, roles, responsibilities and a rota - copies available on request	Fully compliant	In addition to the Core Standards expectations, a suite of actions cards will be developed to support the Handbook along with a regular programme of training and exercising for the on-call team both internally and externally	EPRR & BC Manager	31 March 2022	Within EPRR Team work-plan for 2021-22
Domain 5 - Training and exercising											
Domain 6 - Response											
30	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has Incident Co-ordination Centre (ICC) arrangements	Y		The Incident Response Plan (July 2021) details the establishment of the **Incident Coordination Cell (ICC)** including the role, membership and how this is activated. The trust has a dedicated ICC which has all the required equipment to assist the team in dealing with any incidents. Alternative venues have also been identified as secondary areas for strategic, tactical and operational cells to supoort the ICC when required - copy available on request	Fully compliant	A regular programme of training and exercising will be developed to test the setting up of an ICC in alignment to the testing and exercising of revised trust plans	EPRR & BC Manager and EPRR Coordinator	ONGOING over the year	Within EPRR Team work-plan for 2021-22
32	**Response**	**Management of business continuity incidents**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans	A range of **Business Continuity (BC) plans** are in place across the trust to respond to a BC incident whether planned or unplanned, these are reviewed and updated as necessary and are based on ISO 22301. All plans require review.	Fully compliant	A full review and refresh of Business Continuity Plans is required to in this standard A work programme and timeline is being developed to achieve this and a copy is available on request	EPRR & BC Manager and EPRR Coordinator	31 October 2021	Within EPRR Team work-plan for 2021-22
34	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Y	• Documented processes for completing, signing off and submitting SitReps	The trust has a process in place for receiving, completing authorising and completing **Situation Reports** that are completed by the trust Information teams and via the ICC / Site Resilience Team with a sign-off in place by exception dependant upon the request	Fully compliant	Although compliant with the standard, during the Covid-19 response a dedicated email box was established to coordinate and facilitiate the completion of requests received by the trust - this approach will be considered moving forward for requests including as part of the Winter Planning 2021-22 and any EPRR reporting requirements.	Site Resilience Team	31 October 2021	Within EPRR Team work-plan for 2021-22
35	**Response**	**Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'**	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Y	• Guidance is available to appropriate staff either electronically or hard copies	A version of the guidance is available **electronically and as a hard copy** as part of the trust Incident Response Plan and Action Cards https://www.england.nhs.uk/wp-content/uploads/2018/12/B0128-clinical-guidelines-for-use-in-a-major-incident-v2-2020.pdf	Fully compliant	Although complaint, the current staff Action Cards require review and updating to align to new Incident Response Plan A staff programme of training and exercising is required and will be developed to test the trust response to a critical incident	EPRR & BC Manager and EPRR Coordinator	30 June 2022	Within EPRR Team work-plan for 2021-22
36	**Response**	**Access to 'CBRN incident: Clinical Management and health protection'**	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.	Y	• Guidance is available to appropriate staff either electronically or hard copies	A version of the guidance is available **electronically and as a hard copy** as part of the trust Incident Response Plan and Action Cards https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/712888/Chemical_biological_radiological_and_nuclear_incidents_clinical_management_and_health_protection.pdf	Fully compliant	Although complaint, the current staff Action Cards require review and updating to align to new Incident Response Plan A staff programme of training and exercising is required and will be developed to test the trust response to a critical incident	EPRR & BC Manager and EPRR Coordinator	30 June 2022	Within EPRR Team work-plan for 2021-22
Domain 7 - Warning and informing											
37	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Y	• Have emergency communications response arrangements in place • Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response • Using lessons identified from previous major incidents to inform the development of future incident response communications • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work	Communication between partner organisations is identified in the trust I**ncident Response Plan** and **Major Incident Plan,** and has an **individual communications team plan** to support the trust response**.** The trust has a dedicated **Social Media Policy (OP79)** specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response - a copy is available on request The trust also has a **MAJAX email box** which is specifically used during major incidents. Information and communications are shared through the various meetings (e.g. LHRP & LRF) that are attended by Trust representatives where partner organisations are also in attendance, where plans, policies and procedures can be shared and reviewed. **Debriefing and using organisational learning** is an essential stage of the Incident Response Plan to inform the development of future incident response communications	Fully compliant	Although currently fully complaint, there will be an internal review of communications to take place with a refreshed overall strategy for the trust in incident response	Head of Communications and Head of EPRR	31 March 2022	Within EPRR Team work-plan for 2021-22
38	**Warning and informing**	**Warning and informing**	The organisation has processes for warning and informing the public (patients, visitors and wider population) and staff during major incidents, critical incidents or business continuity incidents.	Y	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing	The Trust has a **Media Relations Policy (OP63)** recently recevied which is available on the intranet and deals with the distribution of information - a copy is available on request The comms team also have a **Major Incident Action Card** which covers key messages,monitoring messages from news, social media etc. then decide what communications to send out to the public, partners and staff - a copy is available on request **Media Training** has been held for some of the On-Call Team	Fully compliant	There will be an internal review of communications to take place with a refreshed overall strategy for the trust in incident response	Head of Communications and EPRR Team	31 March 2022	✓ **Change to compliant**
39	**Warning and informing**	**Media strategy**	The organisation has a media strategy to enable rapid and structured communication with the public (patients, visitors and wider population) and staff. This includes identification of and access to a media spokespeople able to represent the organisation to the media at all times.	Y	• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy	The Trust has a **Media Relations Policy (OP63)** recently received which is available on the intranet and deals with the distribution of information - a copy is available on request The comms team also have a **Major Incident Action Card** which covers key messages,monitoring messages from news, social media etc. then decide what communications to send out to the public, partners and staff - a copy is available on request **Media Training** has been undertaken for some members of the On-Call Team	Fully compliant	There will be future internal review of communications to take place with a refreshed overall strategy for the trust which will include incident response	Head of Communications and Head of EPRR	31 March 2022	✓ **Change to compliant**
Domain 8 - Cooperation											
42	**Cooperation**	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate	There is NHS England and Improvement for the North East and Yorkshire - **'Incident Management for Escalation and Mutual Aid Plan'** to support local systems across the Region - copy available on request Northumbria LRF also have a **Multi-Agency Mutual Aid Agreement** for it's constitute partner organisations which are formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Fully compliant	Although fully compliant, the current internal approach to Mutual Aid and staff Action Cards require review and updating, and aligned to the Incident Response Plan A staff programme of training and exercising is required and will be developed to test and validate the updated plan	EPRR & BC Manager and EPRR Coordinator	30 June 2022	Within EPRR Team work-plan for 2021-22
46	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders, during major incidents, critical incidents or business continuity incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 'duty to communicate with the public'.	The trust signed up to the **Northumbria Local Resilience Forum Information Sharing Protocol** that was developed in March 2014 - a copy is available on request This evidences the consideration of the relevance guidance including the Freedom of Information Act 2000 and the Civil Contingencies Act 2004 'duty to communicate with the public'.	Partially compliant	This version is outdated and a review is currently ongoing within Northumbria LRF to bring the protocol in date with organisational changes and in line with General Data Protection Regulation (GDPR) regulations which will require internal trust consultation before final approval.	EPRR & BC Manager with Information Governance Manager, GHFT	31 October 2021	Within EPRR Team work-plan for 2021-22
Domain 9 - Business Continuity											
47	**Business Continuity**	**BC policy statement**	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continutiy Management System (BCMS) in alignment to the ISO standard 22301.	Y	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement	The Trust has a **Business Continuity Policy statement [RM66]** in place based on ISO 22301 and was developed circa 2018 - copy available on request. The policy requires major review.	Fully compliant	A full review and refresh of the Business Continuity Management System including the policy statement is required in this standard A work programme and timeline is being developed to achieve this and a copy is available on request	EPRR & BC Manager and EPRR Coordinator with strategic oversight from Head of EPRR	31 October 2022	Within EPRR Team work-plan for 2021-22
48	**Business Continuity**	**BCMS scope and objectives**	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • Stakeholders	The trust has a **Business Continuity Policy Statement [OP66]** and **Business Continuty Management Response Plan [SOP-QE-BCP-O]** which includes the scope, BIA process, roles and responsibilities, identification of business threats and risk assessment, KPI's, training and communication. The statement and plan requires major review.	Fully compliant	A full review and refresh of the Business Continuity Management System and associated documents including the scope and objectives is required in this standard A work programme and timeline is being developed to achieve this and a copy is available on request	EPRR & BC Manager and EPRR Coordinator with strategic oversight from Head of EPRR	31 October 2022	Within EPRR Team work-plan for 2021-22
50	**Business Continuity**	**Data Protection and Security Toolkit**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Statement of compliance	Gateshead Health NHS Foundation Trust completes the **Data Security and Protection Toolkit (DSPT) each year in line with NHSD expectations**. The annual assessment includes collaboration between the Trust's IG and IT departments. On the 30th June 2021, the Trust's external auditors (AuditOne) provided an independent review against the Trust's self-assessment and declared the Trust had provided **'Substantial Assurance'** based on the confidence level of the independent assessor in the accuracy of the Trust's self-assessment.	Fully compliant	Annual Assessment undertaken and reviewed by external auditors	Information Governance Manager	Currently in place	Within EPRR Team work-plan for 2021-22
51	**Business Continuity**	**Business Continuity Plans**	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation	A range of **Business Continuity (BC) plans** (SOP-QE-BCP) are in place across the trust to respond to a BC incident whether planned or unplanned, these are reviewed and updated as necessary and are based on ISO 22301 - a sample copy is available on request. The plans require major review.	Fully compliant	A full review and refresh of Business Continuity Plans is required in this standard A work programme and timeline is being developed to achieve this - a copy is available on request	EPRR & BC Manager and EPRR Coordinator with strategic oversight from Head of EPRR	31 October 2022	Within EPRR Team work-plan for 2021-22
53	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Audit reports	The **BCMS is part of the trust Audit plan** and is audited by 'Audit One' - an external audit company commissioned by the trust. Previous outcomes from audits have been reported to the internal EPRR Committee and Executive Risk Management Group by exception with clear timescales for improvement and resolution - a copy of the recent audit report is available on request.	Fully compliant	A full review and refresh of the Business Continuity Management System including findings from previous audits is required in this standard A work programme and timeline is being developed to achieve this and a copy is available on request	EPRR & BC Manager and EPRR Coordinator with strategic oversight from Head of EPRR	31 October 2022	Within EPRR Team work-plan for 2021-22

54	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectivness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Action plans	The Trust has a **Business Continuity Policy statement [RM66]** in place based on ISO 22301 and was developed circa 2018 - copy available on request. The statement requires review.	Fully compliant	A full review and refresh of the Business Continuity Management System including the policy statement is required in this standard A work programme and timeline is being developed to achieve this and a copy is available on request	EPRR & BC Manager and EPRR Coordinator with strategic oversight from Head of EPRR	31 October 2022	Within EPRR Team work-plan for 2021-22
55	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	Y	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements	The Trust has a **Business Continuity Policy statement [RM66]** in place based on ISO 22301 and was developed circa 2018 - copy available on request. The policy requires major review The trust has a **Third Party Supplier Questionnaire [IG20 v3.0]** that must be completed and signed by any third party who is entering into an agreement or contract with the Trust and where they will have access to personal and/or confidential information. Part I asks if they have BCPs in place - copy available on request.	Fully compliant	A full review and refresh of the Business Continuity Management System including findings from previous audits is required in this standard A work programme and timeline is being developed to achieve this and a copy is available on request	EPRR & BC Manager and EPRR Coordinator with strategic oversight from Head of EPRR	31 October 2022	Within EPRR Team work-plan for 2021-22
Domain 10: CBRN											
56	CBRN	Telephony advice for CBRN exposure	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Y	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements	Contact details for the radiation Advisor is included in the current **Major Incident Plan {SOP-QE-EPRR-04}** - copy available on request	Fully compliant	Although complaint on this element, the current MAJAX Plan and staff Action Cards require updating to align to new Incident Response Plan A staff programme of training and exercising is required and will be developed to test the trust response to a major incident	EPRR & BC Manager and EPRR Coordinator	30 June 2022	Within EPRR Team work-plan for 2021-22
57	CBRN	HAZMAT / CBRN planning arrangement	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Y	Evidence of: • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	The Trust has a **CBRN Plan (SOP-QE-EPRR-08)** which includes all the relevant information regarding the response to a CBRN incident, information on the type of patients the trust may receive and details on the type of contaminants that they may have been infected with. It also includes information on PRPS suits in regards to how staff are to put them on and their removal. Also includes instruction on Inital Operational Response and the various pieces of equipment to be used - copy available on request.	Partially compliant	A full review and refresh of the CBRN Plan is required including from previous training and exercising. A work programme and timeline is being developed to achieve this and a copy is available on request	EPRR Coordinator	28 February 2022	Within EPRR Team work-plan for 2021-22
58	CBRN	HAZMAT / CBRN risk assessments	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	Y	• Impact assessment of CBRN decontamination on other key facilities	**Risk Assessments around CBRN decontamination** are in place and all hazardous waste is contained and disposed of correctly whether items of clothing or liquids,	Partially compliant	A full review and refresh of the CBRN Plan is required including from previous training and exercising. A work programme and timeline is being developed to achieve this and a copy is available on request	EPRR Coordinator	28 February 2022	Within EPRR Team work-plan for 2021-22
59	CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	Y	• Rotas of appropriately trained staff availability 24 /7	**Trained staff are based within the Emergency department** which is where patients would first attend are trained in CBRN decontamination techniques. Estates staff are trained in the erection of the CBRN decontamination tent should it be required - availability of staff to be further explored.	Partially compliant	A full review and refresh of the CBRN Plan is required including from previous training and exercising. A work programme and timeline is being developed to achieve this and a copy is available on request	EPRR Coordinator	28 February 2022	Within EPRR Team work-plan for 2021-22
60	CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	• Completed equipment inventories; including completion date	The trust has **appropriate equipment supplies** of paper towels, Ramgene monitors, FFP3 masks, paper boiler suits and also a UK Reserve National Stock is established for rapid deployment in major incidents, including mass casualty situations. - Each Pod is for the needs of 100 people with a 24hour-7 day-a-week response capability. Deployment of all Pods will be the responsibility of North East Ambulance Service. - The equipment Pods are managed by ambulance services. - The modesty Pods are managed by ambulance services. - The Nerve Agent Antidote Pods are managed through Blood Services, but accessed via ambulance services. - The Biological Pods can be mobilised by Directors of Public Health and Consultants in Public Health Medicine, but accessed via the ambulance services The Trust has 15 PRPS suits which is the required minimum number these are included in a monthly check by the medical devices team to ensure they are in date and services are carried out as and when required. As at 15 March 2021, 9 additional suits have been allocated to Queen Elizabeth Hospital, from NHS E via the National Ambulance Resilience Unit (NARU) which will bring levels up to the minimum holding of **24 PRPS suits.** The trust uses an **asset management inventory system** and undertakes monthly visual checks of equipment that is scheduled and undertaken by our Medical Engineering Team. Annual maintenance is undertaken as per the manufacturers recommendations.	Fully compliant	No action at this time	EPRR and BC Manager with QEF Medical Engineering Services Technical Manager	Currently in place	Within EPRR Team work-plan for 2021-22
62	CBRN	Equipment checks	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	Y	• Record of equipment checks, including date completed and by whom. • Report of any missing equipment	There is a **schedule of routine checks in maintanence** is place and the named individual is in the MES Technical Manager within QE Facilities and a lead officer within the Emergency Department. **PRPS suits** are included in a monthly check by the medical devices team to ensure they are in date and services are carried out as and when required. Annual maintenance and life extensions are monitored by the manufacturers Respirex. The **Decontamation Structure/ tent** is erected on a 6 monthly basis to ensure it is still in a usable condition this includes the shower facility and pumps. There are 2 gazebos which would be used as a disrobing area for privacy and dignity. This is undertaken by the Emergency Department. **RAMGENE** monitors are checked on a monthly rota to ensure a visual inspection and the batteries are charged. The monitors are sent to the Department of Health on an annual basis for a full maintenance check and re-calibration.	Fully compliant	Although compliant, work is ongoing to replace the decontamination structure/tent.	Service Line Manager - Urgent and Emergency Care and EPRR & BC Manager	31 January 2022	Within EPRR Team work-plan for 2021-22
63	CBRN	Equipment Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment	Y	• Completed PPM, including date completed, and by whom	There is a **preventative programme of maintenance in place (PPM)** in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment. The trust uses an **asset management inventory system** and undertakes monthly visual checks of equipment that is scheduled and undertaken by the Medical Engineering Team in QEF. This is relation to PRPS suits and the RAMGENE Monitors. Annual maintenance is undertaken as per the specifc manufacturers recommendations.	Fully compliant	No action at this time	EPRR and BC Manager with QEF Medical Engineering Services Technical Manager	Currently in place	Within EPRR Team work-plan for 2021-22
64	CBRN	PPE disposal arrangements	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Y	• Organisational policy	There is an **agreed disposal of PRPS suits** which are used for training purposes internally and externally with partner organisations. This is documetned within the **trust CBRN Plan (SOP-QE-EPRR-08)** and manufacturer / supplier guidance is followed.	Fully compliant	Although compliant, a full review and refresh of the CBRN Plan is required including from previous training and exercising. A work programme and timeline is being developed to achieve this and a copy is available on request	EPRR and BC Manager with QEF Medical Engineering Services Technical Manager	Currently in place	Within EPRR Team work-plan for 2021-22
65	CBRN	HAZMAT / CBRN training lead	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training	Y	• Maintenance of CPD records	The CBRN trainer was trained by NEAS in **decontamination reponse and control methods** - however the training has now lapsed and requires review of approach	Partially compliant	A full review and refresh of the CBRN Plan is required including appropriate training A work programme and timeline is being developed to achieve this	EPRR Coordinator	28 February 2022	Within EPRR Team work-plan for 2021-22
67	CBRN	HAZMAT / CBRN trained trainers	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	Y	• Maintenance of CPD records	The Trust has 2 members of staff that carry out the **CBRN training** - however the training has now lapsed and requires review of approach	Partially compliant	A full review and refresh of the CBRN Plan is required including staff who undertake appropriate organisational training A work programme and timeline is being developed to achieve this	EPRR Coordinator	31 May 2022	Within EPRR Team work-plan for 2021-22
68	CBRN	Staff training - decontamination	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Y	• Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • All service providers - see Guidance for the initial management of self presenters from incidents involving hazardous materials - https://www.england.nhs.uk/publication/eprr-guidance-for-the-initial-management-of-self-presenters-from-incidents-involving-hazardous-materials/ • All service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • A range of staff roles are trained in decontamination technique	Staff are trained in the **trust CBRN Plan** including IOR on the staff away days with records of attendees held, this includes reception staff who have been made aware of the need to isolate patients who may be attending following a CBRN incident - however the training has now lapsed and requires review of approach	Partially compliant	A full review and refresh of the CBRN Plan is required including staff who undertake appropriate organisational training A work programme and timeline is being developed to achieve this	EPRR Coordinator	31 July 2022	Within EPRR Team work-plan for 2021-22
69	CBRN	FFP3 access	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.	Y		**FFP3 masks** are made available for any trust staff that require them and fit tests are carried out.	Fully compliant	No action at this time	EPRR Team with relevant teams	Currently in place	Within EPRR Team work-plan for 2021-22

Gateshead Health
NHS Foundation Trust

Report Cover Sheet

Agenda Item: 16

Purpose of Report	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☐
Report Title:	Part One – Executive Summary – Consolidated Finance Report			
Name of Meeting:	Trust Board			
Date of Meeting:	28th September 2021			
Author	Mrs Jane Fay, Acting Deputy Director of Finance			
Executive Lead	Mrs Kris Mackenzie, Acting Group Director of Finance			
Report presented by	Mrs Kris Mackenzie, Acting Group Director of Finance			
Executive Summary	The Trust has reported an adjusted financial performance surplus of £1.183m for the period April 2021 to Aug 2021 and is projecting a breakeven position as at 30th September 2021			
Recommended actions for Board/Committee)	To note the summary of performance as at 31st August 2021 (Month 5) for the Group (inclusive of Trust and QE Facilities, excluding Charitable Funds).			
Trust Aims that the report relates to: (Including reference to any specific risk)	Aim 1 ☐	We will continuously improve the quality and safety of our services for our patients		
	Aim 2 ☐	We will be a great organisation with a highly engaged workforce		
	Aim 3 ☒	We will enhance our productivity and efficiency to make the best use of resources		
	Aim 4 ☐	We will be an effective partner and be ambitious in our commitment to improving health outcomes		
	Aim 5 ☐	We will develop and expand our services within and beyond Gateshead		
Financial Implications:	As included in the report			
Links to Risks (identify significant risks and DATIX reference)	As included in the report			
People and OD Implications:	None			
Links to CQC KLOE	Caring ☐	Responsive ☐	Well-led ☒	Effective ☐	Safe ☐

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

1. Introduction

1.1 The purpose of this report is to provide a summary of financial performance as at 31st August 2021 (month 5) for the Group (inclusive of the Trust and QE Facilities, excluding Charitable Funds).

2 2021-22 Financial Framework

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

2.2 The 2021-22 H1 financial is underpinned by the following principles:

- A funding envelope for NHS Provider Organisations based on actual expenditure for months 7 to 9 of 2020-21, doubled and with some adjustments for known pressures and policy priorities
- This funding envelope assumes a return to 95% of 2019-2020 activity baselines from July, and includes growth funding in relation to acute services, mental health services, primary care and community services
- A continuation of block contract funding with an inflation uplift of 0.5% on 2020-21 block contract funding inclusive of a 0.28% efficiency target
- 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
- A new national funding stream titled elective recovery fund to support activity recovery in addition to system financial envelopes

2.3 For the period 1st April to 30th September 2021 (H1) the Trust submitted a financial plan predicated on a starting position of 2020-21 M7 to M9 expenditure doubled and adjusted for known financial pressures not reflected in the starting position, centrally calculated block contract values and a share of the North ICP system funding envelope to achieve a breakeven position on its statement of comprehensive income (SOCI). At the request NHS England & Improvement (NHSE&I) an updated plan was recently submitted to include elective recovery fund (ERF) income estimated using H1 activity trajectories. This totals £1.400m additional income for the period April 2021 to September 2021 and is offset by an equivalent value in expenditure on the assumption that all ERF income will be offset by an increase in spend relating to activity recovery or enhancing the Trust infrastructure.

2.4 Reporting for August 2021 is against the Trusts revised financial plan which incorporates ERF.

3 Income and Expenditure

3.1 The Trust has reported an actual 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.

3.2 This is a positive variance of £1.030m 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 August 2021 the Trust has reported actual income of £29.711m and £148.902m for the period to date resulting in an in-month favourable variance from the NHSEI plan of £1.354m and a year to date favourable variance of £7.028m.

3.4 Included in the period to date total is £3.981m Elective Recovery Fund income as provided by NHSEI comprising of expected payments for the months April to June 2021 and nothing expected for the months July to August 2021. The expected ERF income of £3.981m is £2.581m more than the £1.400m included in the Trusts revised financial H1 plan. From 1st July the thresholds for achieving ERF were raised. As a consequence of this increase and the impact of the 3rd wave of COVID it is anticipated that no Organisations across ICS will be able to access ERF funding from 1st July 2021. However, any costs committed in respect of delivery of the Elective Recovery Framework will continue

3.5 For the month of August 2021 the Trust has reported actual expenditure of £29.016m resulting in an in month adverse variance from the NHSEI plan of £0.968m and a year to date adverse variance of £5.857m. These figures include £3.538m of spend directly attributable to the Trusts response to the COVID-19 pandemic.

STATEMENT OF COMPREHENSIVE INCOME

August 2021-22 Red >100k over Amber <> (£50k) - £99.99k Green <(£50.1k)	GROUP POSITION NHSI/E APRIL - SEPT 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	(158,111.8)	(131,774.9)	(136,753.2)	(4,978.4)	(4,120.0)
Income From Local Authority Care Contracts	(45.0)	(37.5)	(37.5)	-	-
Private Patient Revenue	(595.5)	(494.5)	(345.2)	149.3	57.2
Injury Cost Recovery	(168.0)	(140.0)	(59.4)	80.6	83.1
Other non-NHS clinical revenue	-	-	(347.3)	(347.3)	(288.8)
Total Operating Income From Patient Care activities	**(158,920.4)**	**(132,446.8)**	**(137,542.6)**	**(5,095.8)**	**(4,268.5)**
Other Operating Income					
Education and Training Income	(5,047.8)	(4,206.5)	(3,716.7)	489.8	422.8
R&D Income	(363.0)	(305.0)	(248.8)	56.2	55.8
Funding ouside of System Envelope	-	-	(1,287.3)	(1,287.3)	(992.5)
Other Income	(5,901.5)	(4,915.4)	(6,106.2)	(1,190.8)	(891.9)
Donations & Grants Received	-	-	-	-	-
Total Other Operating Income	**(11,312.3)**	**(9,426.9)**	**(11,359.0)**	**(1,932.1)**	**(1,405.7)**
Total Operating Income	**(170,232.6)**	**(141,873.7)**	**(148,901.6)**	**(7,027.9)**	**(5,674.2)**
Operating Expenses					
Employee Expenses - Substantive	106,972.4	89,104.2	84,646.7	(4,457.5)	(2,640.8)
Employee Expenses - Bank	2,756.3	2,297.8	3,241.8	944.0	697.1
Employee Expenses - Agency	2,393.8	1,995.1	1,992.6	(2.4)	99.4
Employee Expenses - Other	354.0	295.0	391.1	96.1	78.0
Total Employee Expenses	**112,476.6**	**93,692.1**	**90,272.3**	**(3,419.8)**	**(1,766.2)**
Purchase of Healthcare - NHS bodeis	2,937.7	2,448.1	2,526.7	78.6	121.5
Purchase of Healthcare - Non NHS bodies	808.6	673.8	688.4	14.6	(15.4)
Purchase of Social Care	-	-	-	-	-
NED's	96.2	80.2	74.1	(6.1)	(4.9)
Supplies & Services - Clinical	17,821.7	14,903.1	16,291.3	1,388.2	905.3
Supplies & Services - General	2,568.4	2,140.4	4,186.4	2,046.0	1,515.9
Drugs	8,491.4	7,076.2	7,600.2	524.0	419.2
Research & Development expenses	1.7	1.4	30.0	28.6	28.6
Education & Training expenses	1,697.9	1,414.9	307.1	(1,107.8)	(953.3)
Consultancy costs	62.1	51.8	242.7	191.0	202.2
Establishment expenses	2,039.2	1,699.4	3,704.5	2,005.2	1,136.7
Premises	7,774.6	6,478.8	8,708.0	2,229.2	1,407.4
Transport	579.4	482.8	495.7	12.9	16.9
Clinical Negligence	4,113.7	3,428.1	3,406.8	(21.3)	(17.0)
Operating Leases	-	-	849.0	849.0	670.6
Other Operating expenses	3,425.6	2,857.2	3,836.0	978.8	932.9
Operating Expenses included in EBITDA	**164,894.8**	**137,428.0**	**143,219.1**	**5,791.1**	**4,600.3**
Depreciation & Amortisation - Purchased / Constructed	3,468.0	2,890.0	3,037.0	147.0	114.5
Depreciation & Amortisation - Donated / Granted	200.0	164.0	152.2	(11.8)	(6.2)
Depreciation & Amortisation - Finance Leases	-	-	-	-	-
Impairment & Revaluation	(182.2)	(151.9)	(220.9)	(69.0)	180.9
Restructuring Costs	-	-	-	-	-
Operating Expenses excluded from EBITDA	**3,485.8**	**2,902.2**	**2,968.3**	**66.2**	**289.2**
Total Operating Expenses	**168,380.6**	**140,330.2**	**146,187.5**	**5,857.3**	**4,889.5**
(Profit)/Loss from Operations	**(1,852.1)**	**(1,543.5)**	**(2,714.2)**	**(1,170.7)**	**(784.7)**
Non Operating					
Non-Operating Income					
Finance Income	(30.0)	(24.9)	(16.3)	8.7	5.4
Total Non-Operating Income	**(30.0)**	**(24.9)**	**(16.3)**	**8.7**	**5.4**
Non-Operating Expenses					
Finance Costs	298.1	248.5	211.8	(36.6)	(33.8)
Gains / (Losses) on Disposal of Assests	-	-	(46.3)	(46.3)	(46.3)
PDC dividend expense	1,381.5	1,151.3	1,242.9	91.7	5.6
Total Finance Costs (for non-financial activities)	**1,679.6**	**1,399.7**	**1,408.5**	**8.8**	**(74.4)**
Other Non-Operating Expenses					
Misc. Other Non-Operating expenses	-	-	-	-	-
Total Non-Operating Expenses	**1,679.6**	**1,399.7**	**1,408.5**	**8.8**	**(74.4)**
(Surplus) / Deficit Before Tax	**(202.5)**	**(168.8)**	**(1,322.0)**	**(1,153.2)**	**(853.7)**
Corporation Tax	202.5	168.8	291.7	122.9	98.3
(Surplus) / Deficit After Tax	**(0.0)**	**(0.0)**	**(1,030.3)**	**(1,030.3)**	**(755.4)**
(Surplus) / Deficit After Tax from Continuing Operations	**(0.0)**	**(0.0)**	**(1,030.3)**	**(1,030.3)**	**(755.4)**
Remove capital donations / grants I&E impact	(200.0)	(165.0)	(152.2)	12.8	7.2
Other Control Total adjustment	-	-	-	-	-
Impairement	-	-	-	-	-
Adjusted Financial Performance (Surplus) / Deficit	**(200.0)**	**(165.0)**	**(1,182.5)**	**(1,017.5)**	**(748.2)**
Adjusted Financial Performance (Surplus) / Deficit	**(200.0)**	**(165.0)**	**(1,182.5)**	**(1,017.5)**	**(748.2)**

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 the required breakeven position. Non-recurring schemes totalling £2.225m have been identified and whilst this mitigates the financial risk for 2021-22 H1 it is imperative the Trust continues to identify recurring schemes via its transformation programme.

5 Cash and Working Balances

5.1 The Trust opened the financial year with £43.862m of cash. The cash position of £49.749m as at 31st August is equivalent to an estimated 30.79 days operating costs and represents a £4.486m increase from July 2021.

5.2 The liquidity metric has improved by 0.68 days against July to -2.71 days driven by a £0.647m increase in the working capital balance.

5.3 The balance sheet is presented in Table 2.

Statement of Position - August 2021

	2021/2022 July 2021 Group	2021/2022 August 2021 Group	Movement from Prior Month	2021/2022 August 2021 QEF	2021/2022 August 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	117,691	117,293	(397)	1,178	116,115
Trade and Other Receivables, Net	2,042	2,031	(10)	729	1,302
Finance Lease - Intragroup				42,743	0
Trade and Other Receivables - Intragroup Loan	0	0	0		15,789
Total Non Current Assets	119,812	119,405	(408)	44,731	150,031
Current Assets					
Inventories	5,128	5,164	35	2,329	2,834
Trade and Other Receivables - NHS	15,385	12,949	(2,436)	535	12,413
Trade and Other Receivables - Non NHS	4,417	4,193	(225)	435	3,758
Trade and Other Receivables - Other	0	0	0		0
Prepayments	6,097	5,996	(101)	446	5,550
Cash and Cash Equivalents	45,262	49,749	4,486	8,882	40,867
Other Financial Assets - PDC Dividend	1,246	1,246	0		1,246
Accrued Income	1,282	1,798	517	1,216	582
Finance Lease - Intragroup				395	0
Trade and Other Receivables - Intragroup Loan					2,339
Total Current Assets	86,486	81,094	2,276	14,239	69,590
Liabilities					
Current Liabilites					
Deferred Income	7,187	5,405	(1,783)	176	5,228
Provisions	5,664	5,539	(125)	743	4,796
Current Tax Payables	3,907	4,058	151	342	3,716
Trade and Other Payables - NHS	1,609	1,660	51	607	1,053
Trade and Other Payables - Other	8,917	8,424	(493)	2,369	6,055
Trade and Other Payables - Capital	176	5	(170)	0	5
Other Financial Liabilities - Accruals	47,485	51,217	3,731	6,628	44,589
Other Financial Liabilities - Borrowings FTFF	999	999	0	0	999
Other Financial Liabilities - PDC Dividend	927	1,158	232	0	1,158
Other Financial Liabilities - Intragroup Borrowings	0	0		2,339	0
Finance Lease - Intragroup	0	0		0	395
Total Current Liabilities	84,540	78,465	1,594	13,206	67,995
NET CURRENT ASSETS (LIABILITIES)	1,946	2,629	682	1,034	1,595
Non-Current Liabilities					
Deferred Income	2,124	2,124	0	1,794	330
Provisions	2,582	2,582	0	0	2,582
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	18,715	0	17,583	59,665
TOTAL ASSETS EMPLOYED	**103,043**	**103,318**	**275**	**28,181**	**91,962**
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)	(42,980)	(42,705)	275	17,905	(60,610)
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	103,043	103,318	275	34,729	85,414
TOTAL ASSETS EMPLOYED	**103,043**	**103,318**	**275**	**34,729**	**85,414**

Table 2 – Statement of Position

6 Capital

6.1 The Trusts 2021/2022 CDEL limit has been set at £6.825m, and additional capital funding totalling £2.898m which totals available capital funding of £9.723m. The additional capital funding of £2.898m includes a successful bid of £1.050m to support the Trust elective recovery programme and a PDC award of £90k for oxygen infrastructure. Whilst the £1.050m is an increase to the Trusts available capital funding envelope it is not supported by additional cash.

6.2 Actual expenditure up to 31st August 2021 totals £2.367m 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
16th September 2021

Gateshead Health
NHS Foundation Trust

Report Cover Sheet

Agenda Item: 17

Purpose of Report	Decision: ☐	Discussion: ☒	Assurance: ☒	Information: ☒
Report Title:	Integrated Oversight Report			
Name of Meeting:	Trust Board			
Date of Meeting:	28th September 2021			
Author:	Deborah Renwick			
Executive Lead:	Jo Baxter			
Report presented by:	Jo Baxter / Deb Renwick			
Executive Summary:	**The following report covers the period of August 2021 where available, 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 constitutional standards and other standards, in relation to the latest surge in Covid infection rates causing operational pressures during the months of July and August 2021 The Trust did not achieve planned **activity levels** in July & August due to bed availability and pausing routine elective cases to safely accommodate Covid positive patients on-site. Progress continues to be made in relation to our **RTT** standards in July and reducing the backlog of patients waiting from 9235 to 9025. **Echocardiology** capacity is significantly below pre-covid levels with considerable backlogs and patients waiting longer than 6 weeks. Derail contained in September's spotlight report. Referrals into **Cancer pathways** continue to rise above pre-covid levels (circa 25%) and treating our urgent and cancer patients remains a key priority. There are notable treatment pressures across all tumour groups, with capacity and treatment levels remaining below pre-covid levels which has increased the backlog of patients waiting.			

<table>
<tr><td></td><td colspan="2">Quality & Safety
In August the Trust reported a Maternity serious incident – details of which are contained in the IOR.

The HSMR – indicates more deaths for the reporting period than expected, this follows several consecutive months of reduction and two consecutive periods of deaths within an expected range. A review by NEQOS has indicated no areas of concern.

Outstanding Patient Safety Alerts For the reporting period (August) there was one outstanding safety alert, which has now subsequently been closed down. To address late closure issues, alert actions will now be proactively monitored through monthly governance arrangements to enable the CBUs / alert leads to identify any challenges to timely completion and escalate these to the Medical Director.

Duty of Candour – Review of data capture and house-keeping underway.

