MEETING OF THE BOARD OF DIRECTORS IN PUBLIC

Gateshead Health NHS Foundation Trust

Date: Wednesday 28th July 2021
Time: 09:30 am
Venue: via Microsoft Teams

AGENDA

	TIME	ITEM	STATUS	PAPER
1.	09:30 am	**Welcome and Chair's Business**		
2.	09:30 am	**Declarations of Interest** To declare any pecuniary or non-pecuniary interests *Check – Attendees to declare any potential conflict of items listed on the agenda to the Trust Secretary on receipt of agenda, prior to the meeting*	Declaration	Verbal
3.	09:30 am	**Apologies for Absence** *Quoracy check: (s3.3.31 SOs: No business shall be transacted at a meeting unless a minimum of **4** members of the Board (including at least **one** Non-Executive and **one** Executive Member of the Board) are present)*	Agree	Verbal
4.	09:35 am	**Minutes of the meeting held on 26th May 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: • Matt Stewart leaves Critical Care	Assurance	Presentation
		ITEMS FOR DECISION		
7.	09:50 am	**Declarations of Interest** To receive the Declaration of Interest of Mrs A Stabler, presented by the Company Secretary	Approval	Enclosure 7
		ITEMS FOR ASSURANCE		
8.	09:55 am	**Assurance from Board Committees** i. Finance and Performance Committee – 29 June & 27 July 2021 (verbal) ii. Audit Committee – 3 June & 1 July 2021 iii. Quality Governance Committee – 23 June & 21 July 2021 (verbal) iv. Digital Committee – 21 June 2021 v. HR Committee - 13 July 2021	Assurance	Enclosure 8
9.	10:15 am	**Freedom to Speak Up Guardian Report** To receive the report presented by the FTSU Guardian	Assurance	Enclosure 9
10.	10:25 am	**Improving our People Practices Update** To receive and update on the recommendations presented by the Executive Director of People & OD	Assurance	Enclosure 10
11.	10:35 am	**COVID Update** To receive an update, presented by the Medical Director	Assurance	Verbal

12.	10:45 am	**Finance Update** To receive the report, presented by the Group Director of Finance	Assurance	Enclosure 12
13.	10:55 am	**Integrated Oversight Report** To receive the report, presented by the Chief Operating Officer	Assurance	Enclosure 13
14.	11:05 am	**Healthcare Associated Infections** To receive the report presented by the Medical Director	Assurance	Enclosure 14
		ITEMS FOR INFORMATION		
15.	11:15 am	**Questions from Governors in Attendance** To receive any questions from governors in attendance		Verbal
16.	11:30 am	**Date and Time of the next Meeting** The next scheduled meeting of the Board of Directors to be held in public will be 28th September 2021 at 9:30 am		Verbal
17.	11:30 am	**Chair Declares the Meeting Closed**		Verbal
18.	11:30 am	**Exclusion of the Press and Public** To resolve to exclude the press and public from the remainder of the meeting, due to the confidential nature of the business to be discussed		Verbal

Trust Board

Minutes of a meeting of the Board of Directors held at 9.30 am on Wednesday 26th May 2021, via Microsoft Teams

Gateshead Health NHS Foundation Trust

Present:	
Mrs A Marshall	Chair
Mrs J Baxter	Chief Operating Officer
Mr A Beeby	Medical Director
Mrs J Bilcliff	Acting Chief Executive
Dr R Bonnington	Non-Executive Director
Cllr M Gannon	Non-Executive Director
Mr P Hopkinson	Non-Executive Director
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	Non-Executive Director
Dr M Sani	Associate Non-Executive Director (NExT Placement)
Mr D Shilton	Non-Executive Director
In Attendance:	
Mrs H Fox	Head of Communications & Engagement
Mrs A Maskery	Interim Trust Secretary
Dr K Roberts	Deputy Director of Nursing, Midwifery and Quality
Ms D Waites	Corporate Services Assistant
Ms A Venner	Deputy Director for People & OD
Governors and Members of the Public:	
Mrs E Adams	Public Governor – Central
Mr J Bedlington	Public Governor – Central
Mrs J Coleman	Staff Governor
Mr S Connolly	Staff Governor
Reverend J Gill	Public Governor – Western
Mrs G Henderson	Public Governor - Western
Mr M Loome	Staff Governor
Mrs K Marley	Staff Governor
Mrs K Tanriverdi	Public Governor – Central
	3 x members of the public
Apologies:	
Ms L Crichton-Jones	Director of People & OD
Mrs Y Ormston	Chief Executive

Agenda Item	Discussion and Action Points	Action By
21/68	**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	

Agenda Item	Discussion and Action Points	Action By
	Orders.	
21/69	**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.	
21/70	**APOLOGIES FOR ABSENCE:** Apologies were received from Ms L Crichton-Jones and Mrs Y Ormston.	
21/71	**MINUTES OF THE PREVIOUS MEETING:** The minutes of the meeting of the Board of Directors held on Wednesday 31st March 2021 were approved as a correct record.	
21/72	**MATTERS ARISING FROM THE MINUTES:** The Board Action Plan was updated accordingly to reflect matters arising from the minutes.	
21/73	**PATIENT & STAFF STORY:** Mrs H Fox, Head of Communications & Engagement presented the following virtual patient and staff stories: • Abraham Adler (patient) • Winter Volunteer Programme (staff) The Board thanked Mr Adler and the Volunteer team for providing their stories and acknowledged the hard work undertaken by volunteers. Mrs Fox left the meeting.	
21/74	**SELF CERTIFICATION DECLARATION:** Mrs J Bilcliff, Acting Chief Executive, presented the Annual Self Certification Declaration which provides assurance that the Trust is compliant with the conditions of its NHS provider licence.	

Agenda Item	Discussion and Action Points	Action By
	Mrs Bilcliff confirmed that the Trust meets all the provisions and after consideration it was: **RESOLVED:** to approve the annual Self Certification Declaration as required by the NHS Provider Licence.	
21/75	**ASSURANCE REPORTS FROM BOARD COMMITTEES** The Board Committee Chairs provided updates from the assurance reports as follows: **i) Finance & Performance Committee** Mr M Robson provided the assurance report for the Committee meeting held on 30th March 2021, 27th April 2021 and 25th May 2021 (verbal). He highlighted the following key points: • Discussions at the meeting on 27th April 2021 largely centred around closedown and various levels of assurance were provided. • Month 12 finance report highlighted that risks remain around the audit process which is still currently ongoing. • Capital programme under target however maximised to best ability and will continue into new financial year. • IOR report highlighted the recovery work and issues re. endoscopy, cancer targets, RTT, covid restrictions however the Committee were assured plans in place • Planning for new financial year and H1 update on planning process however concerns raised regarding risk of the delivery system and currently remains unclear • Month 1 report (25th May 2021) – no matters to escalate. Performance remains within plan. • Savings in year identified as non-recurrent in nature therefore concerns re. savings on transformation work on a recurrent basis. Difficult in financial framework. • Uncertainty in relation to H2 period however revised financial framework expected by July 2021. Progress reports to be presented at July meeting and Transformation Board to be reinstated. • H1 complete and H2 planning taking place re. delivery risks • BAF updates on agenda. 2020/21 BAF now closed and outstanding actions to be discussed with Mrs MacKenzie and Mrs Baxter. **ii) Quality Governance Committee** Mr D Shilton provided the assurance report for the Committee meeting held on 21st April 2021 and 19th May 2021. He	

Agenda Item	Discussion and Action Points	Action By
	highlighted the following key points: • BAF 2020/21 some assurances to be carried forward and headlines for new BAF agreed. Small group to meet to populate 2021/22 actions for approval at next QGC. • CQC action plan re. Sunniside development. Issue re. cleaning products and safe storage. Mrs Baxter leading on with QEF to resolve. • Pressure sores deep dive undertaken. Further work to be completed. • Duty of Candour report - compliance and timescales. Review work has addressed issues and now compliant. Digital document amended and further update in due course • IPC BAF positive assurance - minor concern re. responsibility for FIT testing. Clarification required re. responsibility of assessments and documentation. Mr Beeby reported that a 12 month plan will be put in place • IQLR reported highlighted progress re. falls, pressure sores, mortality rate indicators and further discussion will take place later in the meeting. Medication errors and incident reporting good compliance and actions completed quickly. • Maternity – good assurance provided via peer review paper. H&S report provided good assurance. Some work identified to do in relation to key metrics and review report frequency. **iii) Digital Committee** Mr A Moffat provided the assurance report for the Committee meeting held on 19th April 2021. He highlighted that previous meetings had been stood down due to Covid. He highlighted the following key points: • Data security protection – annual self-assessment tool to measure performance. 3 top risks being addressed. • Training threshold 95% - discussed at SMT and further measures to be undertaken and completed by end of June. Action plan in place to achieve standard • Mandatory training - executive summary and assurances being put in place and will report back. **iv) HR Committee** Dr R Bonnington provided the assurance report for the committee meeting held on 6th April 2021. She highlighted that this was the first meeting since October 2020 due to Covid pressures. She highlighted the following key points: • New strategic aims agreed and there will be 5 themes to be monitored by HRC • People Plan - national plan aligned with development of local	

Agenda Item	Discussion and Action Points	Action By
	strategy. • Learning lessons to improve people practices - NHSI requirements still in development. External agency to review. • Staff survey results – working group set up to develop action plan. • OD metrics – red rating. Executive teams looking at plans and to monitor closely. • BAF assurance and reporting – work around new BAF to refresh POD risks. Mr P Hopkinson, Non-Executive Director, felt that it may be useful to have a section for future actions on the new template and Mrs Baxter, Chief Operating Officer, reported that this will be captured on the new BAF and cycle of business. After consideration, it was: **RESOLVED:** to receive the reports for assurance	
21/76	**COVID UPDATE:** Mr A Beeby, Medical Director, provided a verbal update to the Board on the work being carried out due to new Covid requirements. He reported that there is one Covid case at present with no impact on recovery. Patient testing is being maintained and Staff Test and Trace is also in place. As discussed earlier, fit testing is in place and there is a potential for an autumn Covid vaccine booster. Mrs J Bilcliff, Acting Chief Executive, highlighted that recent communications have been distributed in relation to the local position following the confusion surrounding government messages for North Tyneside. After further discussion, it was: **RESOLVED:** to receive the update for assurance	
21/77	**FINANCE UPDATE:** Mrs K Mackenzie, Acting Group Director of Finance, provided the Board with a summary of performance as at 30th April 2021 (Month 1) for the Group (inclusive of Trust and QE Facilities, excluding Charitable Funds). Mrs Mackenzie explained that the Trust has reported an adjusted	

Agenda Item	Discussion and Action Points	Action By
	financial performance surplus of £0.249m for the period April 2021 following plans to break even and highlighted that costs and income are higher than anticipated. As part of the Trust's 2021/22 H1 financial plan, an efficiency requirement of £2.225m has been identified and Mrs MacKenzie is confident that this will be delivered on a non-recurrent basis this year due to vacancies. The Trust has a strong cash position at present however capital spend limited with priority focus on the delivery of schemes for last year. Mrs Mackenzie drew attention to the identified risks in particular H2 funding allocation however this also includes other NHS organisations. After consideration, it was: **RESOLVED:** to receive the report for assurance	
21/78	**INTEGRATED QUALITY & PERFORMANCE REPORT:** Mrs J Baxter, Chief Operating Officer, presented the Integrated Quality and Performance Report (IQPR) and highlighted that this is a new and evolving report which will replace existing reports relating to finance, workforce and performance once content is agreed. This will include moving away from the existing RAG rating format. Mrs Baxter highlighted that work around the elective recovery plans continue against H1 planning thresholds and performance measures whist maintaining our focus on staff wellbeing. Areas of improved performance include: • Combined elective activity levels exceeding April threshold of 70% • Whilst April's A&E performance below standard, benchmarking data suggests we are performing well 12th out of 139 providers • 31 Day cancer standard achieved • 28 Day faster diagnostic target achieved • Patient safety alerts closed within target • No reported never events • Improving sickness absence levels Areas of focus and risk include: • Access targets at risk (A&E, RTT, Diagnostics, Cancer 2 week waits and treatments) and back log management, despite higher activity volumes • Understanding current HMSR rates and impact of Covid – NEQOS analysis completed and plans for team to provide	

Agenda Item	Discussion and Action Points	Action By
	presentation at Board Strategy Session. Targeted work re. respiratory deaths undertaken and no concerns raised. • Understanding sudden increase in emergency c-section rates – Mr Beeby reported that there are plans to review • Under performance against core training and staff appraisal targets. Following a query from Mr D Shilton, Non-Executive Director, in relation to the increase in cancer referrals and the impact on resources and financial plans, Mrs Bilcliff, Acting Chief Executive, reported that discussions have taken place at the Finance & Performance Committee and this has been recognised including looking at ways of managing validation of patients that need to be seen sooner. Following further discussion and consideration, it was: **RESOLVED:** i) to receive the IQPR for April 2021 ii) to note Trust performance and regional achievement against standards iii) to seek further information and test robustness of plans as is required, allowing judgement regarding levels of assurance for future levels of operational performance.	
21/79	**INTEGRATED QUALITY AND LEARNING REPORT:** Dr K Roberts, Deputy Director of Nursing, Midwifery and Quality, provided an update to the Board on the Trust's quality and safety performance up to April 2021. She highlighted that incident reporting rates continue to show special cause variation however positively, is explained by increased reporting of incidents by staff along with the retrospective reporting of patient safety incidents related to nosocomial infections as outbreak investigations remain ongoing. A number of these relate to falls and medication errors. Mrs Roberts reported that one fall was subsequently reported to the SI panel. Trust acquired pressure damage is also displaying special cause variation for pressure damage incidents occurring in a community setting and a deep dive paper has been presented to the Quality Governance Committee highlighting targeted work. A further report will be presented in September 2021. The Trust's Hospital Standardised Mortality Ratio (HSMR) is showing more deaths than expected when compared to the National expected value and a mortality review is taking place.	KAR

Agenda Item	Discussion and Action Points	Action By
	Following consideration, it was: **RESOLVED:** to receive the report for assurance	
21/80	**CNST MATERNITY COMPLIANCE REPORT:** Mr A Beeby, Medical Director, presented the CNST Maternity compliance report in line with the Maternity Incentive Scheme (MIS) 10 safety actions and Ockenden Immediate and Essential 7 safety actions Mr Beeby reported that the maternity service now expects to report full compliance with all 10 safety actions. The detail is assured through the Risk and Safety Council prior to Board sign-off. He highlighted that the updated guidance requires a commitment from the Board to facilitate face to face training once this is allowed (Safety action 6 and 8). Training has been on-going within the maternity service during the pandemic in line with IPC restrictions and with significant use of online packages. Reduced capacity MDT PROMPT training is planned to resume from June 2021 although medical staffing pressures may delay this. Ockenden IEA 3 also requires confirmation from Directors of Finance and the Board that maternity training funding be ring-fenced and evidence that this has been used to support maternity staff training. Mr D Shilton, NED Lead, reported that he has had the opportunity to visit the Maternity Unit and was impressed with the enthusiasm of the staff and Mrs Marshall thanked him for his time and efforts as Lead NED. After discussion, it was: **RESOLVED:** i) to approve the facilitation of local, in-person training once this is allowed ii) to confirm that any premium that is returned to the Trust following full compliance with the Maternity Incentive Scheme is ring-fenced for maternity services	
21/81	**HEALTHCARE ASSOCIATED INFECTIONS (HCAI):** Mr A Beeby, Medical Director and Joint Director of Infection Prevention and Control, provided an update to the Board on the current performance of HCAI mandatory reporting for the Trust throughout the 2020/21 period.	