Workforce: Operational staffing pressures continue as front-line staff continue to be impacted by self-isolation and the summer annual leave period. Under performance continues against our Well Led measures as the focus has been on ensuring patients are safe and staff time dedicated to the front line.</td></tr>
<tr><td>Recommended actions for Board/Committee)</td><td colspan="2">The Committee are asked to:
a) Receive the IOR for current reporting month of August
b) Note Trust performance & achievement against standards & remedial actions being taken in areas where metrics are outside of expected parameters.
c) Note additional shadow monitoring of new UEC measures identified within the UEC section of the report.
d) To seek further information and test robustness of plans as is required, allowing judgement regarding levels of assurance for future levels of operational performance.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:
(Including reference to any specific risk)</td><td>Aim 1
☒</td><td>We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td>We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td>We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☒</td><td>We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☐</td><td>We will develop and expand our services within and beyond Gateshead</td></tr>
</table>

<table>
<tr><td>Financial Implications:</td><td colspan="6">There are direct financial implications to recovering the organisational performance position and delivering activity plans. ERF Attainment in Q2 is at risk.
Across all indicators, potential future actions to improve operational performance are likely to incur additional spend.</td></tr>
<tr><td>Links to Risks (identify significant risks and DATIX reference)</td><td colspan="6">Covid – the continuing impact of Covid-19 remains a key risk to:
Delivery of Trust services;
Our people and staffing in key areas;
The ability to sustain elective services and recover backlogs
Workforce planning & financial impact
Annual leave and the number of staff receiving alerts from the NHS COVID App to self -isolate is having a significant effect on staffing levels and delivery of services.
Recruitment issues is also increasing the use of bank/agency for back -fill and outsourcing options.</td></tr>
<tr><td>People and OD Implications:</td><td colspan="6">Key People & OD implications are discussed at HR Committee</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: (including reference to any specific implications and actions)</td><td>Obj.1
☐</td><td colspan="5">The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance between working life and personal commitments</td></tr>
<tr><td>Obj. 2
☐</td><td colspan="5">All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers</td></tr>
<tr><td>Obj. 3
☐</td><td colspan="5">Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve</td></tr>
</table>

Integrated Oversight Report: September 2021

Gateshead Health NHS Foundation Trust

Contents:

Key Messages

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

Areas of positive performance include:

- No reported never events (last reported October 2020)
- RTT >52 weeks 37 *(July position)* Lowest volume of >52 week waiters in ICP.
- Benchmarked UEC activity places the Trust 21st of 139 providers

Areas of focus & risk include:

- Activity thresholds in Q2 (July & August) are below national thresholds
- ED pressures continue with a number of metrics triggering concern
- Maternity SI reported in month
- HSMR – increased to 'More deaths than expected' in reporting month
- Cancelled elective operations within 24 hours not readmitted within 28 days
- Cancer treatment backlogs on 62 day pathways are increasing (indicative across North ICP)
- Echocardiology recovery plans delayed
- Access targets (A&E, RTT, Diagnostics, Cancer) and total back log management.
- Sickness, core training and staff appraisal continue to underperform

KLOE Summary

Responsive

A&E: August 21 The Trust continues to underachieve, reporting August performance against the 4 hour standard as 81.8%. Footfall through A&E has decreased in August but is on average 30 attendances per day more than last year (13.3% increase). The latest national benchmarking data places the Trust at 21st of 139 Type 1 providers.

The Trust reported 34 30-60 minute and 24 over 60 minute ambulance delays in August.

RTT: July 21 The waiting-list is still showing special cause variation. July's performance against the 18 week standard is reported with an slight decrease to 81.0% with a decrease of patients on the RTT waiting list to 9,025 and a reduction to 37 patients waiting over 52 weeks.

Cancer: August 2ww The Trusts position against the 2 week wait target in August improved to 89.8% although still below the 93% standard . In August 2021 971 Two week wait referrals were received which shows an increase of 23.6% in comparison to the same period last year and 15.2% on the same period in 2019, breast service referrals (classic 2ww and ENCB) remain high with 479 referrals in August, representing a 2.4% decrease on August 2019 figures. Referrals to the lung service have increased to 47 referrals in August which is an increase from 37 in the same period in 2019.

Cancer: 62 day treatments July The Trusts position against the 62 day standard showed a decline in performance in July reporting performance at 56.6% with only Haematology achieving the performance standard of over 85%.

Gynaeoncology, Lower GI , Upper GI, Lung, Breast and Urology were unable to achieve the standard with the most notable pressures visible within Gynaeoncology with only 1 treatment of 10.5 treatments achieving the 62 day standard.

Diagnostics: July The Trust failed the diagnostic standard in July reporting 69.15% of our patients seen with 6 weeks of referral, a further decrease. Echocardiography continues to be the main challenge with audiology , urodynamics and cystoscopy also of concern.

Duty of candour: August Verbal compliance with Duty of candour has increased in August to 88.1% and is no longer triggering special cause variation

Cancelled elective operations within 24 hours not readmitted within 28 days Four cancelled operations in July followed by seven in August raising concern

The initial focus within the Trust will be to protect the elective care programme as much as possible whilst maintaining the COVID Clinical operating model and working withing IPC guidelines. Working towards achieving the Accelerator success measurements and ERF levels of activity is proving very challenging.

KLOE Summary

Safe

One maternity **Serious Incident** reported in August

There is a national **Patient safety alert not closed by deadline** of the 1st June :NatPSA/2020/008/NHSPS Deterioration due to rapid offload of pleural effusion fluid from chest drains. The LoCSSIP has been updated and the alert was closed on the 6th September 2021.

The latest **Never Event** was observed in October 2020.

Effective

The Trust **Hospital Standardised Mortality Ratio** (HSMR) 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 decreased from 69.6% in June to 69.3% in July and **appraisals** decreased from 63.1% to 61.4% during the same period.
Sickness Absence rates deteriorated from 4.8% in June to 5.6 in July

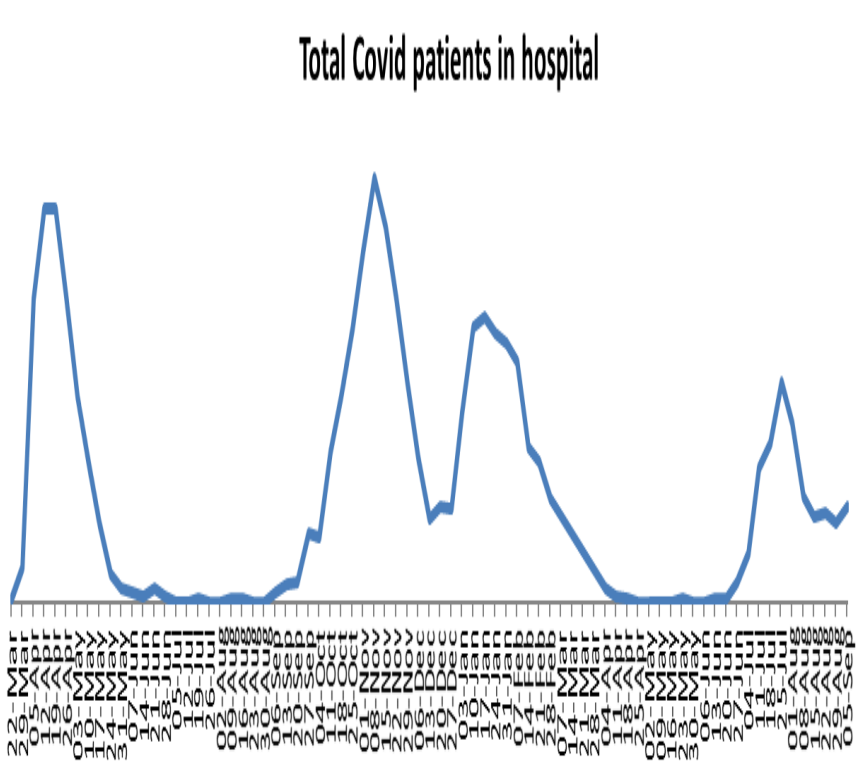
Caring

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

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 2000 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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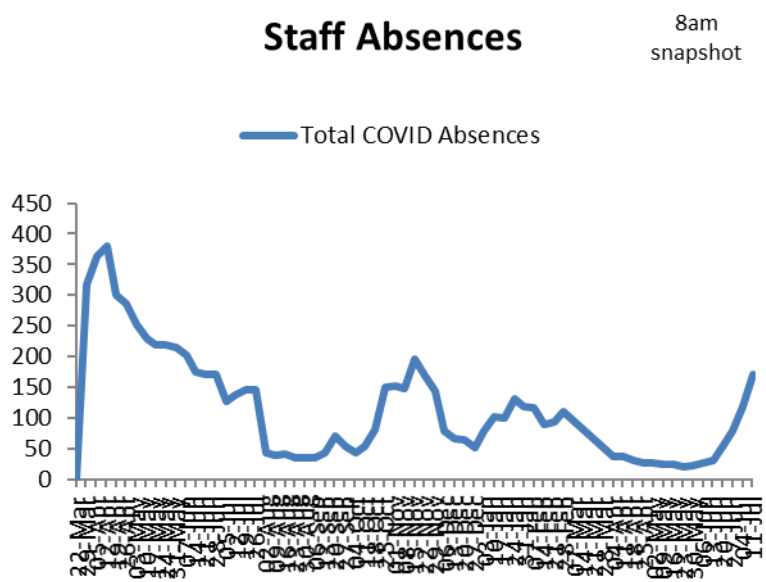
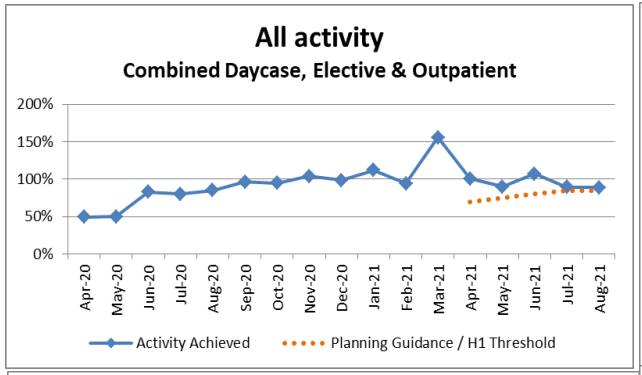
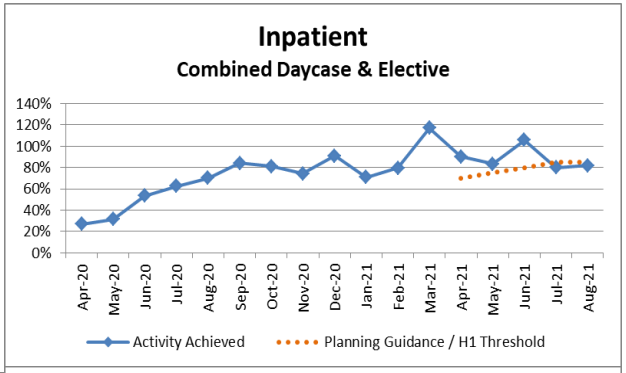


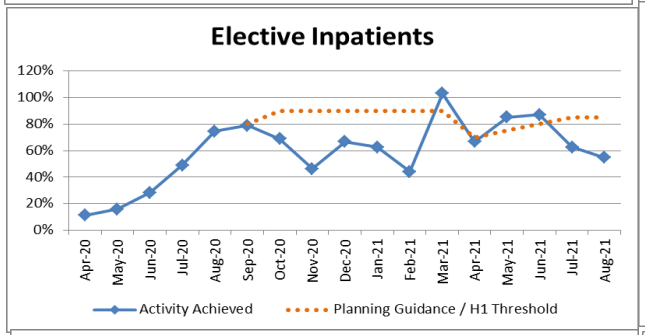
H1 Activity & Recovery

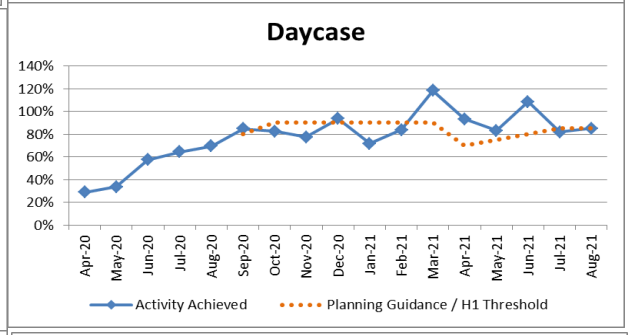
Gateshead Health NHS Foundation Trust

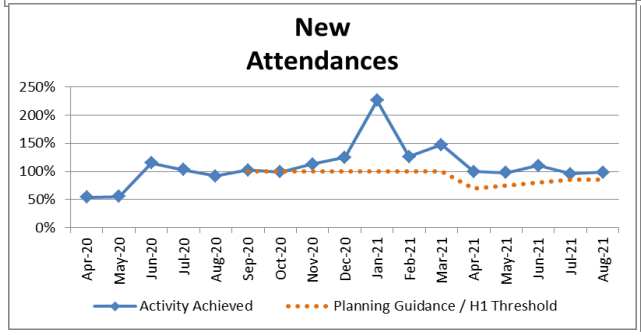
Planning guidance had stated Trusts should meet the following activity (value) thresholds as a minimum:
70% April, 75% May, 80% June, 95% from July onwards. Success criteria & financial values are currently monitored at ICS level. Across the ICS the Accelerator programme is required to deliver 100%

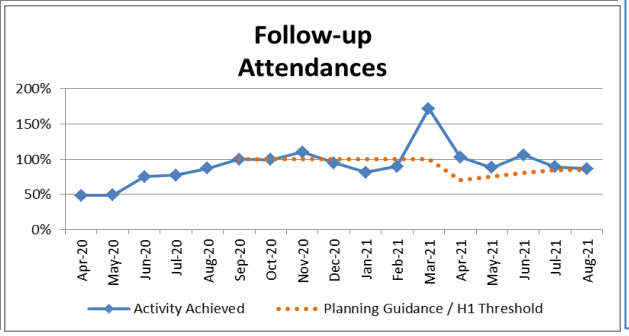












Commentary for August 2021

Combined activity (indicative) **August: 89%** below the revised 95% ERF threshold.
August (Indicative)Activity:
Day cases 85%
Elective overnights 55%
Outpatients 89%

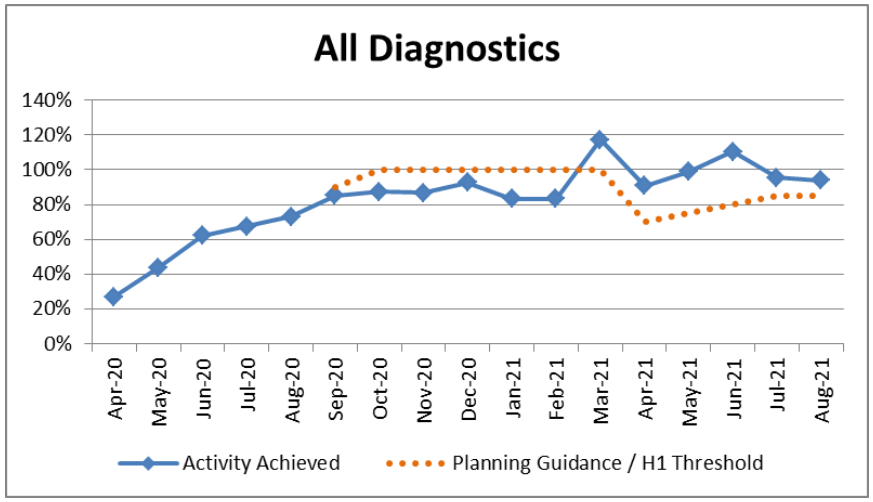
Other key requirements:
25% of Outpatient appointments to be virtual and PIFU activity to be actively recorded and submitted to NHSE. Whilst there are no financial consequences in Q2, NHSE advise that these will be key requirements in H2. In the meantime the trust is shadow monitoring.

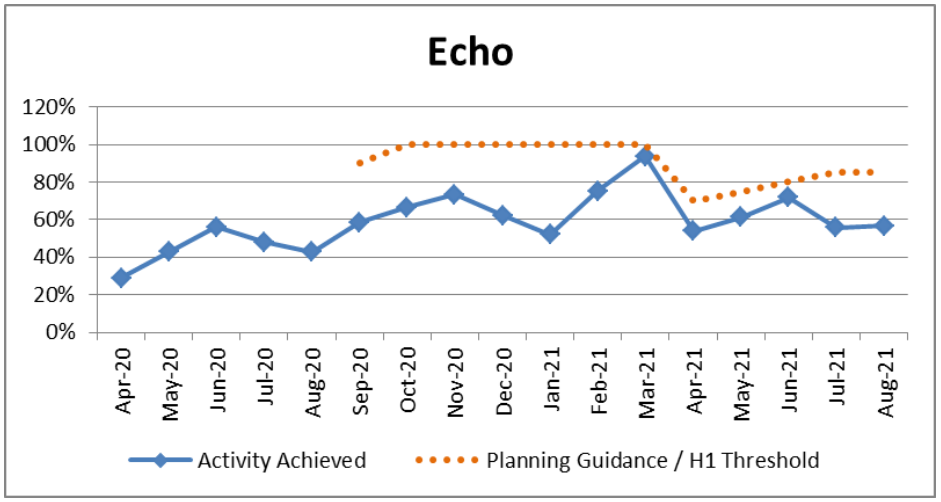
The Trust is in a healthy position: with 28% of all outpatient attendances conducted remotely & over 500 Patient Initiated follow-up activities recorded.

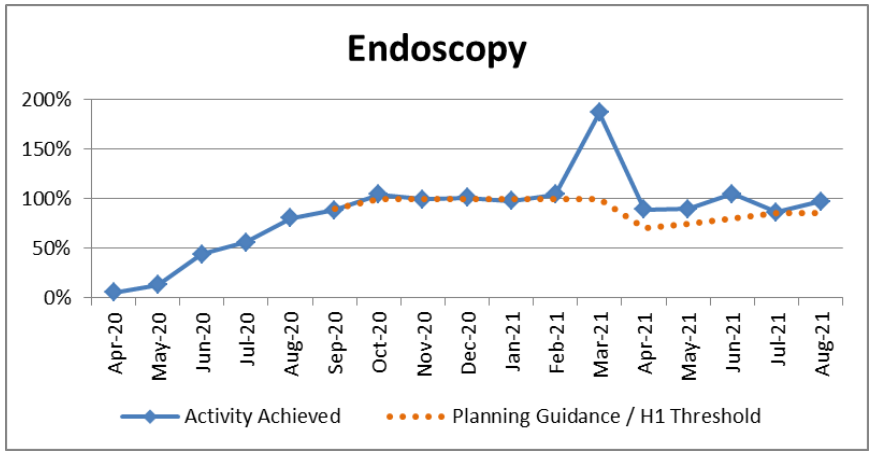
H1 Activity & Recovery

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 94% Endoscopy: Activity at 104% Echocardiology: Activity 56%
Pressures continue in echocardiography – activity delivered in August 57% of same period in 19/20 : Number of waiters> 6 weeks 88% 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 88% of the diagnostic waiters > 6 weeks with 77% of the echocardiography tests waiting longer than 6 weeks.
- Audiology accounts for 8% of the diagnostic waiters over 6 weeks with 30% of the audiology patients waiting longer than 6 weeks.
- Cystoscopy and Urodynamics percentage of over 6 week waiters are increasing.

Integrated Oversight Report –Summary Indicators

	Measure	Latest period		Target	Latest 12 months	Variation	Assurance	Comment
	Patient Safety Alerts not completed by deadline	1	Aug-21	0			?	There is a national Patient safety alert not closed by the deadline of the 1st June :NatPSA/2020/008/NHSPS Deterioration due to rapid offload of pleural effusion fluid from chest drains. Awaiting confirmation form clinical staff that the Trust is compliant before signing off.
EFFECTIVE	Hospital Standardised Mortality Ratio	110.44	Jul 20 -Jun 21			H		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	81.8%	Aug-21	95%	87.6%	L	?	Below target since August 2020. Special Cause Variation (concern) from July 2021
	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway	81.0%	Jul-21	92%	75.6%	H	F	Special variation (improvement) from October 2020, performance below target since January 2020
	Cancelled elective operations within 24 hours not readmitted within 28 days	7	Aug-21		18			7 cancelled operations within 24 hour recorded for August triggering special cause variation (concern).
	Cancer 2ww compliance	89.8%	Aug-21	93%	77.5%		?	Compliance achieved in March 2021, the first time since March 2020. Common cause variation.
	Cancer 2ww ENCB compliance	94.1%	Aug-21	93%	91.3%		?	Special cause variation for May and June 2020
	Cancer 28 day compliance	76.0%	Jul-21	75%	73.8%		?	Target achieved in for the last six consecutive months. Special cause variation (improvement) observed in February and March 2021
	Cancer 28 day exhibited compliance	100.0%	Jul-21	75%	81.6%		?	Below target in October 2020 and January 2021.
	Cancer 28 day screening compliance	64.4%	Jul-21	75%	62.7%		?	Target achieved in May 2021, the fist time since October 2020.
	Cancer 31 day compliance	95.2%	Jul-21	96%	98.5%		?	Target failed in July 2021. Special cause variation (concern) in June 2020, target achieved in 15 of 18 months.
	Cancer 31 day subsequent drugs compliance	100.0%	Jul-21	98%	99.3%		?	Target achieved in July 2021, Special cause variation in June 2020.
	Cancer 31 day subsequent surgery compliance	100.0%	Jul-21	94%	95.7%		?	Target achieved in July 2021. Performance fluctuates around the target.
	All cancers - maximum 62-day wait for first treatment from urgent GP referral for suspected cancer	56.6%	Jul-21	85%	68.8%		?	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	94.0%	Jul-21	90%	84.3%	H	?	Target achieved in July 2021. Special cause variation (improvement) identified from October 2020 to date. Performance above target between October 2020 and February 2021 and above mean since October 2020.
	Maximum 6-week wait for diagnostic procedures	66.5%	Jul-21	99%	65.2%	H	F	Special cause variation (Improvement) from December 2020 with 8 consecutive points above the mean, performance below target since March 2020
WELL-LED	Staff sickness	5.6%	Jul-21	4%	4.8%		?	June 2021 above target. Special cause variation - concern for April 2020. Target achieved 3 out of 18 months
	Appraisals	61.4%	Jul-21	85%	61.5%	L	F	Special cause variation - concern, shift in performance from October 2020 and consistently below target
	Core Training	69.3%	Jul-21	85%	74.0%	L	F	Special cause variation - concern. Recent performance below 18 month mean for the last 7 months. 3 of the last 4 months below the lower process limit. Consistently below target.

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

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	81.8%	Aug-21	95%	87.6%	L	?	Below target since August 2020. Special Cause Variation (concern) from July 2021
	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway	81.0%	Jul-21	92%	75.6%	H	F	Special variation (improvement) from October 2020, performance below target since January 2020
	Number of patients on an incomplete pathway	9025	Jul-21					Common cause variation displayed however 9 points (non consecutive) of the last 12 are above the mean.
	Number of patients waiting 52 weeks or more on an incomplete pathway	37	Jul-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	66.5%	Jul-21	99%	65.2%	H	F	Special cause variation (Improvement) from December 2020 with 8 consecutive points above the mean, performance below target since March 2020
	Duty of Candour - Verbal Compliance	88.2%	Aug-21					Duty of Candour verbal compliance now showing common cause varaition following triggering last month
	Formal Complaints	34	Aug-21		266			Clinical Treatment - Surgical Group (18) Communications (7) Values & Behaviours (Staff) (5) Appointments including delays & cancellations (2) Trust Administration (1) Admissions, discharge & Transfers (1)
	Informal complaints	40	Aug-21		544			
	Compliments	65	Aug-21		448	H		

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Integrated Oversight Report

Gateshead Health NHS Foundation Trust

Responsive

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RESPONSIVE	Cancer 2ww compliance	89.8%	Aug-21	93%	77.5%			Compliance achieved in March 2021, the first time since March 2020. Common cause variation.
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	Cancer 62 day upgrade compliance	N/A	Jun-21	94%	47.0%			

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.

Integrated Oversight Report

Gateshead Health NHS Foundation Trust

Safe

	Measure	Latest period		Target	Latest 12 months	Variation	Assurance	Comment
SAFE	Occurrence of any Never Event	0	Aug-21	0	1			1 never event in October 20
	Emergency c-section rate	12.2%	Aug-21		14.9%			
	Venous thromboembolism (VTE) risk assessment	98.9%	Aug-21	95%	98.8%			
	C difficile actual	5	Aug-21		34			
	Clostridium difficile - infection rate	40.6	Aug-21		24.4			
	Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	0	Apr - Mar 21/22	0	0			
	P. aeruginosa bacteraemia infection rate	16.3	Aug-21		18.5			
	Klebsiella spp: bacteraemia infection rate	65.0	Aug-21		35.6			
	COVID Hospital-Onset Indeterminate Healthcare-Associated	4	Aug-21					
	COVID Hospital-Onset Probable Healthcare-Associated	3	Aug-21					
	COVID Hospital-Onset Definite Healthcare-Associated	5	Aug-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.

Integrated Oversight Report

Gateshead Health NHS Foundation Trust

Safe

	Measure	Latest period		Target	Latest 12 months	Variation	Assurance	Comment
	Medication errors per 1000 FCEs	8	Aug-21		8.9			A general upward trend over the past 18 months, levelling over recent months
	Patient Falls per 1000 bed days	6.9	Aug-21		10.1			Common cause variation
	Trust Acquired Pressure Damage per 1000 bed days (Category 2 and above)	1.4	Aug-21		3.0			Common cause variation
	Potential under-reporting of patient safety incidents	35.7	Aug-21		41.5			Common cause variation
	Serious Incidents reported to StEIS	7	Aug-21		71			Common cause variation
	Patient Safety Alerts not completed by deadline	1	Aug-21	0				There is a national Patient safety alert not closed by the deadline of the 1st June :NatPSA/2020/008/NHSPS Deterioration due to rapid offload of pleural effusion fluid from chest drains. Awaiting confirmation form clinical staff that the Trust is compliant before signing off.
	Escherichia Coli (E. coli) bacteraemia bloodstream infection (BSI) rate	130.0	Aug-21		172.6			
	Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemia infection rate	8.1	Aug-21		12.7			
	Care hours per patient day	8.25	Jun-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.

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	1.00	Apr 20 - Mar 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					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	105	Aug-21		1132			
	Crude Mortality - Covid Deaths	25	Aug-21		251			
	Mortality Review Compliance	59.3%	Aug 20 - Jul 21					
	Potentially Avoidable Deaths (%/#)	0.3% (2)	Aug 20 - Jul 21					
	Mortality Review Compliance - Learning Disability Deaths	73.7%	Aug 20 - Jul 21					
	Potentially Avoidable Deaths - Learning Disability Deaths (%/#)	0.0% (0)	Aug 20 - Jul 21					
	Long Length of Stay Patients	53.8	Aug-21		44.0			
	Readmissions within 30 days	10.8%	May-21		10.5%			
	Pre procedure elective bed days	0.21	Jul-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.

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	81.3%	Aug-21		85.7%			FFT in inpatient areas was launched in May 2021 using Health call Text Messaging. Reporting by cards is also available by exception. The service will be going live for outpatient clinics soon. Maternity is to use the Badger system at a later date however a number of text message responses were received via the text message collection.
	Inpatient & day case scores from Friends & Family Test - % positive	97.6%	Aug-21		98.0%			
	Maternity scores from Friends & Family Test - % positive	100.0%	Aug-21		93.3%			
	Outpatient scores from Friends & Family Test - % positive	100.0%	Aug-21		100.0%			
	Community scores from Friends & Family Test - % positive	-	Aug-21		100.0%			
	Mental Health scores from Friends & Family Test - % positive	-	Aug-21		100.0%			
	Written Complaints rate per 1000 WTE	4.6	Jul-21					

Well Led

	Measure	Latest period		Target	Latest 12 months	Variation	Assurance	Comment
WELL-LED	Staff sickness	5.6%	Jul-21	4%	4.8%			June 2021 above target. Special cause variation - concern for April 2020. Target achieved 3 out of 18 months
	Staff turnover	1.45%	Jul-21		1.43%			Special cause variation - concern for August 2020
	Appraisals	61.4%	Jul-21	85%	61.5%			Special cause variation - concern, shift in performance from October 2020 and consistently below target
	Core Training	69.3%	Jul-21	85%	74.0%			Special cause variation - concern. Recent performance below 18 month mean for the last 7 months. 3 of the last 4 months below the lower process limit. Consistently below target.
	Data Quality Maturity Index (DQMI) - MHSDS dataset score	85.9%	May-21		89.4%			

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.

Single Oversight Framework

Gateshead Health NHS Foundation Trust

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

2021/22 Trust Performance Dashboard
NHS Improvement - Single Oversight Framework

NHS Gateshead Health NHS Foundation Trust

Category	Performance Indicator Information	PSF Trajectory	2020/21	2021/22 Performance												Standard	Trigger for Potential Support Need:-
				Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	2021/22	(2 consecutive months of non delivery of standard/PSF trajectory)*
Operational	Incomplete RTT Pathways - Waiting < 18 weeks	N	69.0%	76.7%	80.3%	81.3%	81.0%									79.8%	92%	
	Maximum Waiting Time 4 hours in A&E	Y	91.4%	93.5%	91.3%	87.8%	80.4%	81.8%								86.8%	95%	
	62 day wait for 1st definitive treatments	N	68.1%	68.6%	74.4%	70.6%	56.8%									69.9%	85%	
	62 day wait for treatment (screening patients)	N	76.4%	88.1%	85.7%	83.1%	94.0%									88.2%	90%	
	Maximum 6-week wait for diagnostic procedures	N	55.8%	71.6%	70.8%	69.8%	69.1%									70.3%	99%	

Dashboard Key:

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

Operational Measures

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)

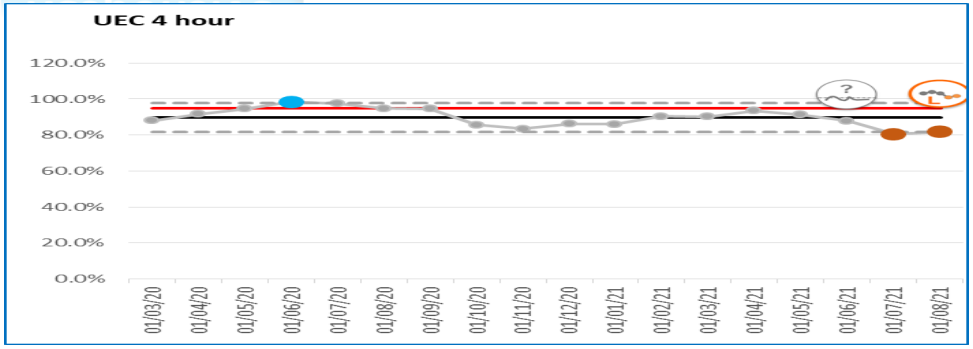
Pefrormance Measure	RO	Last Period		This Period		This Period Status	Variation	Assurance	Target (where applicable) or trajectory	Target type
Referral to treatment within 18 weeks	JBa	81.3%	Jun-21	81.0%	Jul-21	×	H	F	92%	National
Referral to treatment Total Incomplete waiters	JBa	9325	Jun-21	9025	Jul-21				8,590	Activity and recovery monitoring
Referral to Treatment >52 week waiters	JBa	46	Jun-21	37	Jul-21				0	Activity and recovery monitoring
A&E seen within 4 hours	JBa	87.4%	Jul-21	81.8%	Aug-21	×	L	?	95%	National
A&E attendances	JBa	8115	Jul-21	7998	Aug-21				10,268	Activity and recovery monitoring
Handover delays 30-60 minutes	JBa	55	Jul-21	34	Aug-21		H		0	National
Handover delays >60 minutes	JBa	42	Jul-21	24	Aug-21		H		0	National
Bed Occupancy	JBa	94.5%	Jul-21	89.6%	Aug-21				92%	National
Cancer 2 ww - first seen	JBa	85.9%	Jul-21	89.8%	Aug-21	×		?	93%	National
Cancer 2ww to treatment within 62 days	JBa	70.6%	Jun-21	56.8%	Jul-21	×		?	85%	National
Cancer 62 day treatment screening	JBa	83.1%	Jun-21	94.0%	Jul-21	×		?	90%	National
Cancer waits over 104 days (all pathways)	JBa	18	Jul-21	12	Aug-21		L	F	0	Local monitoring
Diagnostic waits % within 6 weeks	JBa	69.8%	Jun-21	69.2%	Jul-21	×	H	F	99%	National
Diagnostic waiters	JBa	6103	Jun-21	6437	Jul-21					National
Endoscopy waiters (subset of the above)	JBa	435	Jun-21	455	Jul-21					National

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
UEC Shadow Performance Measures	95 % Target	95%	93.45%	91.30%	87.78%	80.69%	81.78%
	QEH ED Total Attendances		7390	7790	8394	8115	7998
	(Activity levels 2019/20)		10268	10636	10350	10987	10740
	Activity as proportion of base year		72%	73%	81%	74%	74%
	Type 1 Attendances		6881	7177	7744	7786	7621
	Type 3 Attendances		509	613	650	329	377
	Percentage Assessed within 15 minutes		68.17%	70.35%	65.51%	53.92%	68.47%
	30 minute Ambulance Breaches		2	4	22	55	34
	Total patients spending > 12hrs in Dept.		4	6	5	52	81
	No of patients with TCI > 12 hours		0	0	0	0	5
	Average Time in Dept - Non-Admitted		132	130	135	147	145
	Average Time in Dept - Admitted		243	264	293	363	354
S DEC	% of 0 LOS Admission as proportion of total NEL Activity		22.40%	20.80%	19.97%	16.07%	

Situation

The Trust continues to underachieve against the 4 hour standard, this is the twelfth consecutive month the Trust has failed the 4 hr target. In August the Trust saw 81.8 % of the patients presenting through UEC within 4 hours, compared to 94/7% in August 2020.

Background

Activity levels for August at 74% of those of the comparable period in August 2019, pre-COVID. Footfall and patient numbers decreased slightly in August although daily attendances average 30 more than August 2020 (13.3%)

Assessment

The impact of challenges within the 111 service are being seen in increases in attendances at ED. Staff isolation (nursing and medical) from test and trace tracking, along with a rise in general sickness levels has seen staffing levels in all areas of the Trust reduced, along with COVID configuration and the acuity of patients, 'surge' arrival of patients have presented challenges and affected flow throughout the Trust and extended ED duration times. Across the region all Trusts are reporting an increase in ED attendances. The acuity of patients presenting is high, increasing average length of stay.

Actions

Several work streams are underway to improve performance:

- Talk before you Walk
- Telephone triage for Urgent Treatment Centre
- Move of EAU to take place in September to allow SDEC to be created
- Bed reconfiguration and modelling
- Review of options for POC testing to allow streaming of patients direct to surgical wards
- Detailed review of surge times and medical staffing rota
- Review of speciality pathways
- A regional review of UEC is underway, as ED presentations across the region are increasing and pressure across primary care is evident.

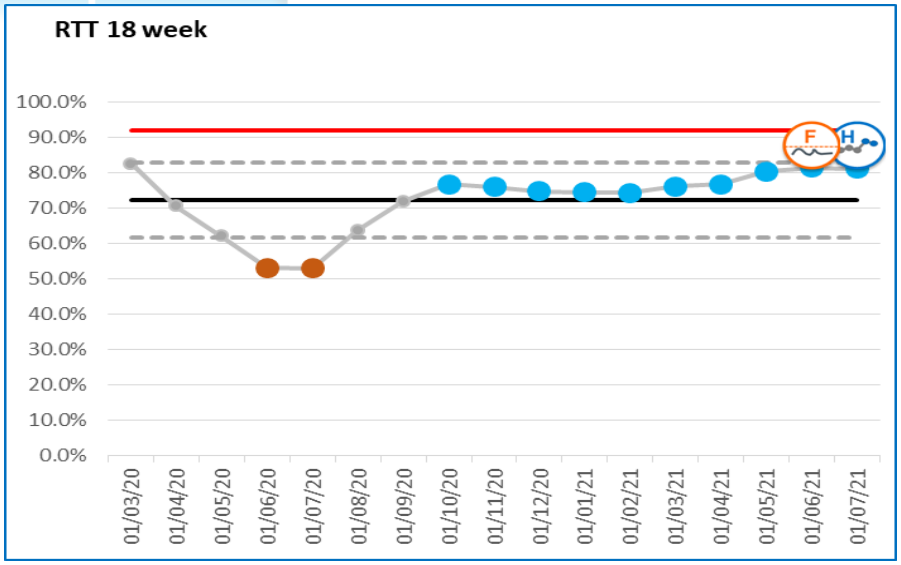
Recommendation

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%

Gateshead Health NHS Foundation Trust

Responsive



Combined impact analysis

Financial impact

Not yet known

Quality impact

Long waits for elective surgery could mean that patients 'conditions may change from being first seen. This also has the potential to adversely impact on patient experience.

Workforce impact

- Maximising capacity
- Additional sessional work to support backlog maintenance commenced

Operational performance impact

Trajectory set to fail.

Situation

RTT performance significantly decreased between February and July 2020. The standard has not been achieved since December 2019. A shift in performance is observed from March 2020 with performance below the 18 month mean from April 2020 to September 2020. Recent performance shows 10 consecutive months above the 18 month mean triggering special cause variation for improvement.

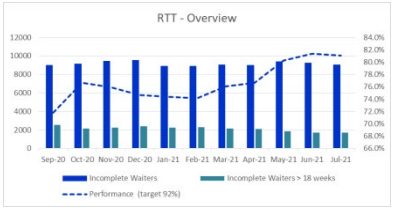
The indicator is highlighted to consistently fail based on current performance and variation.

Background

Recovery progress has been affected by COVID levels and staffing challenges impacting on the ability to deliver Inpatient overnight stays.

Assessment

The indicator is flagging as the standard is consistently failed based on current performance and monthly variation. General Medicine (95.74%), Rheumatology (95.15%) and Geriatric Medicine (94.69%) achieved the 18 week standard in July.



Actions

- Business Units are working towards achieving the expectations in the planning guidance 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.
- Local expectation to eradicate >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

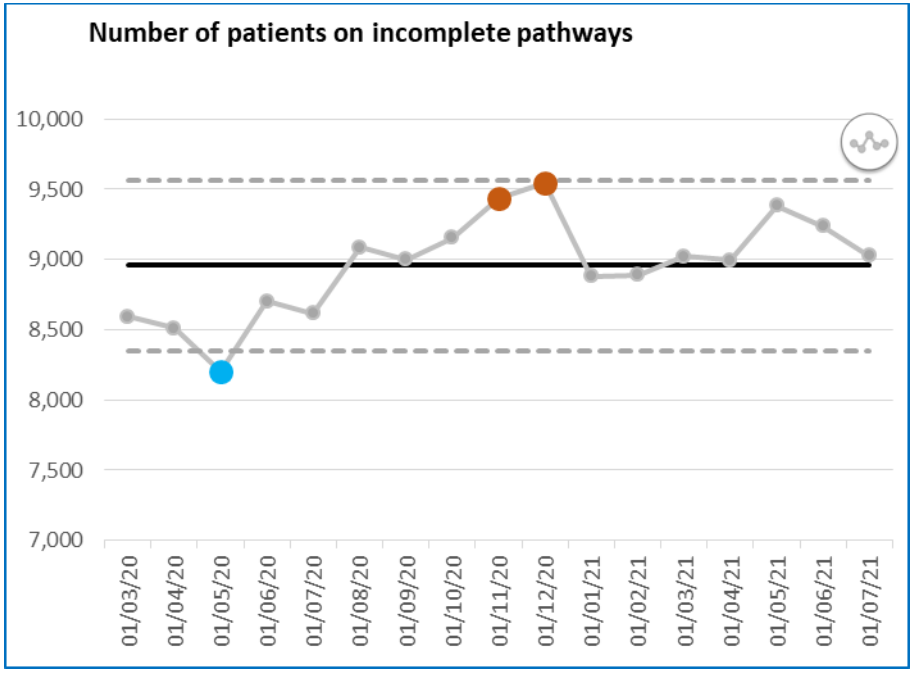
Finance & Performance Committee are to note that the above plans remain in place whilst current COVID levels are maintained.

Report by exception: Responsive – Spotlight Number of patients on an incomplete pathway

Gateshead Health NHS Foundation Trust

Detail on this measure is included as a significant shift is observed in the number of patients on an incomplete pathway –

Responsive



Situation

At the end of July 2021 there were 9025 patients on an incomplete pathway, an increase of 408 patients on July 2020.

Background

Restart of elective recovery is well underway and patient confidence is returning as increased referrals have impacted on the growth in the waiting list.

Assessment

The number of patients waiting longer than 18 weeks has fallen from 4,055 patients in July 20 to 1,714 in July 21.
All specialties are making good progress and reducing their backlog in line with clinical prioritisation programme.
Areas of pressure remain in the surgical business unit in General Surgery & Trauma & Orthopaedics with 297 and 310 patients waiting longer than 18 weeks.

Actions

- Business Units are working towards achieving the expectations in the planning guidance & Accelerator programme where possible given the current operational challenges
- 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.
- Local expectation to eradicate >52 week waiters by end of the financial year.
- Technical validation of the waiting list to be repeated to understand patients' treatment options and review 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.

Recommendation

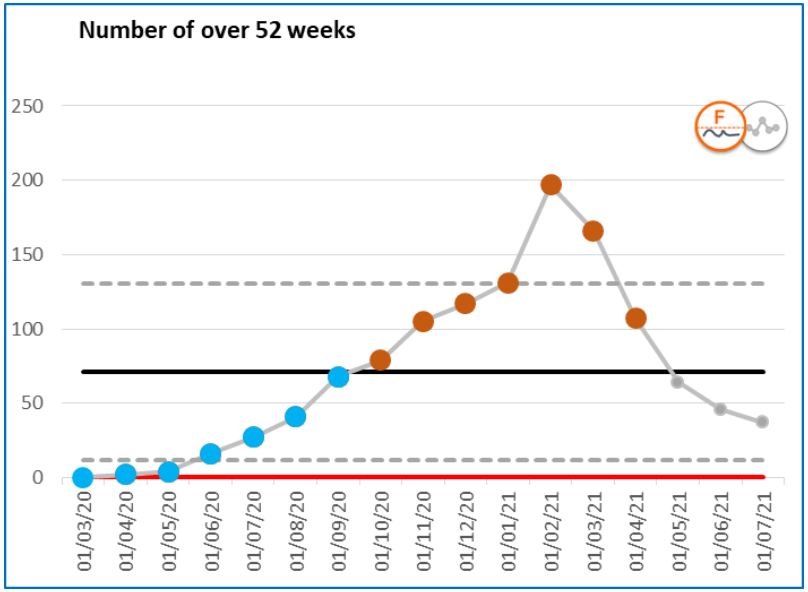
Finance & Performance Committee are to note that the above plans remain in place whilst current COVID levels are maintained.

Report by exception: Responsive – Spotlight Number of patients waiting 52 weeks or more on an incomplete pathway

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

NHS Gateshead Health NHS Foundation Trust

Responsive



Combined impact analysis

Financial impact
Not yet known
Quality impact
Long waits for elective surgery could mean that patients 'conditions may change from being first seen. This also has the potential to adversely impact on patient experience.
Workforce impact
Maximising IS capacity – Surgeons operating at Nuffield, and Spire.
Operational performance impact
Over 52 week waiters will continue to grow, until elective capacity is truly protected.

Situation

The number of patients waiting 52 weeks increased triggering special cause variation from September 2020 to April 2021 , however common cause variation is displayed since.

Assessment

Following consecutive decreases the July figures is displaying common cause variation at 37 patients. Weekly PTL data demonstrates a slight increase to 43 patients.

Monitoring and delivery plans are in place to ensure the accelerator trajectory is managed and delivered, and any issues expedited. Cancellations are being reviewed to ensure long waiters can still progress where possible.

>52 week waiters	06-Jun	13-Jun	20-Jun	27-Jun	04-Jul	11-Jul	18-Jul	25-Jul	01-Aug	08-Aug	15-Aug	22-Aug	29-Aug	05-Sep
100 General Surgery	12	13	11	10	9	11	12	11	9	8	8	8	10	9
101 Urology	7	6	6	5	5	5	4	3	3	5	5	5	6	5
110 Trauma & Orthopaedics	32	28	26	20	18	22	20	21	21	22	20	20	24	21
301 Gastroenterology	1	4	3	3	3	3	4	3	2	1			1	1
320 Cardiology											1	1	1	1
502 Gynaecology	2	3	3	3	3	3	3			1	2	2	5	5
X01 Other	3	4	3	3	3	2	1	1	2		1	1	1	1
TOTAL >52 weeks	57	58	52	44	41	46	44	39	37	37	37	37	48	43

Latest weekly benchmarking performance – highlights the Trust as better performing with more than half of the longest waits with planned treatment dates or next events.

Actions

Business Unit are exploring all options to maximise capacity
Technical validation of the waiting list is ongoing to understand any changes patients' treatment choices and options, specifically for those choosing to delay treatment but remain on the waiting list.
All 52 week waiters are fully validated as 'true' waits.
Treatment cancellations by priority type are now monitored and are sit-rep reportable.

Recommendation

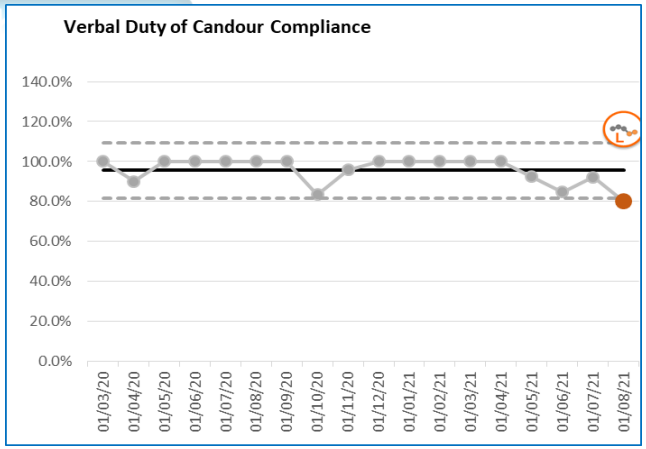
Finance & Performance Committee are to note that the above plans remain in place whilst current COVID-19 levels are maintained.

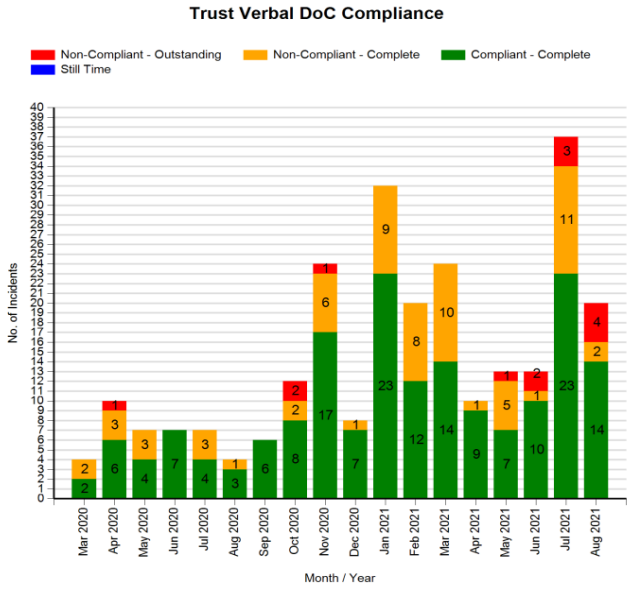
Report by exception: Responsive – Duty of Candour Verbal Compliance

Gateshead Health NHS Foundation Trust

Detail on this measure is included as special cause variation (low) is identified in July 2021.

Responsive





Situation

Verbal Duty of Candour compliance is displaying special cause variation for concern in August 2021 with compliance at 80%% (16 of 20 cases compliant).

Background

Duty of Candour is governed by the Health and Social Care act 2008 (Regulated Activities) Regulations 2014: Regulation 20 Verbal Duty of Candour (stage 1)

Regulation 20 stipulates that an individual (or other appropriate person) must be notified "as soon as reasonably practicable" after a notifiable patient safety incident has and the NHS Standard Contract requires that verbal discussion must be within 10 working days of the incident being reported to the local system and sooner where possible.

Assessment

Historically the Trust have clearly done very well in terms of compliance with the verbal Duty of Candour process. Compliance rates for the Trust overall , pre-pandemic, were 99% for the verbal Duty of Candour ; the pandemic has had a significant impact on compliance rates over the last 18 months with rates previously dropping to as low as 54.2% in January 2021.

The Duty of Candour compliance for April 2021 is 91.7%; May 2021 is 85.7%, June 2021 is 84.6% and July 2021 is 92.1% and August 80.0%. The apparent reasoning for the significant recent decline in the compliance rate is due to recent significant pressures with staff self-isolation and the increased clinical and operational pressures the Trust are experiencing in the 4th wave of the COVID pandemic.

You will note from the chart that 4incidents are showing as non-compliant; This "non-compliance" will most likely be in relation to "housekeeping" and the capturing of data on the Datix system.

The Legal Services team have attempted to contact individuals assigned to the outstanding incidents seeking assistance from Matrons, SLMs, assistant SLM,s and Risk Leads but given the ongoing current situation clinically and operationally at the time of preparing this data no updates can be provided for the outstanding cases. The Legal team have attempted to collate and review all available medical records however a number of these patients are currently still inpatients and the wards are reluctant to release the medical records for review.

Actions

The Legal Services team are continuing to work with the business units with an aim to review all the red non-compliant incidents as above and to review the outstanding Notification letters and Findings letters. A process is being implemented in the Medicine Business unit whereby a daily huddle is undertaken where cases are reviewed, the level of harm assigned, and duty of candour undertaken where applicable and recorded appropriately

Recommendation

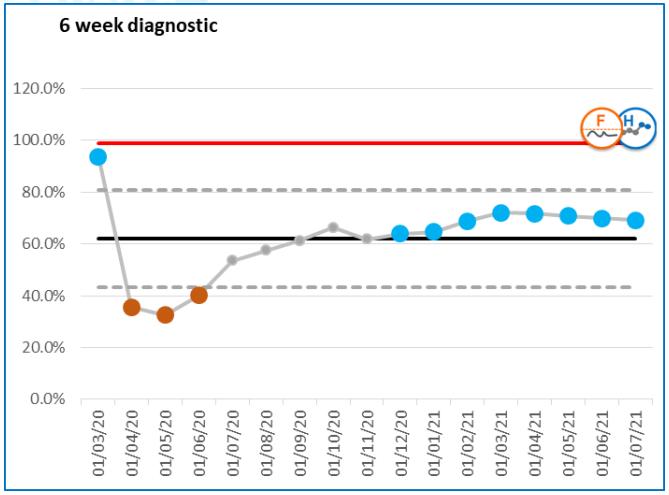
To be reviewed and discussed at the Quality Governance Committee

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

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

NHS Gateshead Health NHS Foundation Trust

Responsive



July 2021 Diagnostic Waits				
Procedure	Diagnostic waits 0 - < 6 weeks	Diagnostic waits 6 - < 13 weeks	Diagnostic waits 13 weeks +	Performance
Barium Enema	21	1		95.45%
CT	317	3	2	98.45%
MRI	360	6		98.36%
Non-obstetric ultrasound	1962	19		99.04%
Dexa	423	7		98.37%
Audiology	355	139	13	70.02%
Echocardiography	531	451	1303	23.24%
Peripheral Neurophysiology				#DIV/0!
Urodynamics	49	20		71.01%
Colonoscopy	166	4	1	97.08%
Flexisigmoidoscopy	70	2		97.22%
Cystoscopy	30	11		73.17%
Gastroscopy	167	4		97.66%
Total	4451	667	1319	69.15%
Performance Percentage	69.15%	10.36%	20.49%	

Situation

The 6 week wait target has not been met since February 2020 with a significant reduction in performance observed from March 2020 onwards. Following a general upward trend in performance July performance of 69.1% demonstrates seight consecutive months above the 18 month mean, thus triggering special cause improvement.

The indicator is flagged as a consistent fail as current performance and variation means that the target cannot be achieved without a change in process.

Background

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.

Assessment

All modalities have recovery plans to re-instate additional capacity, Echocardiography still remains a particular area of concern accounting for 88% of the patients waiting over 6 weeks – and current performance at 23% of patients waiting within 6 weeks. Activity levels for echocardiography dropped in July and remain below Pre-COVID 2019/20 levels: 54% in April, 61% in May, 72% in June and 57% in July.

Audiology referrals have increased – capacity is now being reviewed on a weekly basis. In Gynaecology there is a business case identified for additional nursing staff and in Urology the current capacity and availability of clinics is being reviewed.

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.

Recommendation

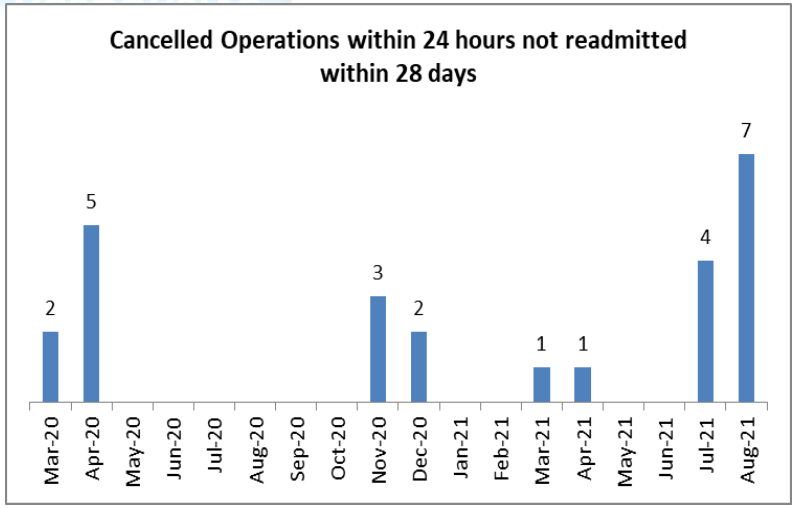
Detailed discussion and scrutiny at Finance & Performance Committee

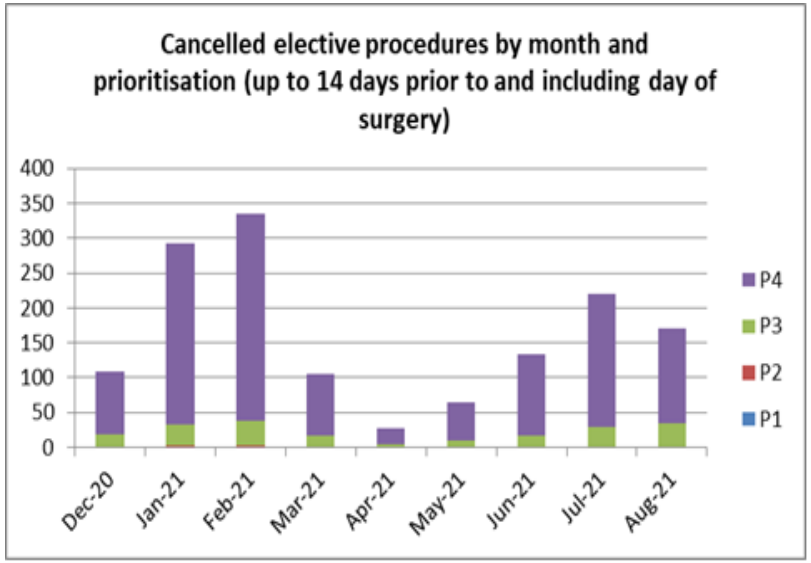
Report by exception: Responsive – Cancelled elective operations within 24 hours not readmitted within 28 days

Gateshead Health NHS Foundation Trust

Detail on this measure is included as special cause variation (high) is identified in August 2021.

Responsive





Situation

Seven Cancelled elective operations within 24 hours not readmitted within 28 days recorded for August 2021. This follows four for July raising concern.

Background

Due to the impact of the Covid pandemic the hospital bed state during this month re-purposed an elective orthopaedic ward into a general medicine/gastro/COTE inpatient area. This prevented elective orthopaedic operations from taking place as the Trust had no ring-fenced orthopaedic beds as per orthopaedic GIRFT expectations.

Assessment (graph 1 – Last minute cancellations – on or day before surgery)

The below are the details for the 7 breaches in August.

4 Orthopaedic patients were unable to be rebooked due to lack of beds, 2 have now been seen and the remaining 2 have TCI dates.

2 General Surgery patients were unable to be rebooked within the 28 days because the consultant was self isolating and one where the consultant was unavailable for other reasons.

1 patient has been treated, a further patient was given another dates but was unfortunately cancelled again due to lack of theatre staff and the remaining patient is awaiting a new date as cancer patients are being prioritised currently.

Graph 2 all cancelled or rescheduled patients by priority type. The Trust has not cancelled or rescheduled any cancers (P2's) or extremely urgent operations (P1's)

Actions

All appropriate processes were followed, but limited capacity created extremely challenging months in both July and August for matching capacity with demand (theatres was busy with cases but a lot of staff were on leave or absent due to a combination of Covid-19 reasons and other short-term sickness)

Recommendation

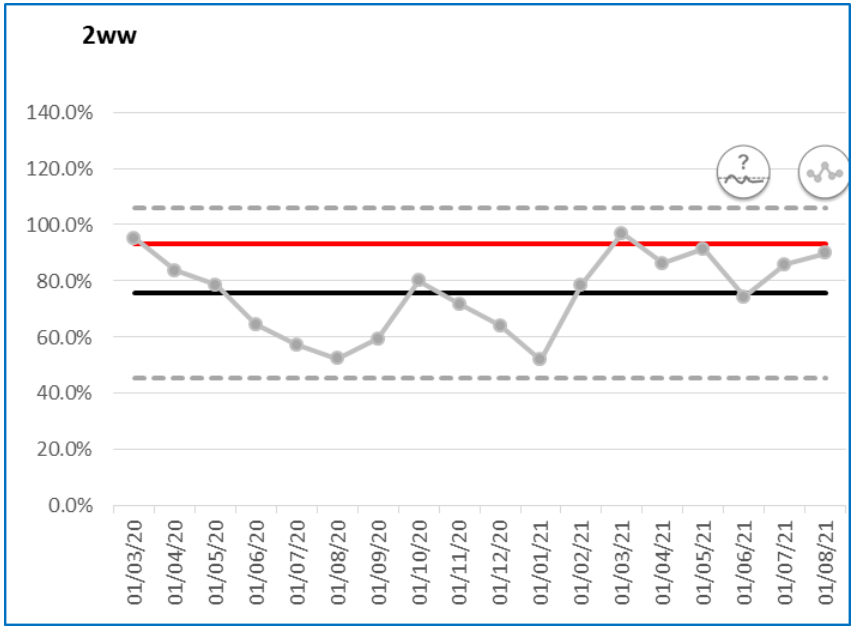
Additional monitoring to take place to link in with a live-report that will be able to see any patients that have had their procedures cancelled on the day and have yet to have seen again. This will help identify any patients that could breach due to having either a TCI date outside of 28 days or one not yet booked.

Report by exception: Responsive – Cancer 2 week wait compliance

Detail on this measure is included as performance and variation means that the target may or may not by achieved as a result of normal variation.

Gateshead Health NHS Foundation Trust

Responsive



Situation
Cancer two week: August's performance was below the 93% performance target at 89.8% and above the 18 month mean of 75.7%. March's performance of 97% demonstrated compliance against this standard. However the target has not been achieved since.

The indicator is flagged as performance and variation means that the target may or may not by achieved as a result of normal variation.

Background
August saw 971 patients referred on a two week wait pathway. This is a 15.2% increase in comparison to August 2019 data.

Assessment
The breast service showed an increase in performance to 89% against the 93% performance standard. The total number of breast referrals in August was 471 (2ww classic and ENCB) this is a 2.4 % reduction in comparison with August 2019.

Actions
- Ongoing pathway development within the lung team and continued development of the navigator role should continue to deliver improvements within 2ww performance.
- Northern Cancer Alliance funding has been agreed to support the Lung Cancer pathway in relation to faster turnaround times for CT scans.
- Gynaecology Rapid Diagnostic Concept started on the 2nd August with a defined triage process established to support the clinical team.
- The Lower GI cancer navigator is now in post and processes have begun to support the 2ww pathway.

Recommendation
Detailed discussion and scrutiny at Finance & Performance Committee

Combined impact analysis

Financial impact Not yet known

Quality impact – Long waits at the start of the pathway can potentially impact on timely treatments.

Workforce impact- Additional clinics are being supported by current staff. The breast team have successfully appointed into the current consultant vacancy.

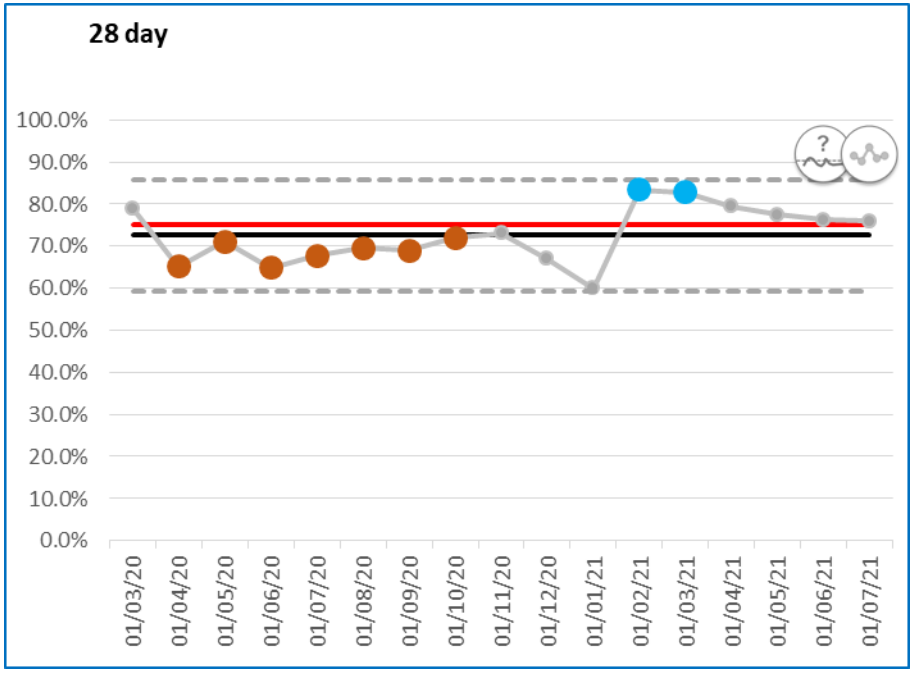
Operational performance impact

Report by exception: Responsive – Cancer 28 day Faster Diagnosis Standard compliance

Detail on this measure is included as the standard is subject to achieve or fail the target as a result of variation in performance

Gateshead Health NHS Foundation Trust

Responsive



Situation

Cancer 28 day compliance is flagged as performance and variation means that the target will not be consistently achieved.

The target was achieved in the last six consecutive months with July compliance at 76.0%.

Background

This is currently a shadow monitored target. It will be introduced as a performance monitored target in October 2021 with a target of 75%

Assessment

Individual tumour site performance is monitored:

28 day standard performance by Tumour site	Jul-21
Breast	95.96%
Children's	100.00%
Gynaecology	64.66%
Haematology	62.50%
Lower GI	52.23%
Lung	50.00%
Other	50.00%
Upper GI	61.76%
Urological	48.65%

Actions

Ongoing review of each tumour site to optimise performance against this standard.

Combined impact analysis

Financial impact

Quality impact Waiting for a potential diagnosis of cancer is very stressful for patients and their families.

Workforce impact- Maximising radiology, endoscopy and pathology capacity is necessary to achieve this target

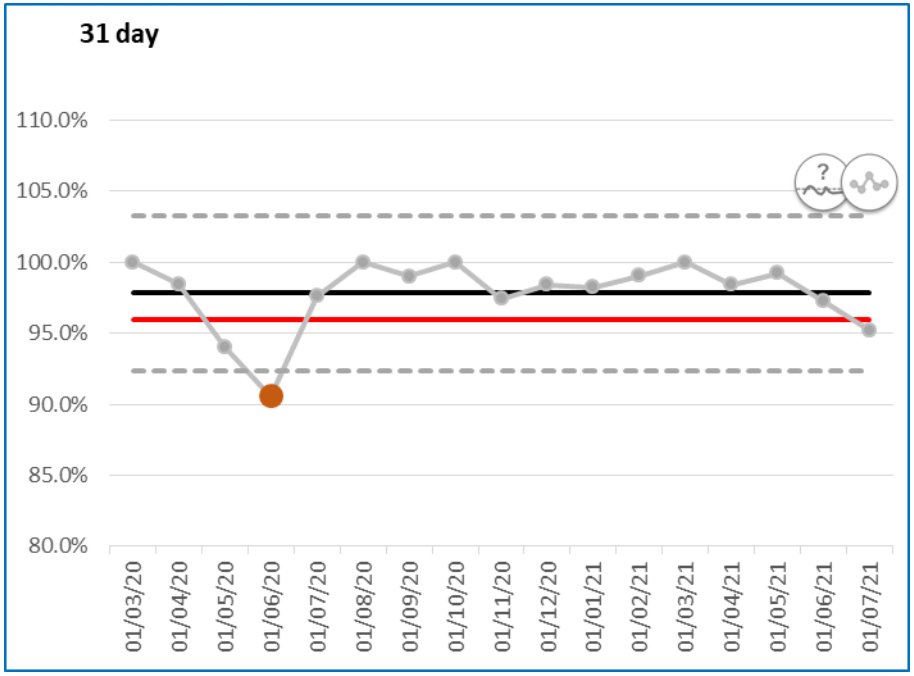
Operational performance impact

Report by exception: Responsive – Cancer 31 day compliance

Detail on this measure is included as the standard is subject to achieve or fail the target as a result of variation in performance

NHS Gateshead Health NHS Foundation Trust

Responsive



Situation
The target was achieved in all but three of the last 18 months (June-20, July-20 & July-21) Special cause variation (low) identified in Jun-20.

The target was not achieved in July 2021 with compliance at 95.2% against the 96.0% target

Background This target measures the numbers of patients with a cancer diagnosis who are treated within 31 days of a decision being made to treat.

Assessment Breast had 3 treatment breaches of 44 dropping to 93.18% performance and Gynaecology also had 3 treatment breaches against a total of 25 treatments reporting an 88% performance.

Actions Ongoing review

Combined impact analysis

Financial impact

Quality impact

Workforce impact

Operational performance impact

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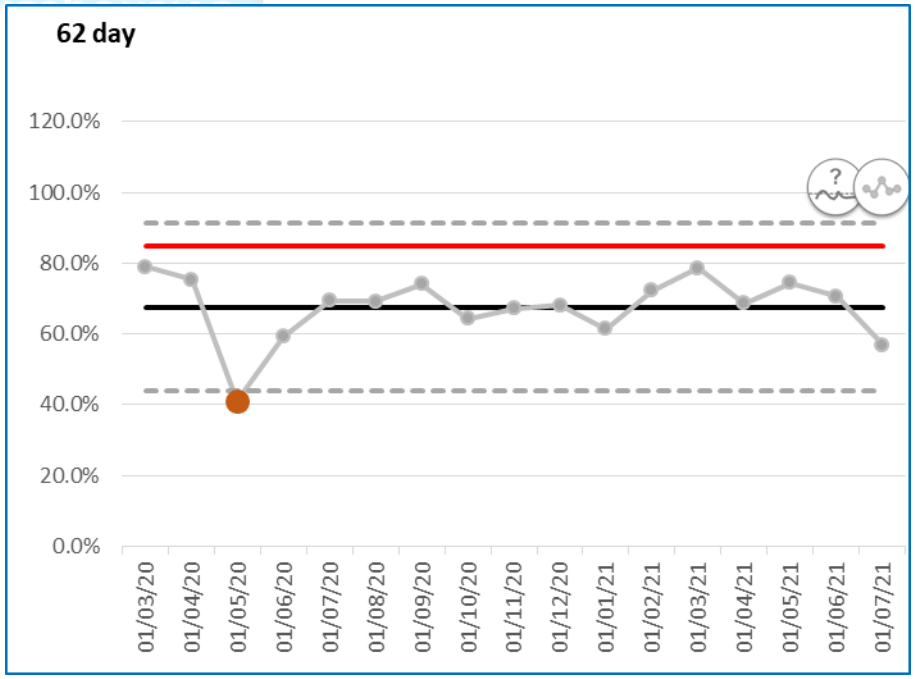
Report by exception: Responsive – All Cancer 62 wait for treatment from GP referral

Gateshead Health NHS Foundation Trust

Detail on this measure is included as the standard is subject achieve or fail the target as a result of variation in performance

Responsive



Combined impact analysis

Financial impact

Quality impact

Workforce impact

Operational performance impact

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Situation

Cancer 62 day compliance has not met the standard since October 2019. July performance is 56.8% against a performance standard of 85%. This is a decrease on the previous months performance with latest month falling below the 18 month mean.

Background

Pressures were evident prior to the pandemic. The Trust has not achieved this target since October 2019 and had been on a downward trajectory since April 2018. All tumour sites have been affected.

Assessment

The COVID pandemic continues to impact on the Trusts ability to undertake cancer treatments within the 62 day performance target. Haematology was the only tumour site to achieve the performance standard of over 85%. There are sustained pressures across the other tumour sites with particular pressure within the Gynaeoncology service having 9.5 breaches of 10.5 treatments (9.52%), Urology 10 breaches of 15.5 treatments (35.48%). Treatments have decreased from 71.5 in June to 66 in July.

Actions

Chemotherapy day unit expansion is now underway which will increase treatment capacity.
Ongoing collaboration between business units, cancer services and performance team to maintain focus on recovery and accelerator criteria.
Proactive planning to maximise theatre and critical care capacity with a cancer surgeries taking priority.

Recommendation

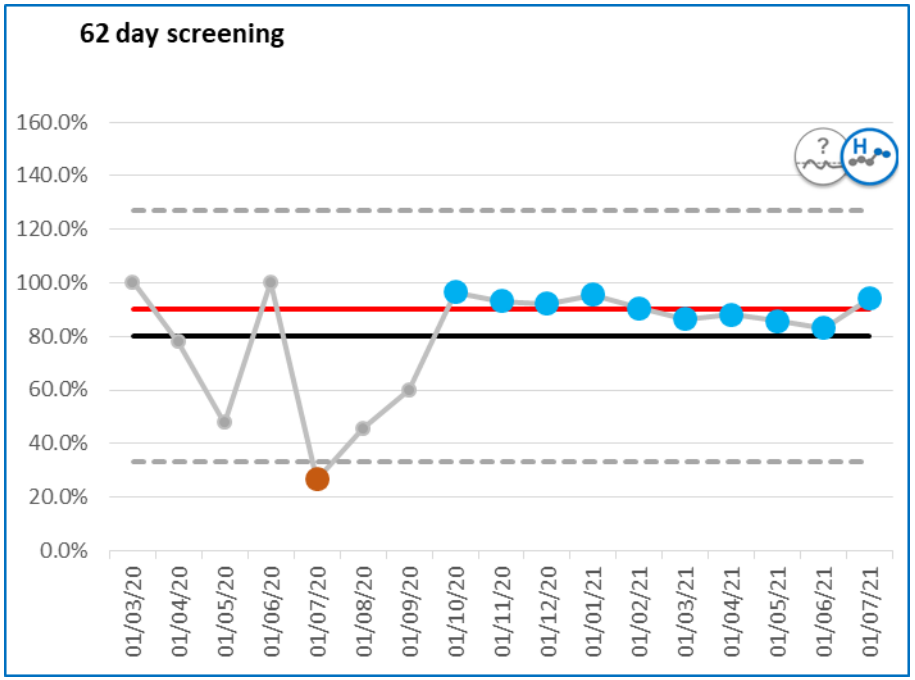
Detailed discussion and scrutiny at Finance & Performance Committee

Report by exception: Responsive – All Cancer 62 wait for treatment from NHS cancer screening service referrals

Detail on this measure is included as the standard is subject to achieve or fail the target as a result of variation in performance

NHS Gateshead Health NHS Foundation Trust

Responsive



Situation
The target was achieved in July 20 21, the first time since February 2021.

Ten consecutive points above the mean triggering special cause variation for improvement.

July compliance is above the target at 94.0% against a 90% target.