Agenda Item	Discussion and Action Points	Action By
	Mr Beeby reported that there have been no mandatory reporting objectives published by NHSE/I for 2020/21 or 2021/22 and from April 2020, the financial sanctions and associated appeals process for CDI cases were discontinued. He highlighted that there has been no cases of flu or norovirus and precautions and focus continue in relation to Covid. There have been 31 outbreaks affecting both clinical and non-clinical areas for the financial year 2020/21. The Trust reports the number of Covid positive in-patients via SitRep and investigates and reports all identified nosocomial COVID-19 cases and COVID-19 outbreaks. From the commencement of the national reporting methodology in June 2020 to end of March 2021 the Trust identified – seventy nine (79) indeterminate; seventy four (74) probable and fifty two (52) definite hospital onset healthcare associated cases. GHNFT has reported zero (0) nosocomial COVID cases during April 2021 The Board acknowledged the noticeable impact of the work done to reduce rates as a result of learning and thanked the team for their hard work during this difficult time. After consideration, it was: **RESOLVED:** to receive the report for assurance	
21/82	**SUSTAINABLE DEVELOPMENT MANAGEMENT PLAN:** Mr A Robson, provided the Board with an update on the recent changes regarding sustainability nationally, regionally and internally particularly in regards to new guidance, targets and governance. During the last 12 months there has been several significant changes regarding sustainability within the NHS at a national level, including dissolving the Sustainable Development Unit, who previously released all guidance and strategies and the removal of the Sustainable Development Assessment Tool (SDAT) which was used by Trusts to benchmark and track progress and formulate actions for Sustainable Development Management Plans (SDMP's) which have now been replaced by longer strategies called Green Plans. A new Sustainability Committee has subsequently been set up with five working groups to focus on work in particular areas this includes travel and transport and green spaces and will provide reports back to the Committee. Following a query from Mrs Marshall regarding working with local	

Agenda Item	Discussion and Action Points	Action By
	authorities, Cllr M Gannon, Non-Executive Director, reported that this has been identified as a priority area and a lot of work is required. He reported that a consultative forum and research will be undertaken to gain public engagement and support. After further discussion, it was: **RESOLVED:** to receive the report for assurance	
21/83	**QE FACILITIES SIX MONTHLY UPDATE:** Mr A Robson, provided a brief update for the last 6 months with examples of what the company has delivered and moving towards current activity Areas of note included: • Final accounts position – profit of £4.078m before tax and subject to audit. Refund of £1.8m returned to FT via the unitary payment in March 2021. • KPI performance – 93% compliance despite a number of KPIs being suspended due to Covid. • Estates changes – 51 areas including reconfiguration of wards, departments, oxygen supply. • Transport team relocated to Spire House in Washington. Support to partners including, CCG, care homes, Coventry, Leeds, NEAS, PPE distribution • CQC inspection for the patient transport service and ISO accreditation provided. • IT procurement framework – over £700k in profit before taxation. • Facilities team have delivered exceptional performance during difficult times. Thanks to domestic, security and portering staff • Preliminary audit for QEF accounts continuing. Conclusion expected in next few weeks. • Decarbonisation funding – application successful • Mask manufacture – Team production supervisor appointed. The Board acknowledged the support from QE Facilities colleagues in their response to Covid and thanked the teams for their hard work. Assurance was also provided to the Board for work ahead. Following consideration, it was: **RESOLVED:** to receive the report for assurance.	

Agenda Item	Discussion and Action Points	Action By
21/84	**GATESHEAD SYSTEM ALLIANCE AGREEMENT:** Mrs J Baxter, Chief Operating Officer, reminded the Board that it was approved at the last meeting to sign up to the Gateshead Cares Alliance agreement in April 2021. The final agreement and associated documents confirms the overarching framework for the strengthening of place-based collaborative arrangements for health and care provision in Gateshead and replaces the current MOU in place. Mrs Baxter reported that the agreement is intended to provide a further formal underpinning for this approach and build on the existing but exciting collaboration between the partners for the benefit of the Gateshead population. The agreement will be iterative and subject to further development as the collaboration develops. After discussion, it was: **RESOLVED:** to receive the report for information	
21/85	**QUESTIONS FROM GOVERNORS IN ATTENDANCE:** Mr J Bedlington raised a query in relation to the contribution of falls and pressure sores and Mrs Baxter indicated that this was associated with extended length of stay particularly Covid patients. He also raised query regarding the rise in incidents in relation to medical devices and Mrs Baxter explained that the Trust will continue to look at this and will be the primary focus of teams over the next few months to recover standards. Mrs Roberts confirmed that there was a targeted campaign by the Tissue Viability nurses to address this. Mr J Bedlington requested further information on the local involvement in the development of the ICS structures and Mrs Bilcliff reported that Regional Networks were looking at this this and further guidance is expected however Mrs Bilcliff confirmed that she will continue to keep the Board and Governors updated. Mr S Connolly commented on the statement within the Self Certification Declaration highlighting governor training, and felt that there was only a small group of governors who have received training from NHS Providers Governwell and Mrs A Maskery reported that this will be reflected in the statement however reminded the group that the majority of training has been unable to take place due to Covid restrictions. Mrs A Marshall highlighted that this will be Mr P Hopkinson's final public Board meeting after nearly 15 years as a Non-Executive	

Agenda Item	Discussion and Action Points	Action By
	Director and Governor and thanked him for his contribution. Rev J Gill also thanked Mr Hopkinson on behalf of the governor colleagues for his commitment to role and wished him well in the future.	
21/86	**DATE AND TIME OF THE NEXT MEETING:** **RESOLVED:** that the next meeting of the Board of Directors will be held at 9:30 am on Wednesday 28th July 2021 via Microsoft Teams	
21/87	**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
21/12	31/01/2021	IQFR – new process for pressure damage grading. To review and report to go to QGC next month	30/04/2021	KR	QGC April meeting – further report to be presented in September 2021
21/13	31/01/2021	Mortality Report – NEQOS session re. HSMR. Schedule in for future Board Strategy Session	31/07/2021	AMa/DW	To be arranged.
21/14	31/01/2021	Serious Incidents – focus going forward to ensure Board sighted on details (inc maternity). To look at interim actions	31/07/2021	JMB	SI learning under review
21/43	31/03/2021	Digital update – to link with people agenda. To discuss with K Roberton re. transformation work	31/05/2021	LCJ	
21/48	31/03/2021	EPRR Assurance – six monthly reports going forward	30/09/2021	JMB	Next report due September 2021
21/49	31/03/2021	GP Practices Contract • GP clinical lead to be invited to present to Board on six monthly basis • Further report for discussion at April Board Strategy Session	30/09/2021	PH	PH to bring back to Board for update (July)

Gateshead Health NHS Foundation Trust

Report Cover Sheet

Agenda Item: 7

Purpose of Report	Decision: ☒	Discussion: ☐	Assurance: ☐	Information: ☐
Report Title:	Declaration of interest			
Name of Meeting:	Board of Directors – Part 1			
Date of Meeting:	28 July 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. Anna Stabler, Non-Executive Director, joined the Board of Directors on 1 July 2021. Assurance can be provided that Anna Stabler completed both the declaration of interests and fit and proper person declaration on 14 May 2021 prior to commencing in post. No interests have been declared and Anna Stabler 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 Anna Stabler'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				

Gateshead Health NHS Foundation Trust

Assurance Report

Agenda Item: 8i

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	Finance and Performance Committee – 29.06.2021			
Name of Meeting:	Trust Board			
Date of Meeting:	28.07.2021			
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 2</u> The Financial Revenue Report for Month 2 was received showing a small adjusted surplus. The main variances are due to those aspects of service that were not in reference period which are the GP contract and Pillar One testing. The Trust has achieved the better payment practice code based on value of invoices. A detailed discussion took place in relation to the ERF funding within the ICS. Within the position there is an underlying surplus which the Trust will explore in more detail once the month three and quarter one information is produced. The Committee noted that the Trust is still awaiting the H2 guidance. <u>Capital Update</u> The Committee received a paper which outlines the proposed schemes and noted that excluded from this are the requisite changes to support a potential new operating model – yet to be agreed. Partial assurance was received recognising that there is limited capital available and that the priority is the backlog maintenance programme and maternity. The Committee noted that QE Facilities have secured			

<table>
<tr><td></td><td colspan="6">additional funding for decarbonisation works.

<u>Integrated Oversight Report</u>
The Committee received good assurance in relation to elective recovery plans against the H1 planning thresholds and the previous months spike in emergency c section rates.

Risks remain in echocardiology due to workforce and capacity issues. Risks were also identified in relation to access targets in A&E, RTT, Diagnostics, Cancer, 2 week waits and treatments. A&E attendance is increasing and other Trusts are in the same position.

The Committee noted the increased pressure with Track and Trace and childcare issues.

<u>Board Assurance Framework (BAF)</u>
The Board Assurance Framework was updated accordingly noting that there is still uncertainty going forward into H2 planning. The Committee were partially assured with the Finance Revenue Report, Capital Update and Integrated Oversight Report.

<u>Organisational Risk Register</u>
The Committee received the Organisational Risk Register for assurance and a meeting will take place to fill in the gaps.</td></tr>
<tr><td>Recommended actions for Board</td><td colspan="6"></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>
<tr><td>Aim 2
☐</td><td colspan="5">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td colspan="5">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☐</td><td colspan="5">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☒</td><td colspan="5">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Financial Implications:</td><td colspan="6"></td></tr>
<tr><td>Links to Risks (identify significant risks and DATIX reference)</td><td colspan="6"></td></tr>
<tr><td>People and OD Implications:</td><td colspan="6">Workforce issues across the Organisation due to Track and Trace.</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>
</table>

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

Gateshead Health NHS Foundation Trust

Assurance Report

Agenda Item: 8ii

Purpose of Report	Decision: ☐	Discussion: ☒	Assurance: ☒	Information: ☒
Committee Reporting Assurance:	Audit Committee – 01/07/2021			
Name of Meeting:	Trust Board			
Date of Meeting:	28th July 2021			
Author:	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 Audit Committee			
Matters to be escalated to the Board:	A review of Medical Devices Training in 2019/20 resulted in eight recommendations being made, five of which were classed as 'high priority'. The implementation date of the recommendations has been delayed three times, with delivery of all now anticipated by 31 March 2022. However, as implementation of the recommendations appears to be mainly reliant upon the procurement of a new system, which currently is at 'business case' stage, uncertainty remains regarding when the recommendations will be implemented.			
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	**Counter Fraud Progress Report –** The Audit Committee received the Counter Fraud Progress Report highlighting the following areas: - Annual Work Plan for 2021/22 which was approved by the Committee subject to further information being supplied in relation to the actions to be undertaken in order for the Trust to be compliant with the Counter Fraud Functional Standard which was introduced by the Cabinet Office into the NHS in 2020. - Third Party Expenditure Review – concerns were raised in relation to controls and how suppliers are managed in the report. Discussions took place with respect to a recommendation from a previous review relating to existing mitigation measures to protect the Trust should QEF get into financial difficulty. Further work is to be undertaken by Group Finance in conjunction with QEF regarding this scenario and to review the assurances currently in place.			

- Pharmacy Review – a detailed discussion took place in relation to the concerns identified for data analysis and why some implementations did not happen. Areas were highlighted that the Pharmacy Department will take on Board.

Internal Audit Progress Report – The Committee discussed the reasonable assurances in detail which included the following:

- Risk Management
- System Management Control
- Disciplinary Process
- Control Management and Performance – Gateshead FT
- Contract Management / Performance Monitoring– Coventry FT

The Committee noted that there are 36 audits for 2021/22 and that 10 are in progress.

External Audit –

<u>QE Facilities Audit Planning Report</u>

The Committee received an update on the risk and areas of focus. Risk of fraud in recognition and misstatements due to fraud or error have had no change in risk or focus. Going Concern has increased in risk as the uncertainty of the financial framework impacts on the company's financial forecast this is not a new requirement for QEF. The materiality has been set at £1.64m which represents 3% of turnover in the audited financial statements for the year ended 31 March 2020.

<u>Final Audit Results Report</u>

The Committee noted the remuneration pension disclosures issue which led to the delay in audit. The Trust provided good cash disclosures and no issues were found in relation to PPE.

Audit Committee Annual Report – The Committee received the final of the Audit Committee Report which has been included in the Annual Report. Subject to one minor amendment this was approved.

Executive Risk Management (ERM) Group Report – The Committee received a summary of the work that has been undertaken setting the framework elements and governance framework. The Business Units have started to attend to present their risks 15 and above for the Executives assurance.

Recommended actions for Board						
Trust Strategic Aims that the report relates to: (Including reference to any specific risk)	**Aim 1** ☐	We will continuously improve the quality and safety of our services for our patients				
	Aim 2 ☐	We will be a great organisation with a highly engaged workforce				
	Aim 3 ☐	We will enhance our productivity and efficiency to make the best use of resources				
	Aim 4 ☐	We will be an effective partner and be ambitious in our commitment to improving health outcomes				
	Aim 5 ☐	We will develop and expand our services within and beyond Gateshead				
Financial Implications:						
Links to Risks (identify significant risks and DATIX reference)						
People and OD Implications:						
Links to CQC KLOE	Caring ☐	Responsive ☐	Well-led ☐	Effective ☐	Safe ☐	
Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)	**Obj.1** ☐	The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance between working life and personal commitments				
	Obj. 2 ☐	All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers				
	Obj. 3 ☐	Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve				

Gateshead Health NHS Foundation Trust

Assurance Report

Agenda Item: 8iii

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☒
Committee Reporting Assurance:	Quality Governance Committee – 23.06.21			
Name of Meeting:	Trust Board			
Date of Meeting:	28 July 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 23 June 2021. The key agenda items discussed were as follows;- **<u>Items for Decision</u>** Quality Governance Committee Terms of Reference and Cycle of Business – strong assurance was received with actions to be completed. This will come back to the Committee in 6 months. Maternity Incentive Scheme – publication of Board declaration form – no gaps in assurance the Committee were fully assured. **<u>Item for Discussion</u>** Quality Report/Priorities – no gaps the Committee were fully assured with clear priorities going forward. There was particular assurance relating to Volunteers and Patient experience. **<u>Items received for Assurance</u>** Medical Examiner Update – The Committee received			

	assurance around the process, however, there are gaps with the multiple policies as these are not currently aligned. The 4 outstanding policies will be aligned by March 2022. Learning will be shared more widely. Freedom to Speak up Guardian Update – The Committee accepted the report and were partially assured, however, there is a risk on the staff survey with gaps on reporting. which will be brought back to the Committee in 6 months in order to clarify on how this report to the Trust Board. IPC Board Assurance Framework – the Committee were fully assured and noted that assurance was received with regards to falls. Gaps will be completed when this is discussed at future meetings. Integrated Quality and Learning Report – the process for Duty of Candour will be reviewed. KR/KJ to look at this off line in order to follow the pathway through. CQC Action Plan Update – The Committee received partial assurance on progress and there are still gaps in assurance relating to Sunniside and Chlorclean and COSHH. Reports will be brought back in September. Internal Audit Report QEF CAS Alert – not discussed at end of meeting to be included in the assurance report. Safe Staffing Report – The Committee were partially assured. COSHH and Systems of Control of Chlorclean - not discussed at end of meeting to be included in the assurance report. BAF and Risk Register - not discussed at end of meeting to be included in the assurance report.	
Recommended actions for Board	Board are asked to note the work of the committee and the assurances received and note the areas of risk identified but note the actions in place to resolve.	
Trust Strategic Aims that the report relates to: **(Including reference to any specific risk)**	**Aim 1** ☒	We will continuously improve the quality and safety of our services for our patients
	Aim 2 ☐	We will be a great organisation with a highly engaged workforce
	Aim 3 ☐	We will enhance our productivity and efficiency to make the best use of resources
	Aim 4 ☐	We will be an effective partner and be ambitious in our commitment to improving health outcomes

<table>
<tr><td></td><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">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)</td></tr>
<tr><td>People and OD Implications:</td><td colspan="6"></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="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>

Gateshead Health NHS Foundation Trust

Assurance Report

Agenda Item: 8iv

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	Digital Committee			
Name of Meeting:	Trust Board			
Date of Meeting:	28th July 2021			
Author:	Nick Black			
Executive Lead:	Jackie Bilcliff			
Report presented by:	Andrew Moffat, Chair of Committee			
Matters to be escalated to the Board:	Further to its meeting on 19 April 2021 the Digital Committee escalated to the Board 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 requires the level of Information Governance training to be at least 95%. As a result of action taken by SMT an improved percentage of 93% was reported to the Digital Committee on 21 June 2021. It is subsequently pleasing to report that this increased to 96% by 30 June 2021, thereby achieving compliance the DS&PT standard.			
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	The 10 Strategic Objectives (from the Trust total of 44) to be reported through the Digital Committee for assurance were agreed and mapped against the previously established Digital Strategy. Review of the Digital Strategy and Transformation Roadmap identified no significant delivery risks, although pressures were noted on resource capacity and supplier delivery. The lengthy roll out process of Digital KPIs continues. For the first-time KPIs covering Information Governance (IG) and Clinical Coding were received. The IG training levels were identified as an area of concern (mentioned above), as was the response level for Freedom of Information requests; the latter was attributed to staffing pressures relating to the pandemic. Additional KPIs will be added for the next meeting in August.			

<table>
<tr><td></td><td colspan="6">The Committee received a Clinical Safety action plan to refresh and update the clinical safety processes and procedures; all actions to be concluded by the end of 2021.

The limited assurance NHS Data Security & Protection Toolkit (DS&PT) interim audit report from March 2021 was discussed. Assurance was provided that the issues flagged in the report will be addressed, with formal audit of this currently underway. Once completed the toolkit will be submitted with the standard marked as achieved.
NB: Subsequent to the meeting the DS&PT) final audit report dated on 30 June 2021 concluded that the level of assurance was ‘substantial’.

The minutes of the Digital Committee’s sub committees (the Digital Assurance Group and Digital Transformation Group) were reviewed and noted.</td></tr>
<tr><td>Recommended actions for Board</td><td colspan="6">Accept the assurances provided in the report, ensure the increase in uptake of mandatory Information Governance training.</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>
<tr><td>Aim 2
☒</td><td colspan="5">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td colspan="5">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☒</td><td colspan="5">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☒</td><td colspan="5">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Financial Implications:</td><td colspan="6"></td></tr>
<tr><td>Links to Risks (identify significant risks and DATIX reference)</td><td colspan="6">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.</td></tr>
<tr><td>People and OD Implications:</td><td colspan="6">Workforce implications within the Digital Team and the wider Trust.</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☒</td><td>Effective
☒</td><td 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: 8v

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	Human Resources Committee – 13 July 2021			
Name of Meeting:	Trust Board			
Date of Meeting:	28.07.21			
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 13 July 2021. The key agenda items discussed were as follows: <u>People and OD Strategy Items</u> The Committee discussed the reports from the People and OD Portfolio Board, People Plan 2020-21 and People Plan Operational Guidance in detail noting that there are challenges with all the work but that it is on track. The Committee noted reasonable assurance. <u>Strategic Theme: Protect and Understand the Health and Well-being of our Staff</u> The Committee discussed in detail and noted that there are a lot of challenges within the Trust. Reasonably assurance was received and the Committee was assured with the progress made in relation to data collection. There are risk around Mental Health related absences increasing and annual leave not being balanced across the year. <u>Strategic Theme: Develop a Leadership and OD Strategy for the Trust</u> Reasonable assurance was received in relation to the delivery of the strategic objectives, staff survey action plan, EDI and Freedom To Speak Up. The Committee noted that positive actions are being taken across the Trust and this was moving in the right direction.			

	Risks were noted with regards to current capacity to progress key pieces of work and the Freedom To Speak Up deteriorating trend. The Committee highlighted the size of the task ahead in terms of Equality Diversity and Inclusion and asked for the timescales to be reviewed along with a request for a deep dive into both FTSU and EDI <u>Strategic Theme: Strategic Workforce Planning</u> Reasonable assurance received in relation to the delivery of this objective. Again, the Committee noted that the main risk is around current capacity within the POD team to progress key pieces of work. <u>Strategic Theme: People Quality, Performance and Governance</u> Reasonable assurance was received. The Committee was assured in relation to the data and narrative presented. Risks were highlighted around staff absence particularly in relation to mental health and ongoing Covid, appraisals and core training. A detailed discussion took place around the External Reviews that have taken place within the People and OD Directorate and actions that were highlighted, the risks they presented and how these will be taken forward. The Committee noted that progress is being made and thanked the team.	
Recommended actions for Board	Note main assurances against the strategic People and OD themes detailed and key associated risks.	
Trust Strategic Aims that the report relates to: **(Including reference to any specific risk)**	**Aim 1** ☐	We will continuously improve the quality and safety of our services for our patients
	Aim 2 ☒	We will be a great organisation with a highly engaged workforce
	Aim 3 ☐	We will enhance our productivity and efficiency to make the best use of resources
	Aim 4 ☐	We will be an effective partner and be ambitious in our commitment to improving health outcomes
	Aim 5 ☐	We will develop and expand our services within and beyond Gateshead
Financial Implications:	Investment required in People & OD structure to build capacity to deliver on key pieces of work to enable strategic themes to be progressed.	
Links to Risks (identify significant risks and DATIX reference)	The following risks were highlighted: - Increasing staff absence in relation to Mental Health - Annual leave not being balanced across the year - Freedom To Speak Up deteriorating trend	

<table>
<tr><td></td><td colspan="5">- Appraisal and core training rates
- POD capacity to progress key pieces of work
- Risks linked to the external service reviews</td></tr>
<tr><td>People and OD Implications:</td><td colspan="5">As set out</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>

Freedom to Speak Up **Guardian**

2020-21

NHS Gateshead Health NHS Foundation Trust

Division		Q1 2020-21	Q2 2020-21	Q3 2020-21	Q4 2020-21	2020-21 TOTAL
Chief Exec						
Clinical Support and Screening		5	4	3	4	16
Community And MH		-	-	2	1	3
Finance		-	-	-	-	-
Information		-	5	2	2	9
Medicine & Elderly		3	2	3	1	9
Nursing & Midwifery		1	1	_	1	3
Strategy & Transformation		_	_	_	_	-
Surgical Services		2	-	1	-	3
QEF		-	-	-	-	-
NOT KNOWN		-	-	-	-	
		11	**12**	**11**	**9**	43

Professional Group		Q1 2020-21	Q2 2020-21	Q3 2020-21	Q4 2020-21	2020-21 TOTAL
Medical		2	-	2	-	**4**
Nurses		1	1	1	-	**3**
Health Care Assistant		-	3		2	**5**
Midwives		1		2	1	**4**
Dentists		-	-	-	-	**-**
AHP		5	-	3	-	**8**
Admin/ Clerical		1	5	2	1	**9**
Cleaning, Catering, Maintenance, Ancillary		-	2	1		**3**
Board Members		-	-	-	-	**-**
Corporate Staff		-	-	-	-	**-**
Other		-	-	-	2	**2**
Not Known		1	1	-	3	**5**
		11	**12**	**11**	**9**	**43**

Freedom to Speak Up **Guardian**

2020-21

NHS Gateshead Health NHS Foundation Trust

Concern	Q4	Q1 2020-21	Q2 2020-21	Q3 2020-21	Q4 2020-21	2020-21 TOTAL
Cases Raised Anonymously		5	1	2	3	**11**
Element of Patient Safety/ Quality		1	2	4	3	**10**
Element of Bullying and Harassment		10	10	7	6	**33**
Cases reporting DETRIMENT for Speaking Up						
Fraud						
		11	12	11	9	**43**

Contacts by Month	Individual meetings/contacts	Contacts within training	Cards
April 2020	6	20	
May 2020	37	35	
June 2020	30	97	
	73	**152**	
July 2020	28	30	
August 2020	23	91	
September 2020	33	30	
	84	**151**	
October 2020	38	4	
November 2020	31	5	
December 2020	27	O	
	96	**9**	
January 2021	14		
February 2021	42	33	
March 2021	51	9	
	107	**42**	
TOTAL	360	354	

Freedom to Speak Up **Guardian**

2020-21

NHS Gateshead Health NHS Foundation Trust

Concerns BY SOURCE	Email	Telephone	Datix	Face to Face	Other
April 2020	0	0	0	0	0
May 2020	1	0	4	1	0
June 2020	2	1	1	1	0
	3	1	5	2	0
July 2020	1			2	
August 2020	1	1		1	
September 2020	3		1	2	
	5	1	1	5	
October 2020	4	0	1	3	1
November 2020	1	0	0	1	0
December 2020	0	0	0	0	0
	5	0	1	4	
January 2021	1	1	1	0	0
February 2021	2	1	1	1	
March 2021					
	3	4	3	1	
TOTAL	**16**	**4**	10	12	1

2020FTSU INDEX (from Staff Survey)

Gateshead – 24th Overall Nationally. (13th in 2018)

2nd in NE (Northumbria 1st) (1st in 2018)

Best Combined Acute/ Community Trust ??

2018 – 83% 2019 - 82.8 %

Cases by Year

2018-19	**22**
2019-20	**22**
2020-21	**43**

Gareth Rowlands, Freedom to Speak Up Guardian

g.rowlands@nhs.net

1/4/2021

Gateshead Health
NHS Foundation Trust

Report Cover Sheet

Agenda Item: 9

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Report Title:	Freedom to Speak Up Guardian Report			
Name of Meeting:	Trust Board			
Date of Meeting:	28/7/2021			
Author:	Gareth Rowlands			
Executive Lead:	Yvonne Ormston / Lisa Crichton Jones NED Lead: Hilary Parker			
Report presented by:	Gareth Rowlands			
Executive Summary:	Reports of FTSUG activity have previously been presented to the Trust HR and Quality Governance Committees. As recommended in the recent Governance Review, the FTSUG reports will now be presented to the full trust board and this is the first report in that regard. This paper and accompanying presentation, comprise a brief reminder as the history and context of raising concerns and FTSU, our approach at Gateshead and sets out information from the 2021 Index report before concluding with next steps and a brief overview of current work underway. Gateshead has a history of strong performance in this area of work although members will note (as reported in most recent staff survey results) there is a slight deterioration in the index score however overall, the trust remains in the top 3 (3rd) best rated Trust in NE and Cumbria (behind CNTW and Northumbria Healthcare trusts). This is an essential part of our work on safety and people cultures and strategies and the overarching People Plan. We would be happy to return for a more detailed Board development session if considered helpful.			
Recommended actions for Board/Committee)	The Board is asked to receive the report, note the *Guidance for Boards* if not previously considered, the work underway and further advise, if helpful, of the opportunity to schedule a detailed discussion as part of a Board Development session along with the expected launch of 'Follow Up' training for Boards.			

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 currently, although some small costs may arise as we expand our network of FTSUG champions and this will be considered as needed via Senior Management or Executive Team meetings.					
Links to Risks (identify significant risks and DATIX reference)						
People and OD Implications:	This is an essential part of our work on safety and people cultures and strategies					
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

Freedom to Speak Up Guardian

Introduction and Background

This report provides an update on the activity by and recommendations from the Trust's Freedom to Speak Up Guardian (FTSUG) from April 2020-April 2021

The role specification set by the National Guardian's Office includes:

- Developing an open culture;
- Ensuring processes are in place to empower and encourage staff to speak up safely;
- Working with the Executive Team and Board in an independent capacity, providing challenge where appropriate;
- Being an individual to who staff can raise concerns outside of existing incident reporting and human resources processes;
- Ensure appropriate 'signposting' of concerns, that necessary investigations are undertaken, and assurance that staff who raise concerns are treated fairly;
- Reporting concerns raised quarterly to the Chief Executive and to the Board.

The Care Quality Commission (CQC) assess a Trust's speaking up culture during inspections under key line of enquiry 3 (KLOE 3) as part of the 'well-led- question. The guidance issued by NHS Improvement and the National Guardian's Office is aligned with the good practice set out in the well-led framework.

National Policy Framework

The National Guardian's Office issues regular reports which have continued to raise the profile of the FTSUG nationally. The Care Quality Commission and NHS Improvement attach significance to the role as an indicator for a well-led organisation. The Board can access information about current case reviews and other publications via:

National Guardian's Office

New guidance for boards was issued in July 2019 on Freedom to Speak Up in NHS trusts and NHS foundation trusts, (Report template - NHSI website (nationalguardian.org.uk). This sets out expectations of NHS Boards and details individual responsibilities of executive directors which includes;

- Behave in a way which encourages workers to speak up
- Demonstrate commitment
- Have a strategy to improve your FTSU culture
- Support your FTSU Guardian
- Be assured your FTSU culture is healthy and effective
- Be open and transparent with external stakeholders

There is specific focus on what boards should seek assurance on with regard to Speaking Up, which should be discussed and agreed between the Chief Executive, Board Chairman and the Freedom to Speak Up Guardian.

This publication also provides guidance regarding the content of the FTSU Guardian report to the Board, and sets out that these reports should provide the following information;

- Assessment of cases (number and types of cases dealt with by FTSU Guardian, analysis of trends, information on the characteristics of people speaking up, information on what the Trust has learnt)
- Potential patient safety or worker experience issues (information on how FTSU matters fit into broader patient safety/worker experience context, to maximise potential to earn and improve)
- Action taken to improve Speaking Up culture (increasing visibility of the FTSU Guardian, assessments of the effectiveness of the Speaking Up process, information on instances where staff feel they have suffered detriment when Speaking Up)
- Recommendations (suggestions for any priority action required)

Further guidance was issued in August 2019, on Freedom to Speak Up training in the health sector in England. The guidelines state that all staff within the organisation are required to complete training on speaking up. 20190812-National-guidelines-on-FTSU-training.pdf (nationalguardian.org.uk)

This guidance has since been followed by *Speak Up, Listen Up, Follow Up* training modules for all staff (in conjunction with Health Education England) National Guardian's Office, with *Listen Up* being a module specially for Executive, Non-Executive, lay members and governors which is expected to launch later this year.