Assessment Continued improvement

Actions Ongoing review

Recommendation
Detailed discussion and scrutiny at Finance & Performance Committee

Report by Exception Integrated Oversight Report

Safe

Gateshead Health NHS Foundation Trust

Maternity Serious Incident (SI)

Datix 88972 / SI 2021/18088 / HSIB MI- 004070

Summary:
This baby met the criteria for HSIB reporting as she was a term baby who was transferred to Sunderland at 6 hours of age for more intensive respiratory support (but not requiring ventilation). Mild HIE 1 (hypo ischaemic encephalopathy) was suspected and therapeutic cooling commenced as a precautionary measure. This treatment was for 72 hours as per protocol and initial tests performed were normal. We have reported this to HSIB and as an SI until we have all outstanding test results as we can downgrade if needed. An MRI performed prior to discharge home on day 8 – awaiting report but baby well, discharged home with Mum bottle feeding.
This is the first reportable HSIB case since October 20 and parents have been kept fully informed and a FLO assigned.
Actions:
Duty of Candour performed & point of contact given (K Hooper to support as FLO)
Await MRI & decision by HSIB triage as to whether they will investigate
Rapid review did not reveal any significant concerns

Requirements from Maternity services for Trust board cycle of oversight:

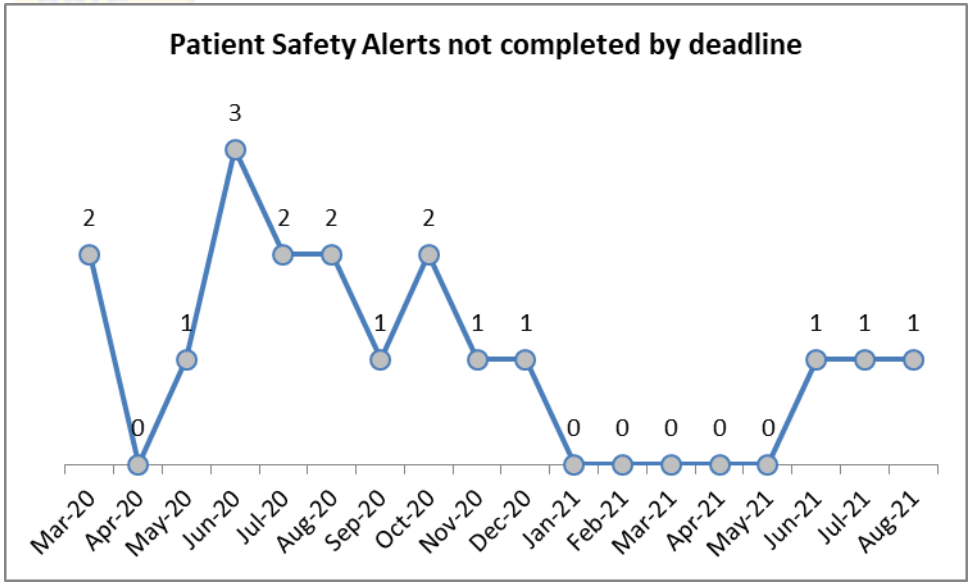
SI reporting by exception and bi-monthly updates
Development of performance and outcome measures bi-monthly report – minimum data set agreed
From August 2021 quarterly oversight of all perinatal deaths
6 monthly staffing updates of Medical, Paediatric, Anaesthetic, Neonatal and Midwifery establishments
Action plan agreed around implementation of Continuity of carer action plan by March 2022 with Board safety Champions
HOM to work with performance lead and Safety Champions to streamline the reporting process

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

Detail on this measure is included as there have a number of patient safety alerts were not completed by the deadline in the last 18 months

Gateshead Health NHS Foundation Trust

Safe



Combined impact analysis

Financial impact

Quality impact

Workforce impact

Operational performance impact

Situation

A patient safety alert due to be closed in June 2021 remains open. NatPSA/2020/008/NHSPS Deterioration due to rapid offload of pleural effusion fluid from chest drains
Issue date: 01/12/2020
Completion Deadline date: 01/06/2021
Status on 1st July 2021: Ongoing
Closed: 06/09/2021

Background

This National Patient Safety Alert was issued in December and leads from the relevant specialities were identified following the agreed process outlined in the trust policy RM63.

Assessment

Actions required include a review of trust-wide chest drain LocSSIPs and post-procedure management plans that will align with BTS guidelines. Observation charts should include the key elements of the LocSSIP regarding patient observation and escalation procedures for deteriorating patients.

Actions

To address late closure, alert actions will be proactively monitored through monthly governance arrangements to enable the CBUs / alert leads to identify any challenges to timely completion and escalate these to the Medical Director.

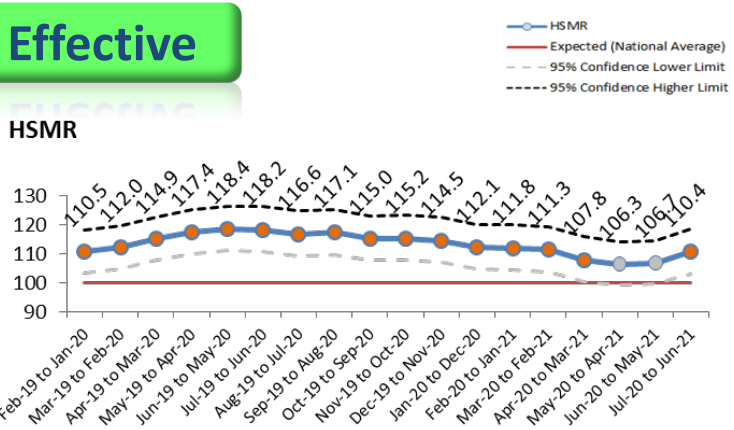
Recommendation

Discussion for information at Quality Governance Committee

Report by exception: Effective – Hospital Standardised Mortality Ratio

Gateshead Health NHS Foundation Trust

Effective



Mortality Review

Period: August 2020 – July 2021

	Deaths in period	Deaths reviewed	%	Hogan 1	Hogan 2	Hogan 3	Hogan 4	Hogan 5	Hogan 6	Potentially Avoidable Deaths
All Deaths	1166	692	59.3%	93.5%	5.5%	0.7%	0.3%	0.0%	0.0%	0.3% (2)
Learning Disability Deaths	19	14*	73.7%	92.9%	0.0%	7.1%	0.0%	0.0%	0.0%	0.0%

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 – 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.

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 August 2020 to July 2021 there were 1166 deaths; 692 have been reviewed (59.3%). Of these 93.5% 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.
- 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

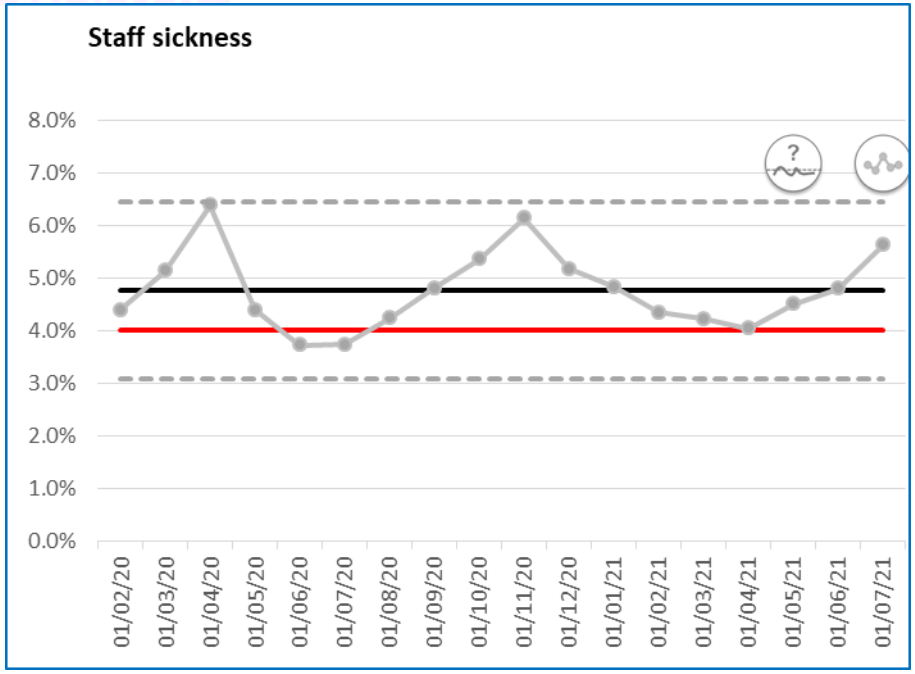
Recommendation - Continue to inform & note actions undertaken at Mortality and Morbidity steering group and Quality Governance Committee via the Integrated Oversight Report and Mortality Paper.

Report by exception: 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



Situation Common cause variation displayed
The target has been achieved in two of the last 18 months
Current performance of 5.6 % represents a fail of the Trust target.

Background
Sickness levels have understandably peaked during waves 1 and 2 of the Covid pandemic, and we have been experiencing an increase again as levels of the Delta variant have built in the local community. As this continues it will also affect those staff who remain at work.

Assessment
We have seen a further increase in sickness absence levels, at a time when the trust continues to experience significant pressures linked to patient acuity and other reasons for absence related to the pandemic (isolation, childcare). We recognise that staff are working extremely hard, and often working very flexibly and with regular addition bank shifts to provide additional staffing in key areas.

Actions
The Workforce Cell has continued to provide urgent support to staff and services. There has been a focus on Health & Wellbeing, Communications, and the flexible deployment of staff. More recently the focus has turned to thanking staff for their hard work and commitment, and this has been very positively received. The HR helpline continues to function to help manage absence from work due to the Covid 19 App and track and trace system. Changes in advice relating to Covid will be reviewed to enable staff to return to work in as timely as practicable, and support colleagues and services.

Recommendation
Continued scrutiny through HR committee, and the HWB Programme Board.

Combined impact analysis

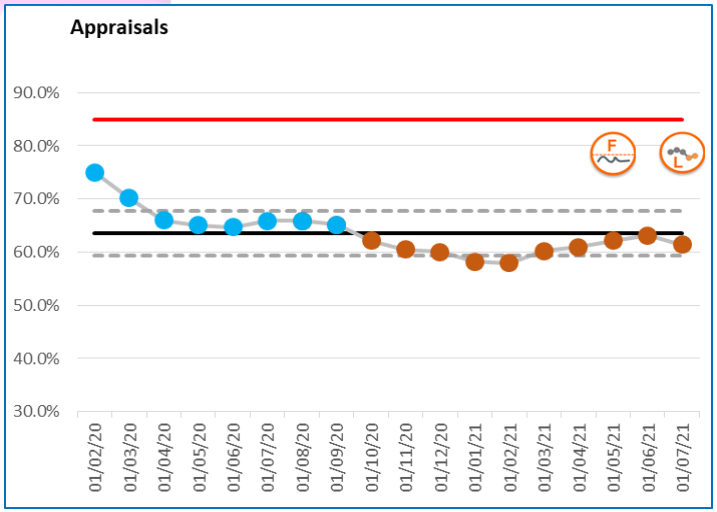
Financial impact
Increased staff sickness is expensive for the Trust in terms of loss of productivity and associated backfill costs.
Quality impact
No direct quality impact yet identified.
Workforce impact
Less workforce available.
Operational performance impact
No direct operational performance impact identified.

Report by exception: Well led – Appraisals

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

Gateshead Health NHS Foundation Trust

Well Led



Combined impact analysis

Financial impact

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

Quality impact

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

Workforce impact

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

Operational performance impact

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

Situation

Appraisal compliance consistently fails the 85% target, with this target not being achieved during the past 18 months. A general downward trend is observed.

Special cause variation is observed from October 2020, with a shift in performance identified by ten consecutive points below the mean. Significant pressure on staff and managers meant that priority was given to the covid response.

Background

The Trust expects all staff, who are a valued part of the organisation to have an annual conversation about their objectives, performance and development as a minimum. However it is recognised that in times of extreme pressure, such as with the current surge in the Covid pandemic, the focus should be on supporting staff to achieve the operational demands of the service as safely and effectively as practicable.

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 61.4 % against an 85% target representing an increase from 63.1% in June

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. Therefore POD have moved from additional weekly reporting to a monthly report to line managers. This reduces the volume of information, but includes 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 update ESR information for managers to offer further support if needed at this busy time.

Recommendation

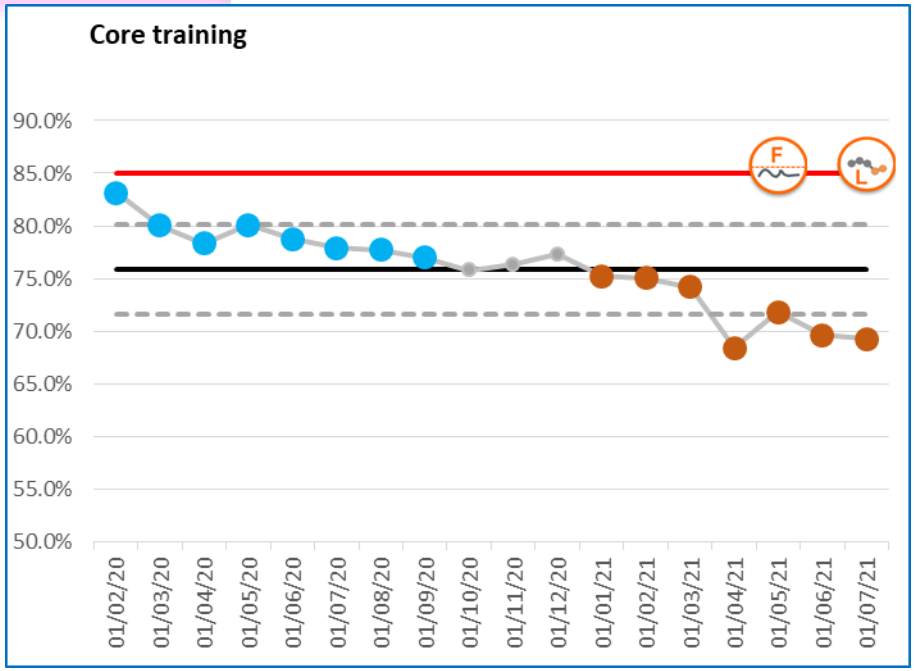
Continued scrutiny through HR committee and SMT

Report by exception: Well led – Core training

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

Gateshead Health NHS Foundation Trust

Well Led



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 September 2020 with special cause variation (low) triggering for the last seven months and remaining from this point. A general downward trend is observed.

The indicator is flagging to consistently fail the target based on current performance and monthly variation. Significant pressure on staff and managers meant that priority was given to the covid response and for a short period of time a number of courses had to be cancelled. Social distancing continues to affect the ability to deliver training to larger groups, and difficulties with suitable accommodation continue to have an impact.

Background
Core training covers those programmes which are recognised as core or essential training for all employees. The skills that make up the core skills package are being refreshed and discussed by the Trust Education & Training Group

Assessment
Current compliance is at 69.3% against an 85% target, a marginal decrease from 69.6% in June.

Actions
A paper with options was discussed at Execs in April and SMT now monitor compliance. However previous work undertaken to project a recovery plan to improve compliance levels would not have anticipated the volume of staff absence and the difficulties and staffing pressures experienced as a result of an increase in Covid 19 in the local community and in hospital. Trainers have adapted courses to deliver in operational areas (Wards) to overcome accommodation issues. The trust also achieved the 95% compliance with Information Governance.

Recommendation
Continued scrutiny through HR committee and SMT .

Appendices

Benchmarking

Reporting Changes

Introduction to SPC

Benchmarking

Benchmarking – UEC – all activity

The table below presents the April position for UEC (All activity) against the 4 hour standard.
The latest national benchmarking data places the Trust at 21st of 139 Type 1 providers and 3rd within the local Trusts with no local Trust reaching the 95% standard in August 2021.

	April	May	June	July	August
Gateshead	93.5%	91.3%	87.8%	80.4%	81.8%
Newcastle	92.4%	92.0%	89.8%	86.7%	85.6%
Durham & Darlington	88.0%	83.9%	80.8%	74.4%	73.6%
South Tyneside & Sunderland	89.8%	88.0%	84.4%	78.4%	81.5%
Northumbria	95.6%	95.8%	95.0%	92.7%	92.7%
	April	**May**	**June**	**July**	**August**
National rank out of 139 type 1 providers	12th	16th	17th	33rd	21st
					3rd in region

Benchmarking – Referral Rates

The charts below represent the cumulative referral rates (GP & other). Total cumulative referral rates are less than they were pre-COVID across the ICS. Gateshead's referral rate is at 102%, Northumbria has the highest rate at 123% and South Tees has the lowest cumulative rate at 89%.

Total referral summary (GP and other)

% above charts represents cumulative referrals YTD 21/22 vs 19/20

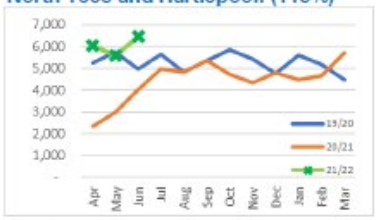
Cumbria and North East STP: (103%)
3% more referrals = 9,065

County Durham and Darlington: (93%)

Gateshead Health: (102%)

North Cumbria Integrated Care: (93%)

North Tees and Hartlepool: (113%)



Northumbria Healthcare: (123%)

South Tees Hospitals: (89%)

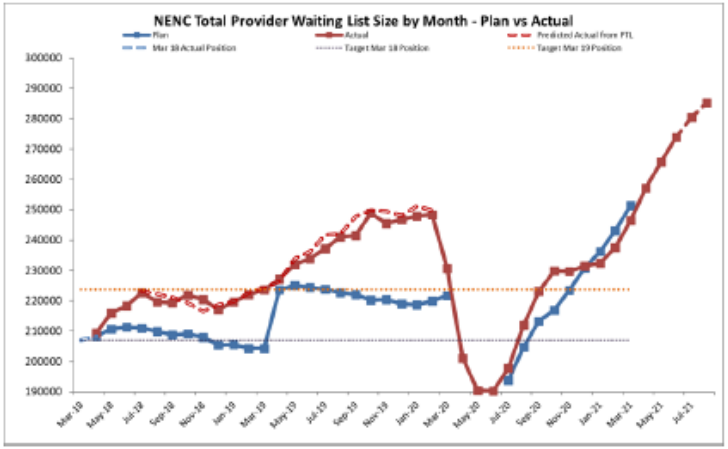
South Tyneside and Sunderland: (112%)

Newcastle Upon Tyne Hospitals: (106%)

Benchmarking – Waiting List

The table below represents the current summary RTT wating lists across the ICS, and the number of long waiters. Gateshead's RTT waiting list has reduced to 8983 at the time of this report. More than half of Gateshead's +52 week waiters have a planned treatment (TCI) or next event in their pathways.

Waiting List



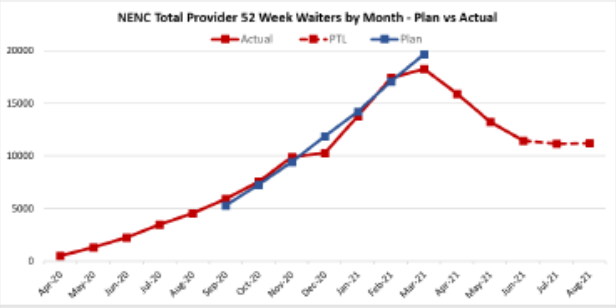
Weekly RTT PTL Summary (WE 29/08/2021)	Total Waiting List	40-52wws	% of waiters with a TCI or appt	52+ wws	% of waiters with a TCI or appt	% of waiters with a TCI or appt	104+ wws	% of waiters with a TCI or appt
NORTH ICP			40-52wws		52-78wws	78-104wws		104+wws
GATESHEAD HEALTH NHS FOUNDATION TRUST	9,390	179	51%	48	59%	82%	0	
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	25,442	342	25%	88	37%	100%	0	
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	91,940	3,948	15%	5,172	19%	28%	113	8%
CENTRAL ICP								
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	26,252	1,123	18%	1,257	20%	21%	31	19%
SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST	45,182	513	29%	174	35%	57%	1	
SOUTH ICP								
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	16,382	207	42%	112	35%	33%	0	
SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	39,042	2,314	23%	2,553	25%	20%	145	26%
NORTH CUMBRIA ICP								
NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	31,662	1,702	19%	1,792	20%	16%	120	11%
NORTH EAST & NORTH CUMBRIA	285,292	10,328	20%	11,196	22%	24%	410	16%

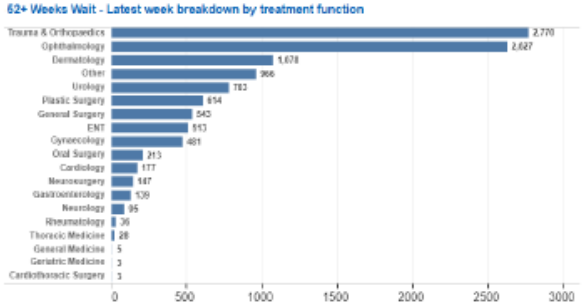
Benchmarking – Waiting List

The table below represents the weekly movement of >52 week waiters across the ICS, and the average volume change per week based on the last 4 weeks. Gateshead is on average removing 2 long waiters per week. Patient choice also affects the patients who are able to be seen.

Referral to Treatment Weekly Analysis

Unpublished RTT Weekly PTL submitted to NHS England & NHS Improvement via SDCS





52 Week Waiters	WE 25 Jul 21	WE 01 Aug 21	WE 08 Aug 21	WE 15 Aug 21	WE 22 Aug 21	WE 29 Aug 21	Change from previous week	Average volume change per week (based on latest 4 weeks)
GATESHEAD HEALTH NHS FOUNDATION TRUST	39	37	37	37	45	48	3	3
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	92	91	90	93	89	88	-1	-1
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	5,068	5,117	5,138	5,179	5,177	5,172	-5	14
NORTH ICP	5,199	5,245	5,265	5,309	5,311	5,308	-3	16
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	1,203	1,252	1,270	1,260	1,261	1,257	-4	1
SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST	191	181	179	171	167	174	7	-2
CENTRAL ICP	1,394	1,433	1,449	1,431	1,428	1,431	3	-1
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	94	94	99	108	116	112	-4	5
SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	2,654	2,612	2,621	2,619	2,586	2,553	-33	-15
SOUTH ICP	2,748	2,706	2,720	2,727	2,702	2,665	-37	-10
NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	1,709	1,781	1,790	1,774	1,780	1,792	12	3
NORTH EAST & NORTH CUMBRIA	**11,050**	**11,165**	**11,224**	**11,241**	**11,221**	**11,196**	**-25**	**8**

Benchmarking – Long waiters > 52 weeks

Long Waiters by Treatment Functions *(NHS Trusts only)*

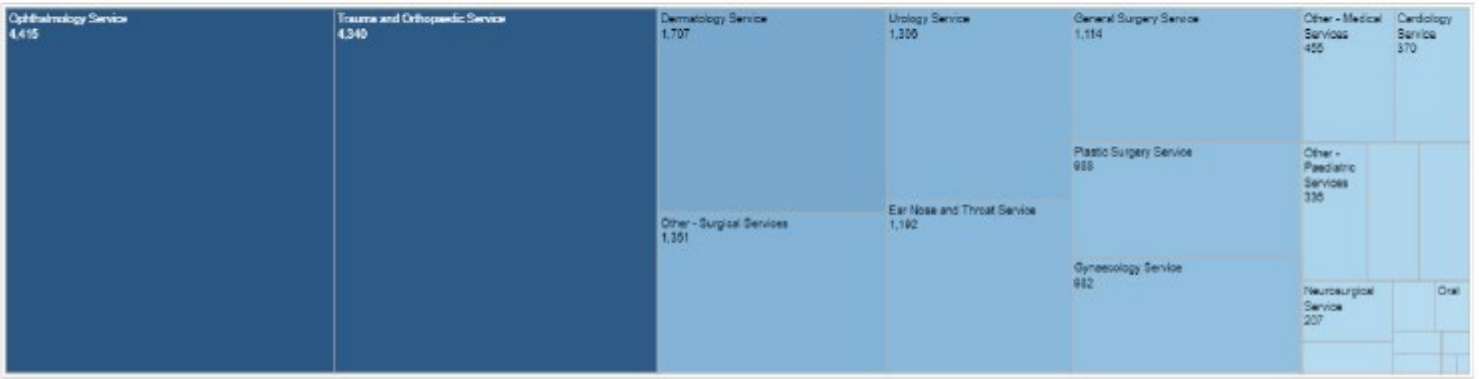
NHS

Long Waiters by Treatment Functions (>40 Weeks) June 2021

Please note that the sort option is available for each column when you hover over the column name.

Choose Region	Choose Organisation	All Specialties	Cardiology Service	Cardiothoracic Surgery Service	Dermatology Service	Ear Nose and Throat Service	Elderly Medicine Service	Gastroenterology Service	General Internal Medicine Service	General Surgery Service	Gynaecology Service	Neurology Service	Neurosurgical Service	Ophthalmology Service	Oral Surgery Service	Other - Medical Services	Other - Mental Health Services	Other - Other Services	Other - Paediatric Services	Other - Surgical Services	Plastic Surgery Service	Respiratory Medicine Service	Rheumatology Service	Trauma and Orthopaedic Service	Urology Service
North East and Yorkshire	The Newcastle Upon Tyne Hospitals...	4,312	142		1,459	278		8	4	3	305	3	32	3,804	1	70		67	143	354	216	6	1	1,230	208
	South Tees Hospitals NHS Foundati...	4,139	15	10	20	442		9		246	166	91	175	155	4	298		2	73	500	282	3	1	966	676
	North Cumbria Integrated Care NH...	3,299	197		142	242	7	169	3	205	123	135		221	54	10		6	2	427		5	2	1,008	321
	County Durham and Darlington NH...	2,462	5	1	86	230		34	29	370	321	28		232	2	23	6		109		433	46	20	464	
	Northumbria Healthcare NHS Foun...	470	1					10		134	8										50	1		226	37
	South Tyneside and Sunderland NH...	460	8				1			67		1		2	3	21		2	2		6	18	1	322	7
	North Tees and Hartlepool NHS Fo...	280								46	41							10	7	89				36	46
	Gateshead Health NHS Foundation ...	234	1					10		43	16					33	35	18		1		1		54	9

>40 Weeks Long Waiters By Treatment Function (June 2021)



Benchmarking – North ICP Weekly activity summaries

Weekly Activity | Week ending – 29/08/2021

Weekly Activity Summary (WE 29/08/2021 only)	2020/21 (as % of 2019/20)			
	First Outpatient	Follow Up Outpatient	Day case	Ordinary
GATESHEAD HEALTH NHS FOUNDATION TRUST	77%	67%	70%	60%
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	73%	72%	70%	107%
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	87%	83%	80%	71%
CENTRAL ICP				
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	87%	78%	94%	66%
SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST	57%	84%	74%	82%
SOUTH ICP				
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	76%	106%	73%	93%
SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	75%	75%	80%	98%
NORTH CUMBRIA ICP				
NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	83%	62%	52%	83%
NORTH EAST & NORTH CUMBRIA	**77%**	**79%**	**75%**	**83%**

Latest Weekly Activity Return (WAR) data used to compare the weekly position to the equivalent week in 2019/20.

Weekly Activity Summary (WE 29/08/2021)	Elective activity			Outpatient activity									
	Number of ordinary elective admissions	Day case elective spells	Regular attendances	First outpatient attendance (OPFA) - face to face	Of which; First outpatient attendance with a procedure - face to face	Follow-up outpatient attendance (OPFU) - face to face	Of which; Follow Up outpatient attendance with a procedure - face to face	Total - face to face	First outpatient attendance (OPFA) - video/ telephone	Follow-up outpatient attendance (OPFU) - video/ telephone	Total - video/ telephone	Total outpatients	Remote consultations as % of total outpatients 20% threshold in gateway criteria
NORTH ICP													
GATESHEAD HEALTH NHS FOUNDATION TRUST	40	463	0	497	24	835	19	1,332	159	277	436	1,768	24.7%
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	146	896	0	1,288	154	2,548	358	3,836	615	937	1,552	5,388	28.8%
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	321	1,861	0	4,601	432	9,536	1,575	14,137	585	2,507	3,092	17,229	17.9%
CENTRAL ICP													
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	85	679	0	2,429	616	3,242	686	5,671	359	758	1,117	6,788	16.5%
SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST	229	1,147	0	1,809	235	3,940	878	5,749	463	1,508	1,971	7,720	25.5%
SOUTH ICP													
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	77	513	0	744	215	1,771	364	2,515	239	607	846	3,361	25.2%
SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	322	1,033	0	2,110	584	4,770	1,532	6,880	448	1,999	2,447	9,327	26.2%
NORTH CUMBRIA ICP													
NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	81	396	0	1,369	265	2,090	558	3,459	217	329	546	4,005	13.6%
NORTH EAST & NORTH CUMBRIA	**1,301**	**6,988**	**0**	**14,847**	**2,525**	**28,732**	**5,970**	**43,579**	**3,085**	**8,922**	**12,007**	**55,586**	**21.6%**

Benchmarking –Diagnostic Weekly Activity

Diagnostics: Weekly Activity | Week ending – 29/08/2021

Weekly Diagnostic Activity | WE 29/08/21		Weekly Activity (DM01 definitions) from			< 6 week waiters	> 6 week waiters|		Total Waiting List	Diagnostic Performance (percentage of patients waiting > 6wks)	
Test Type: Total		Waiting list	Planned	Unscheduled	Total < 6 weeks	Without a TCI	With a TCI	(snapshot as at midnight Sunday)	WE 29/08/21 (WAIT data)	Jun21 (published data)
	CUMBRIA AND NORTH EAST STP	18,507	1,159	4,646	54,721	15,139	7,344	77,204	29%	21.9%
	GATESHEAD HEALTH NHS FOUNDATION TRUST	1,223	140	154	3,152	1,503	495	5,150	39%	30.2%
	NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	2,907	208	890	10,025	945	1,077	12,047	17%	7.9%
	THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	2,126	343	1,207	10,151	758	1,760	12,669	20%	19.7%
	NORTH ICP	6,256	691	2,251	23,328	3,206	3,332	29,866		
	COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	3,521	0	0	8,315	73	180	8,568	3%	2.6%
	SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST	2,730	112	146	4,328	3,762	681	8,771	51%	36.2%
	CENTRAL ICP	6,251	112	146	12,643	3,835	861	17,339		
	NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	1,909	54	699	5,479	633	993	7,105	23%	9.3%
	SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	2,560	79	711	7,282	1,631	705	9,618	24%	16.9%
	SOUTH ICP	4,469	133	1,410	12,761	2,264	1,698	16,723		
	NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	1,531	223	839	5,989	5,834	1,453	13,276	55%	46.8%
Test Type: Non-obstetric ultrasound	CUMBRIA AND NORTH EAST STP	6,330	247	1,031	21,250	2,960	1,224	25,434		
Test Type: Magnetic Resonance Imaging	CUMBRIA AND NORTH EAST STP	3,193	112	430	12,134	2,987	1,441	16,562		
Test Type: Cardiology - echocardiography	CUMBRIA AND NORTH EAST STP	1,761	62	136	4,418	3,770	2,150	10,338		
Test Type: Computed Tomography	CUMBRIA AND NORTH EAST STP	5,037	409	3,013	8,685	1,062	291	10,038		
Test Type: DEXA scan	CUMBRIA AND NORTH EAST STP	494	69	5	2,068	999	644	3,711		
Test Type: Neurophysiology - peripheral neurophysiology	CUMBRIA AND NORTH EAST STP	171	12	0	757	100	414	1,271		
Test Type: Urodynamics - pressures and flows	CUMBRIA AND NORTH EAST STP	83	2	0	172	216	185	573		
Test Type: Respiratory physiology - sleep studies	CUMBRIA AND NORTH EAST STP	92	0	0	311	23	9	343		
Test Type: Cardiology - electrophsiology	CUMBRIA AND NORTH EAST STP	0	0	0	6	0	0	6		
Test Type: Gastroscopy	CUMBRIA AND NORTH EAST STP	583	97	22	1,938	1,378	399	3,715		
Test Type: Colonoscopy	CUMBRIA AND NORTH EAST STP	400	99	2	1,675	1,348	321	3,344		
Test Type: Flexi sigmoidoscopy	CUMBRIA AND NORTH EAST STP	129	16	7	677	329	186	1,192		
Test Type: Cystoscopy	CUMBRIA AND NORTH EAST STP	234	34	0	630	57	80	767		
Test Type: Endoscopy (Total)	CUMBRIA AND NORTH EAST STP	1,346	246	31	5,108	3,112	986	9,206		

- **Waiting List:** includes all patients waiting for diagnostic test or procedure.
- **Planned:** patients waiting for a planned diagnostic and recorded on a planned waiting list i.e. a procedure which is required for clinical reasons to be carried out at a specific time or repeated at a specific frequency.
- **Unscheduled:** diagnostic tests carried out on patients following emergency admissions, as well as any diagnostic tests/procedures on patients in A&E.

Benchmarking – 62 Day Backlog

The table below shows the actual backlog for 62 day cancer, with and without a decision to treat, combined. Comparing the weekly position over the previous 10 and 4 weeks. Gynaecology oncology is the main tumour site affecting the position at Gateshead.

North East and North Cumbria - Backlog Summary	Week Ending										Change compared to latest week			
Trust Name	w-e 27 Jun 21	w-e 04 Jul 21	w-e 11 Jul 21	w-e 18 Jul 21	w-e 25 Jul 21	w-e 01 Aug 21	w-e 08 Aug 21	w-e 15 Aug 21	w-e 22 Aug 21	w-e 29 Aug 21	8 weeks ago	8 weeks ago	4 weeks ago	4 weeks ago
Gateshead Health NHS Foundation Trust	56	55	53	57	46	46	45	64	67	73	18	↑	27	↑
Northumbria Healthcare NHS Foundation Trust	56	52	48	51	50	56	43	46	45	55	3	↑	-1	↓
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	195	208	220	258	252	240	260	287	292	356	148	↑	116	↑
North ICP	307	315	321	366	348	342	348	397	404	484	169	↑	142	↑
County Durham and Darlington NHS Foundation Trust	166	167	190	204	204	221	217	219	225	234	67	↑	13	↑
South Tyneside and Sunderland NHS Foundation Trust	65	55	57	70	63	80	73	79	64	64	9	↑	-16	↓
Central ICP	231	222	247	274	267	301	290	298	289	298	76	↑	-3	↓
North Tees and Hartlepool NHS Foundation Trust	72	75	80	77	67	69	66	78	91	92	17	↑	23	↑
South Tees Hospitals NHS Foundation Trust	142	141	133	136	157	153	182	170	186	79	-62	↓	-74	↓
South ICP	214	216	213	213	224	222	248	248	277	171	-45	↓	-51	↓
North Cumbria Integrated Care NHS Foundation Trust	184	216	172	188	189	206	205	215	202	236	20	↑	30	↑
North East and North Cumbria	**936**	**969**	**953**	**1041**	**1028**	**1071**	**1091**	**1158**	**1172**	**1189**	**220**	↑	**118**	↑

The table shows the actual backlog for 62 days Cancer, with and without a decision to treat, combined. Comparing the weekly position over the previous 10 and 4 weeks.