The Speaking Up Service at GHNFT

Gareth Rowlands was appointed as FTSUG May 2018. Since January 2019, there has been 6 hours per week backfill provided into the substantive role to enable the fulfilment of the FTSUG role. On average, the role takes at least one whole day per week. The FTSUG currently reports directly to Mrs Yvonne Ormston, CEO (Lisa Crichton-Jones – Director of People and OD on an Interim Basis).

In addition, Hilary Parker has recently taken up the NED lead for this area of work and regular meetings are scheduled between her, the Guardian, the Director of People and OD. This is an opportunity to maintain oversight on FTSU work and scope further actions to continue to drive improvements and best practice.

As part of the role, the FTSUG attends the Regional Network in order to share learning, good practice and peer support. From December 2020, Gareth has been elected as Regional Chair for the North East and Cumbria FTSUG Network.

Each FTSUG is required to submit Data to the National Guardian's Office on a quarterly basis. The submitted Data is presented below.

Freedom to Speak Up Index Report 2021

Following analysis of the results of the most recent NHS staff survey by the National Guardian's Office in May 2021, Gateshead NHS Foundation Trust was identified to have continued to record a high FTSU index score for 2020, however the Trust's score is on a slightly downwards trajectory.

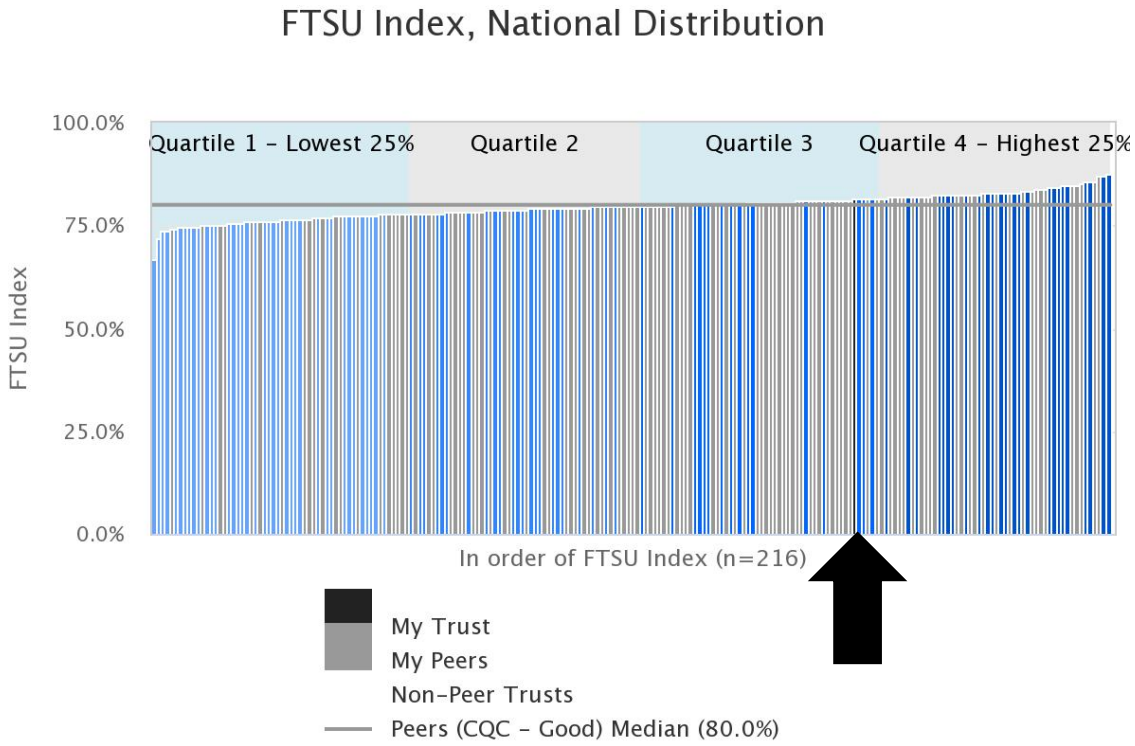
Gateshead Health	**(National Average)**
2018 – 83%	(78.1%) - Winner of best Combined Acute/ Community Trust
2019 - 82.8%	(78.7 %)
2020 – 81.4%	(79.2%)

Overall, we are still the third best rated Trust in NE and Cumbria (behind CNTW and Northumbria). However, you will see that whilst we are still above the national average, our trajectory is downwards and the actions at the end of the paper set out some of the work underway to bring additional focus to this work.

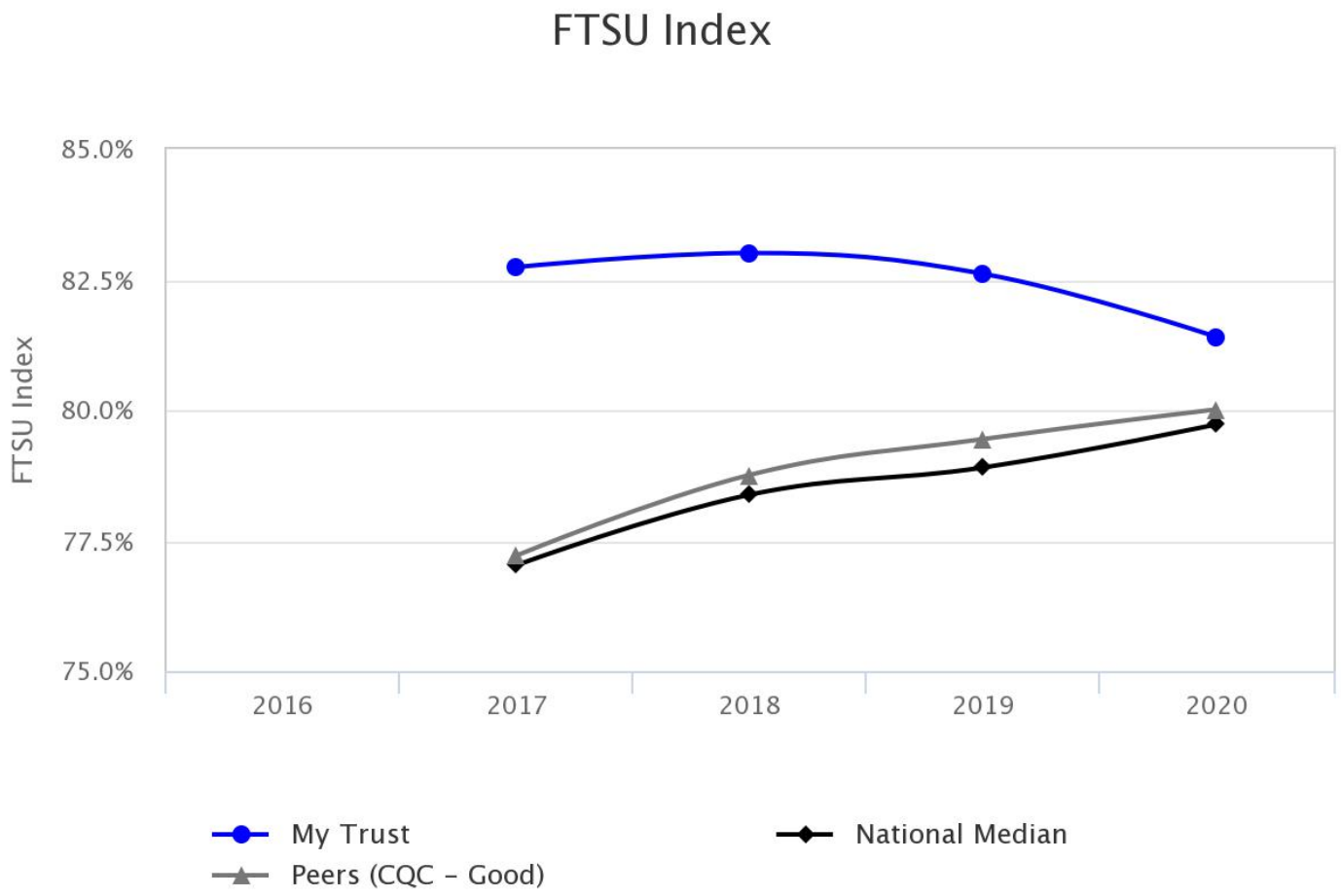
The FTSU Index is based on Questions 16a; 16b; 17a, 17b and 18f of the Staff Survey.

However, from my point of view, Question 17c (which does not form part of the FTSU Index.) is most concerning. *(I am confident the organisation would address my concern).*

Together with HR BPs, I am looking to see if this is across the Trust or whether there are particular hotspots.



The table above shows our position at the entry point to Quarter 4, which whilst noting the downwards trajectory, is overall, a positive position to be in.



The table above shows the previously mentioned downwards trend against that of peers (CQC Good rated) and the national median.

Theme 8 - Safety Culture		6.93	Not Significant	6.96	Not Significant	6.76
16a.	My organisation treats staff who are involved in an error, near miss or incident fairly.	66%	Not Significant	67%	**Significantly Better**	62%
16c.	When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.	76%	Not Significant	77%	**Significantly Better**	73%
16d.	We are given feedback about changes made in response to reported errors, near misses and incidents.	65%	Not Significant	62%	Not Significant	62%
17b.	I would feel secure raising concerns about unsafe clinical practice.	76%	Not Significant	75%	**Significantly Better**	71%
17c.	I am confident that my organisation would address my concern.	68%	**Significantly Declined**	63%	**Significantly Better**	59%
18b.	My organisation acts on concerns raised by patients / service users.	80%	Not Significant	79%	**Significantly Better**	74%

The table above sets out the staff survey results for Safety Culture and what is described as the significant deterioration in staff being confident that the organisation would address their concern. As a result, work to address this is included within the trust wide staff survey action plan and is subject to discussion at the new staff survey group.

FTSU Activity in Gateshead Health NHS Foundation Trust 2020-21

Historically, Gateshead Health has recorded 22 cases in each of the past 2 years (2018-19 and 2019-20).

In 2020-21, 43 new Cases have been recorded. Whilst some of these issues have related to COVID 19, no concerns have been escalated to the FTSUG regarding the provision of suitable PPE.

Appendix 1 includes the full summary of cases.

In Summary:

43 Cases raised	11 raised anonymously
33 – element of B&H / interpersonal	10 Patient Safety/ Quality
360 Contacts/ Meetings	354 Contacts within Training
18 cases have been closed / resolved (Green)	9 cases – Open or Watching brief

16 Cases are considered Serious and Ongoing: These are often subject to formal investigation and the FTSUG continues to regularly liaise with and updates to the Director of People and OD and the designated FTSU Non-Executive Director

Of these, one person is claiming detriment

7 Internal investigation with FTSUG (OPD, Health Records Dept, Cragside)

8 External Investigations by partner (Workforce 1 / Capsticks Advisory Service) (6 Cases (individuals) in Health Records department, 1 PCAS, 1 CQC)

1 Police.

Training

As per many other training subjects, it has been difficult to maintain a high level of training during Covid 19. From July 2021, we are reintroducing face to face induction for new starters, which will include a FTSU presentation. However, further discussions are required to agree how existing staff will continue to receive the appropriate training, which includes 'harder to reach' staff such as contractors and night shift workers. This will be taken forward via the new Education and Training Group and we need to consider its inclusion in our mandatory training programme and refresh the monitoring and compliance rates for training completion across all staff groups.

Moving forward:

- Review Freedom to Speak Up Policy (Awaiting new National Guidance) ***(By end of 2021)***
- Development and implementation of FTSU Guardian Strategy. ***(By end of 2021)***
- Continue to meet regularly with Director of People and OD and NED for FTSU to discuss cases / trends. ***(Ongoing)***
- Continue to raise profile of FTSU Guardian and promote Speaking Up, particularly to those staff in vulnerable groups. ***(Ongoing)***
- Continue to maintain comprehensive Activity Log and report quarterly to NGO ***(Ongoing)***
- Scope and implement a wider network of FTSU Champions/Ambassadors ***(By end of 2021)***
- Continue to develop and improve reporting of FTSU activity within the Trust, ensuring compliance with national standards ***(Ongoing)***
- As a result of Governance Review, FTSUG will report directly to Board twice a year - with the next Board Report looking at Q1 and Q2 for 2021-22. ***(Start July 2021)***
- Agreement for how new NGO FTSU training guidance (Follow Up) will be fully implemented within the organisation. ***(Currently we are waiting for the VSM module to be produced)***

Recommendation

The Board are asked to receive the report, note the *Guidance for Boards* if not previously considered, the work underway and further advise if helpful to schedule a detailed discussion as part of a Board Development session, along with the expected launch of Follow Up training for Boards.

Freedom to speak up

NHS
Gateshead Health
NHS Foundation Trust

November 2008

Sir Robert Francis QC

Following his review and report on the failings in Mid Staffordshire

6 February 2013

Freedom to Speak Up Guardian

NHS
Gateshead Health
NHS Foundation Trust

The Freedom of Speak Up (FTSU) Guardian works alongside Trust leadership teams to support the organisation in becoming a more open and transparent place to work, where ALL STAFF are actively encouraged and enabled to speak up safely.

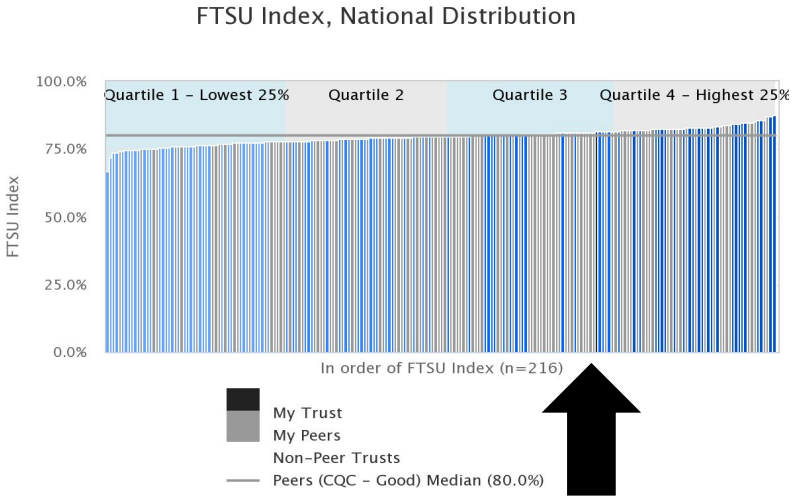
Freedom to speak up

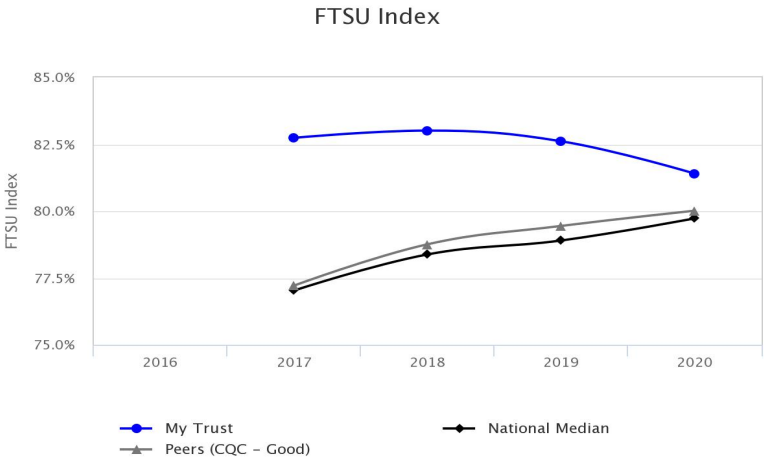
NHS
Gateshead Health
NHS Foundation Trust

- To safeguard patient care
- To look after our staff
- To ensure that we deliver high quality services
- To develop an open and supportive culture
- To enable the Trust to learn and improve

Benchmarking

Gateshead Health NHS Foundation Trust





Staff Survey

Theme 8 - Safety Culture		6.93	Not Significant	6.96	Not Significant	6.76
16a.	My organisation treats staff who are involved in an error, near miss or incident fairly.	66%	Not Significant	67%	**Significantly Better**	62%
16c.	When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.	76%	Not Significant	77%	**Significantly Better**	73%
16d.	We are given feedback about changes made in response to reported errors, near misses and incidents.	65%	Not Significant	62%	Not Significant	62%
17b.	I would feel secure raising concerns about unsafe clinical practice.	76%	Not Significant	75%	**Significantly Better**	71%
17c.	I am confident that my organisation would address my concern.	68%	**Significantly Declined**	63%	**Significantly Better**	59%
18b.	My organisation acts on concerns raised by patients / service users.	80%	Not Significant	79%	**Significantly Better**	74%

Freedom to speak up

Moving Forward

NHS
Gateshead Health
NHS Foundation Trust

- Review Freedom to Speak Up Policy (Awaiting new National Guidance) ***(By end of 2021)***
- Development and implementation of FTSU Guardian Strategy. ***(By end of 2021)***
- Continue to meet regularly with Director of People and OD and NED for FTSU to discuss cases / trends ***(Ongoing)***
- Continue to raise profile of FTSU Guardian and promote Speaking Up, particularly to those staff ***(Ongoing)*** staff in vulnerable groups.
- Continue to maintain comprehensive Activity Log and report quarterly to NGO ***(Ongoing)***
- Scope and implement a wider network of FTSU Champions/Ambassadors ***(By end of 2021)***
- Continue to develop and improve reporting of FTSU activity within the Trust, ensuring ***(Ongoing)*** compliance with national standards
- As a result of Governance Review, FTSUG will report directly to Board twice a year – with the ***(Start July 2021)*** next Board Report looking at Q1 and Q2 for 2021-2
- Agreement for how new NGO FTSU training guidance (Follow Up) will be fully implemented within the organisation. ***(Currently we are waiting for the VSM module to be produced)***

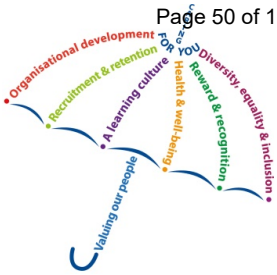
NHS
Gateshead Health
NHS Foundation Trust

Cherokee Indian saying :

If you listen to the whispers, you won't have to hear the screams…

Speaking Up protects Patients and improves the working lives of ALL NHS workers.

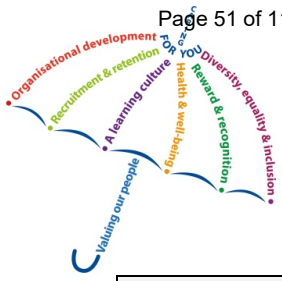
Freedom to speak up



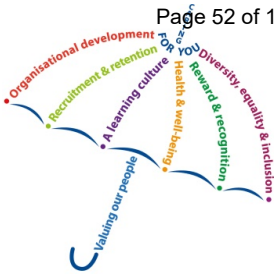
NHS
Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 10

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Report Title:	Improving Our People Practices Update			
Name of Meeting:	Trust Board			
Date of Meeting:	28.07.21			
Author	Natasha Botto, Senior HR Business Partner			
Executive Lead	Lisa Crichton-Jones, Executive Director of People and OD			
Report presented by	Lisa Crichton-Jones, Executive Director of People and OD			
Executive Summary	This paper provides an updated position in response to the NHSI 'Learning Lessons to Improve Our People Practices' recommendations which were presented to Trust Board in March 2021. Previously, as a Trust we RAG rated ourselves Amber across all seven recommendations. This position remains unchanged, although it is important to note a number of actions have been taken and implemented with immediate effect. Those not yet fully implemented are entwined with the ongoing, external HR Advisory Team service review. However, working through the specific actions detailed in the table it is anticipated by the end of September, the majority, if not all of the current amber status' will have progressed to green.			
Recommended actions for Board/Committee)	Trust Board are asked to receive the report and note the current position, actions and next steps within and associated timescales.			
Trust Aims that the report relates to: **(Including reference to any specific risk)**	**Aim 1** ☐	We will provide consistently high quality care in all our services		
	Aim 2 ☒	We will be a great organisation to work in		
	Aim 3 ☐	We will deliver value for money and strengthen delivery of our clinical services		
	Aim 4 ☐	We will work with our partners to help make Gateshead a place where everyone thrives		
	Aim 5 ☐	We will use our expertise to provide specialist services beyond Gateshead		
Financial Implications:	None			
Links to Risks (identify significant	There are a series of potential risks arising from adapting			



<table>
<tr><td>risks and DATIX reference)</td><td colspan="6">our people practices and implementing the recommendations, which could include a person who is subject of an investigation or disciplinary procedure suffering serious harm – either physical or mental.
2792 - Basic level workforce metrics in place, limited data, unable to drive improvements in performance.
2798 - Potential backlog on employee relations due to team diversion onto HR Covid Advisory line.
2802 - Significant workforce team workload capacity pressures due to covid requirements resulting in backlog of work and slow progress.</td></tr>
<tr><td>People and OD Implications:</td><td colspan="6">Staff wellbeing
Staff attendance
Staff engagement
EDI implications
Capacity pressures for managers and staff arising from this work</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☒</td><td>Effective
☒</td><td>Safe
☒</td><td></td></tr>
<tr><td rowspan="3">Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)</td><td>Obj.1
☒</td><td colspan="5">The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance between working life and personal commitments</td></tr>
<tr><td>Obj. 2
☐</td><td colspan="5">All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers</td></tr>
<tr><td>Obj. 3
☒</td><td colspan="5">Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve</td></tr>
</table>



Gateshead Health NHS Foundation Trust

Learning Lessons to Improve Our People Practices Update Paper

1.0 Background

1.1 Since the previous Trust Board discussions, on 30 April 2021 the Trust responded to a request from Prerana Issar, NHS Chief People Officer to update our Regional Director of Workforce and OD, Daniel Hartley with progress against the 'learning lessons to improve people practice' recommendations.

1.2 Previously, the Trust has received an initial position statement on the Trust's current performance against the recommendations, practices and associated RAG rating.

1.3 Key points to note at the time were that as a Trust, our assessment was Amber across all seven recommendations, and we identified several actions that were required to be taken based on current practice at the time.

1.4 Prior, in December 2020, following the appointment of the Executive Director of People and OD, the Trust also commissioned Capsticks HR Advisory Service to deliver an independent, comprehensive review of the way in which employee relations matters are managed within the organisation. Included within the scope of this work was a review of current process against current best practice and a review of the Trust's Disciplinary Policy. These two areas of work align and are considered in the round.

1.5 NHSEI requested that the Trust provide an update on their status against completed actions by the end of June 2021. This was provided to Daniel Hartley on 30 June 2021 (Appendix 1).

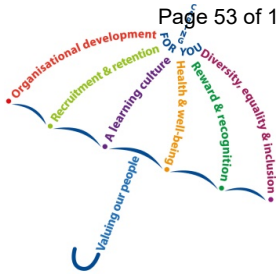
2.0 Current Position

2.1 A full report from the external review, outlining findings and recommendations was not received in its final state until late May 2021, due to COVID-19 related capacity pressures within the Trust team, notably the ability to provide the relevant data and complete the factual accuracy check.

2.2 The report has since been shared within the senior People and OD Leadership Team, the Executive Team, HR Advisory Team / Business Partners and Trust Senior Management Team, with an assurance report provided to HR Committee.

2.3 At a high level, the review found there were concerns relating to all parts of the disciplinary process which fall short of best practice in the following areas:

- Resources are a challenge and timescales for completion are excessive.
- Decision making/Accountability – transparency, rationale, impartiality, senior oversight.
- Suspension used too frequently and not reviewed in line with policy.
- Adherence to policy and best practice.
- Lack of consistent paperwork and evidence.
- Lack of Health and wellbeing/support and appropriate comms for those involved.



2.4 The original 'Learning Lessons to Improve People Practice' position paper and suggested actions has now been shared with all our staff networks, staff side and HR Business Partner colleagues and discussed via our Local Negotiating Committee for views and input. In addition, we are fortunate to employ a member of staff who sat on the national advisory group for this work and they have partnered with the HR Advisory Team to share further experience and knowledge and are assisting the team with this improvement work.

2.5 Recommendations made as part of the external review have been considered alongside the LLIPP requirements and a more informed improvement plan is now agreed with key actions and owners identified – these have been prioritised and timescales attached.

2.6 Previously, as a Trust each recommendation of LLIPP was RAG rated Amber. Considering the timescale slippage and more detailed understanding and recommendations arising from the external review, this position remains unchanged overall. However, it is important to note that a number of improvement actions have been taken and implemented with immediate effect. A summary position can be found in Appendix 2. It is anticipated by the end of September, the majority; if not all, of the previously reported amber status' will have progressed to green.

2.7 Of further note, work is commencing to review the People and OD Team Directorate structure with an intent to narrow the scope of the Head of HR role to ensure the post holder can give greater focus to some of our important, operational processes and coproduce some of this work with staff side and staff networks. In addition, the Executive Team have agreed additional investment into the People and OD Directorate to build capacity to address a number of risks across the function.

3.0 Next Steps and Actions

3.1 Weekly meetings are now in place to review progress against recommendations and a working group is to be formed to further agree and progress the actions and recommendations prior to policy updates being submitted to the Joint Consultative Committee (with staff side colleagues) on 8 September 2021. The working group will comprise cultural ambassadors, operational, staff side and clinical management colleagues as well as representatives from the People and OD team and the Trust representative who was part of the national advisory group.

3.2 We have also recently received business case approval to purchase an employee relations case management system and would expect to have the system in place by the end of September 2021. Relevant policies, templates, letters and processes will need to be refreshed as per the recommendations and actions contained within this plan and the outcome of the external review.

4.0 Appendices

Appendix 1 Update to NHSEI dated 30 June 2021
Appendix 2 Summary Position Against Recommendations

Natasha Botto: Senior HR Business Partner
19 July 2021

Appendix 1 Update to NHSEI dated 30 June 2021

Gateshead Health
NHS Foundation Trust

30 June 2021

Gateshead Health NHS Foundation Trust
Trust Headquarters
Queen Elizabeth Hospital
Sheriff Hill
Gateshead
NE9 6SX

0191 445 6042
Lisa.Crichton-Jones@nhs.net

Daniel Hartley
Regional Director of Workforce & OD
NHS England & NHS Improvement

Sent via email: danielhartley@nhs.net

Dear Daniel,

I hope you are keeping well and continuing to stay safe. I write by way of an update following my letter dated 30 April 2021.

We have continued our work in reviewing and considering the recommendations set out in response to 'Learning Lessons to Improve Our People Practices'. A further update will be presented to our HR Committee on 13 July 2021 and will subsequently flow through to Trust Board.

In my previous correspondence I referenced that we had commissioned an independent, comprehensive review of the way in which employee relations matters are managed within the organisation.

The scope of this work included a review of current process against current best practice and a review of the Trust's Disciplinary Policy. I am pleased to confirm that this review has now been concluded and the recommendations have informed our next steps and plans for this work.

The report, in its final state, was not received until late May and hence there has been some slippage with our original reported timescales. In the interests of transparency and learning, we have shared the external report with our Executive and Senior Management Teams and again, will provide assurance through to HRC and Board. We are of course committed to progress the recommendations in their entirety as soon as we can.

Working through the specific actions detailed in the original recommendations and our external report, it is anticipated by the end of September, the majority, if not all the previously reported amber status' will have progressed to green. As an aside, we are looking to narrow the scope of our Head of HR role to ensure the postholder can give greater focus to some of our important, operational processes and coproduce some of this work with staff side and staff networks.

If you require any further information or a greater level of detail, please do not hesitate to contact me and I will be more than happy to assist.

Yours sincerely,

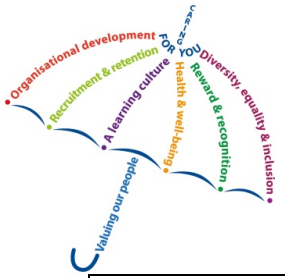
Lisa Crichton-Jones
Executive Director of People and OD
Gateshead Health NHS Foundation Trust

cc Amanda Venner, Deputy Director of People and OD
Rebekah Coombes, Head of HR
Natasha Botto, Senior HR Business Partner

NHS
Gateshead Health
NHS Foundation Trust

Appendix 2 Summary Position Against Recommendations

Recommendation	Detail	Updated Position – June 2021	Timescales	RAG Rating
Adhering to best practice	Development and application of local investigation and disciplinary procedures should be informed and underpinned by the provisions of current best practice, principally that which is detailed in the ACAS 'Code of practice on disciplinary and grievance procedures' and other non-statutory ACAS guidance; the GMC's 'principles of a good investigation'; and the NMC's 'best practice guidance on local investigations' (when published). All measures should be taken to ensure that complete independence and objectivity is maintained at every stage of an investigation and disciplinary procedure, and that identified or perceived conflicts of interest are acknowledged and appropriately mitigated (this may require the sourcing of independent external advice and expertise).	Capsticks have made suggested amends to policy in line with best practice and NHSEI recommendations to include the following: • Robust informal process, suspension process and investigation process, including a remit for managers involved in the process to ensure the investigator is not the decision maker. • Inserted a "fast track" procedure to allow for warning to be agreed mutually. • Inserted a section on support for employee and a cultural ambassador programme. • Created a robust assurance/monitoring framework. • Removed sections which are repetitive. • Removed that warnings can be extended due to absence. Amendments to be reviewed and agreed as part of a working group to be formed.	To go to JCC Policy Sub Group on 18 August 2021. To presented at JCC on 8 September 2021.	Amber