Benchmarking – Cancer Performance Measures

Cancer Waiting Times Standards - Summary — **Monthly Performance: July 2021** — **Provisional Data**

Provider Based Reports

Please note that this data is now derived from a data extract provided by CADEAS

	S Tyneside and Sunderland	N Cumbria	Gateshead	Newcastle	Northumbria	S Tees	North Tees & Hartlepool	Durham & Darlington	NCA
2WW Referrals	92.3 (1151/1247)	77.75 (947/1218)	85.82 (890/1037)	55.04 (1228/2231)	96.26 (1417/1472)	88.77 (1557/1754)	93.18 (1038/1114)	78.41 (1663/2121)	81.11 (9891/12194)
Breast Symptomatic Referrals	0 (0/0)	81.93 (68/83)	81.25 (13/16)	38.95 (67/172)	95.51 (85/89)	100 (5/5)	94.72 (233/246)	82.02 (146/178)	78.2 (617/789)
31 Day First Treatments	99.01 (201/203)	86.21 (100/116)	94.59 (105/111)	92.76 (474/511)	100 (143/143)	94.35 (234/248)	94.66 (124/131)	89.27 (158/177)	93.84 (1539/1640)
31 Day Subsequent Treatments - Drugs	100 (95/95)	0 (0/0)	95.12 (39/41)	97.57 (241/247)	100 (18/18)	100 (111/111)	100 (54/54)	100 (11/11)	98.61 (569/577)
31 Day Subsequent Treatments - Radiotherapy	0 (0/0)	0 (0/0)	0 (0/0)	97.49 (350/359)	0 (0/0)	96.79 (181/187)	0 (0/0)	0 (0/0)	97.25 (531/546)
31 Day Subsequent Treatments - Surgery	100 (12/12)	100 (7/7)	100 (9/9)	75.71 (106/140)	100 (7/7)	100 (14/14)	87.5 (7/8)	76.92 (30/39)	81.36 (192/236)
62 Day Target - 2WW	83.64 (89.5/107)	57.66 (39.5/68.5)	62.16 (34.5/55.5)	63.29 (115.5/182.5)	82.69 (86/104)	81.67 (122.5/150)	72.25 (62.5/86.5)	75.1 (96.5/128.5)	73.26 (646.5/882.5)
62 Day Target -Screening	83.33 (2.5/3)	87.5 (3.5/4)	89.39 (29.5/33)	76.92 (40/52)	50 (3.5/7)	50 (1.5/3)	86.27 (22/25.5)	72.73 (4/5.5)	80.08 (106.5/133)
62 Day Target - Upgrade	91.84 (22.5/24.5)	100 (6.5/6.5)	0 (0/0)	61.11 (16.5/27)	94.44 (8.5/9)	87.27 (24/27.5)	94.44 (8.5/9)	92.59 (12.5/13.5)	84.62 (99/117)
28 Day Target - 2WW	73.24 (884/1207)	68.49 (765/1117)	75.87 (808/1065)	56.41 (1158/2053)	77.04 (1003/1302)	82.1 (1050/1279)	71.29 (787/1104)	88.1 (1525/1731)	73.49 (7980/10858)
28 Day Target -Breast Symptomatic	0 (0/0)	87.8 (72/82)	100 (16/16)	60.98 (100/164)	66.35 (69/104)	88.89 (8/9)	96.47 (246/255)	92.94 (158/170)	83.63 (669/800)
28 Day Target - Screening	33.33 (5/15)	66.67 (2/3)	66.67 (96/144)	82.07 (151/184)	71.93 (41/57)	0 (0/1)	81.62 (151/185)	65.31 (32/49)	74.92 (478/638)

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

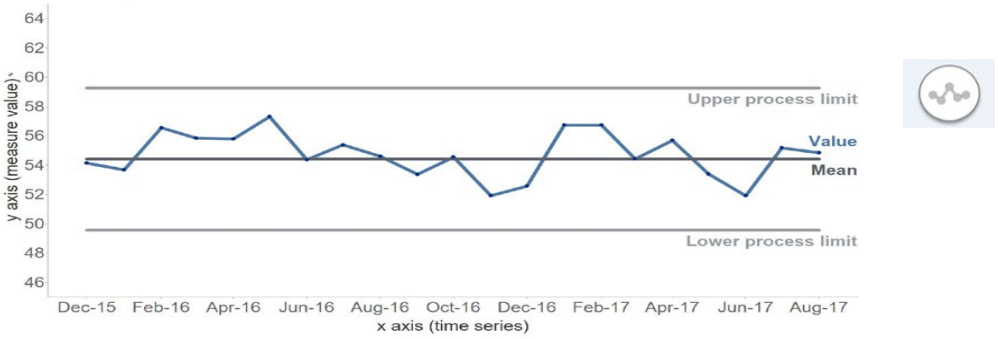
This report provides an integrated summary of the performance indicators from all domains of the Single Oversight Framework (SOF) that the Trust monitors and is monitored by NHSI and additional indicators as identified by the Trust's Board as priorities.

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'.

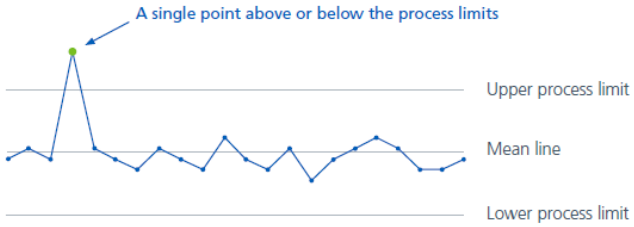
Integrated Oversight Report

Using SPC to identify special cause variation

Gateshead Health NHS Foundation Trust

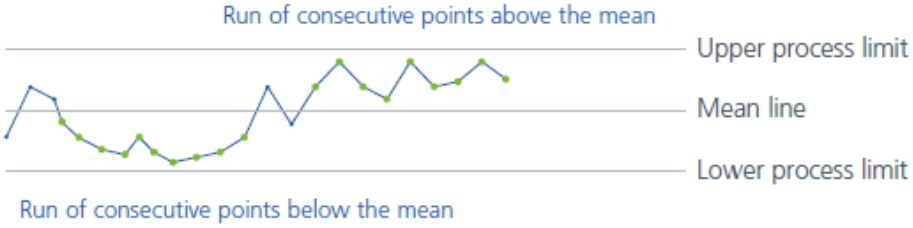
A single point outside the control limits

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.



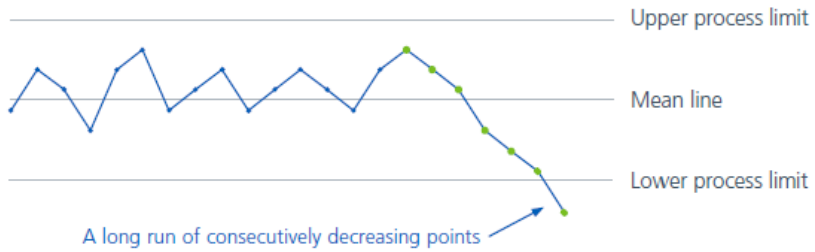
Consecutive points above or below the mean line

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.



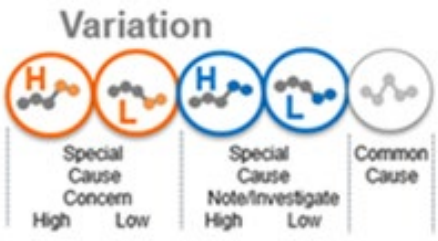
Integrated Oversight Report

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: 18

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Report Title:	Learning from Deaths Report			
Name of Meeting:	Trust Board			
Date of Meeting:	28th September 2021			
Author:	Andrew Ward – Senior Information Analyst – Quality and Patient Safety Wendy McFadden – SafeCare Lead Clinical Effectiveness			
Executive Lead:	Andy Beeby – Medical Director			
Report presented by:	Andy Beeby – Medical Director			
Executive Summary:	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 (Jul-20 to Jun-21) is 110.44 placing the Trust with 'More Deaths than expected' as calculated by the model. This indicator continues to be monitored closely. Trust has the sixth highest HSMR when compared to peer group performance of neighbouring Trusts. The HSMR is sensitive to palliative care coding, the Trust has increased its palliative care coding rate over the last 18 months and this is now line with the national average. 59.3% (692 of 1,166) of inpatient deaths have been reviewed for deaths occurring between August 2020 to July 2021. 73.7% (14 of 19) learning disability deaths have been reviewed, the remaining cases will be scheduled for future mortality council meetings Where mortality alerts have been triggered, case note review demonstrates that a good proportion of deaths have been reviewed, and the vast majority identified as 'definitely not preventable'. Those cases that demonstrate evidence of preventability continue to be reviewed by the Trust's Mortality Council where learning and actions are identified. A recent LeDeR audit by the lead nurse for learning			

	disabilities highlighted some concerns regarding the appropriate completion of DNACPRs. The recommendation from the audit is for Learning Disability awareness training with an emphasis on DNACPR to be provided to appropriate staff. The Lead Medical examiner and Medical Examiner team provide 6 sessions per week of Medical Examiner service, Monday to Friday. The service went live on 7th September 2020. The Medical examiner pathway 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.					
Recommended actions for Board/Committee)	Receive the report for assurance					
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					
Links to Risks (identify significant risks and DATIX reference)	None					
People and OD Implications:	None					
Links to CQC KLOE	Caring ☐	Responsive ☐	Well-led ☐	Effective ☒	Safe ☐	
Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)	**Obj.1** ☐	The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance between working life and personal commitments				
	Obj. 2 ☒	All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers				
	Obj. 3 ☐	Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve				

Learning from Deaths Report

Executive Summary

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 (Jul-20 to Jun-21) is 110.44 placing the Trust with 'More Deaths than expected' as calculated by the model. This indicator continues to be monitored closely.

Trust has the sixth highest HSMR when compared to peer group performance of neighbouring Trusts. The HSMR is sensitive to palliative care coding, the Trust has increased its palliative care coding rate over the last 18 months and this is now line with the national average.

59.3% (692 of 1,166) of inpatient deaths have been reviewed for deaths occurring between August 2020 to July 2021. 73.7% (14 of 19) learning disability deaths have been reviewed, the remaining cases will be scheduled for future mortality council meetings

Where mortality alerts have been triggered, case note review demonstrates that a good proportion of deaths have been reviewed, and the vast majority identified as 'definitely not preventable'. Those cases that demonstrate evidence of preventability continue to be reviewed by the Trust's Mortality Council where learning and actions are identified.

A recent LeDeR audit by the lead nurse for learning disabilities highlighted some concerns regarding the appropriate completion of DNACPRs. The recommendation from the audit is for Learning Disability awareness training with an emphasis on DNACPR to be provided to appropriate staff.

The Lead Medical examiner and Medical Examiner team provide 6 sessions per week of Medical Examiner service, Monday to Friday. The service went live on 7th September 2020. The Medical examiner pathway 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.

1. Introduction:

The purpose of this paper is to update the Board upon on going work in relation to mortality within Gateshead Health NHS Foundation Trust. Within the paper is an update on the Summary Hospital-level Mortality Indicator (SHMI) which is the national mortality ratio score developed for use across the NHS, a summary of the Hospital Mortality Standardised Ratio (HSMR) provided by Healthcare Evaluation Data (HED), and learning from mortality review.

2. The National Picture: Summary Hospital-level Mortality Indicator (SHMI)

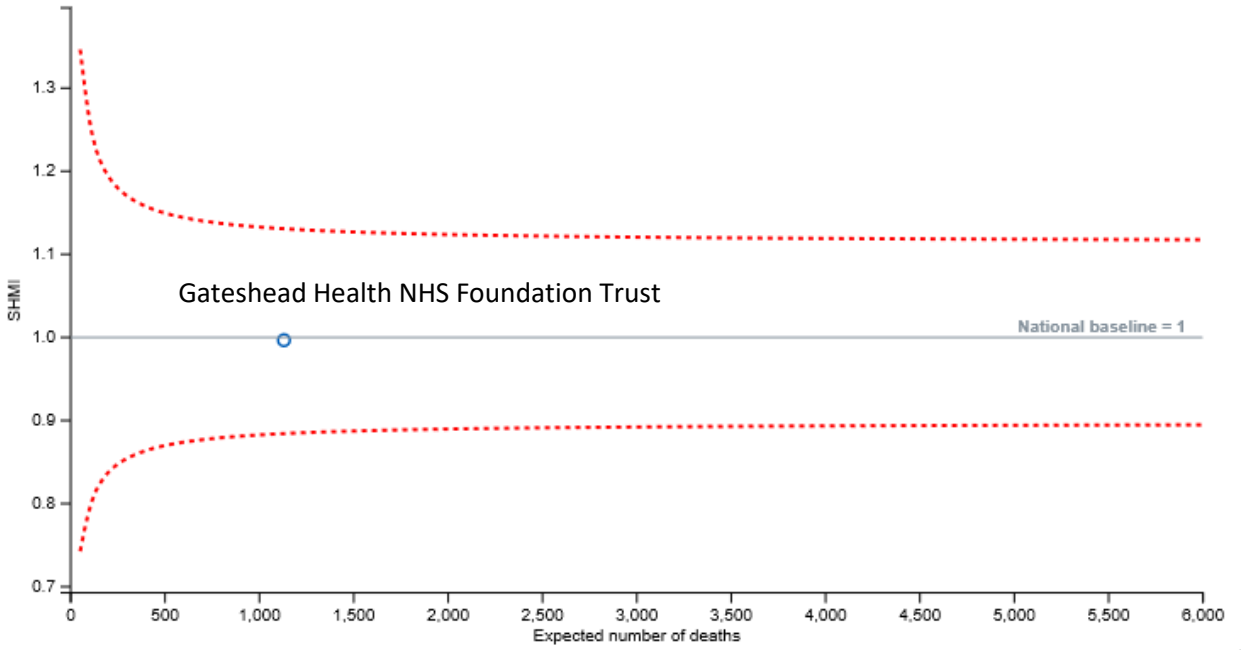
The SHMI is currently published on a monthly basis. Each publication includes discharges in a rolling twelve-month period.

The SHMI compares the actual number of patients who die following hospitalisation (both in-hospital deaths and deaths within 30 days of discharge) at a trust with the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

For any given number of expected deaths, an upper and lower bound of observed deaths is considered to be 'as expected'. If the observed number of deaths falls outside of this range, the trust in question is considered to have a higher or lower SHMI than expected.

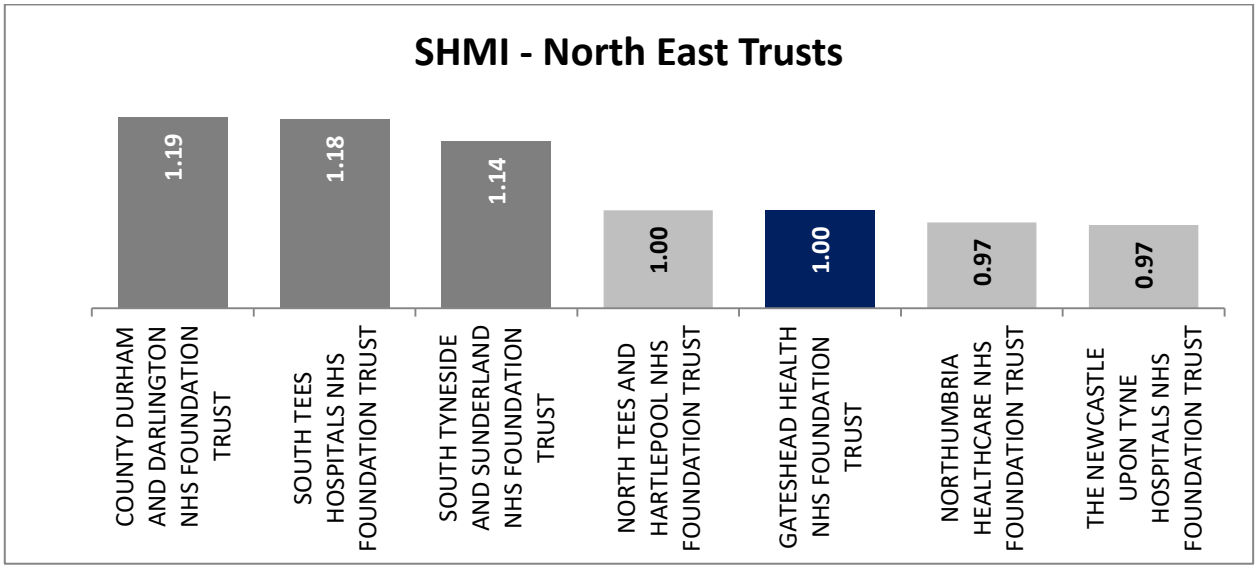
COVID-19 activity has been excluded from the SHMI. The SHMI is not designed for this type of pandemic activity and the statistical modelling used to calculate the SHMI may not be as robust if such activity were included.

The latest SHMI published for Gateshead Trust on 12th August 2021 covering the period from April 2020 to March 2021 has a SHMI Banding of 'As Expected' with a score of 1.00, equalling the national baseline.



- 15 Trusts had a higher than expected number of deaths.
- 94 Trusts had a number of deaths within the expected range.
- 14 Trusts had a lower than expected number of deaths.

From comparison with local Trusts, Gateshead Health NHS Foundation Trust has the third lowest SHMI of North East Trusts for the period. South Tees, County Durham, and South Tyneside and Sunderland have 'Higher Deaths than expected. The remaining four Trusts have deaths 'As Expected'.



3. Trust based data analysis:

The Hospital Standardised Mortality Ratio (HSMR) is a risk-based assessment using a basket of 56 primary diagnosis groups which account for approximately 80% of hospital mortality.

The HSMR is the ratio between the number of patients who die in hospital compared to the expected number of patient deaths on the basis of average England figures given the characteristics e.g., presenting and underlying conditions, age, sex, admission method, palliative coding.

COVID 19 activity is excluded from the HSMR based on the clinical coding of patient spells placing these deaths outside of the 56 diagnosis groups considered by the model. However, a patient may be still included if their primary diagnosis does not include COVID-19 but a subsequent diagnosis does.

The HSMR covering the twelve-month period July 2020 to June 2021 is 110.44, identifying the Trust as having 'More Deaths as Expected' when compared to Trusts nationally, taking into account the Trust patient case mix.

#	Trust	Score
1	NORTH TEES & HARTLEPOOL RTD	92
2	THE NEWCASTLE UPON TYNE HOSPITALS	92
3	COUNTY DURHAM & DARLINGTON	93
4	SOUTH TEES HOSPITALS	98
5	NORTHUMBRIA HEALTHCARE	106
6	GATESHEAD HEALTH	110
7	SOUTH TYNESIDE AND SUNDERLAND	130

Colouring Key:

Green: Represents that the trust is below or between the 95% Control limits.

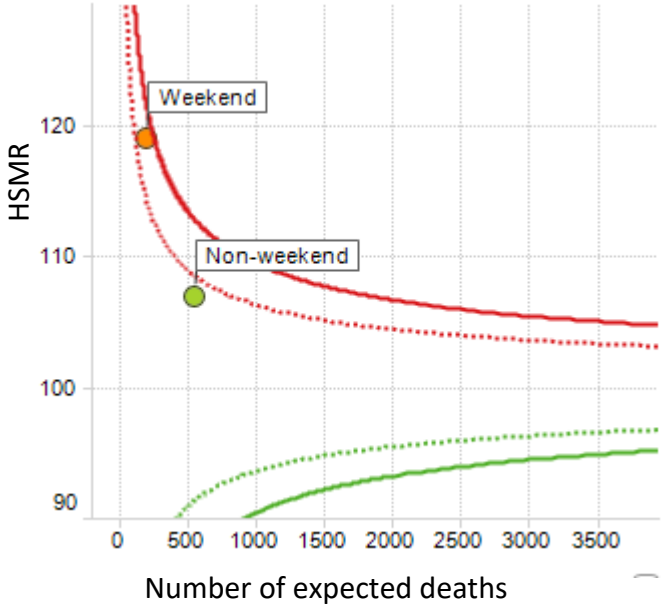
Amber: Represents that the trust is between the 95% and 99.8% Control limits.

Red: Represents that the trust is above the 99.8% Control limits.

Comparing to regional Trusts, Three Trusts have an HSMR with fewer deaths than expected (Newcastle, North Tees, County Durham and Darlington); One Trusts has deaths as expected (South Tees); and three Trusts have a more deaths than expected for this period (Northumbria, Gateshead and South Tyneside & Sunderland).

Inpatient deaths HSMR by day of admission

Data from HED shows that the HSMR for weekday admissions is within the expected range (HSMR = 107); The HSMR from weekend admissions is above the 95.0% control limit (HSMR= 119)



Mortality Alerts from HED (Healthcare Evaluation Data)

Below are details of the recent mortality alerts identified in HED, the system used to monitor and analyse mortality indicators by the Trust.

Pneumonia deaths continue to feature for the Trust however case note review continues to provide assurance that these cases were definitely not preventable.

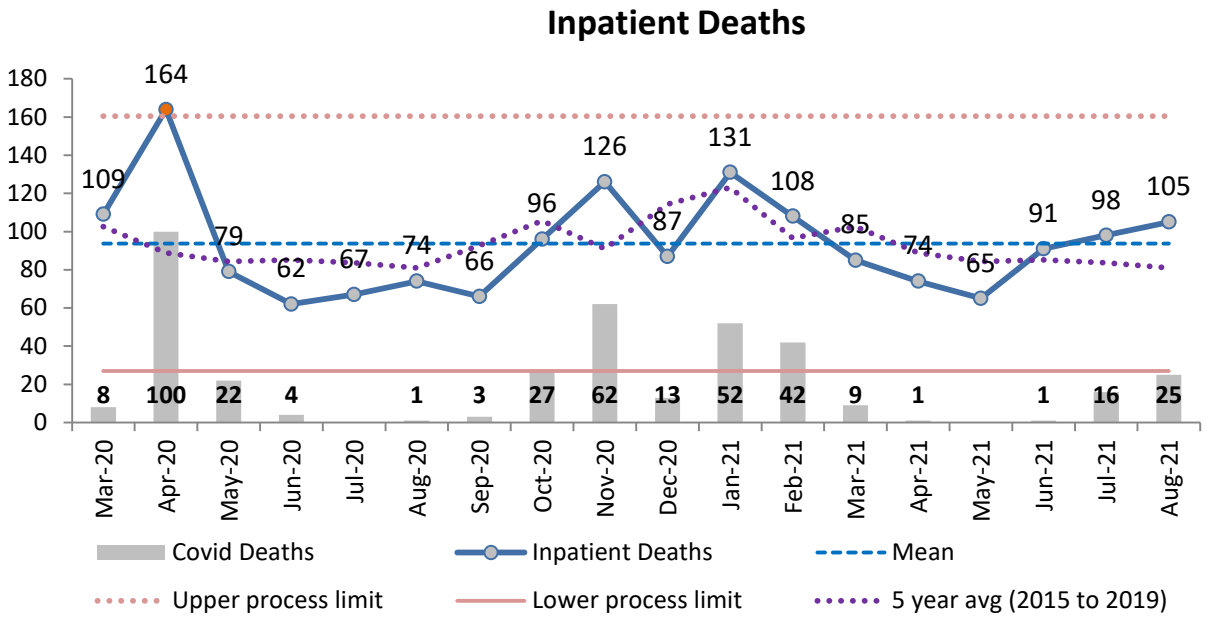
The SHMI does not consider palliative care coding in case mix adjustment. Cancer of bladder is not showing in HSMR with palliative care adjustment. 4 of 6 inpatient deaths palliative and 6 of the 9 total cases were palliative cases.

CUSUM Alerts continue to be reviewed as they are flagged. All cases reviewed from the most recent alerts were 100% Definitely not preventable and scored as Good Practice.

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%

Inpatient mortality

Increased inpatient mortality was observed during both COVID-19 waves. The chart below provides the figures for inpatient deaths and Covid-19 deaths.



4. Trust Mortality Database and Learning from Deaths

The Trust is required to provide figures relating to mortality review and preventability, these figures are provided below.

Mortality Review

Period: August 2020 – July 2021

	Deaths in period	Deaths reviewed	%	Hogan 1	Hogan 2	Hogan 3	Hogan 4	Hogan 5	Hogan 6	Potentially Avoidable Deaths
All Deaths	1166	692	59.3%	93.5%	5.5%	0.7%	0.3%	0.0%	0.0%	0.3% (2)
Learning Disability Deaths	19	14	73.7%	92.9%	0.0%	7.1%	0.0%	0.0%	0.0%	0.0%

Mortality Review Compliance

59.3% (692 of 1,166) deaths have been reviewed for deaths occurring between August 2020 and July 2021.

Patients who died in hospital and whom also contracted Covid in hospital have been scored as Hogan 2 – Slight evidence of preventability and NCEPOD 3 Room for improvement in organisational care.

- 93.5% of cases are identified as being definitely not preventable.
- 82.5 % of cases reviewed were identified as good practice.
- 17.0% of cases identified room for improvement.
    - 12.0% room for improvement in organisational care
- 2 deaths identified as potentially avoidable (Hogan score >=4) – details of the cases are provided below:

Case one

Level 1 review undertaken by clinical team on 16th September 2020 was scored as Hogan 4 and NCEPOD 5. The case was reviewed by Mortality Council on 22nd October 2020, a datix was submitted around post-operative care following death after elective procedure. The case was then discussed at the Serious Incident Panel on 4th February 2021 and was reported as a serious incident to the commissioners the following day. The patient's family are being supported by Family Liaison Officers and the investigation remains ongoing. The case will return to the Mortality Council for final scoring on completion of the investigation.

Case two

Level 1 review undertaken by clinical team on 14th May 2021 was scored as Hogan 4 and NCEPOD 2. The case was reviewed by the Mortality Council on 18th August 2021 and following the discussions that took place, it was felt the clinical team had been over critical of the care they provided during their level 1 review, therefore the scores were amended to Hogan 2 and NCEPOD 2.

Learning Disability Mortality Reviews

Learning Disability Deaths

During the period August 2020 to July 2021, there were 19 patient deaths recorded as learning disability deaths. 14 Learning disability deaths have been reviewed of which 10 have been reviewed by the level 2 mortality council. One case identified as potentially avoidable. Remaining cases will be scheduled for future Mortality Council meetings.

LeDeR Reviews

LeDeR is a service improvement programme to improve services for people with a learning disability and autistic people.

Established in 2017 and funded by NHS England and NHS Improvement, it is the first of its kind and was created to improve care, reduce health inequalities and prevent people with a learning disability dying sooner than the general population. From late 2021 LeDeR will include improving services for autistic people too

LeDeR reviews are about looking at the life of a person with a learning disability and/or who is autistic that died and finding out about the health and social care services which that person received throughout their life. It is not a mortality review because its purpose is not to find out why that person died nor is it an investigation into their death. We look at the person's life and the care they received so we can improve services. We do this by looking for potential areas which require improvement, areas we can learn from, and examples of good practice which can be replicated across the country to help reduce inequalities in care for people with a learning disability and help reduce the number of people dying sooner than they should.

LeDeR Audit

The Lead Nurse for Learning Disabilities undertook an audit focused on all deaths of patients with a learning disability within the Queen Elizabeth Hospital between 1st April 2020 and 31st March 2021. Within the period a total of 15 people with a learning disability dies within Queen Elizabeth Hospital under our care. All 15 sets of notes were requested from deceased medical records and reviewed.

Research has shown that on average, people with a learning disability die earlier than the general public, and do not receive the same quality of care as people without a learning disability. LeDeR reviews deaths to see where we can find areas of learning, opportunities to improve, and examples of excellent practice. This information is then used to improve services for people living with a learning disability.

Reports issued by LeDeR show in 2020, 24% of learning disability deaths were caused by COVID-19 compared to just 13% of deaths in the general population, within Gateshead 26% of learning disability deaths were caused by COVID-19.

The main focus around this audit was the issuing of Do not attempt cardiopulmonary resuscitation (DNACPR) and the appropriate paperwork to support this legal framework following a number of non-compliant cases being observed. There were 15 sets of notes reviewed; 12 of which had a DNACPR in place at the time of death, 9 of those were implemented by Trust staff. 6 of these (50% of the total and 75% of the DNACPR implemented by Trust staff) were not completed appropriately.

A summary of cases where the DNACPR was not completed appropriately is provided below.

1. 52-year-old woman with DNACPR stating that the decision was made following best interests process, however nothing clearly documented in notes, no Mental Capacity Act (MCA) 1&2 paperwork or Deprivation of Liberty (DOLS), not a COVID-19 related death.
2. 80-year-old woman DNACPR was implemented by QE Hospital for the reason 'severe functional dependence' however within notes there is nothing clinical documented only that the lady needed support with activities of daily living (ADL) and mobility and nothing to suggest who this was discussed with.
3. 49-year-old woman with DNACPR was implemented with the rationale documented as 'down syndrome, severe learning difficulties, epilepsy and bed bound'
4. 61-year-old man with DNACPR paperwork was not clearly documented who the decision was discussed with
5. 60-year-old man with DNACPR was implemented with the rationale documented as 'severe COVID-19 and poor functional status' COVID-19 appropriate however there is nothing documented to suggest this gentleman has any other physical health needs but did need help with ADL.
6. 33-year-old man with DNACPR questions on the document were not completed fully.

Gender, age, and cause of death findings from the audit echoed the findings of the National LeDeR report.

The recommendations from the audit are:

- Learning Disability awareness within the diamond standards training to be offered to all staff.
- Learning Disability awareness training with an emphasis on DNACPR documentation to be arranged for staff implementing DNACPR's

5. Learning from Mortality Council

For the period January to July 2021, 138 cases had a level 2 review undertaken by the Mortality Council. The cases were mix of COVID-19 and non-COVID-19 deaths. The scores of the review are detailed in the table below:

Hogan 1 – Definitely not preventable	85 cases
Hogan 2 – Slight evidence of prevention	41 cases
Hogan 3 – Possibly preventable, less than 50:50	4 cases

NCEPOD 1 – Good practice	48 cases
NCEPOD 2 – Room for improvement clinical care	5 cases
NCEPOD 3 – Room to improve organisation of care	66 cases
NCEPOD 4 – Room to improve clinical and organisational	12 cases
NCEPOD 6 – Insufficient data	1 case

Six cases were unable to be scored and will come to the committee on completion of the relevant investigations.

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

Learning identified/actions taken:

In response to issues raised with the Mortality Council in relation the process around DNACPR as well as concerns raised by family's, guidance has been developed for junior doctors specifically for patients with COVID-19 and also broader in terms of communication with patients and relatives and comprehensive documentation of discussions. This is available on the intranet.

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

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

Discharges of COVID-19 positive patients' home when there are family members at home – patient information required.

Clinically extremely vulnerable patients, for example, those on Chemotherapy, have been nursed in bays as opposed to cubicles, which, due to the prominence of COVID-19 at that time, increased the risk of contracting COVID-19

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

Infection Control team input into Mortality Council discussions is required, particularly with regards to COVID-19 cases. A representative from the team now attends each meeting.

Issues with regards to fluid balance and the use of the correct fluid charts across the organisation have been highlighted. A Task and Finish Group has been set up to develop innovative strategies to engage with clinicians and develop training and education to be delivered in ways to ensure the key messages are shared.

A theme of reviewing test results within the Emergency Department emerged over recent months, with particular relevance to blood tests and reviewing ECGs. The complexity of varying staff members doing various jobs to manage the flow in the Emergency Department was highlighted. The team are looking at ways to ensure test results are reviewed. It was agreed that until resolved this should be added to the risk register.

A number of medication incidents mentioned within mortality reviews where learning was highlighted. These included delayed and missed medication, prolonged steroid use, and incorrect medication. In the majority of cases this did not impact on the patient outcomes however these present opportunities for learning and have been shared with the medicines safety officer.

6. Update on the Medical Examiner Service

A Medical Examiner update was provided to Quality Governance Committee in June 2021.

The Lead Medical examiner and Medical Examiner team provide 6 sessions per week of Medical Examiner service, Monday to Friday, supported by the Medical Examiner Officer. The service went live on 7th September 2020, and all in-hospital deaths since that time have been scrutinised including A&E deaths and those referred to the Coroner in order to identify any lessons to be learnt.

All patient documents produced from the medical examiner scrutiny are saved on Medway, and are available as part of the clinical records. The Medical examiner pathway 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.

7. Recommendation

The Board is asked to receive this paper for information and assurance.

Trust Board

Gateshead Health NHS Foundation Trust

Report Cover Sheet

Agenda Item: 19

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☒
Report Title:	Nursing Staffing Exception Report			
Name of Meeting:	Trust Board			
Date of Meeting:	28th September 2021			
Author	Michael Shaw and Janet Thompson			
Executive Lead	Gill Findley, Chief Nurse			
Report presented by	Gill Findley, Chief Nurse			
Executive Summary	This report provides information relating to ward staffing levels (funded against actual) and details of the actions taken to address any shortfalls. There were significant staffing challenges in the months of June and July 2021 as the organisation experienced an increase surge of 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 via the number of Datix reports relating to staffing. Assurance will be strengthened going forward as a task and finish group is being established to look at reporting, recording and escalation of staffing in more detail. Quality Governance Committee will be updated as the group progresses.			
Recommended actions for Board/Committee)	The Board are asked to: • receive the report for assurance • note the work being undertaken to address the shortfalls in staffing			
Trust Aims that the report relates to: **(Including reference to any specific risk)**	**Aim 1** ☒	We will provide consistently high quality care in all our services		
	Aim 2 ☐	We will be a great organisation to work in		
	Aim 3 ☐	We will deliver value for money and strengthen delivery of our clinical services		

	Aim 4 ☐	We will work with our partners to help make Gateshead a place where everyone thrives				
	Aim 5 ☐	We will use our expertise to provide specialist services beyond Gateshead				
Financial Implications:						
Links to Risks (identify significant risks and DATIX reference)						
People and OD Implications:						
Links to CQC KLOE	Caring ☒	Responsive ☒	Well-led ☐	Effective ☒	Safe ☒	
Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)	**Obj.1** ☐	The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance between working life and personal commitments				
	Obj. 2 ☐	All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers				
	Obj. 3 ☒	Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve				

Gateshead Health NHS Foundation Trust

Nursing and Midwifery Staffing Exception Report

June / July 2021

1. Introduction

This report is to provide assurance to the Board that staffing establishments are being monitored on a shift-to-shift basis and that remedial actions are being taken where necessary. The Board and Quality Governance Committee 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 any shortfalls. This report provides information for June and July 2021.

2. Staffing

The actual ward staffing against the budgeted establishments for the whole trust for June and July are presented in summary in Tables 1 and 2. Appendices 1 and 2 show the information broken down into each ward area. 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 June 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 (%)**
91.4%	97.0%	97.3%	120.0%

Table 2: Whole Trust wards staffing July 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 (%)**
84.0%	90.8%	97.2%	107.3%

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%.

The exceptions to report for June and July 2021 are as below:

June 2021	
Qualified Nurse Days	**%**
Ward 4 (JASRU)	67.5%
Ward 22	67.9%
Ward 24	73.4%
Ward 27	73.4%
Cragside Court	74.0%
HealthCare assistant Days	**%**
Sunniside	68.6%

3. Contextual information and actions taken

Wards 4, 22, 24 and Cragside have been affected by higher levels of sickness/absence together with some vacancies. Additionally, ward 4 was supporting wards 11/12 with a Registered Nurse. Ward 27 have low fill rates due to reduced nurse rostering with their current operating model. Sunniside unit had low healthcare assistant fill rates due to collaboratively working with Cragside court during the redevelopment of their unit. This is a short term measure that is expected to resolve when the new unit opens.

July 2021	
Qualified Nurse Days	**%**
Ward 11 Gen Medicine	73.1%
Ward 14a Trauma	68.3%
Ward 22 Gen Medicine	63.2%
Ward 23 Jubilee Wing	70.9%
Ward 24 Jubilee Wing	72.2%
Ward 25 Jubilee Wing	68.2%
Ward 27 Treat/Centre	58.4%
Qualified Nurse Nights	**%**
Emergency Admissions Unit	73.4%
Healthcare Assistant Days	**%**
Ward 21 Jubilee Wing Gynae/Oncol	71.2%
Ward 25 Jubilee Wing	64.0%
Ward 27 Treat/Centre	72.2%
Critical Care Dept	72.4%
Sunniside Unit	71.7%

July fill rates are presented above however were not reported nationally. This was due to the significant organisational challenges due to a July wave of COVID 19 and a view from the Chief Nurse and Chief operating Officer that the reported fill rates available at the time the submission was due were not reflective of the actual position across the Trust. Figures have now been validated and are presented above. Staff were redeployed around the organisation to support the expansion of critical care, opening of covid areas on ward 22, 25 and a respiratory support unit on ward 1. Furthermore, there were a significant number of staff affected by both the internal and national Test and Trace teams together with the NHS COVID19 App.

In July the Trust invoked the agreed the clinical covid model. This meant at times some wards listed above had lower patient occupancy and the staff were redeployed appropriately to areas requiring support. This accounts for the low average fill rates for wards 11,14a, 22,23,25,27. Wards 22 and 25 had reduced occupancy as they became designated covid wards.