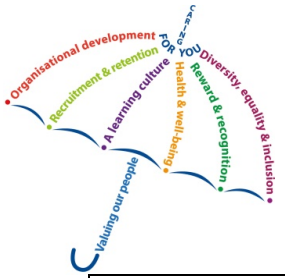


Gateshead Health NHS Foundation Trust

Applying a rigorous decision-making methodology	Consistent with the application of 'just culture' principles, which recognise that it is not always appropriate or necessary to invoke formal management action in response to a concern or incident, a comprehensive and consistent decision-making methodology should be applied that provides for full and careful consideration of context and prevailing factors when determining next steps. In all decision-making that relates to the application of sanctions, the principle of plurality should be adopted, such that important decisions which have potentially serious consequences are very well informed, reviewed from multiple perspectives, and never taken by one person alone.	Review of just culture framework principles and supporting documentation included as part of the wider implementation plan provided as part of the Capsticks review. This forms a fundamental part of the work we take forward in terms of our strategic objective around leadership and OD. Monthly case reviews have now been implemented within the HR team, which are led and overseen by the Head of HR and Deputy Director of People and OD. As a minimum, the Head of HR and Deputy Director of HR will be sighted on and sign off any suspensions prior to taking them taking place. A Commissioning Manager and Investigating Officer framework has been drawn up and implemented outlining the remit of both roles and scope of practice. More careful consideration to be given around making use of external panel representatives and the diversity balance of a panel when this is formed, considering factors such as gender, ethnicity and role. Panel debriefs to be more robustly implemented.	Some actions have already been taken, work towards the end of September 2021 for others.	**Amber**

		The Trust's Cultural Ambassador programme has been rolled out.		
Ensuring people are fully trained and competent to carry out their role	Individuals should not be appointed as case managers, case investigators or panel members unless they have received related up to date training and, through such training, are able to demonstrate the aptitude and competencies (in areas such as awareness of relevant aspects of best practice and principles of natural justice, and appreciation of race and cultural considerations) required to undertake these roles.	As part of the service review commissioned by Capsticks, further training has been scoped to increase the Investigating Officer pool in addition to training for Disciplinary and Appeal Chairs. A training proposal has been provided by Capsticks to ensuring that those involved in formal processes, are appropriately trained for these roles.	Date TBC – likely to be late 2021/early 2022 dependant on updated policy being approved and any operational pressures that may be faced with future waves of COVID-19.	**Amber**
Assigning sufficient resources	Before commencing investigation and disciplinary procedures, appointed case managers, case investigators and other individuals charged with specific responsibilities should be provided with the resources that will fully support the timely and thorough completion of these procedures. Within the overall context of 'resourcing', the extent to which individuals charged with such responsibilities (especially members of disciplinary panels)	As we develop our workforce quality systems, with the purchase of an employee relations case management system, we will more formally and closely monitor timescales for case work completion. As identified above, monthly case reviews have now been implemented within the HR team, which are led and overseen by the Head of HR and Deputy Director of People and OD, which includes a review of	Some actions have already been taken, work towards the end of September 2021 for	**Amber**

	are truly independent should also be considered.	suspensions. We will re-introduce fact finding to firstly identify if a formal investigation is needed, and if so, understand the scope of this as a result, what resource is required to support. Also as part of the wider implementation plan, investigation plans are to be introduced and signed off and agreed by the Commissioning Manager.	others.	
Decisions relating to the implementation of suspensions/exclusions	Any decision to suspend/exclude an individual should not be taken by one person alone, or by anyone who has an identified or perceived conflict of interest. Except where immediate safety or security issues prevail, any decision to suspend/exclude should be a measure of last resort that is proportionate, time bound and only applied when there is full justification for doing so. The continued suspension/exclusion of any individual should be subject to appropriate senior-level oversight and sanction.	As indicated above, as a minimum, the Head of HR and Deputy Director of HR will be sighted on and sign off any suspensions prior to taking them taking place – this should also have Operational Director level and clinical professional input. With immediate effect, any ongoing suspension review will take place between the Commissioning Manager and HRBP rather than the investigating officer and the HR Advisor. A check and challenge process around suspension and timescales will also be built into the investigation plan.	Some actions have already been taken, work towards the end of September 2021 for others.	**Amber**
Safeguarding people's health and wellbeing	Concern for the health and welfare of people involved in investigation and disciplinary procedures should be paramount and continually assessed. Appropriate professional occupational health assessments and intervention	Moving forward we will look to incorporate this as a core element of the process rather than it simply being offered. Consideration is being given to an initial support conversation being offered with Occupational Health as a standard,	End of September 2021.	**Amber**



	should be made available to any person who either requests or is identified as requiring such support. A communication plan should be established with people who are the subject of an investigation or disciplinary procedure, with the plan forming part of the associated terms of reference. The underlying principle should be that all communication, in whatever form it takes, is timely; comprehensive; unambiguous; sensitive; and compassionate. Where a person who is the subject of an investigation or disciplinary procedure suffers any form of serious harm, whether physical or mental, this should be treated as a 'never event' which therefore is the subject of an immediate independent investigation commissioned and received by the board. Further, prompt action should be taken in response to the identified harm and its causes.	observing the same fast-track timescales that would be followed for a referral for stress. As part of this initial conversation the frequency of support and contact would be agreed with the individual. Formal communication plans to be developed in line with recommendations. Also, as a Trust we are exploring the possibility of developing a network of 'fairness and dignity' champions to support those going through a formal process from a health and wellbeing perspective.		
Board-level oversight	Mechanisms should be established by which comprehensive data relating to investigation and disciplinary procedures is collated, recorded, and regularly and openly reported at board level. Associated data collation and reporting should include, for example: numbers of procedures; reasons for those procedures; adherence	Business case approval granted to purchase an employee relations case management system which will provide the level of board reporting and assurance recommended. As an interim measure, a reporting framework has been suggested and is currently being reviewed for use.	End of September 2021.	**Amber**

	to process; justification for any suspensions/exclusions; decision-making relating to outcomes; impact on patient care and employees; and lessons learnt.		

Gateshead Health NHS Foundation Trust

Report Cover Sheet

Agenda Item: 12

Purpose of Report	Decision: ☐	Discussion: ☒	Assurance: ☒	Information: ☐
Report Title:	Part One – Executive Summary – Consolidated Finance Report			
Name of Meeting:	Trust Board			
Date of Meeting:	Tuesday, 27th July 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 £0.574m for the period April 2021 to June 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 30th June 2021 (Month 3) 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			

<table>
<tr><td>People and OD Implications:</td><td colspan="5">None</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. Introduction

1.1 The purpose of this report is to provide a summary of financial performance as at 30th June 2021 (month 3) 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 85% 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 As from June 2021 financial reporting is against the Trust's updated financial plan which incorporates ERF.

3 Income and Expenditure

3.1 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.

3.2 This is a positive variance of £0.481m against the year to date plan as detailed on the Trust Statement of Comprehensive Income (SOCI) presented in Table 1.

3.3 The Trust reported total income of £29.923m for the period of June 2021 and £87.871m for the period to date. Included in the June 2021 actual position, as mandated by NHSEI, is Elective Recovery Fund income of £2.207m, based on estimates provided by NHSEI for the period April to June 2021. This is in excess of the mandated ERF figures of £1.100m that were fed into plan, again values as indicated by NHSEI. At this point the Trust has been unable to validate the actual figures that it has been directed to recognise in the accounts.

3.4 A letter issued by Julian Kelly (Chief Financial Officer) and Pauline Philip (National Director of Emergency & Elective Care) on the 9th July 2021 has advised that the thresholds for achieving ERF are being raised, with a backdated impact, becoming effective from the 1st July 2021. Early discussions and calculations across the ICS DoF 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.

3.5 For the month of June 2021 the Trust has reported actual expenditure of £29.435m resulting in an in month adverse variance from the NHSEI plan of £0.386m and a year to date adverse variance of £2.465m. These figures include £1.705m of spend directly attributable to the Trusts response to the COVID-19 pandemic.

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 £43.486m as at 30th June is equivalent to an estimated 26.91 days operating costs and represents a £4.126m increase from May.

5.2 The liquidity metric has improved by 0.74 days against May to -3.89 days driven by a £0.623m increase in the working capital balance.

5.3 The balance sheet is presented in Table 2.

STATEMENT OF COMPREHENSIVE INCOME

June 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	(158,111.0)	(78,814.3)	(81,054.4)	(2,240.1)	(1,874.4)
Income From Local Authority Care Contracts	(45.0)	(22.5)	(22.5)	-	-
Private Patient Revenue	(343.5)	(171.0)	(289.7)	(118.7)	42.4
Injury Cost Recovery	(168.0)	(84.0)	(2.4)	81.6	27.2
Other non-NHS clinical revenue	(253.0)	(125.0)	(211.9)	(86.9)	(150.7)
Total Operating Income From Patient Care activities	**(158,920.6)**	**(79,216.8)**	**(81,580.9)**	**(2,364.1)**	**(1,955.5)**
Other Operating Income					
Education and Training Income	(5,047.8)	(2,523.9)	(2,097.2)	426.7	252.8
R&D Income	(363.0)	(183.0)	(141.3)	41.7	28.2
Funding ouside of System Envelope	-	-	(336.1)	(336.1)	(308.7)
Other Income	(5,901.5)	(2,949.2)	(3,715.7)	(766.5)	(448.8)
Donations & Grants Received	-	-	-	-	-
Total Other Operating Income	**(11,312.3)**	**(5,656.1)**	**(6,290.3)**	**(634.2)**	**(476.6)**
Total Operating Income	**(170,232.8)**	**(84,872.9)**	**(87,871.2)**	**(2,998.2)**	**(2,432.1)**
Operating Expenses					
Employee Expenses - Substantive	106,955.6	53,198.5	51,185.1	(2,013.4)	(996.6)
Employee Expenses - Bank	2,756.3	1,381.0	1,932.7	551.7	342.4
Employee Expenses - Agency	2,411.3	1,205.5	1,263.3	57.9	113.6
Employee Expenses - Other	354.0	177.0	238.8	61.8	43.7
Total Employee Expenses	**112,477.3**	**55,961.9**	**54,620.0**	**(1,342.0)**	**(496.9)**
Purchase of Healthcare - NHS bodeis	2,940.0	1,470.0	1,545.9	75.9	175.8
Purchase of Healthcare - Non NHS bodies	810.0	405.0	375.0	(30.0)	19.1
Purchase of Social Care	-	-	-	-	-
NED's	93.0	47.0	44.4	(2.7)	(2.6)
Supplies & Services - Clinical	17,822.0	8,944.8	10,371.6	1,426.8	1,308.3
Supplies & Services - General	2,568.0	1,284.0	2,113.4	829.4	269.8
Drugs	8,490.3	4,245.0	4,422.7	177.7	35.9
Research & Development expenses	1.7	0.8	21.0	20.1	16.8
Education & Training expenses	1,697.9	848.9	111.1	(737.8)	(535.2)
Consultancy costs	63.0	31.0	236.7	205.8	(15.2)
Establishment expenses	2,040.0	1,019.8	913.3	(106.5)	(28.5)
Premises	7,773.0	3,887.1	5,037.6	1,150.5	624.2
Transport	577.0	288.9	294.3	5.4	3.0
Clinical Negligence	4,116.0	2,057.5	2,044.1	(13.4)	(8.5)
Operating Leases	-	-	-	-	-
Other Operating expenses	3,424.0	1,719.1	2,472.7	753.5	635.6
Operating Expenses included in EBITDA	**164,893.2**	**82,210.9**	**84,623.7**	**2,412.8**	**2,001.6**
Depreciation & Amortisation - Purchased / Constructed	3,468.0	1,734.0	1,816.9	82.9	49.8
Depreciation & Amortisation - Donated / Granted	200.0	92.0	91.3	(0.7)	4.9
Depreciation & Amortisation - Finance Leases	-	-	-	-	-
Impairment & Revaluation	(182.2)	(91.1)	(120.6)	(29.4)	21.1
Restructuring Costs	-	-	-	-	-
Operating Expenses excluded from EBITDA	**3,485.8**	**1,734.9**	**1,787.7**	**52.8**	**75.8**
Total Operating Expenses	**168,379.0**	**83,945.8**	**86,411.3**	**2,465.5**	**2,077.3**
(Profit)/Loss from Operations	**(1,853.9)**	**(927.1)**	**(1,459.8)**	**(532.7)**	**(354.8)**
Non Operating					
Non-Operating Income					
Finance Income	(31.0)	(15.1)	(9.4)	5.6	6.2
Total Non-Operating Income	**(31.0)**	**(15.1)**	**(9.4)**	**5.6**	**6.2**
Non-Operating Expenses					
Finance Costs	298.1	149.1	116.8	(32.3)	(3.9)
Gains / (Losses) on Disposal of Assests	-	-	-	-	-
PDC dividend expense	1,381.4	690.7	695.0	4.3	2.9
Total Finance Costs (for non-financial activities)	**1,679.5**	**839.8**	**811.8**	**(28.0)**	**(1.0)**
Other Non-Operating Expenses					
Misc. Other Non-Operating expenses	-	-	-	-	-
Total Non-Operating Expenses	**1,679.5**	**839.8**	**811.8**	**(28.0)**	**(1.0)**
(Surplus) / Deficit Before Tax	**(205.4)**	**(102.4)**	**(657.5)**	**(555.0)**	**(349.6)**
Corporation Tax	203.0	101.2	175.0	73.8	49.2
(Surplus) / Deficit After Tax	**(2.4)**	**(1.2)**	**(482.5)**	**(481.3)**	**(300.4)**
(Surplus) / Deficit After Tax from Continuing Operations	**(2.4)**	**(1.2)**	**(482.5)**	**(481.3)**	**(300.4)**
Remove capital donations / grants I&E impact	(200.0)	(92.0)	(91.3)	0.7	(4.9)
Other Control Total adjustment	202.4	-	-	-	-
Impairement	-	-	-	-	-
Adjusted Financial Performance (Surplus) / Deficit	**(0.0)**	**(93.2)**	**(573.8)**	**(480.6)**	**(305.3)**
Adjusted Financial Performance (Surplus) / Deficit	**(0.0)**	**(93.2)**	**(573.8)**	**(480.6)**	**(305.3)**

Table 1: Trust Statement of Comprehensive Income

Statement of Position - June 2021

	2021/2022 May 2021 Group £000's	2021/2022 June 2021 Group £000's	Movement from Prior Month £000's	2021/2022 June 20201 QEF £000's	2021/2022 June 2021 FT £000's
Assets					
Non-Current Assets					
Investments	80	80	0	80	16,824
Property, Plant and Equipment, Net	118,102	117,915	(187)	1,164	116,751
Trade and Other Receivables, Net	2,075	2,050	(25)	729	1,321
Finance Lease - Intragroup				42,743	0
Trade and Other Receivables - Intragroup Loan	0	0	0		15,789
Total Non Current Assets	120,257	120,045	(212)	44,717	150,686
Current Assets					
Inventories	5,261	5,018	(243)	2,251	2,767
Trade and Other Receivables - NHS	12,878	12,834	(44)	666	12,168
Trade and Other Receivables - Non NHS	3,251	3,007	(245)	457	2,549
Trade and Other Receivables - Other	0	0	0		0
Prepayments	5,778	6,483	705	518	5,965
Cash and Cash Equivalents	39,360	43,486	4,126	9,675	33,811
Other Financial Assets - PDC Dividend	1,246	1,246	0		1,246
Accrued Income	1,381	1,530	150	1,145	385
Finance Lease - Intragroup				507	0
Trade and Other Receivables - Intragroup Loan					2,999
Total Current Assets	76,665	73,604	4,450	15,219	61,891
Liabilities					
Current Liabilites					
Deferred Income	6,825	5,975	(850)	191	5,784
Provisions	10,625	5,845	(4,780)	743	5,101
Current Tax Payables	4,111	4,106	(5)	327	3,778
Trade and Other Payables - NHS	1,952	1,935	(17)	719	1,216
Trade and Other Payables - Other	9,745	10,622	876	3,482	7,140
Trade and Other Payables - Capital	116	261	145	0	261
Other Financial Liabilities - Accruals	33,104	41,753	8,649	6,613	35,140
Other Financial Liabilities - Borrowings FTFF	1,178	999	(180)	0	999
Other Financial Liabilities - PDC Dividend	469	701	232	0	701
Other Financial Liabilities - Intragroup Borrowings	0	0		2,999	0
Finance Lease - Intragroup	0	0		0	507
Total Current Liabilities	75,635	72,195	4,071	15,075	60,626
NET CURRENT ASSETS (LIABILITIES)	1,030	1,409	379	144	1,265
Non-Current Liabilities					
Deferred Income	2,124	2,124	0	1,794	330
Provisions	2,565	2,549	(16)	0	2,549
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	18,699	18,683	(16)	17,583	59,632
TOTAL ASSETS EMPLOYED	**102,588**	**102,771**	**183**	**27,277**	**92,318**
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)	(43,435)	(43,253)	183	17,233	(60,486)
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	102,588	102,771	183	34,057	85,538
TOTAL ASSETS EMPLOYED	**102,588**	**102,771**	**183**	**34,057**	**85,538**

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 As at the end of June the Trust has an approved a capital programme totalling £9.493m which is inclusive of £2.057m recently approval by the Trust Board to in relation to the Post Covid Operating Model leaving an uncommitted balance of £0.231m.