The emergency admissions unit has low fill rates due their vacancy factor which was further compounded by staff sickness absence. Staff were redeployed from various areas to support staff staffing levels as described above.

Throughout June and July Areas of deficit were escalated to the Senior Nurse on duty and when necessary to the Chief Operating Officer/acting Chief Nurse 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 People and Organisational Development team to address the sickness levels within the divisions and to recruit to any vacancies.

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 9 staffing incidents in June none of which resulted in patient harm.

In July there were 12 staffing incidents reported of the areas in scope of which none have resulted in patient harm.

The rise in staffing incidents are an effect of the Global COVID19 pandemic and subsequent government guidelines around self-isolation when staff have tested positive or had significant contact throughout the 4th wave of COVID 19. As the government guidance has now changed, the situation is anticipated to improve in August 2021.

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. A task and finish group is being established to ensure that we are correctly recording, reporting and escalating any staffing concerns in line with the national guidance and Trust procedures.

6. Conclusion

This paper provides an exception report for nursing and midwifery staffing in June and July 2021 and details of the remedial actions taken.

7. Recommendations

The Board is asked to receive this report for assurance and note the actions being taken to address the shortfalls in staffing.

Michael Shaw (Author)

Appendix 1 – Table 3: Ward by Ward staffing June 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	77.9%	92.3%	120.2%	128.1%	475	3.8	4.4	8.2
Ward 2 - SSU	87.1%	148.4%	101.3%	131.9%	559	3.3	3.4	6.7
Ward 4	67.5%	123.0%	101.6%	77.1%	575	2.7	3.6	6.3
Ward 8	83.2%	80.6%	100.5%	96.7%	605	2.9	2.5	5.4
Ward 9	135.9%	152.7%	87.0%	74.5%	679	3.3	2.9	6.2
Ward 11	101.8%	111.5%	158.8%	159.6%	695	4.0	4.2	8.2
Ward 14 Medicine	92.0%	124.5%	105.8%	139.6%	598	2.9	3.4	6.3
Ward 14A	79.1%	87.1%	103.3%	138.9%	628	3.4	3.6	7.0
Ward 21	93.7%	84.1%	102.0%	202.7%	611	2.9	2.6	5.5
Ward 22	67.9%	84.5%	103.6%	127.1%	833	2.2	2.7	4.9
Ward 23	75.8%	106.5%	101.5%	147.8%	686	2.4	4.1	6.5
Ward 24	73.4%	87.2%	100.3%	116.1%	834	2.3	2.8	5.1

	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	80.5%	79.0%	101.2%	112.1%	870	2.3	2.2	4.5
Ward 26	81.2%	85.3%	99.7%	103.7%	529	3.4	3.8	7.3
Ward 27	73.4%	80.4%	98.9%	113.9%	818	2.4	2.6	5.0
Cragside Court	74.0%	95.3%	100.4%	101.3%	238	6.9	7.5	14.4
Critical Care	80.2%	76.6%	82.5%	108.1%	246	27.4	4.3	31.7
EAU	99.3%	157.7%	79.0%	116.2%	617	6.1	2.8	8.9
Maternity	146.9%	91.7%	91.7%	144.0%	546	14.0	4.9	18.9
Paediatrics	121.7%	117.8%	128.9%	-	58	43.0	13.8	56.8
SCBU	87.1%	134.4%	93.0%	83.1%	107	14.7	6.0	20.7
St Bedes	103.2%	93.4%	99.9%	108.3%	264	5.9	4.7	10.6
Sunniside	91.0%	68.6%	103.5%	202.7%	215	7.1	6.8	14.0

Appendix 2 – Table 4: Ward by Ward staffing July 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	81.3%	107.3%	127.9%	125.4%	506	3.9	4.7	8.5
Ward 2 - SSU	84.5%	147.9%	120.4%	122.7%	602	3.3	3.2	6.5
Ward 4 Stroke (JASRU)	61.1%	116.2%	100.2%	65.5%	591	2.5	3.3	5.8
Ward 8 Cardiology	80.3%	96.9%	103.9%	91.5%	620	2.9	2.8	5.7
Ward 9 Respiratory	118.0%	163.9%	88.6%	64.6%	685	3.1	2.9	6.0
Ward 11								
Ward 14 Medicine	83.5%	124.1%	105.5%	123.3%	632	2.7	3.2	5.8
Ward 14A (Trauma)	68.3%	77.5%	102.2%	125.4%	650	3.0	3.2	6.3
Ward 21	83.6%	72.2%	94.4%	129.8%	579	2.8	2.2	5.0
Ward 22	63.2%	77.8%	101.4%	112.2%	784	2.3	2.7	4.9
Ward 23	70.9%	82.3%	102.0%	113.7%	615	2.7	3.6	6.3
Ward 24	72.2%	77.8%	102.1%	110.3%	856	2.3	2.6	4.8

	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	68.2%	72.4%	99.1%	92.8%	741	2.5	2.4	4.9
Ward 26	89.8%	81.8%	105.3%	114.0%	678	3.0	3.1	6.1
Ward 27	58.4%	71.7%	103.7%	81.1%	760	2.3	2.4	4.7
Cragside Court	64.4%	88.3%	93.8%	82.2%	116	13.0	14.0	27.1
Critical Care	81.3%	71.2%	90.8%	120.3%	250	29.2	4.4	33.5
EAU	93.0%	164.5%	73.4%	138.0%	659	5.5	3.0	8.5
Maternity	124.9%	83.8%	89.3%	136.0%	541	12.9	4.7	17.7
Paediatrics	102.9%	108.9%	128.1%	-	55	41.9	13.9	55.8
SCBU	87.6%	124.7%	96.7%	87.2%	137	12.1	4.7	16.8
St Bedes	98.6%	95.8%	102.5%	142.8%	287	5.5	4.9	10.5
Sunniside	104.5%	64.0%	87.1%	156.3%	128	12.6	10.2	22.8

Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 20

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Report Title:	**Healthcare Associated Infection (HCAI) Performance Report**			
Name of Meeting:	Trust Board			
Date of Meeting:	28 September 2021			
Author	Louise Caisley , Head of Infection Prevention and Control			
Executive Lead	**Andy Beeby** – Medical Director Director of Infection Prevention and Control			
Report presented by	**Andy Beeby** – Medical Director Director of Infection Prevention and Control			
Executive Summary	*The mandatory reporting thresholds for 2021/22 have been published by NHS England/NHS Improvement. From April 2020 the financial sanctions and associated appeals process for CDI cases were discontinued.* The Trust continues to adopt the national aspiration of attaining a zero tolerance approach to all avoidable infections and will set internal reduction objectives for all mandatory reportable organisms. COVID-19 was the prominent area of focus in 2020, and continues to dominate healthcare in 2021 We have introduced SPC charts into this report as a way of monitoring our infection rates and identifying where there is special cause variation requiring further work For Q1 and Q2 2021/22 we note common cause variation in the rates of all mandatory reportable infections. For Q2 2021/22 there have been zero (**0**) norovirus outbreaks and nine (**9**) COVID-19 outbreaks. From May 2020 the Trust was required to report COVID -19 positive results against four categories: • Community-Onset – First positive specimen date <=2 days after admission to Trust; • Hospital-Onset indeterminate Healthcare-Associated (HOIHA)– First positive specimen date 3-7 days after admission to trust; • Hospital-Onset probable Healthcare-Associated (HOPHA) - First positive specimen date 8-14 days after admission to trust;			

<table>
<tr><td></td><td colspan="5">Hospital-Onset definite Healthcare-Associated (HODHA) – First positive specimen date 15 or more days after admission to trust.
The Trust reports the number of COVID-19 positive in-patients via SitRep and investigates and reports all identified nosocomial COVID-19 cases and COVID-19 outbreaks. To the end of Q2 2021/22 the Trust has identified– eighteen (18) indeterminate; thirteen (13) probable and ten (10) definite hospital onset healthcare associated cases. GHNFT has reported zero (0) nosocomial COVID cases during in August 2021</td></tr>
<tr><td>Recommended actions for Board/Committee)</td><td colspan="5">Accept this report for assurance</td></tr>
<tr><td rowspan="5">Trust Aims that the report relates to: (Including reference to any specific risk)</td><td>Aim 1
☒</td><td colspan="4">We will provide consistently high quality care in all our services</td></tr>
<tr><td>Aim 2
☐</td><td colspan="4">We will be a great organisation to work in</td></tr>
<tr><td>Aim 3
☐</td><td colspan="4">We will deliver value for money and strengthen delivery of our clinical services</td></tr>
<tr><td>Aim 4
☐</td><td colspan="4">We will work with our partners to help make Gateshead a place where everyone thrives</td></tr>
<tr><td>Aim 5
☐</td><td colspan="4">We will use our expertise to provide specialist services beyond Gateshead</td></tr>
<tr><td>Financial Implications:</td><td colspan="5">To note the Trust performance on mandatory HCAI reporting and other infection prevention activity as required.</td></tr>
<tr><td>Links to Risks (identify significant risks and DATIX reference)</td><td colspan="5">HCAI has implications for the whole healthcare economy. The expertise, advice and support of the IPC team are crucial in ensuring that the risk and spread of infection is minimised.</td></tr>
<tr><td>People and OD Implications:</td><td colspan="5">Organisational culture and behaviours, engagement, responsibility and ownership required across the whole healthcare economy.</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 rowspan="3">Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)</td><td>Obj.1
☒</td><td colspan="4">The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance between working life and personal commitments</td></tr>
<tr><td>Obj. 2
☐</td><td colspan="4">All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers</td></tr>
<tr><td>Obj. 3
☒</td><td colspan="4">Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve</td></tr>
</table>

1.0 EXECUTIVE SUMMARY

The mandatory reporting thresholds for 2021/22 have been published by NHS England/NHS Improvement. From April 2020 the financial sanctions and associated appeals process for CDI cases were discontinued.

The Trust continues to adopt the national aspiration of attaining a zero tolerance approach to all avoidable infections and will set internal reduction objectives for all mandatory reportable organisms.

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

We have introduced SPC charts into this report as a way of monitoring our infection rates and identifying where there is special cause variation requiring further work
For Q2 2021/22 we note common cause variation in the rates of all mandatory reportable infections.

For Q2 2021/22 there have been zero (**0**) norovirus outbreaks and nine (**9**) COVID-19 outbreaks.

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

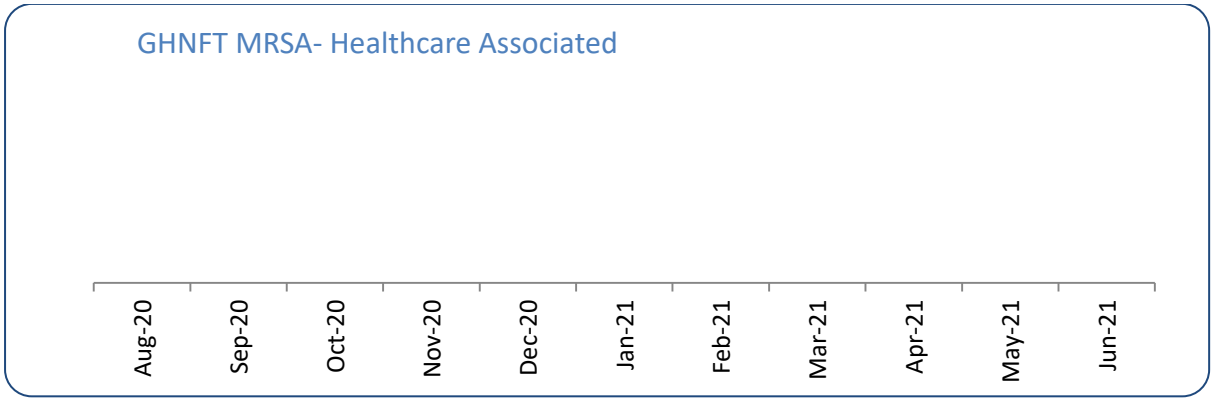
- Community-Onset – First positive specimen date <=2 days after admission to Trust;
- Hospital-Onset indeterminate Healthcare-Associated (HOIHA)– First positive specimen date 3-7 days after admission to trust;
- Hospital-Onset probable Healthcare-Associated (HOPHA) - First positive specimen date 8-14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

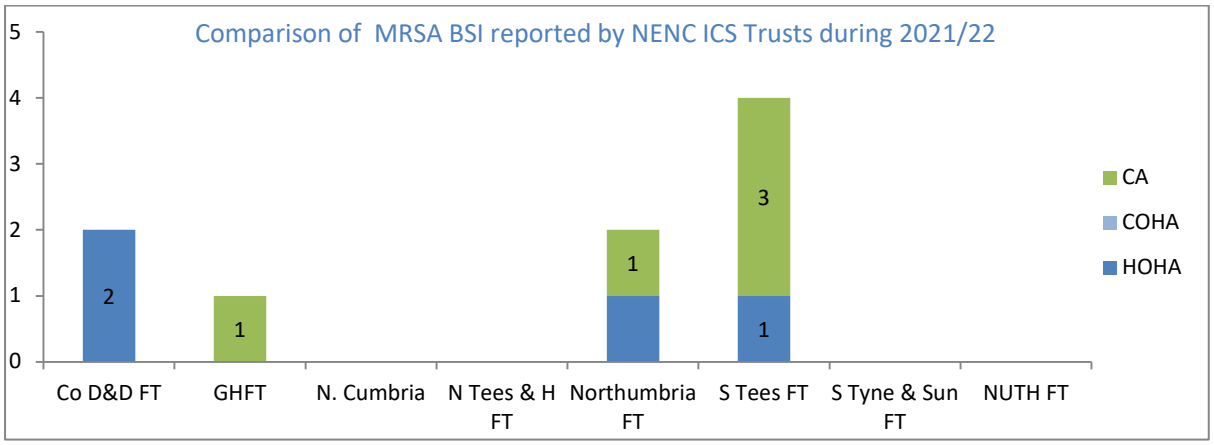
The Trust reports the number of COVID-19 positive in-patients via SitRep and investigates and reports all identified nosocomial COVID-19 cases and COVID-19 outbreaks. To the end of Q2 2021/22 the Trust has identified– eighteen (**18**) indeterminate; thirteen (**13**) probable and ten (**10**) definite hospital onset healthcare associated cases. GHNFT has reported zero (**0**) nosocomial COVID cases during in August 2021

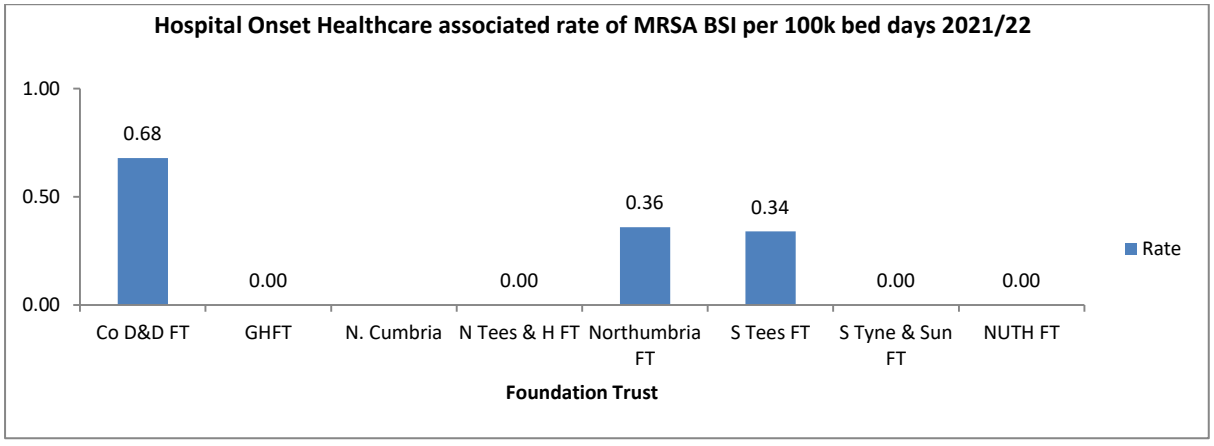
2.0 MANDATORY HCAI SURVEILLANCE

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

To end Q2 2021 GHNFT has reported zero (**0**) healthcare associated MRSA BSI and one (**1**) community associated MRSA BSI.



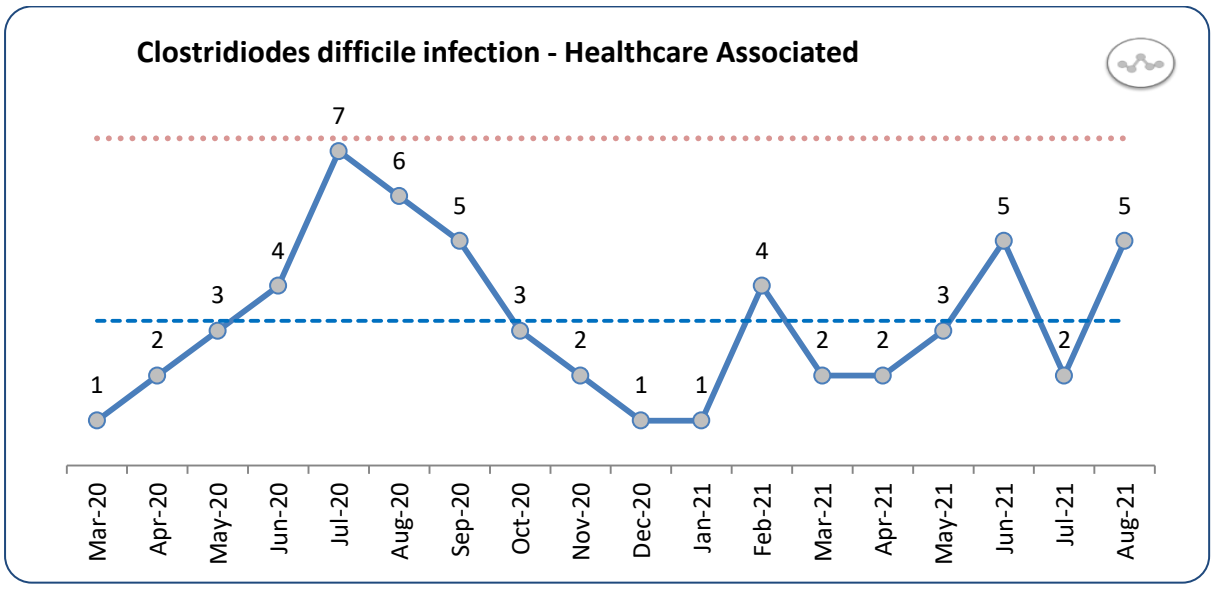


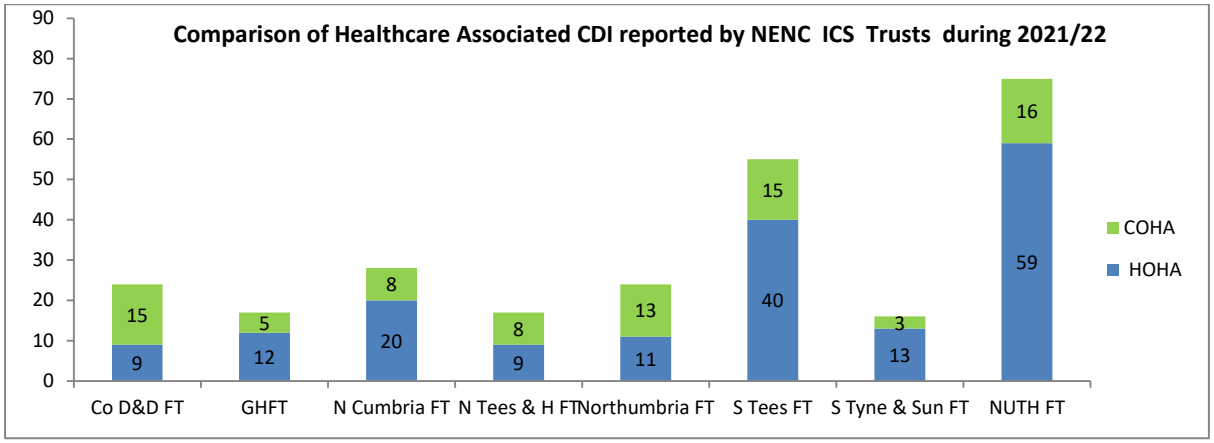


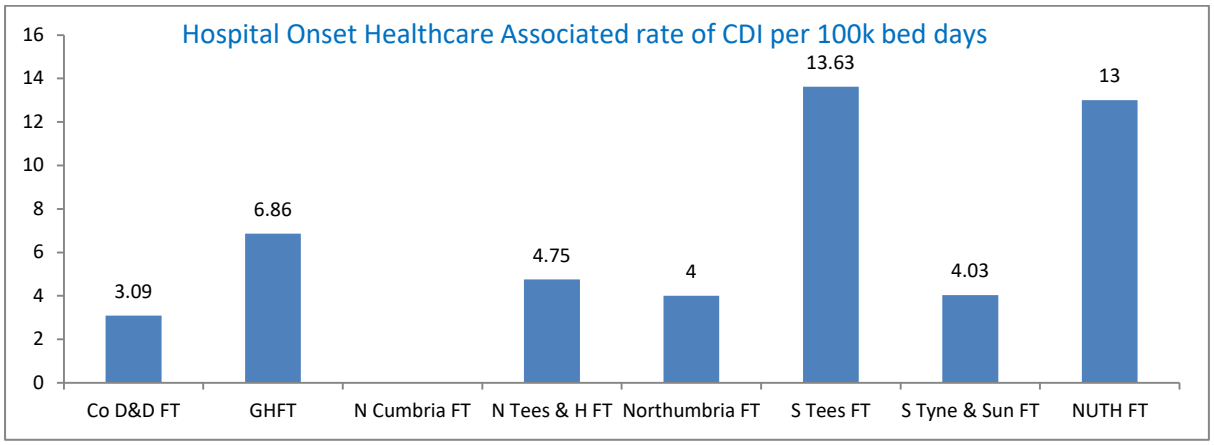
2.2 *Clostridioides difficile* Infection (CDI)

From April 2020 the financial sanctions and the associated appeals process for CDI cases were discontinued. NHS England /Improvement has set GHNFT healthcare associated CDI threshold for 2021/22 at 42 cases.

To the end of Q2 2021/22, GHNFT has reported ten (**17**) CDI healthcare associated samples, seven (**12**) hospital onset healthcare associated (HOHA) and three (**5**) community onset healthcare associated (COHA). These cases have been subjected to internal review and no lapses in care identified.



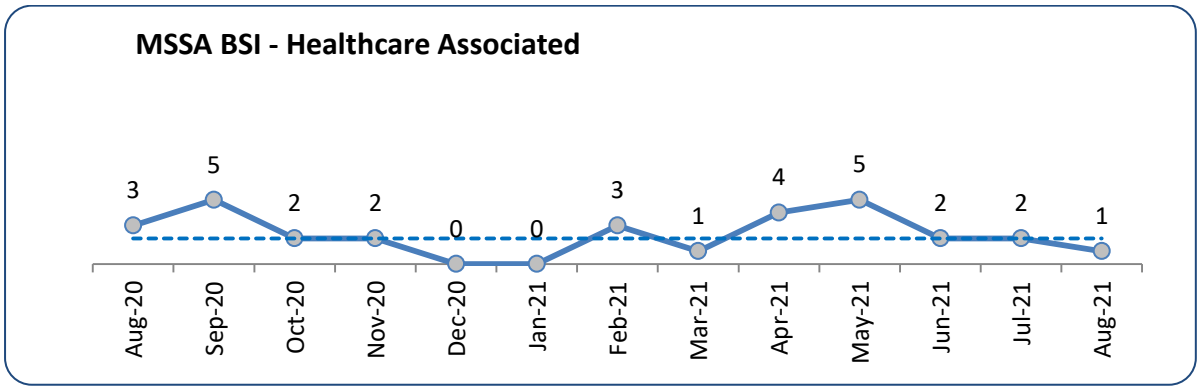


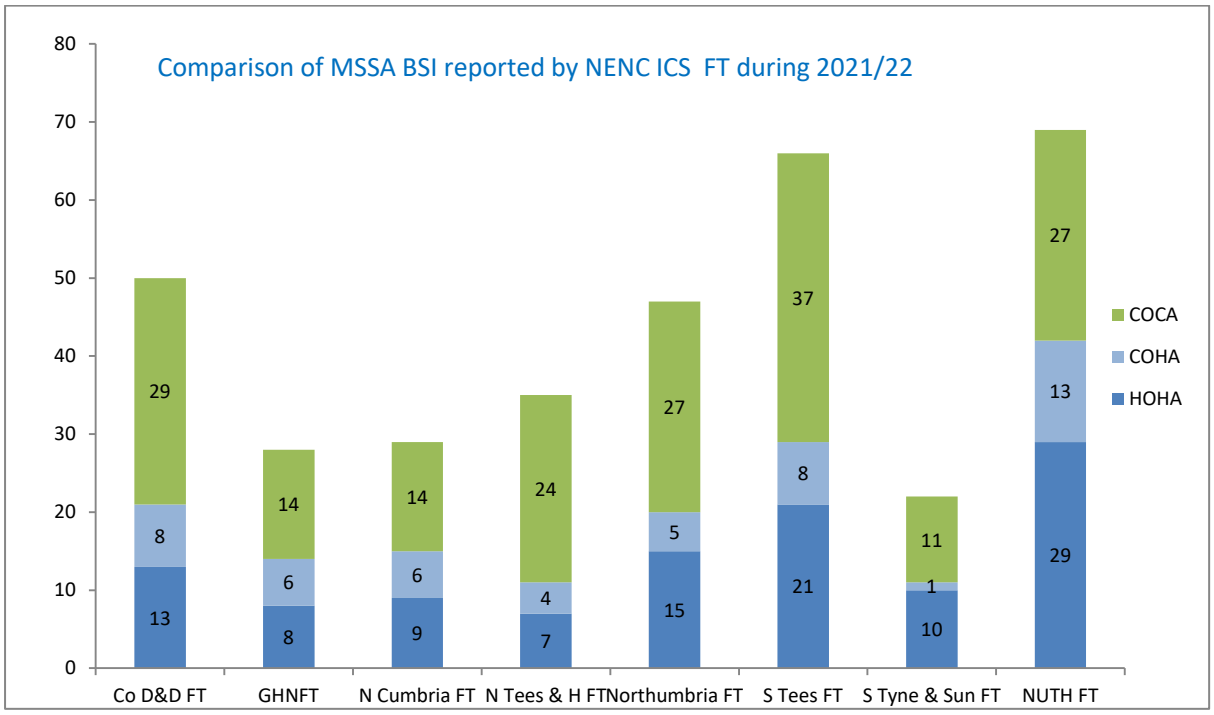


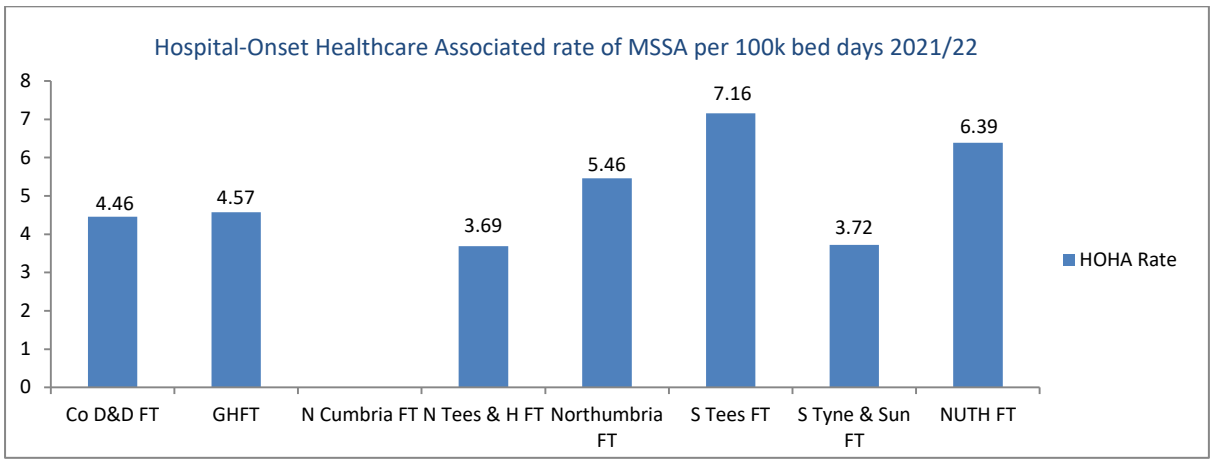
2.3 Meticillin Sensitive *Staphylococcus aureus* (MSSA) Blood Stream Infections (BSI)

NHS England /Improvement have not set GHNFT a threshold for MSSA BSI.

Q2 2021/22 GHNFT has reported fourteen (**14**) healthcare associated MSSA BSI – eight (**8**) HOHA and six (**6**) COHA - and fourteen (**14**) community associated cases.







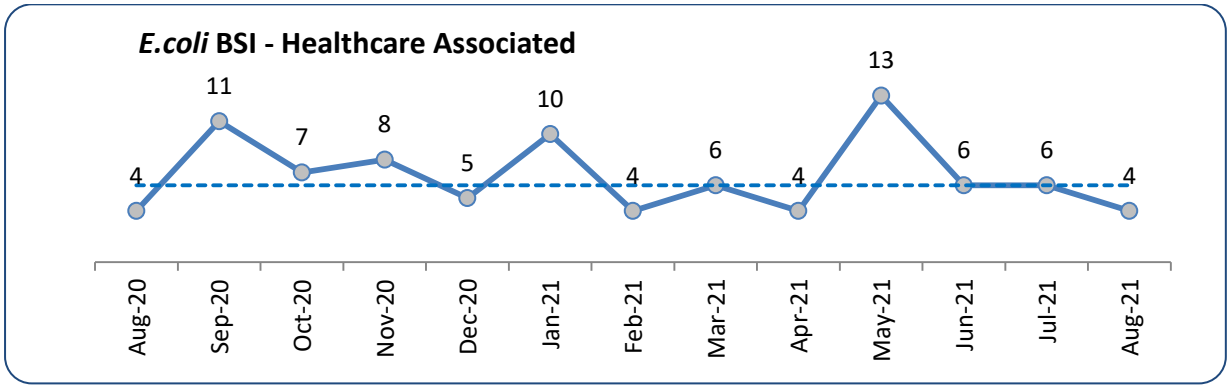
3.0 GRAM-NEGATIVE BLOOD STREAM INFECTIONS (GNBSI) - ENGLAND ONLY

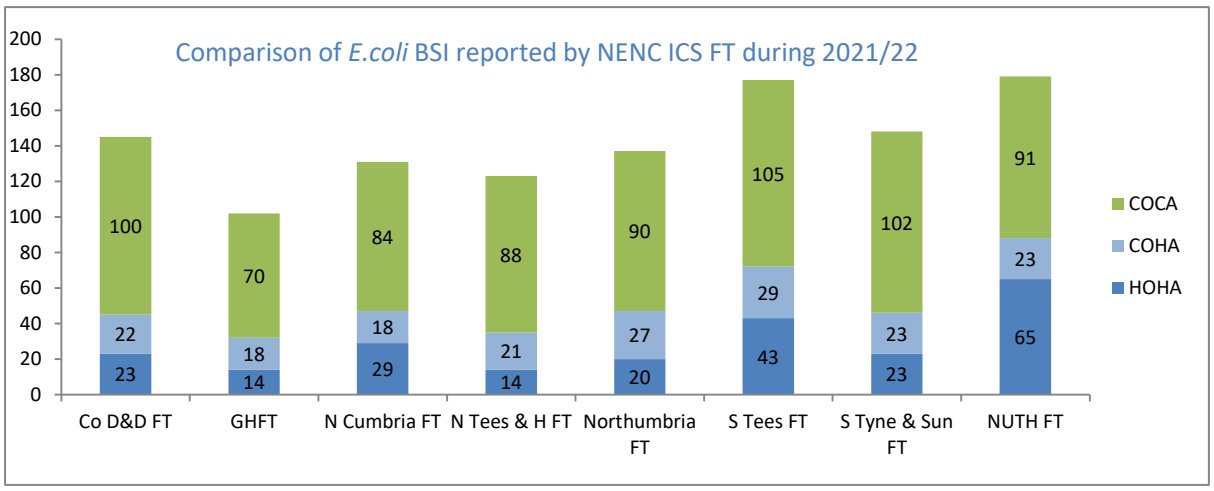
The anticipated Gram-negative BSI reporting thresholds for 2021/22 have now been published.

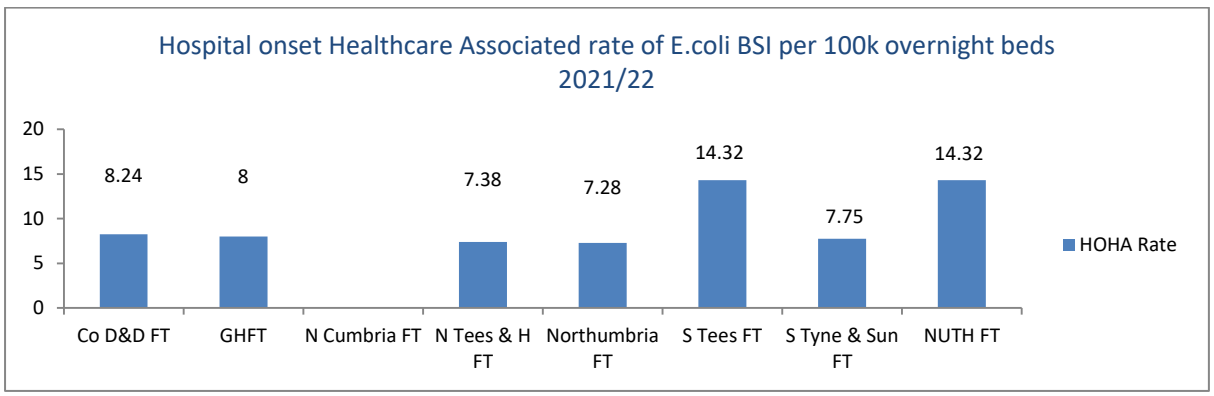
The following data representing *E. coli*, *Klebsiella* species and *Pseudomonas aeruginosa* blood stream infections (BSI) and demonstrate that the main proportion of BSI occur within the primary and social care environment.

3.1 Escherichia coli BSI (*E. coli*)

To the end of Q2 2021/22 GHNFT reported thirty two (**32**) healthcare associated E.coli BSI – fourteen (**14**) HOHA and eighteen (**18**) COHA – and seventy (**70**) community associated cases.

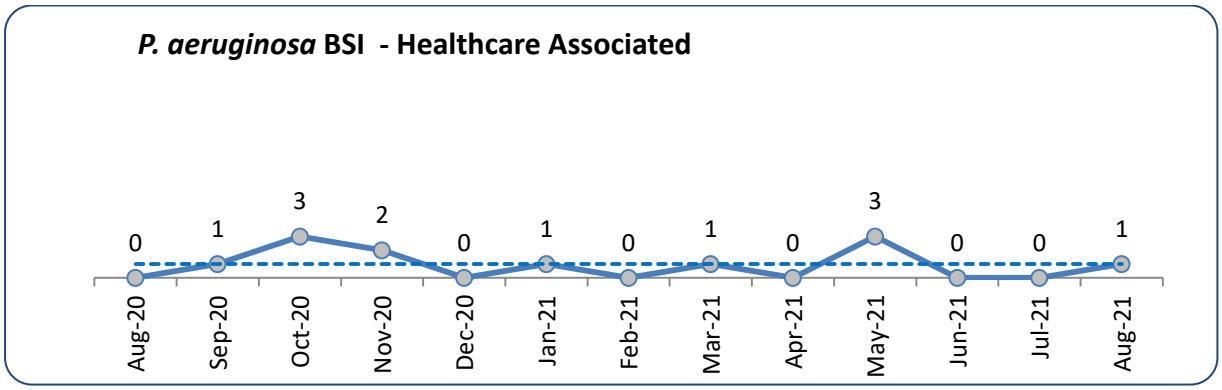


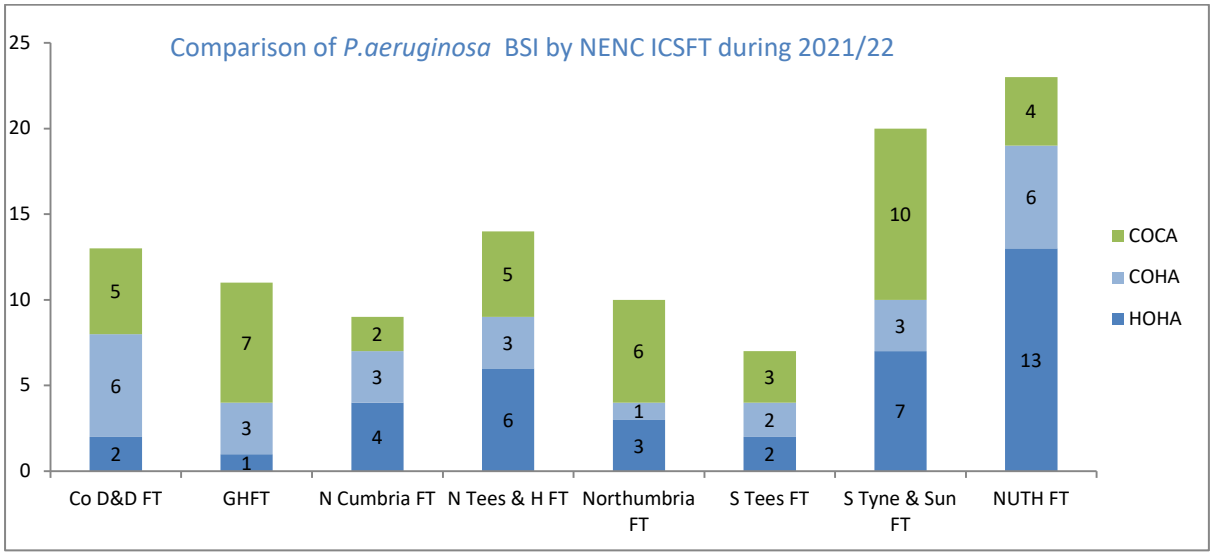


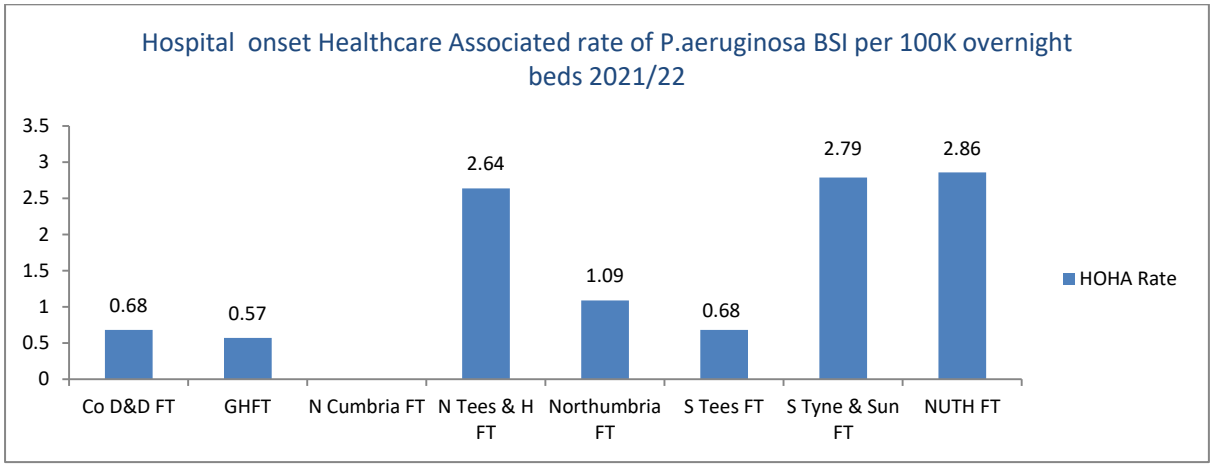


3.2 *Pseudomonas aeruginosa* BSI

To the end of Q2 2021/22 GHNFT has reported four (**4**) healthcare associated *Pseudomonas aeruginosa* BSI - one (**1**) HOHA and three (**3**) COHA - and seven (**7**) community associated cases.

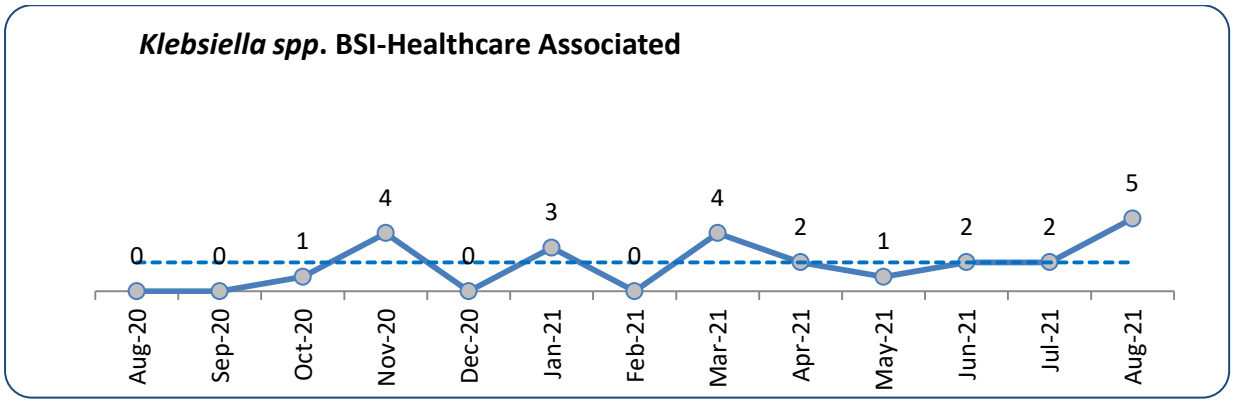


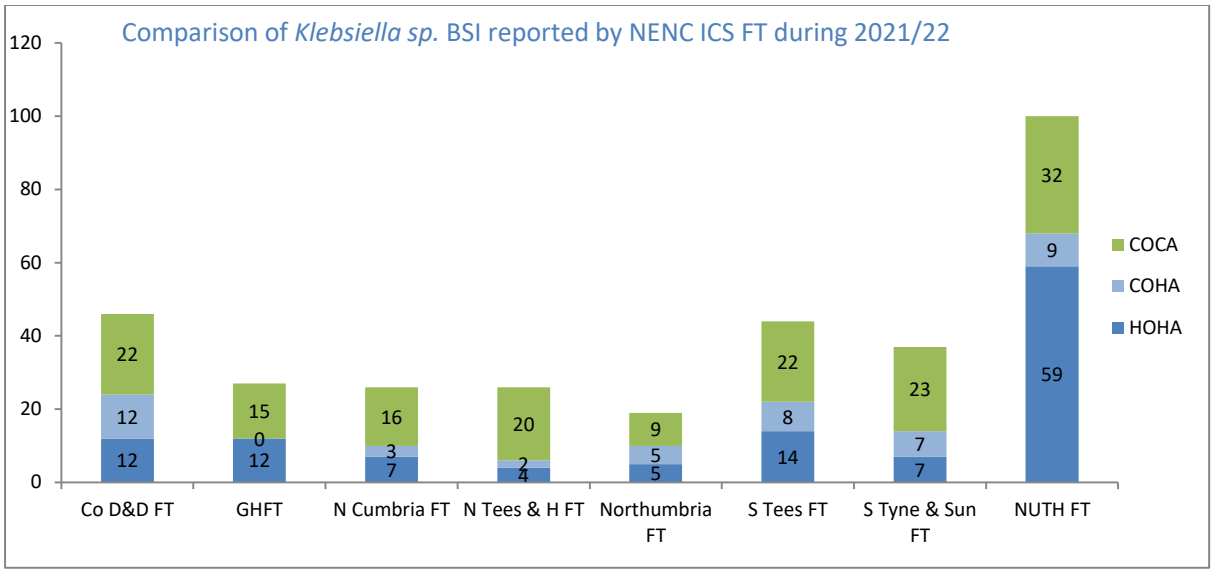


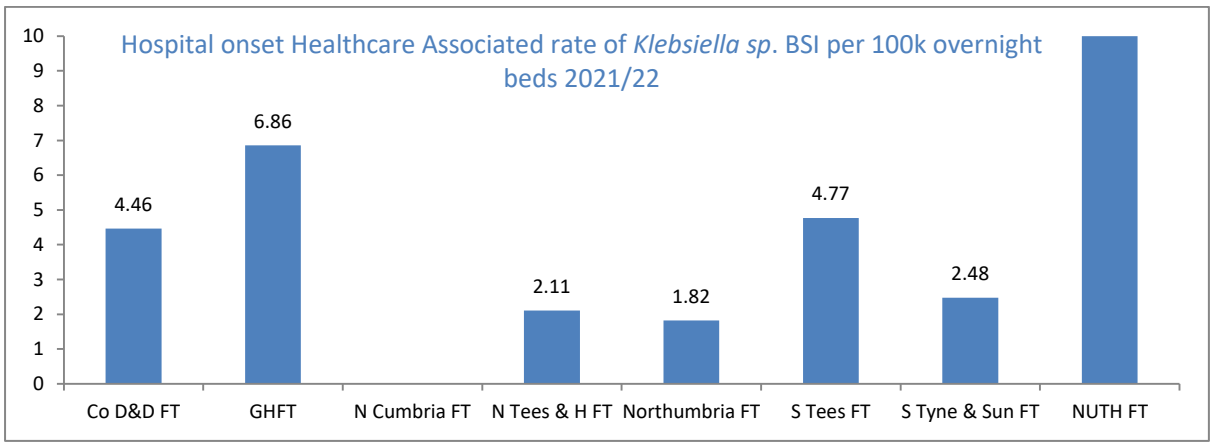


3.3 Klebsiella species BSI

To the end of Q2 2021/22 GHNFT has reported twelve (**12**) healthcare associated *Klebsiella sp.* BSI – five (**12**) HOHA and zero (**0**) COHA – and fifteen (**15**) community associated cases.







4.0 PERIODS OF INCREASED INCIDENCE (PII) AND OUTBREAKS

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

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

The Trust has experienced zero (**0**) PII due to confirmed Norovirus infections during the Q1 of financial year 2020/21,

5.0 COVID - 19

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

2020 was dominated by the COVID-19 pandemic and it continues to dominant 2021/22.

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

The Trust continues to report instances of Healthcare associated COVID-19 cases against 3 categories

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

Table 1 indicates the number of cases reported by the organisation from April 2020.

Table 1	Q1			Q2			Q3			Q4			Total
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
HOiHA	n/a	1	0	0	0	1	19	23	8	20	2	5	79
HOpHA	n/a	0	0	0	0	0	32	21	1	11	8	1	74
HOdHA	n/a	0	0	0	0	1	14	24	1	6	5	0	51
Total	n/a	**1**	**0**	**0**	**0**	**2**	**65**	**68**	**10**	**37**	**15**	**6**	**204**
2021-2022													
HOiHA	**0**	**0**	**2**	**10**	**6**								**18**
HOpHA	**0**	**1**	**0**	**10**	**2**								**13**
HOdHA	**0**	**0**	**0**	**5**	**5**								**10**
Total	**0**	**1**	**2**	**25**	**13**								**41**

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

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

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

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

The trust has reported nine (9) COVID outbreaks to the end of Q2 of 2021/22 (table 7).

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

Table 7 **COVID-19 outbreaks**	**Q1**			**Q2**			**Q3**			**Q4**		
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
20/21Clinical setting	**0**	**0**	**0**	**0**	**0**	**1**	**5**	**4**	**2**	**3**	**3**	**0**
20/21 Non clinical setting	**0**	**0**	**0**	**0**	**0**	**3**	**5**	**1**	**1**	**3**	**0**	**0**
Total	**0**	**0**	**0**	**0**	**0**	**4**	**10**	**5**	**3**	**6**	**3**	**0**
21/22Clinical setting	**0**	**0**	**0**	**5**	**2**							
21/22 Non clinical setting	**0**	**0**	**0**	**2**	**0**							
Total	**0**	**0**	**0**	**7**	**2**							

Louise Caisley
Head of Infection Prevention and Control

Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 21

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Report Title:	Update on the WRES and WDES action plans			
Name of Meeting:	Board of Directors			
Date of Meeting:	Tuesday 28th September 2021			
Author:	Kuldip Sohanpal			
Executive Lead:	Lisa Crichton-Jones			
Report presented by:	Lisa Crichton-Jones			
Executive Summary:	**Background** The Workforce Race Equality Standard (WRES) was first mandated in July 2015 to ensure employees from black and minority ethnic (BAME) backgrounds have equal access to career opportunities and receive fair and equal treatment in the workplace. The Workforce Disability Equality Standard (WDES) was first mandated in July 2018 and seeks to promote the concept of disability as an asset, as research has found that disabled people have poorer experience of working in the NHS in England than non-disabled colleagues. This report provides an overview of the key findings, work undertaking in both areas and highlights work that is still required as well as the expected outcome in both areas. **Engagement undertaken** An engagement approach has been undertaken whilst compiling this report. This has included initially reviewing the staff survey with an EDI lens and liaising with the BAME network and the D-Ability Network. Business units have also been involved, ensuring EDI is embedded in everything that we do to ensure that this is covered within business unit plans. The action plans and the findings have been discussed at the newly established Human Rights Equality Diversity Inclusion Group which has a cross-section of organisational representation as well as the networks (26 August 2021), at senior management team (7 September 2021), executive management team (9 September), the Human Resources Committee (14 September). **Overall rating** The overall rating for both the WRES and the WDES is amber – partially			

compliant. The associated action plans for both reports identify actions required to move the ratings from amber to green – fully compliant.

Key highlights
In respect of both the WRES and WDES, the key highlights are as follows:

WRES
Bullying and harassment, specifically around:

- The percentage of BME staff experiencing harassment, bullying or abuse
- The percentage of BME staff compared to White staff reporting harassment, bullying or abuse at work
- Percentage of staff experiencing harassment, bullying or abuse from patients / service users, Mangers and Colleagues

Data collected show's that in some of the KPI's there has been an decrease in incidents, but the numbers of BME staff reporting was proportionally very small. However further work is required to ensure a zero tolerance approach is implemented in the Trust.

Other key significant areas identified are:

- Staff views on whether the organisation provides equal opportunities for career progression / promotion have continued to vary by ethnicity. There is however a widening gap. Once again the numbers of BME respondents were proportionately low.
- The Trust is assessing how to roll out Reverse / reciprocal mentoring.
- The Trust is assessing the best way to incorporate the Cultural Ambassador role into our disciplinary and grievance processes.

WDES
Bullying and harassment, specifically around:

- The percentage of disabled staff experiencing harassment, bullying or abuse
- The percentage of disabled staff compared to non-disabled staff reporting harassment, bullying or abuse at work
- Percentage of staff experiencing harassment, bullying or abuse from patients / service users, Mangers and Colleagues

Data collected show's an increase in the figures and further work is required to ensure a zero tolerance approach is implemented in the Trust.

Other key significant areas identified are:

- Declaration rates around disability are also low and we need to continue to promote staff to declare their disability status to improve the reliability of equalities monitoring.
- Recruitment processes will also be examined to assess why disabled applicants are shortlisted but are unsuccessful at interview.
- The Trust has retained its Disability Confident employer status this year, we will start assessing what extra work is required to achieve the next level.

<table>
<tr><td></td><td colspan="5">Recommendations

WRES
A priority in addressing the following:
• Data aligned to the WRES KPIs has resulted in a specific WRES action plan indicating all areas that need improvement.
• Specifically refreshing the Recruitment and Selection process across all Bands
• Implementing a Race Disparity Audit
• Assessing external / internal development programs for all staff across all Bands
• Working towards a Zero Tolerance policy

WDES
• Adopt a program of review and development to include recommendations for change across all of the ten WDES indicators
• Data aligned to the WDES KPIs has resulted in a specific WDES action plan indicating all areas that need improvement

The Human Rights Equality Diversity Inclusion Group will have responsible to monitor the ongoing progress of actions. This group reports into the People and OD Portfolio Board.</td></tr>
<tr><td>Recommended actions for Board/Committee)</td><td colspan="5">The Board is asked to note the content of this report and agree the WRES and WDES Action Plan.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:
(Including reference to any specific risk)</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>Financial Implications:</td><td colspan="5">None perceived at the moment – however there may be budget implication for development purposes once further detailed scoping against deliverables has taken place.</td></tr>
<tr><td>Links to Risks (identify significant risks and DATIX reference)</td><td colspan="5">Risk 2760 - The People Plan places equality, diversity and inclusion as a critical strategic workforce priority; further work is needed to embed this fully across the trust</td></tr>
<tr><td>People and OD Implications:</td><td colspan="5">Highlighted within action plan</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

Workforce Race Equality Standard (WRES) Report and way forward

1 Summary and Background

The purpose of this paper is to provide an update on progress against the Workforce Race Equality Standard indicators and propose future actions. These actions will form part of the Trust's Equality Objectives and overarching Equality Diversity & Inclusion Work Plan for 2021 and beyond.

The WRES was first mandated in July 2015 to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair and equal treatment in the workplace. The WRES standard is also cross referenced to the Equality Delivery System 2 (EDS2) to support performance review, set equality objectives and deliver on the Public Sector Equality Duty (PSED which sets out the **'general'** and **'specific'** duties on public authorities as indicted below:

2 The General Duty to:

- Eliminate unlawful discrimination, harassment and victimisation, and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

3 The Specific Duty to:

- Publish equality information at least once a year to show how they've complied with the equality duty.
- Prepare and publish equality objectives at least every 4 years.

To put the WRES into context the NHS People Plan states that…
'… to embed the important interventions that improve the experience of our people, we will develop a new offer with our people setting out explicitly the support they can expect from the NHS as a modern employer…'

This will be framed around the broad themes of:
'… creating a healthy, inclusive and compassionate culture, enabling great development and fulfilling careers, and ensuring everyone feels they have voice, control and influence…'

The interim plan then expands on 'Creating a healthy, inclusive and compassionate culture' *by setting out 'action to improve equality will need to run through all elements of the work on this new offer. This will include further action to embed the Workforce Race Equality Standard…..'.*

4 Recommendations

1. Adopt a program of review and development to include recommendations for change across all of the 9 WRES indicators. The Key Priorities are;
    - Review and refresh the policy around Recruitment and Selection.
    - Undertake a Race Disparity Audit
    - Engage with external development programs
    - Work towards a Zero Tolerance policy

2. Incorporate data from the WRES outcomes and develop a specific WRES action plan indicating all areas that need improvement

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1 Introduction

In recent years there have been a number of major developments in equality legislation and codes of practice. The Stephen Lawrence Enquiry which lead to the McPherson Report gave impetus to the issue pertaining to race equality, and introduced the term 'institutional discrimination' to describe the way in which organisational systems, structures, processes and procedures can operate against equality of opportunity. This debate in its own right paved the way for addressing inequalities across all protected characteristics as reflected in the Equality Act 2010. But addressing inequalities and ensuring Equality and Diversity is reflected in all we do is not only a legal duty, but integral to promote equality on moral and democratic grounds.

2 WRES Metrics

NHS England provides all Trusts with a standard submission template through the NHS Digital's Strategic Data Collection Service (SDCS). The submission of data is made by 31st August, and a narrative report published externally by 31st October.

From a NHS England report, based upon 5 years WRES data collected against several of the indicators, indicated that although progress has been made, more work is still needed. **Nationally the positive findings for 2020 show that:**

- 6.8% of very senior managers in NHS Trusts 2020 are from a BME[1] background (5.4% in 2016)
- 10% of all trust board members are from a BME background (7% in 2017)
- The relative likelihood of BME staff entering the disciplinary process is at the lowest level since data collection began
- **However the relative likelihood of BME staff accessing non – mandatory training is at the lowest since this data collection began**.

3 WRES data report for the Trust

The WRES was developed to help NHS organisations make a positive impact for staff from BME

[1] BME refers to those members of the NHS who are not White. The definitions used in the WRES have followed the national reporting requirements of ethnic categories in the NHS data model, that is BME. The Trust has used the acronym BAME – incapsulating BME, but including Asian

backgrounds working in the NHS. The WRES aims to inform year on year improvements in reducing those barriers that impact most on the career opportunities and workplace experiences of BAME staff - driving changes in attitudes, increasing employment and career opportunities, and implementing long-lasting change for BAME staff.

The Trusts BAME Staff Network and HR and Workforce Systems manager gathered data in respect of the 9 indicators. The collated information was discussed at the Human Rights Equality Diversity and Inclusion Programme Board (HREDIP). Additional feedback was incorporated into the attached action plan, which will be monitored on an ongoing basis by the above group. Any revisions / additions to the action plan will pay due regard to BAME groups input including National discussions to future proof the action plan. This action plan will enable us to measure our progress towards improving the experiences of our BAME employees.

Finally, the actions will be incorporated into the Trust's integrated work plans for equality, diversity and inclusion.

The HR Committee is responsible for governance and assurance.

4 Key indicators and way forward

The key finding across all of the metrics are indicated in Appendix 1.

Appendix 2 is the detailed WRES action Plan

5 Recommendation

The Board members are asked to note the content of this report and agree the WRES Action Plan and key priorities.

Appendix 1

Key Findings: Red indicates improvement required → Green indicates getting better → Amber indicates no movement →

WRES indicators for Gateshead NHS Trust: 2019 - 2021

Please note the number of staff who responded to the staff survey was significantly reduced in 20/21.

WRES Indicator			2018 - 19	2019 - 20	2020 – 21	Trajectory		
1	Percentage of BME staff	Overall	5.43%	5.4%	5.68%	↗	**Increase**	
		VSM	0*	0	0	↔	**Decrease**	
2	Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants		1.94	3.08	1.8	↘	**Decrease**	
3	Relative likelihood of BME staff entering the formal disciplinary process compared to white staff.		0.97	0.38	0.4*	↗	**Slight Increase – Please see * below**	
4	Relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff		0.97	1.18	0.96	↘	**Decrease**	
5	Percentage of staff experiencing harassment, bullying or abuse from patient's relatives or public in the last 12 months	BME	29.5% *(78 staff)*	16.5% *(85 Staff)*	16% *(14 staff)*	↘	**Decrease**	**Low response across both BME and White**
		White	21.2% *(1429 staff)*	22.1% *(1394 staff)*	*21% (30 staff)*	↘	**Decrease**	
6	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	BME	35.7% *(78 staff)*	32.9% *(85 Staff)*	29% *(24 staff)*	↘	**Decrease**	**Low response across both BME and White**
		White	19.9% *(1431 staff)*	20.8% *(1396 staff)*	16% *(214 staff)*	↘	**Decrease**	
7	Percentage of staff experiencing believing that the trust provides equal opportunities for career progression or promotion	BME	79.1% *(43 staff)*	72.5% *(51 Staff)*	73% *(37 staff)*	↗	**Slight Increase**	**Low response across both BME and White**
		White	90.8% *(985 staff)*	90.5% *(972 staff)*	91% *(890 staff)*	↗	**Slight Increase**	
8	Percentage of staff experiencing discrimination at work from a manager / team leader or other colleagues	BME	11.5% *(78 staff)*	17.1% *(82 staff)*	17% *(14 staff)*	↘	**Slight Decrease**	**Low response across both BME and White**
		White	4.2% *(1418 staff)*	4.7% *(1393 staff)*	5% *(66 staff)*	↗	**Slight Increase**	
9	BME Board membership			0	*1 Associated NED*	↗	**Increase**	

*This figure represents only 1 BME in respect of this indicator compared with 12 for the White category. Further investigation will be carried out to understand if data captured the first or final stage of a disciplinary process. This is also not reflective of the data that is coming through from the NMC and national data sets, as it shows that more BME colleagues are reprimanded which often leads to a formal disciplinary action.

Appendix 2

Narrative and Action Plan in respect of each of the WRES indicators

Key

	Not compliant
	Partially compliant
	Fully compliant
	Exceeding

Workforce Race Equality Standard (WRES). – Detailed action plan	Overall rating

WRES Indicator 1

Percentage of staff in each of the AfC Bands 1-9 and VSM (including Executive Board members) compared with the percentage of staff in the overall workforce

Narrative

There has been minimal change to this indicator in the last year.

Different occupational groups have different proportions of BME staff - for example there is a higher proportion of BME staff working in clinical roles, compared to non-clinical roles. The declaration of demographic profiles is a concern. Nationally it is recognised that although reporting remains low in ESR, staff are more likely to share this data as part of the NHS Staff Survey because it is anonymised. However during the Covid-19 pandemic and the recognition that BAME groups were at higher risk, all staff who had not declared their ethnicity in ESR were approached directly encouraging them to update their record.

In March 2019, the Trust worked alongside other local Trusts, and the local Ambulance Service on a BAME recruitment campaign, highlighting the many and varied careers within the NHS. The event was extremely well attended, and is planned to take place again Oct 2021.

Attraction of potential employees and meeting our strategic goal, to be an employer of choice in the region, is an area where we believe a number of actions can be taken.

WORK UNDERTAKEN TO DATE	WHAT WORK IS STILL REQUIRED	EXPECTED OUTCOME	TIME FRAME	LEAD
• Work around attracting campaigns that are diverse and appealing to the BME community is ongoing. Last year a programme around recruiting BAME colleagues into the Trust was undertaken.	• Current engagement in partnership with our neighboring Trusts to deliver a BAME and Recruitment Event	• *Increase the numbers of BAME appointments across Bands*	Oct 2021	Head of People, Planning, Performance and Quality
• Links with community groups and local schools, colleges and universities established to increase the profile of the NHS and the Trust as an employer of choice	• Ongoing work with external providers	• *Raise the profile of Jobs. Increased understanding of the range of jobs available within the NHS. The exercise will aid applicants in applying for jobs within the Trust and the generation of interest in the scope and work of the Trust within our communities, and fostering of good relations between people from different groups.*	Oct 2021 onwards for the duration of the plan	As above

	• Additional job fairs to be established and promoted within local communities and faith groups served by The Trust once in person and face to face interaction can take place.	• *As above*	Oct 2021	Head of People, Planning, Performance and Quality
	• Hold virtual open days for potential candidates, hosted by the Recruitment Team. Consider the use of 'Positive Action' in future recruitment campaigns either for specific roles, professions or grades.	• *As above*	Oct 2021 onwards – undertaken twice a year for the duration of this plan	Head of People, Planning, Performance and Quality
	• BAME staff network group to actively engage staff to self-report and improve demographic profiles	• *Improved demographic data that will aid in specific, targeted interventions and support as required. Additionally this data will highlight where the disparities are and what needs to be done to decrease the difference in proportion of BAME staff within the lower, middle and upper tiers*	As above	EDI Manager/Staff Network
	• Undertake a Race Disparity ratio of BME staff at various AfC bands	• *As above*	As above	EDI Manager
	• Implement a 'reverse mentoring' programme within the Trust.	• *Improve the number of BAME employees who are qualified coaches and are active as part of our coaching / mentoring network.*	Oct / Nov 2021	EDI Manager/Staff Network

WRES Indicator 2
Relative likelihood of white staff being appointed from shortlisting compared to BME staff

Narrative
There has been and decrease in the likelihood of white staff being appointed from shortlisting compared to the previous reporting year. However we need to understand the validity of this metric and revisit the number of campaigns where there were both BAME and white applicants to ensure for accuracy. A number of actions to ascertain this have been identified below.
The current data from NHS Jobs does not help us understand where we lose applicants in their recruitment journey. We are however in the process of moving to a new platform for collecting data and the functionality will allow us to interrogate the data further. Untill this process is undertaken, we still have the issue with the demographic data fields in NHS jobs often not completed (as they are not mandatory) and therefore, we have no accurate data to compare ratio of those shortlisted to those hired by ethnicity.

WORK UNDERTAKEN TO DATE	WHAT WORK IS STILL REQUIRED	EXPECTED OUTCOME	TIME FRAME	LEAD
• Recruitment data is captured, monitored and reported	• Review the current recruitment data captured broken down by Race (Ethnicity) and Faith where possible and • analyse and produce Quarterly workforce data: - on the numbers of applications for posts - on the numbers shortlisted and appointed broken down by ethnicity, banding and profession to be produced as standard metrics. • Reports to be presented to various meetings eg SMT/Exec Team	• *Information collected will:* *- inform the development of specific training in cultural competence, understanding where bias can come into play and appropriate interventions required and be posted on the intranet at the end of each quarter.* *- To be monitored by the HREDIG*	To commence September 2021	Head of People, Planning performance and quality
	• Work with the BAME group to: - sample recruitment outcome documentation to identify whether it is appropriate and /or identifies issues for further training and education. - review recruitment practices, to assess and advise in unintended cultural bias and	• *All data collected will inform the WRES reporting, indicating where there may be a detrimental impact*	Start August 2021 ongoing for duration of plan	EDI Manager

	unconscious bias			
	• BAME staff network group to actively engage staff to self-report in ethnic and faith monitoring to improve demographic profiles	• *Improved demographic data that will aid in specific, targeted interventions and support as required.*	As above	Staff Network
• Bitesize Recruitment and Selection training offered to all staff involved in recruitment processes. Training includes elements on diversity, inclusion, unconscious bias and fair recruitment practices.	• Recruitment practices to be reviewed by HR with the support of the BAME network • Bitesized training to be superseded by the managing well at Gateshead programme	• *Recruitment and Selection exercise from start to finish incorporates the principles of 'Best person for the Job' whilst ensuring there is no detriment to any candidate within the overall process.*	As above	Head of Education, Learning and Development
• Standardised documentation is used as part of recruitment to ensure fair, unbiased and consistent processes are followed.	• EDI is threaded throughout the whole process and documentation reflects this. Any identified service areas where BME groups are consistently not appointed should be interrogated to determine why this is the case	• *Any negative detriment noted is shared with HR and appropriate action are undertaken*	Start Sept 2021 ongoing for duration of plan	Head of People Services
	• BAME Network to sample recruitment outcome documentation to identify whether it is appropriate and / or identifies issues for further training and education and whether or not the values of the Trust have been adhered to.	• *As above*	As above	Head of People Services
	• Recruitment panels are diverse and representative panellists for secondments and acting up positions are introduced	• *Panel membership is more reflective of communities served and staff composition. Application of good practice is followed through. Feedback from the lived experiences of our staff informs process, and addresses*	As above	Head of People Services

		cultural/management issues.		
	• Training for network staff for recruitment processes • Discuss use of cultural ambassadors in recruitment • Include members of the BAME network at shortlisting, recruitment and interview at Bands 8 upwards as panel members for a range of post, grades and/or professions	• *Ensure clear and coherent recruitment that aims to address cultural or unconscious bias.*	As above	Head of People Services
	• Review and analyse the data in relation to recruitment to internal posts, identifying outcomes by ethnicity (and faith groups) if appropriate.	• *Consistent review, refresh and update of equality and diversity training available to ensure it is fit for purpose*	As above	Head of People, Planning, Performance and quality
	• Ensure the BAME network has a more active role in induction	• *Increase BME representation and understanding of the BME network*	As above	Head of Education, Learning and Development

WRES Indicator 3
Relative likelihood of BME staff entering the formal disciplinary process compared to White staff

Narrative
The Trust had 3 disciplinary cases involving BAME members of staff in the reporting period for 2020 - 2021. This is the same as in the previous year. Overall 9 members of staff were trained as 'Cultural Ambassadors' by the Royal College of Nursing (although the training was not only for nursing staff, but available to all staff groups) in order for them to be an additional support mechanism when a BME staff member is subject to an employee relations process. Cultural Ambassadors will identify and challenge any issues of being treated less favorably, discrimination and unconscious or conscious cultural bias which are observed during the formal processes, and ensure that they are taken into consideration in the decision - making process. We will incorporate the Cultural Ambassador role into our disciplinary and grievance processes.
Our ICORE values are embedded within key workforce policies such as Probation, Performance and Appraisal. This enables us to ensure that all employees are managed consistently and objectively in line with our values and behaviours, ultimately removing the ability to discriminate intentionally or otherwise when decisions are made by managers in respect of individuals progressing into formal action.

WORK UNDERTAKEN TO DATE	WHAT WORK IS STILL REQUIRED	EXPECTED OUTCOME	TIME FRAME	LEAD
• Continuing to report on data from the employee relations tracker provided to business units.	• Quarterly reports on the data collected to be presented to the HREDIG	• *Identify the strengths and weaknesses of staff management and HR functions to ensure equal process are implemented for all.*	Start Sept 2021 ongoing for duration of plan	Head of People, Planning, Performance and Quality
• Anti- Bullying and Harassment resources and Mediation Services are available throughout the organisation for all staff groups and are monitored.	• The HREDIG to review the current resources, information provided and an overview of anonymised case notes and make recommendations	• *Able to report on frequency of Mediation Service use and identify trends.*	As above	EDI Manager
• 9 Cultural Ambassadors have been trained to be utilised during disciplinary processes where BME members of staff are involved	• Further training regarding grievance and disciplinary process to be offered to the CAs and assess how often the Ambassadors have been utilised in any Grievance / harassment procedures. • Assess the viability of extending the CA programme to Medical staff as well.	• *Staff undergoing disciplinary procedures are confident to engage appropriate support from trained CA's and / or other trained ambassadors.*	As above	Head of People services

• Continue to work collaboratively with our staff side partners to conduct sample review's of some of the cases involving BAME staff to determine if the action was appropriate or to identify any underlying issues.	• Extend and adapt the Cultural Ambassador role and offer it to all members of staff. • Anonymised reports of investigations undertaken and lessons learnt to be brought to the Human Rights EDI group	• *Lessons learnt from the anonymised reports are integrated within the staff policies and procedures.* • *As above*	As above As above	EDI Manager and Network
• Review undertaken of Trust's Disciplinary practices following the national NHSEI Learning Lessons to improve our People Practices Recommendations – this was in the form of a self-assessment complimented by an external review undertaken by Capsticks HR Advisory Service.	• A series of recommendations have been made and a detailed supporting action plan developed to progress these which is currently being implemented.	• *Ensuring as a Trust we are adhering to best practice, applying a rigorous decision-making methodology, ensuring people are fully trained and competent to carry out their role, assigning sufficient resource, safeguarding people's health and wellbeing, and introducing board-level oversight.*	Anticipated that actions will be completed by the end of September 2021.	Head of People services

WRES Indicator 4
Relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff

Narrative:
The relative likelihood of BME staff accessing non-mandatory training is virtually similar to the 2019 – 2020 figure. (dropped from 1.18 to 0.96). This could be due to the lack of opportunities being taken up due to the Pandemic. However, a full range of bitesize training continues to be provided depending upon need. The apprenticeship levy has also opened up opportunities to develop innovative training programmes and this continues to be explored. Requests for training are approved based on the needs of the service and individual staff development plan. This is intended to ensure that training is equitable. Further analysis in respect of the data around the ethnicity of applications and subsequent approval is needed. Work continuous to finalise managing well and leading well in Gateshead these have been developed in partnership with the networks and this will continue through to implementation.