6.3 Actual expenditure up to 30th June 2021 totals £1.312m mainly in respect of 2020/2021 carried forward schemes, 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
18th July 2021

Gateshead Health NHS Foundation Trust

Report Cover Sheet

Agenda Item: 13

Purpose of Report	Decision: ☐	Discussion: ☒	Assurance: ☐	Information: ☒
Report Title:	Integrated Oversight Report			
Name of Meeting:	Trust Board			
Date of Meeting:	28th July 2021			
Author:	Deborah Renwick			
Executive Lead:	Joanne Baxter			
Report presented by:	Joanne Baxter			
Executive Summary:	The Board is asked to note the key messages relating to performance this month: Continued elective recovery plans against H1 Planning thresholds and performance measures whist maintaining our focus on staff wellbeing. Areas of Improved performance include: • Combined elective activity levels exceeding June threshold of 80% • RTT waiting times backlog reducing in line with plans • 31 Day cancer standard achieved • 28 Day faster diagnostic target achieved • Patient safety alerts not completed within timeframe • No reported never events since October 2020 • Improved Appraisal rates Areas of focus & risk include: • Projected risk for July's activity (projections) re Covid and revision of ERF threshold from 85% to 95% in July • Access targets at risk (A&E, RTT, Diagnostics, Cancer 2 week waits and treatments) and back log management, despite higher activity volumes • Understanding current HMSR rates & impact of Covid • Verbal duty of candour compliance • Under performance against our Well Led measures of sickness absence, appraisal and core training			
Recommended actions for Board/Committee)	The Board are asked to: a) Receive the IOR for current reporting month b) Note Trust performance & achievement against standards & remedial actions being taken in areas			

<table>
<tr><td></td><td colspan="6">where metrics are outside of expected parameters.
c) To seek further information and test robustness of plans as is require, allowing judgement regarding levels of assurance for future levels of operational performance.</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>
<tr><td>Aim 2
☒</td><td colspan="5">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td colspan="5">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☒</td><td colspan="5">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☐</td><td colspan="5">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Financial Implications:</td><td colspan="6">There are direct financial implications to recovering the organisational performance position and delivering activity plans.
Across all indicators, potential future actions to improve operational performance are likely to incur additional spend.</td></tr>
<tr><td>Links to Risks (identify significant risks and DATIX reference)</td><td colspan="6">A sustained exceptional level of demand for services that overwhelms (limited) capacity resulting in a prolonged widespread reduction in the quality of patient care and repeated failure to achieve the constitutional standards, with possible harm to patients.
Ongoing risk to Trust’s ability to deliver strategic objectives and the risk to deliver in the national access targets and the ability to recover long waits and patient backlogs:
- Workforce planning & financial incentives
- Emphasis to prioritise cancer patients first and share resource regionally</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: July 2021

Gateshead Health NHS Foundation Trust

Contents:

Key messages

Gateshead Health NHS Foundation Trust

The Trust has continued with the elective recovery plans whilst ensuring a greater focus on staff wellbeing for this reporting period in Q1. Increasing volumes of covid admissions and rising cases in hospital coupled with the impact of track and trace on staff absences are proving extremely challenging.

Areas of Improved performance include:

- Activity levels (on aggregate) exceeding H1 Planning trajectories in April (100%) & May (87%) June indicative (103%)
  *(note: **% value** delivery is a potential risk)*
- No reported never events (last reported October 2020)
- RTT >52 weeks down 64 *(May's position)* Lowest volume of >52 week waiters in ICS.
- The Trust Achieved Cancer 28 Day Faster Diagnostic Standard every month in Q1
- Benchmarked A&E places the Trust 17th out of 139 providers

Areas of focus & risk include:

- Patient Safety Alerts not completed within timeframe
- Access to ERF poses a real risk into July given impact of covid on the elective programme
- Cancer treatment backlogs on 62 day pathways are increasing (indicative across North ICP)
- Access targets (A&E, RTT, Diagnostics, Cancer treatments, Cancer indicative31 day targets & Cancer screening targets) and total back log management, despite higher activity volumes.
- Understanding current HMSR rates & impact of COVID
- Core training and staff appraisal
- Forecasted risk re: July activity projections and changes to ERF threshold from 85% to 95%

Executive Summary

Gateshead Health NHS Foundation Trust

Responsive

A&E: June 21 The Trust continues to underachieve, reporting June's performance at 87.8% against the 4 hour standard. Footfall through A&E has increased and is on average 72 attendances per day more than last year (35% increase). The latest national benchmarking data places the Trust at 17th of 139 Type 1 providers.

The Trust remains one of the better performing hospitals in the region for Ambulance Handovers, reporting 22 30 minute and 2 over 60 minute delays in June.

RTT: May 21 The waiting-list is still showing special cause variation. May's (finalised) performance reports 80.29% of our patients waiting less than 18 weeks, with an increase to 9,385 patients on the RTT waiting list but a reduction to 64 patients waiting over 52 weeks.

Cancer: June 2ww : The Trusts position against the 2 week wait target in June decreased to 74% from May's performance of 91.4%. In June 2021 Two week wait referrals are up by 25% in comparison to the same period last year, breast service referrals remain high with 586 referrals in June, representing a 47% increase on June 2019 figures. Referrals to the lung service have increased to 50 referrals in June which is a slight increase from 49 in the same period in 2019. Total two week wait referrals are 1104 which is a 21% increase in comparison to June 2019.

Cancer 62 day treatments: May 21: The Trusts position against the 62 day standard showed a slight improvement in performance in May reporting performance at 74.1%. Breast, UGI achieved the performance standard of over 85%. .

LGI, Gynaeoncology, Haematology , Lung and Urology were unable to achieve the standard with the most notable pressures visible within gynaeoncology, haematology and lung.

Diagnostics: May The Trust failed the diagnostic standard in May reporting 70.81% of our patients seen with 6 weeks of referral, a decrease since April. Echocardiography continues to be the main challenge; plans for recovery continue to be reviewed – an update will be presented at Finance & Performance Committee.

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 and is currently at risk for July.

Executive Summary

Gateshead Health NHS Foundation Trust

Safe

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 progress of this safety alert was discussed at the Medicine Business Unit Safecare meeting in June and confirmation of compliance is awaited from the identified leads.
The latest **Never Event** was observed in October 2020.
A spike in **Emergency C.Sections** observed in April 2021 is under review and is due to report back to Quality Governance Committee for assurance. The rate has fallen from 22.96% in to expected levels in May & June of 13.57% & 14.02%
One maternity **Serious Incident** reported retrospectively in June relating to a neonatal death in February 2020.

Effective

The Trust **Hospital Standardised Mortality Ratio** (HSMR) remains unchanged as the data stream has not yet been updated. This indicator continues to show more deaths than expected when compared to the National expected value. Following several consecutive months of reduction the Trust is an outlier at the lower 95% confidence level and no longer at the 99.8% confidence level.

Well Led

Core training performance decreased from 71.8% in May to 69.6% in June and **appraisals** also improved from 60.9% to 62.1% during the same period.
Sickness Absence rates deteriorated from 4.5% in May to 4.8% in June

Caring

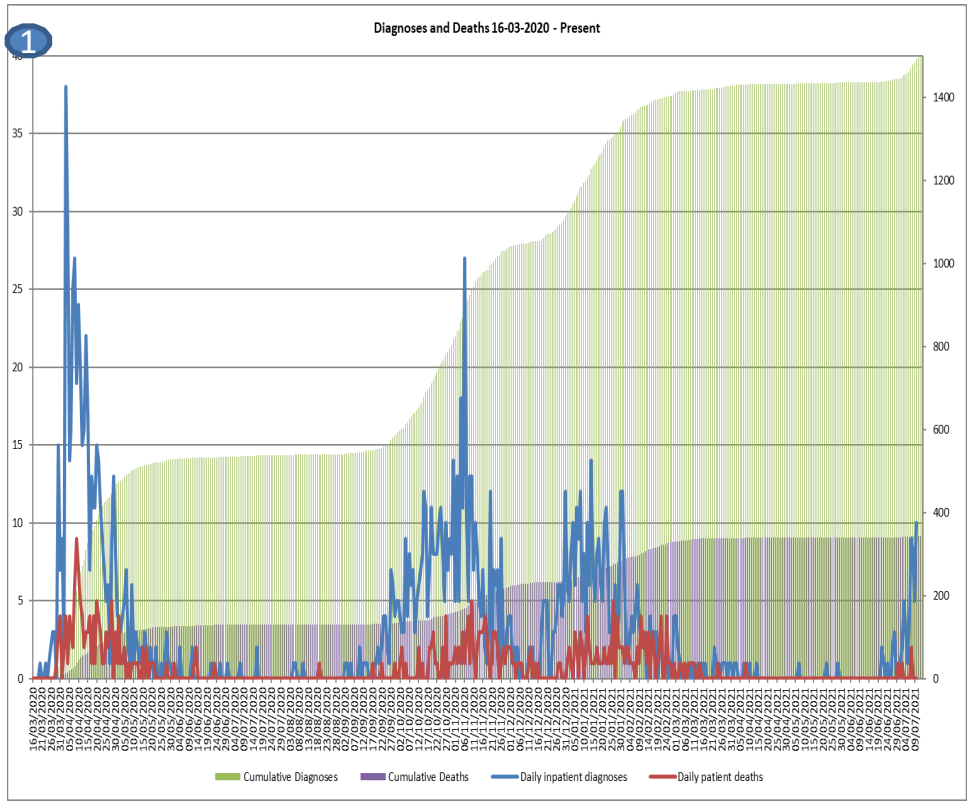
There are **no caring indicators triggering** concern. Electronic patient feedback mechanisms are being rolled out across the Trust.

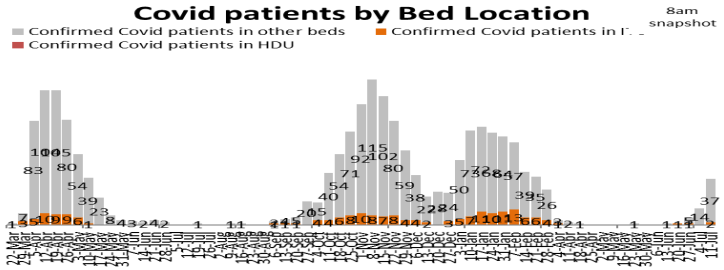
Covid-19: Statistical Update

Gateshead Health NHS Foundation Trust

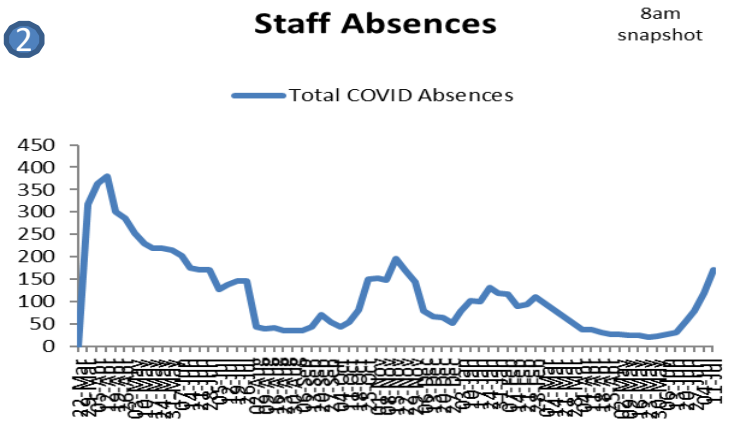
The latest number of patients in hospital with a positive Covid-19 is increasing, to date the Trust has treated more than 2k patients.
The blue line in chart (1) below indicates the start of the 4th wave in the hospital. This pattern is indicative across the NENC ICS patch. Covid positive patients are 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 graph (2) demonstrate the impact of track and trace and increase in covid cases on staff absence. (Admin, clerical and nursing).