WORK UNDERTAKEN TO DATE	WHAT WORK IS STILL REQUIRED	EXPECTED OUTCOME	TIME FRAME	LEAD
• Continue to record and track external funding, particularly for medical staff to ensure there is equity in allocation.	• Quarterly reports to be presented to the HREDIG to review take up by Bands and to include ethnicity and faith.	• *Demonstrate fair and equitable allocation of funding and take up*	Start Sept 2021 ongoing for duration of plan	Head of Education, Learning and Development
	• Offering the role of Cultural Ambassadors to include involvement in appraisals of individuals and their managers where this is identified as helpful.	• *Training to be included in appraisal discussion as a measured indicator of performance. Collective ownership of decision making within the approval process indicating fairness and equity*	As above	Head of Education, Learning and Development
	• Consider whether, in line with national and educational guidance, more can be done to recognise international qualifications differently.	• *Increased motivation for staff applying for Jobs with the Trust as well as increase in acceptability of international qualifications. This will also aid the MWRES data sets*	As above	Head of Education, Learning and Development
	• Engage with external development programes i.e. CWD, NELA stepping up Programme for Band 5-7, Ready Now, coaching and mentoring scheme to support improvements in career	• *Increased development of BAME groups across the Trust.* *- Stepping up / Mentoring programs will help in cultural change.* *- Personal effectiveness improving career*	As above	Head of Leadership, OD and Staff Experience

	progression for BAME staff	*development and interview skills*		
	• Progress internal development programme at Bands 1 – 4	• *Collective ownership of decision making within processes has fairness and eqity threaded throughout process. This will also enable staff the confidence to apply for higher band jobs and aid their personal development*	As above	Head of Education, Learning and Development/ Head of Leadership, OD and Staff Experience
	• Implement a development programme in respect of culturally competent management for Board and middle Managers.which will be included in the managing and leading well	• *As above*	As above	As above

WRES Indicator 5, 6 and 8
Percentage of staff experiencing harassment, bullying or abuse from patient's relatives or public in the last 12 months
Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months
Percentage of staff experiencing discrimination at work from a manager / team leader or other colleagues

WRES Indicator 7
Percentage of staff experiencing believing that the trust provides equal opportunities for career progression or promotion

Narrative:
Whilst all three of these indicators show no change to the data collected last year, it is important to note that the numbers across both BME and White were low compared to last years data collected.
Indicator 5 – shows virtually no change to last year's data for both BME and White groups.
Indicator 6 – also shows a drop in the data collected (24 and 214)
Indicator 8 – also has similar data drop in across both BME and White groups from the last survey (14 and 66)
This could be due to the intensity of the work environment and lack of engagement with families, carers and friends. This could be further elevated due to the patients on our wards and lack of family engagement. However further work is required to understand the reasons.
Interestingly the data for indicator 7 shows that for both BME and White groups, felt that there is equal parity in career progression – however this information needs to be further explored – in terms of Banding, Leadership

WORK UNDERTAKEN TO DATE	WHAT WORK IS STILL REQUIRED	EXPECTED OUTCOME	TIME FRAME	LEAD
	FOR 5, 6 and 8 • Undertake a: - deep dive of the data to understand where specific incidents have taken place - audit of specific issues that colleagues have reported and the outcomes - ensure appropriate EDI training is provided for members of staff - Develop a Zero tolerance policy	• *Understand what factors need to be addressed to ensure that our staff are working to the ICore principles.* • *Ensure appropriate mechanisms are in place to address any issues of harassment*	Start Sept 2021 ongoing for duration of plan	Head of People, Planning, Performance and Quality
	FOR 7 • Understand where blockages occur for BME staff at different bands. Cross referenced to indicator 1 and 4 above	• *As indicated within indicator 1 and 4*	As above	As above & Network

WRES Indicator 9 **Percentage difference between The Trust Board's voting membership and its overall workforce**				
Narrative There have been no Board appointments from BME communities within the last twelve months. However, an Associate NED has been appointed as part of a development programme. Actions (i.e., broader advertising mediums) to encourage job applicants from diverse backgrounds have not resulted in the appointment of a BME representative, and skillset remains a key priority. However only 3.7% of the local population is from a BME background, and there are a relatively small number of posts being recruited in any given year. We have carried out recruitment for 2 NEDS and Chief Nurse this year and for all we worked with an updated recruitment pack to better reflect and attract diverse candidates. We had an External BAME assessor on NED interviews, and we had network representation at stakeholder panels for other senior posts.				
WORK UNDERTAKEN TO DATE	**WHAT WORK IS STILL REQUIRED**	**EXPECTED OUTCOME**	**TIME FRAME**	**LEAD**
• The Trust Board have recognised lack of BME representation at Board level	• Recruitment monitoring will enable us to track the numbers of applicants applying for posts and the conversion rate to hire. Human Rights EDI programme board to review and analyse any recruitment exercise to help in future recruitment processes • CEO and Chair to actively encourage applicants from BAME communities and support aspirant NEDS	• *Recruitment monitoring will help inform if the adverts are attracting a wide range of applications from different communities as well as widening recruitment strategies and promote any vacancies through more diverse routes.*	Start June 2021 ongoing for duration of plan as and when required	Head of People, Planning and Performance and Quality CEO/Chair supported by EDI Manager
• NED interviews addressing shortlisting and interview process undertaken in consultation with an external search consultancy	As above	*As above*	As above	As above
• Independent external panel member present during NED appointment	• Trust Board to consider whether any positive action can be undertaken in order to improve ethnic diversity when further Board positions arise.	• *Board is reflective of the communities served*	As above	As above

	• Sponsor and participate in 'Aspiring NED' programme provided by Gatenby Sanderson 'Insight' Programme for Aspiring NHS NED's.	• *This will facilitate a more diverse range of candidates supply from groups under represented at Board*		
	• Newly appointed NEDs offered 'Buddy' support from an experienced NED.	• *Newly appointed NEDs get a greater clarity around the portfolio of work and help in the engagement agenda with members of staff and role in question.*	As above	Head of Workforce Development/ POD

NHS
Gateshead Health
NHS Foundation Trust

Workforce Disability Equality Standard (WDES) Report and way forward

1. Summary and background

The purpose of this paper is to provide an update on progress against the Workforce Disability Equality Standard indicators and propose future actions. These actions will form part of the Trust's Equality Objectives and overarching Equality Diversity & Inclusion Work Plan for 2021 and beyond.

The WDES was first mandated in July 2018 and it builds on the Workforce Race Equality Standard (WRES), which was introduced in 2015 however focuses on disability. The WDES seeks to promote the concept of disability as an asset, as research has found that disabled people have poorer experience of working in the NHS in England than non-disabled colleagues. The WDES standard is also cross referenced to the Equality Delivery System 2 (EDS2) to support performance review, set equality objectives and deliver on the Public Sector Equality Duty (PSED). The PSED sets out the **'general'** and **'specific'** duties on public authorities as indicted below:

2 The General Duty to:

- Eliminate unlawful discrimination, harassment and victimisation, and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

3 The Specific Duty to:

- Publish equality information at least once a year to show how they've complied with the equality duty.
- Prepare and publish equality objectives at least every 4 years.

To put the WDES into context the NHS People Plan states that in order…
'… to embed the important interventions that improve the experience of our people, we will develop a new offer with our people setting out explicitly the support they can expect from the NHS as a modern employer…'

This will be framed around the broad themes of:
'… creating a healthy, inclusive and compassionate culture, enabling great development and fulfilling careers, and ensuring everyone feels they have voice, control and influence…'

The interim plan then expands on 'Creating a healthy, inclusive and compassionate culture' by setting out 'action to improve equality will need to run through all elements of the work on this new offer. This will include further action to embed the Workforce Disability Equality Standard…..'.

4 Essentially implementing the WDES will help the Trust to:

- Improve understanding of inequalities experienced by disabled staff
- Create fairer, more anti-discriminatory environments and culture which foster the engagement, involvement, inclusivity of disabled staff
- Provide better workplaces and services to patients and service users
- Enable the Trusts commitment to meet the Equality Act's 'Public Sector Equality Duty'; and
- Help the NHS to deliver the government's pledge to increase the levels of disabled people in employment.

5 **There are 10 WDES indicators which improvements are based on are:**

- Workforce data (3 indicators)
- Questions from the NHS Staff Survey (5 indicators)
- Engagement and voices of disabled staff (1 indicator)
- Disability representation on Boards (1 indicator)

6 Recommendations

1..1 Adopt a program of review and development to include recommendations for change across all of the ten WDES indicators

1..2 Incorporate data from the WDES outcomes and develop a specific WDES action plan indicating all areas that need improvement

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1 WDES Metrics

NHS England provides all Trusts with a standard submission template through the NHS Digital's Strategic Data Collection Service (SDCS). The submission of data is made by 31st August, and a narrative report published externally by 31st October.

2. WDES data report for the Trust

The WDES was developed to help NHS organisations make a positive impact for all disabled staff working in the NHS. The WDES aims to inform year on year improvements in reducing those barriers that impact most on the career opportunities and workplace experiences of Disabled staff - driving changes in attitudes, increasing employment and career opportunities, and implementing long-lasting change for Disabled staff.

The Trusts D-Ability Staff Network, HR and Workforce systems Manager helped in gathering data in respect of the 10 indicators. The collated information was discussed at the Human Rights Diversity Inclusion Program Board (HREDIG). Additional feedback was incorporated into the attached action plan, which will be monitored on an ongoing basis by the above group. Any revisions arising as a result

of National discussions and D-Ability network members will be incorporated into the attached action plan to future proof the action plan. The action plan will enable us to measure our progress towards improving the experiences of our disabled staff.

Finally, the actions will be incorporated into the Trust's integrated work plans for equality, diversity and inclusion. These will be further enhanced by any review of the Trust's People Strategy as a result of the publication in August of the NHS People Plan.

The HR Committee and a Committee of the Trust Board is responsible for governance and oversight.

3 Key indicators and way forward

The key finding across all of the metrics are indicated in Appendix 1.

Appendix 2 is the detailed WDES Action Plan.

4 Recommendation

The Board is asked to note the content of this report and agree the WDES Action Plan

Appendix 1

Key Findings: **Red indicates requires improvement →** **Green indicates getting better →** **Amber indicates no movement →**

WDES Indicators			2018 -19	2019 - 20	2020 - 21	Trajectory	
1	Percentage of Disabled staff in AfC paybands or medical and dental subgroups and VSM (including Executive Board members) compared with the percentage of staff in the overall workforce	Overall	**6.5%**	**5. 7.%**	5.28%	↘	**Small Decrease**
		VSM	**0%**	**0%**	**7.7%**	↗	**Increase**
2	Relative likelihood of non-Disabled staff compared to Disabled staff being appointed from shortlisting across all posts.		**1.33**	**1.53**	**0.3***	↗	**Whilst this shows an increase, this is reflective of the number of candidates employed – which was small.**
3	Relative likelihood of Disabled staff compared to non-Disabled staff entering the formal capability process, as measured by entry into the formal capability procedure		*	**0.0***	**0.01**	→	**Static. Overall figures need to be reassed**
4	a) Percentage of disabled staff experiencing harassment, bullying or abuse. b) Percentage of disabled staff compared to non-disabled staff reporting harassment, bullying or abuse at work **NB: 42% Staff Survey 2019 response rate**						
	In the last 12 months, percentage of staff experiencing harassment, bullying or abuse from:		**2018 - 19**	**2019 - 20**	**2020 -21**	**Trajectory**	
	a) Patients/service users, their relatives or other members of the public	Disabled	25%	23%	25%	↗	**Increase**
		Non Disabled	22%	21%	20%	↘	**Slight Decrease**
	b) Managers	Disabled	19%	13%	16%	↗	**Increase**
		Non Disabled	10%	9%	9%	→	**Static**
	c) Colleagues	Disabled	24%	25%	24%	↘	**Slight Decrease**

		Non Disabled	16%	13%	13%	→	**Static**
	d) They or their colleague reported it	Disabled	33%	43%	44%	↗	**Slight Increase**
		Non Disabled	29%	40%	43%	↗	**Slight Increase**
5	Percentage of disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.	Disabled	83%	84%	83%	↘	**Slight Decrease**
		Non Disabled	93%	92%	91%	↘	**Slight Decrease**
6	Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	Disabled	34 %	34%	34%	↔	**Static**
		Non Disabled	21%	19%	22%	↗	**Slight Increase**
7	Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which the organisation values their work.	Disabled	69%	42%	38%	↘	**Slight Decrease**
		Non Disabled	79%	44 %	51%	↗	**Increase**
8	Percentage of disabled staff saying that their employer has made adequate adjustments to enable them to carry out their role.	Disabled	81%	85%	75%	↘	**Decrease**
		Non Disabled	0%	0 %	0%	↔	**Static**
9	Staff engagement score for disabled staff compared to non-disabled staff and the overall engagement for the organisation (out of 10).	Disabled	6.9%	6.9%	6.9%	↔	**Static**
		Non Disabled	7.3%	7.3 %	7.3%	↔	**Static**

For question 4 - Whilst the figures show either an increase or a decrease, the figures are worryingly high, where we should be aiming for zero%
For question 5 – there is a decrease across both groups.
For question 7 – disabled staff do not feel that they receive the same equity compared to white staff
For question 8 – there is decrease in the numbers reporting reasonable adjustments.

10	Percentage difference between the organisation's Board voting membership and the organisation's overall workforce	2018 - 2019			2019 - 2020			2020 - 2021		
		Disabled	**Non-Disabled**	**Disability unknown or Null**	**Disabled**	**Non-Disabled**	**Disability unknown or Null**	**Disabled**	**Non-Disabled**	**Disability unknown or Null**
	Total Board	0%	100%	0%	0%	100%	0%	7.7%	92.3%	0%
	Voting Board	0%	100%	0%	0%	100%	0%	7.7%	92.3%	0%
	Non Voting Board	0%	0%	0%	0%	0%	0%	0%	0%	0%
	Executive Board Member	0%	100%	0%	0%	100%	0%	20%	80%	0%
	Non Executive Board Member	0%	100%	0%	0%	100%	0%	0%	100%	0%

Appendix 2

Narrative and action plan in respect of each of the WDES indicators

Key

	Not compliant
	Partially compliant
	Fully compliant
	Exceeding

Workforce Disability Equality Standard (WDES). – Detailed action plan	Overall rating - AMBER

WDES Indicator 1

Percentage of staff in AfC paybands or medical and dental subgroups and VSM (including Executive Board members) compared with the percentage of staff in the overall workforce

Narrative:

Different occupational groups have different proportions of disabled staff – however there is little differential between Clinical and Non-Clinical staff groups.

As a result of the Covid-19 pandemic and the high risk-factors associated with underlying conditions, the Trusts D-Ability Staff Network group undertook a campaign to increase awareness of the need for employees to declare disabilities. From comparisons to the rates declared in the NHS Staff Survey we need to continue to promote declaration to improve the reliability of equalities monitoring.

Whilst there is a general awareness and understanding in terms of declaring physical disabilities for practical/adjustment purposes or where a disability is visible, there is also the need to promote awareness and ultimately reporting around hidden disabilities. The Health and Wellbeing Steering Group and the D-Ability Network play a key role in increasing awareness and inclusivity across the Trust for all employees with any form of disability.

The Trust has also established an Equality, Diversity and Inclusion Programme Board to support the delivery of Gateshead NHS FT's work on Equality and Diversity which seeks to ensure that all members of staff (Clinical and Non-Clinical) are treated in a fair and equitably manner. The purpose of this Board is as follows:

- Ensure that Gateshead NHSFT is compliant with the Equality Act 2010, Public Sector Equality Duty or any superseding legislation and oversee the EDI agenda and ensure that the functions attributed to EDI are discharged
- Act as champions for monitoring and implementing EDI recommendations arising from National Initiatives e.g. The Workforce Race Equality Standard, The Workforce Disability Equality Standard, Gender and Ethnicity Pay Gaps, The Equality Delivery System.
- Act as the body responsible for ensuring coherence and synchronicity for EDI agenda across the Trust.
- Receive and review equality data presented in respect of recruitment, workforce, service delivery, achievement of staff, potential barriers to achievement and progression.
- Receive reports of collaborative work with partner organisation's / other NHS in equality, diversity and inclusion impacting upon both staff and patients.
- Endorse operational policies and procedures relating to the training which will impact across both staff and service users across Gateshead NHS FT's footprint
- Support and/or commission research on equality, diversity and inclusion issues.
- Ensure that the EDI direction of travel meets the People Plan in line with our service priorities.
- Receive the appropriate reports including annual report for discussion prior to it being tabled at the appropriate committees.

WORK UNDERTAKEN TO DATE	WHAT WORK IS STILL REQUIRED	EXPECTED OUTCOME	TIME FRAME	LEAD
• Continue to work through D-Ability to understand how we can engage staff to self-report and remove any stigma to declaring a disability.	• D-Ability staff network group to actively engage staff to self-report and improve demographic profiles	• *Show case to external applicants that members of the disabled communities are represented within the workforce*	Oct 2021 onwards	Head of People, Planning, Performance and Quality
• Current engagement in partnership with our neighboring Trusts to deliver a Disability Recruitment Event	• Work with colleagues to run joint campaigns across the disability agenda. • Explore with the ICS how the Trust can work in a collective manner across the region.	• *Give applicants the confidence and interest in the scope and work of the Trust and in applying for jobs within the Trust.*	Oct 2021.	As above
• Links with community groups and local schools, colleges and universities established to increase the profile of the NHS and the Trust as an employer of choice this includes finding placements for young people with learning disabilities	• Ongoing: additional job fairs to be established and promoted within local communities served by The Trust once in person and face to face interaction can take place. • Further planning and co-delivery of the Disability Recruitment Events, both internally and externally	• *As above* • *As above*	Oct 2021 onwards – undertaken twice a year for the duration of this plan	Head of Education, Learning and Development
	• Hold virtual open days for potential candidates, hosted by the Recruitment Team • Consider the use of 'Positive Action' in future recruitment campaigns either for specific roles, professions or grades.	• *All recruitment managers will have an increased understanding of the range of disabilities as well why a proactive approach as well as reasonable adjustments might be required.*	Oct 2021.	As above

WDES Indicator 2 **Relative likelihood of non-Disabled staff compared to Disabled staff being appointed from shortlisting across all posts**				
Narrative Further examination is needed of the situations where candidates who declare a disability during the recruitment process and are shortlisted but unsuccessful at interview as well as understanding why disabled candidates who had applied had been shortlisted but subsequently not invited to interview. This will enable us to identify any potential issues to address with recruitment processes. Capturing this information will also enable us to identify what 'reasonable adjustments' are required for candidates both at interview stage and once employed. Whilst the Trust has retained its Disability Confident employer status this year, we will start assessing what extra work is required to achieve the next level. This will be monitored and reported on over the period of the action plan.				
WORK UNDERTAKEN TO DATE	**WHAT WORK IS STILL REQUIRED**	**EXPECTED OUTCOME**	**TIME FRAME**	**LEAD**
• Recruitment data is captured and monitored and reported • Introduction of TRAC (On-line recruitment system)	• Review the current recruitment data capture, broken down by Disability and analyse and produce Quarterly workforce data: - on the numbers of applications for posts - on the numbers shortlisted and appointed broken down by disability, banding and profession to be produced as standard metrics.	• *Information collected will:* *- inform the development of specific training in disability competence, understanding where bias can come into play and appropriate interventions required. To be monitored by the HREDIG.*	Starting July / August 2021	Head of People Services
• Bitesize Recruitment and Selection training offered to all staff involved in recruitment processes. Training includes elements on diversity, inclusion, unconscious bias and fair recruitment practices.	• Undertake sample recruitment outcome documentation to identify the contents to assess and /or identify issues for further training and education. • Recruitment practices to be reviewed by HR, supported by the D-Ability Network to ensure fair and consistent processes are followed and impact of unconscious bias reduced. Reassess our R and S offer • Bitesize training to be replaced by the new managing well at Gateshead Programme	• *All data collected will inform the WDES reporting, indicating where there may be a detrimental impact and agree positive action undertaken and assess the viability of future training.* • *Consistent review, refresh and update of equality and diversity training available to ensure it is fit for purpose.*	Oct 2021 0nwards	Head of People Services

• Standardised documentation is used as part of value based recruitment to ensure fair, unbiased and consistent processes are followed.	• EDI is threaded throughout the whole process and documentation reflects this. • Supported by the D-Ability Network, review a sample of outcome documentation and analyse the data in relation to recruitment to internal and external posts, identifying outcomes by disability as appropriate. • Recruitment panels are diverse and representative panellists for secondments and acting up positions are introduced • Assess the viability of Including members of the D-Ability network at shortlisting, recruitment and interview at Bands 7 upwards as panel members for a range of post, grades and/or professions reported into the HREDIG	• *Recruitment and Selection exercise from start to finish incorporates the principles of 'Best person for the Job' whilst ensuring there is no detriment to any candidate within the overall process.* *Any negative detriment noted is shared with HR. Any identified service areas where disabled groups are consistently not appointed should be interrogated to determine why this is the case.* • *Panel membership is more reflective of communities served and staff composition. Application of good practice is followed through. Feedback from the lived experiences of our staff informs process, and addresses cultural/management issues.*	Start August 2021 ongoing for duration of plan Start Sept 2021 ongoing for duration of plan	Head of People Services

WDES Indicator 3 **Relative likelihood of Disabled staff compared to non-Disabled staff entering the formal capability process as measured by entry into the formal capability procedure.**				
Narrative: The Trust's equivalent to a 'Capability Policy' is the Managing Performance Policy. The small number of employees who entered the formal capability process in did not have their disability information recorded in ESR. As outlined in indicator 1, further work needs to take place to ensure staff feel comfortable sharing their disability information and updating this on ESR. **It should be noted however that ESR is currently only used to record employees on step 3 (formal) of the policy, therefore the data captured would not identify those on step 1 and step 2 (informal) of the policy.** In addition we recognise that the level of declaration in ESR does not reflect the number of cases involving underlying medical conditions the Occupational Health (OH) team deal with. For example, an individual is referred to the OH team as a result of the capability process and it then transpires there is an underlying condition that hasn't been previously declared. As managers then become aware of this they can make relevant adjustments however had the condition been known at the outset this would have been considered at the earlier stages.				
WORK UNDERTAKEN TO DATE	**WHAT WORK IS STILL REQUIRED**	**EXPECTED OUTCOME**	**TIME FRAME**	**LEAD**
• Anti- Bullying and Harassment resources and Mediation Services are available throughout the organisation for all staff groups and are monitored.	• Quarterly report on data from the employee relations tracker provided to business units, broken down by disability to be presented to the HREDIG • Implementation of Selenity – on line employee relations management system • The HREDIG to review the current resources, information provided and an overview of anonymised case notes and make recommendations	• *Identify numbers of staff who have accessed resources , specifically by disabled staff* • *Able to report on frequency of Mediation Service use and identify trends. Ensure relevancy and appropriate resources are maintained.*	TBA	Head of People Services
	• Training regarding grievance and disciplinary process to be offered to the members of staff who may have a disability and are qualified to be part of the disciplinary panel •	• *Help in ensuring no unconscious bias is taking place. The process will also identify strengths and weaknesses of staff management and HR functions to ensure equal process are implemented for all. Staff undergoing disciplinary procedures are confident to engage appropriate support from trained colleagues.*	Start Sept 2021 ongoing for duration of plan	Head of People Services

• Continue to work collaboratively with our Staff Side partners to conduct sample reviews of some of the cases involving Disabled staff to determine if the action was appropriate and / or to identify any underlying issues.	• Anonymised reports of investigations undertaken and lessons learnt to be brought to the HREDIG	• *Lessons learnt from the anonymised reports are integrated within the staff policies and procedures.*	As above	As above

WDES Indicator 4

a) Percentage of disabled staff experiencing harassment, bullying or abuse.

b) Percentage of disabled staff compared to non-disabled staff reporting harassment, bullying or abuse at work

(NB: 42% Staff Survey 2019 response rate)

Narrative:

The data available from the staff survey for this KPI indicates an **increase** in instances of harassment, bullying or abuse while at work from Managers for staff with disabilities, whilst there is a decrease for non disabled staff.

As part of the range of bitesize training there is a bullying and harassment session. The aim of which is to appreciate the legal background to harassment and bullying, have a shared understanding of the risk factors, triggers, possible warning signs and impact of harassment and bullying, understand the managers role in preventing and dealing with harassment and bullying and to understand how to access information and support when dealing with harassment and bullying.

The Trust's D-Ability Staff Network have a key role in increasing awareness amongst all employees of the different protected characteristics, including what different groups find acceptable and unacceptable. Action to tackle harassment and bullying is not restricted to the issues highlighted through the WDES, it is in line with the Trust's core value of 'respect' for all employees.

WORK UNDERTAKEN TO DATE	WHAT WORK IS STILL REQUIRED	EXPECTED OUTCOME	TIME FRAME	LEAD
	• Support for managers in having conversations at an earlier stage to potentially identify sensitive, underlying condition related issues. Cross reference to the conversations that may be had within the Health and Wellbeing offer.	• *Appropriate support is provided for both manager and disabled colleague to ensure conversations have a positive outcome. This may be linked to reasonable adjustments, organizational systems, clarity around aspects impacting upon mental Health and health and well being.*	Ongoing	Head of People Services
• D-Ability have encouraged staff to share their stories and experiences to enable lessons to be learnt.	• Campaigns to encourage staff to report bullying and harassment at workplace, and ensure support is available to staff who experience or witness this. Quarterly data reports to be presented to the HREDIG for review.	• *Increase awareness amongst all employees in respect of what is acceptable behaviour. Review of any trust statements and messages that bullying is not tolerated.*	April 2022	Head of People Services

	• A review of formal complaints received from employees will be undertaken (in conjunction with our staff side colleagues and D-Ability)	• *Understand any discrepancies and identify initiatives which can be introduced to address any findings.*		Head of People Services
• D-Ability continue to promote role models, create myth buster, make videos, arrange group discussions to raise awareness and educate staff to be more inclusive and acceptable of differences.		• *Colleagues understand the background / reasons in respect of disability. Information produced will aid in decision making around disabilities*		
	• Engage with external development programes i.e. CWD, NELA stepping up Programme coaching and mentoring scheme to support improvements in career progression for Disabled staff	• *Increased development of Disabled group of staff groups across the Trust.* *- Stepping up / Mentoring programs will help in cultural change.* *- Personal effectiveness improving career development and interview skills*	As above	Head Leadership, OD and Staff Experience

WDES Indicator 5

Percentage of disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.

Narrative.

This year's results show a miniscule drop in this particular metric. This is possible related to the COVID pandemic and lack of opportunities for members of staff to access training courses. In respect of any offer of training, our ICORE values are embedded within key workforce policies such as Probation, Performance and Appraisal, enabling us to ensure that all employees are managed consistently and objectively in line with our values and behaviours, which aims to remove the ability to discriminate intentionally or otherwise when decisions are made by managers in respect of individuals progressing through the talent management framework (the next stage of our Talent Management process is in the final stages of development) , and alongside training data analysis, will be 'tested' with all of our staff network groups to ensure that it is transparent and inclusive, and offers opportunities for all staff, regardless of disability or any other protected characteristic. **One of the recommendations is for staff members from under-represented groups to be able to self-nominate to progress to Talent Boards.**

WORK UNDERTAKEN TO DATE	WHAT WORK IS STILL REQUIRED	EXPECTED OUTCOME	TIME FRAME	LEAD
• D-Ability network enable's gives disabled employees a trusted way of raising issues and concerns and an opportunity to share their stories and be heard.				
	• Talent Management process in development stage. The process will be 'tested' with the disabled network to for transparency and inclusiveness	• *Staff members from under-represented (in this case Disabled staff) will enable staff to self-nominate progression on Talent Boards.*	**TBA**	Head Leadership, OD and Staff Experience
	• Workforce Development colleagues to ensure that all training opportunities are inclusive and that equality of access is monitored.	• *Increased uptake for disabled members of staff across the whole of the Trust*	**TBA**	Head Leadership, OD and Staff Experience
	• Mentoring of disabled colleagues by executive and non-executive board members to aid progression to senior roles and increase representation.	• *This two-way process will enable a better understanding of the barriers faced by staff who have a disability and what proactive engagement is required by the Trust.*	**TBA**	Head Leadership, OD and Staff Experience

WDES Indicator 6 **Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.**				
Narrative: Staff survey data for the last 3 years shows: - There has not been any change in disabled staff in **NOT** feeling pressured to come to work - Small fluctuation (21% to 22%) for disabled staff who have felt pressurized to come to work. Further work needs to be undertaken to understand the perception of 'pressure' and cross reference this to the Risk assessments that were undertaken in respect of the Pandemic.				
WORK UNDERTAKEN TO DATE	**WHAT WORK IS STILL REQUIRED**	**EXPECTED OUTCOME**	**TIME FRAME**	**LEAD**
• Information is collected in relation to sickness absence.	• Review the content of the sickness absence, supporting mental wellbeing and encourage courageous conversations with Managers	• *Equipping managers with the skills to approach conversations about disability and ensuring that advice about how to support staff with disabilities, including invisible disabilities is integrated into the support offered.*	**TBA**	Head Leadership, OD and Staff Experience
• The welcome back form and other associated absence management documentation to encourage conversations about underlying conditions and the declaration of those conditions earlier in the absence management process has been reviewed and is undertaken via HWB catchups	• Analysis of the H&WB questions by departments/services will be part of the Staff Survey Action Plans.	• *Appropriate action plans will be produced in respect of the findings of the H and WB Staff survey questions to accelerate change*	Start Sept 2021 ongoing for duration of plan	Head Leadership, OD and Staff Experience

WDES Indicator 7
Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which the organisation values their work.

Narrative
There has been a continuous drop in this indicator for both the disabled and not disabled staff over the last two years. This trend has continued for disabled staff, however it is seen as a positive outcome for non-disabled staff.
The new approach to appraisal, which focuses on the demonstration of our values and behaviours as much as the achievement of task objectives should have a positive impact on this result. Discussions within the new process should focus on an individuals' contribution and aspirations for the future, regardless of disability. This coaching style of conversation may also encourage individuals to be more open about any underlying conditions.

WORK UNDERTAKEN TO DATE	WHAT WORK IS STILL REQUIRED	EXPECTED OUTCOME	TIME FRAME	LEAD
• Values and behaviors are integral within the appraisal process	• Encourage managers and employees to have open conversations and discussion about disability	• *Ensure that all employees feel equally valued for their contribution*.	Sept 2021	Head Leadership, OD and Staff Experience

WDES Indicator 8 **Percentage of disabled staff saying that their employer has made adequate adjustments to enable them to carry out their role.**				
Narrative This years' results show a drop in this particular KPI, as disabled members of staff report that inadequate adjustments have been made to enable them to carry out their work. This however could be linked to the pandemic and / or colleagues, either working from home or shielding. As part of our absence management process the Occupational Health team will continue to work closely with managers and employees when providing recommendations for reasonable adjustments to be made. Access to Work and Remploy have supported a number of employees with adjustments and equipment to enable them to carry out their role.				
WORK UNDERTAKEN TO DATE	**WHAT WORK IS STILL REQUIRED**	**EXPECTED OUTCOME**	**TIME FRAME**	**LEAD**
• As part of our absence management process the Occupational Health team work closely with managers and employees when providing recommendations for reasonable adjustments to be made.	• Through the case review process, understand where reasonable adjustments could not be made and the reasons why to identify any trends/themes/issues.	• *There is clarity in understanding what barriers need to be addressed adjustments were not carried out. Ensure that all aspects pertaining disability are taken into consideration where reasonable adjustments are required in consultation with the disabled colleague.*		Head of People Services
• Access to Work and Remploy have supported a number of employees with adjustments and equipment to enable them to carry out their role.	• Seek the view's of staff about their experiences of adequate reasonable adjustments to carry out their role and promote good practice. • Continue to work with the 'Great place to work programme' and implement disability passports.	• *As above* • *As above*	**TBA**	Head of People Services

WDES Indicator 9
Staff engagement score for disabled staff compared to non-disabled staff and the overall engagement for the organisation (out of 10).

Narrative

There has been no change from last year. Typically an engagement score of 7 is average and positive.
It is encouraging to see that the engagement score for both employee groups is very similar. This would indicate that managers are being inclusive in their practice and that at a corporate level all employees feel a high level of engagement with the Trust, its goals and objectives.
As the actions outlined in this report are implemented/embedded we would expect to see a rise in the engagement score of disabled employees. Key to this will be creating a culture of openness and honesty, in line with our values, talking openly and dealing constructively with employees with disabilities.

The D-Ability staff network plays a key role in engaging with our disabled staff community, encouraging feedback and holding listening events to enable the Trust to hear and reflect on staffs lived experiences.

WORK UNDERTAKEN TO DATE	WHAT WORK IS STILL REQUIRED	EXPECTED OUTCOME	TIME FRAME	LEAD
• Current engagement score of 7 is seen as average and positive across both categories	• Continue to work with our disabled staff community via the D-Ability Staff Network to improve engagement.	• *Engaging with our disabled staff community, encouraging feedback and holding listening events will enable the Trust to hear and reflect on staffs lived experiences.*		
	• Analysis of the 3 questions that make up the staff engagement score by services/departments to be part of their Staff Survey Action Plans which are ultimately reported to HR Committee.	• *Consistent change in the data collected to reflect a positive outcome*		Head Leadership, OD and Staff Experience

WDES Indicator 9b
Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?

Narrative
The aim of the D-Ability Staff Network is to be a voice for the differently able, and it meets regularly to provide a friendly, safe, inclusive and confidential environment where staff can access support. D-Abilty is open to all staff with disabilities or LTC's (long term health conditions), and they activity encourage allies to join and support at network meetings and promotional events.
The network supports the 'not every disability is visible' national campaign. With this in mind, toilets have these signs displayed throughout the trust. The Network:

- communicate and carry out promotional events using their own twitter feed, flyers, leaflets and other written communication, and on line communication.
- arrange and support promotional events to provide easy access to advice and guidance, and to help raise awareness across the trust.
- support Project Choice – a HEE initiative helping individuals in securing placements in different departments for young people with learning difficulties. (The Project Lead is also a member of the D-Ability Staff Network.)
- seeks the views of and engage with disabled staff, and this continued during COVID.
- has conducted a staff survey to obtain data and feedback from disabled staff, and this will be used with national research to inform the D-Ability Staff Network plans for further actions and support.

WORK UNDERTAKEN TO DATE	WHAT WORK IS STILL REQUIRED	EXPECTED OUTCOME	TIME FRAME	LEAD
• The D-Ability Staff Network meets regularly to provide a friendly, safe, inclusive and confidential environment where staff can access support and is open to all staff with disabilities or long-term health conditions	•			
• The Network has continued to use their own twitter feed to provide timely and insightful updates, and to promote inclusion for disabled staff and patients.	• Work to continue			
• Toilets have the accessible toilets signs displayed throughout the trust.				
• Promotional events and support to provide easy access to advice and guidance, and to help raise awareness across the trust continue	• The D-Ability Network has conducted a staff survey to obtain data and feedback from disabled staff, and this will be used with	• *Overall:* *Continue to seek and share the views and experiences of disabled staff via surveys, questionnaires, and by sharing staff and*	TBA	Comms / EDI Manager

	national research to inform the D-Ability Staff Network plans for further actions and support.	*patient stories to ensure that there is an equitable outcome for colleagues who have any disabilities.*		
• The Trust participates in Project Choice – a HEE initiative (helping disabled individuals to secure placements in different departments for young people with learning difficulties).				Resourcing Manager

WDES Indicator 10 **Percentage difference between the organisation's Board voting membership and the organisation's overall workforce**				
Narrative There is a change in our report for this KPI. (7.7%) of our current Trust Board have declared a disability compared to the last survey. As part of our continuing recruitment and selection process, we will ensure all applicants are made aware of the importance of self-declaration around any disabilities so that appropriate reasonable adjustments can be put into place				
WORK UNDERTAKEN TO DATE	**WHAT WORK IS STILL REQUIRED**	**EXPECTED OUTCOME**	**TIME FRAME**	**LEAD**
• Ongoing work around capturing disability data continue	• Encourage Board and senior colleagues to review declarations of disabilities and if applicable to openly share their stories.	• *The stance around disabilities will provide a positive impact for other disabled individuals in applying for jobs.*		Company Secretary
	• Trust Board should consider whether any positive action can be considered in order to improve diversity when further Board positions arise.	• *Board is reflective of the communities served*		Company Secretary
	• Recruitment monitoring will enable us to track the numbers of applicants applying for posts and the conversion rate to hire. Human Rights EDI Steering group to review and analyse any recruitment exercise to help in future recruitment processes	• *Recruitment monitoring will help inform if the adverts are attracting a wide range of applications as well as widening recruitment strategies and promote any vacancies through more diverse routes.* • *This will facilitate a more diverse range of candidates supply from groups under represented at Board*	Start June 2021 ongoing for duration of plan as and when required	Head of People Services

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

	Lead	Type of item	Public/Private	Sep-21	Nov-21	Jan-22	Mar-22	May-22 (Ex)	May-22	Jul-22	Sep-22	Nov-22	Jan-23	Mar-23
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	√	√	√	√		√	√	√	√	√	√
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						√					
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			√							√	
Healthcare Associated Infections	Chief Nurse/DIPC	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											