1





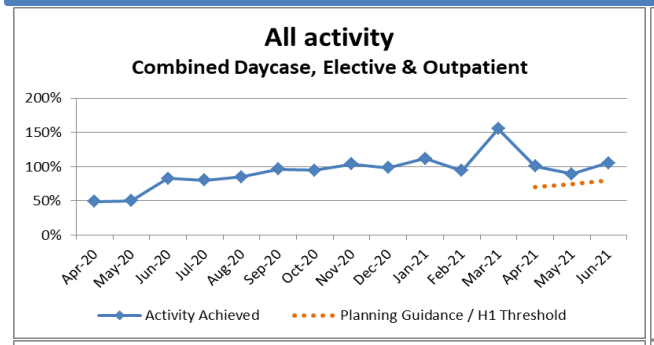
2

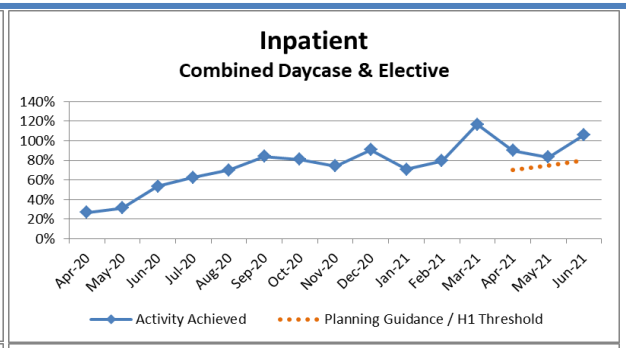


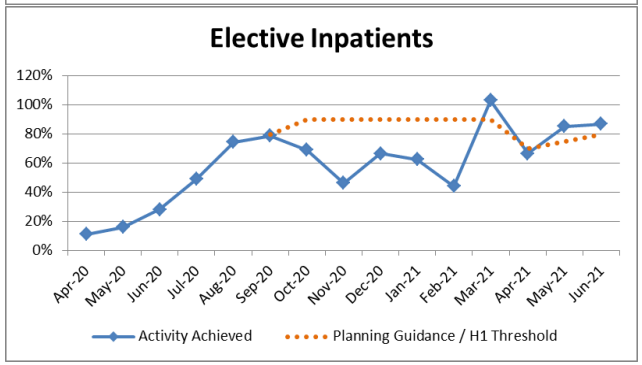
H1 Activity & Recovery

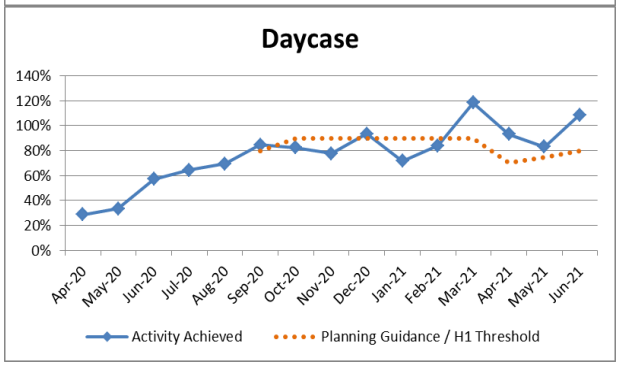
Gateshead Health NHS Foundation Trust

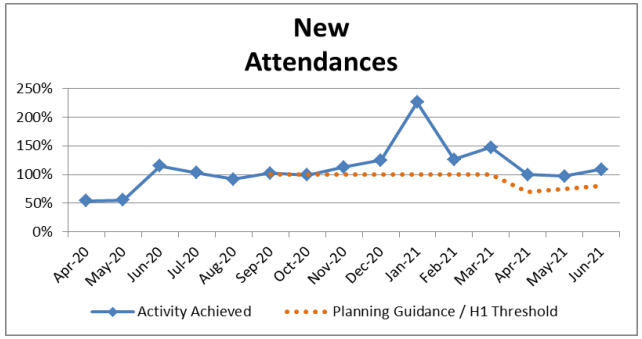
Planning guidance had stated Trusts should meet the following activity (value) thresholds as a minimum:
70% April, 75% May, 80% June, 85% from July onwards. This has recently been amended to increase the threshold to 95% for July to September. The below slides represent Activity delivered in month only (financial values will be attributed when tariffs are confirmed and financial systems are able to be reported).
Success criteria & financial values are currently monitored at ICS level. Across the ICS the Accelerator is required to deliver 100%

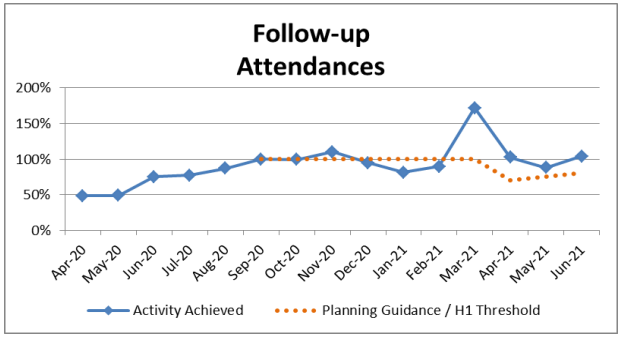












Commentary for June 2021

Refreshed combined activity for April is now at 100% (Previously reported at 95% - *outpatient data processing improvements)*

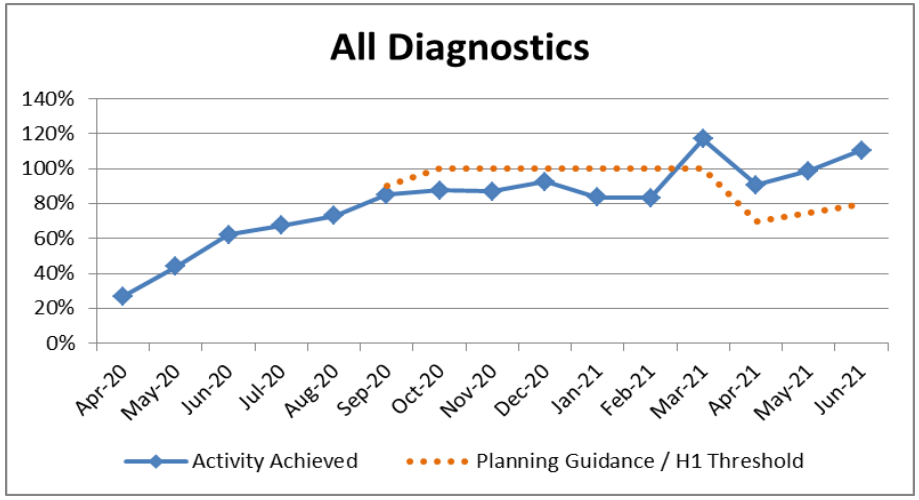
Combined activity (indicative) **June: 105%:** Above 80% ERF threshold working towards accelerator.

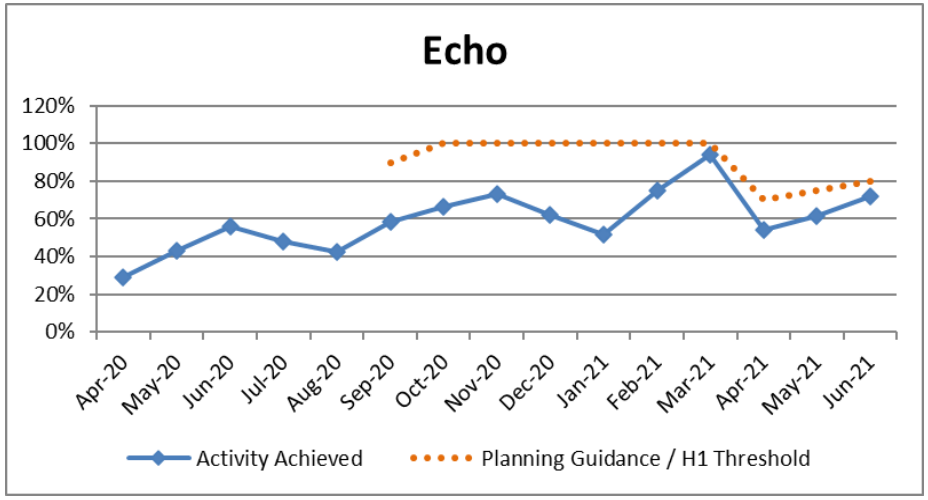
Day cases 109%
Elective overnights 87%
Outpatients 105% - position will improve re: data processing and end of clinic procedures.

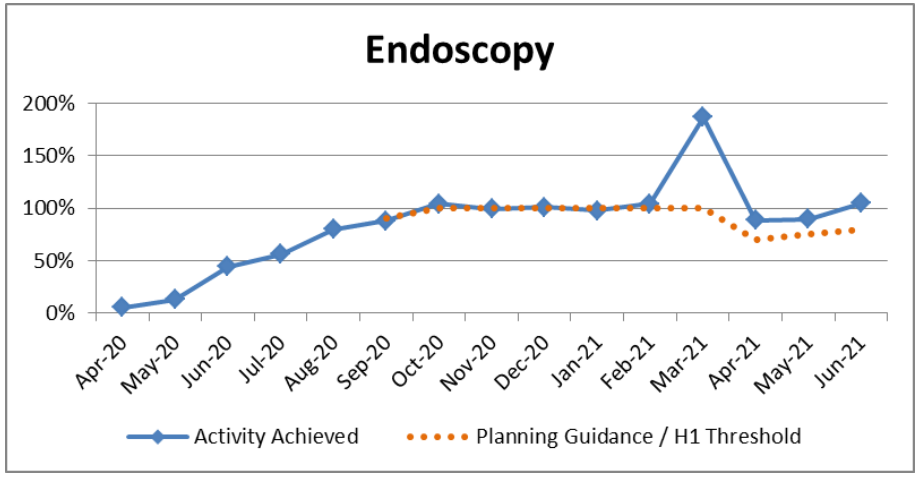
H1 Activity & Recovery

Gateshead Health NHS Foundation Trust

Whist 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 110 % Endoscopy: Activity at 105% Echocardiology: Activity 72%**
Pressures continue in echocardiology – activity delivered in June at 61%: Number of waiters> 6 weeks accounts for 74% of the waiters.







As part of national initiative to manage diagnostic risk, the Trust is required to review all long waiters waiting over 6 weeks and clinically prioritise (as with inpatient waiters). The diagnostic modalities are detailed below with % of the total wait over 6 weeks.

- Echocardiology account for 93% of the waiters > 6 weeks with a waiting list of 73% waiting longer than 6 weeks
- Audiology: account for 5% of waiters over 6 weeks with 24% of patients waiting longer than 6 weeks.

Integrated Oversight Report –Summary Indicators

	Measure	Latest period		Target	Latest 12 months	Variation	Assurance	Comment
SAFE	Patient Safety Alerts not completed by deadline	1	Jun-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.
EFFECTIVE	Hospital Standardised Mortality Ratio	107.8	Apr-20 - Mar 21			H		12 month figure, The Trust is demonstrating 'More Deaths than Expected' for the most recent available period. The HSMR has fallen for a number of consecutive months moving from an outlier at the 99.8% control limit to 95% control limit.
RESPONSIVE	UEC maximum waiting time of four hours from arrival to admission/transfer/discharge	87.8%	Jun-21	95%	90.1%		?	Below target since August 2020 but common cause variation
	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway	80.3%	May-21	92%	70.9%	H	F	Special variation (improvement) from Octber 2020, performance below target since January 2020
	Cancer 2ww compliance	74.0%	Jun-21	93%	72.0%		?	Compliance achived in March 2021, the first time since March 2020. Common cause variation.
	Cancer 2ww ENCB compliance	100.0%	Jun-21	93%	93.7%		?	Special cause variation for May and June 2020
	Cancer 28 day compliance	77.9%	May-21	75%	72.2%		?	Target achieved in for the last 40consecutive months. Special cause variation (improvement) observed in February and March 2021
	Cancer 28 day exhibited compliance	100.0%	May-21	75%	78.3%		?	Target Achieved for the last 4 consecutive months . Below target in October 2020 and January 2021
	Cancer 28 day screening compliance	75.8%	May-21	75%	55.2%		?	Target achieved in May 2021, the fist time since October 2020.
	Cancer 31 day compliance	99.2%	May-21	96%	98.2%		?	Special cause variation in June 2020, target achieved in 16 of 18 months
	Cancer 31 day subsequent drugs compliance	100.0%	May-21	98%	98.7%		?	Special cause variation in June 2020. Target achieved for the last 4 consecutive months.
	Cancer 31 day subsequent surgery compliance	100.0%	May-21	94%	95.9%		?	Perfomance fluctuates arouns the target. Below target in November & December 2020 and February and April 2021.
	All cancers - maximum 62-day wait for first treatment from urgent GP referral for suspected cancer	74.1%	May-21	85%	69.0%		?	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	88.5%	May-21	90%	80.3%		?	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	70.8%	May-21	99%	62.7%		F	Common cause variation since July 2020, performance below target since March 2020
	Duty of Candour - Verbal Compliance	35.7%	Jun-21			L		
WELL-LED	Staff sickness	4.8%	Jun-21	4%	4.7%		?	June 2021 above target. Special cause variation - concern for April 2020. Target achived 3 out of 18 months
	Appraisals	63.1%	Jun-21	85%	61.8%	L	F	Special cause variation - concern, shift in performance from October 2020 and consistently below target
	Core Training	69.6%	Jun-21	85%	74.7%	L	F	Special cause variation - concern. Recent performance below 18 month mean for the last 6 months. The last 3 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

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	87.8%	Jun-21	95%	90.1%		?	Below target since August 2020 but common cause variation
	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway	80.3%	May-21	92%	70.9%	H	F	Special variation (improvement) from Octber 2020, performance below target since January 2020
	Number of patients on an incomplete pathway	9385	May-21					Common cause varaiation displayed however 8 points (non consecutive) of the last 10 are above the mean.
	Number of patients waiting 52 weeks or more on an incomplete pathway	64	May-21					Special cause variation between August 2020 and April 2021. Common cause variation currently displayed as the number of patients waiting 52 weeks in May 2021 has returned below the 18 month mean.
	Cancelled elective operations within 24 hours not readmitted within 28 days	0	Jun-21		4			
	Cancer 62 day upgrade compliance	0.0%	May-21	94%	52.0%			
	Maximum 6-week wait for diagnostic procedures	70.8%	May-21	99%	62.7%		F	Common cause variation since July 2020, performance below target since March 2020
	Duty of Candour - Verbal Compliance	417.7%	Jun-21			L		
	Formal Complaints	18	Jun-21		251			Clinical Treatment (9) Communications (5) Values & Behaviours (Staff) (2) Privacy, Dignity & wellbeing (including patients' property & expenses) (2)
	Informal complaints	50	Jun-21		539			
	Compliments	31	Jun-21		353			

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

Responsive

	Measure	Latest period		Target	Latest 12 months	Variation	Assurance	Comment
RESPONSIVE	Cancer 2ww compliance	74.0%	Jun-21	93%	72.0%			Compliance achived in March 2021, the first time since March 2020. Common cause variation.
	Cancer 2ww ENCB compliance	100.0%	Jun-21	93%	93.7%			Special cause variation for May and June 2020
	Cancer 28 day compliance	77.9%	May-21	75%	72.2%			Target achieved in for the last 40consecutive months. Special cause variation (improvement) observed in February and March 2021
	Cancer 28 day exhibited compliance	100.0%	May-21	75%	78.3%			Target Achieved for the last 4 consecutive months . Below target in October 2020 and January 2021
	Cancer 28 day screening compliance	75.8%	May-21	75%	55.2%			Target achieved in May 2021, the fist time since October 2020.
	Cancer 31 day compliance	99.2%	May-21	96%	98.2%			Special cause variation in June 2020, target achieved in 16 of 18 months
	Cancer 31 day subsequent drugs compliance	100.0%	May-21	98%	98.7%			Special cause variation in June 2020. Target achieved for the last 4 consecutive months.
	Cancer 31 day subsequent surgery compliance	100.0%	May-21	94%	95.9%			Perfomance fluctuates arouns the target. Below target in November & December 2020 and February and April 2021.
	All cancers - maximum 62-day wait for first treatment from urgent GP referral for suspected cancer	74.1%	May-21	85%	69.0%			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	88.5%	May-21	90%	80.3%			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.
	Cancer 62 day upgrade compliance	0.0%	May-21	94%	52.0%			

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

Summary Indicators

Gateshead Health NHS Foundation Trust

Safe

	Measure	Latest period		Target	Latest 12 months	Variation	Assurance	Comment
SAFE	Occurrence of any Never Event	0	Jun-21	0	1		?	1 never event in October 20
	Emergency c-section rate	14.0%	Jun-21		15.5%			Special cause variation previously identified in April 2021. Returned to common cause variation in May and June 2021
	Venous thromboembolism (VTE) risk assessment	98.4%	Jun-21	95%	98.8%		P	
	C difficile actual	8	Apr - Mar 21/22					
	Clostridium difficile - infection rate	26.7	Apr - Mar 21/22					
	Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	0	Apr - Mar 21/22	0	0			
	P. aeruginosa actual	3	Jun-21					
	Klebsiella spp: Actual	4	Jun-21					
	COVID Hospital-Onset Indeterminate Healthcare-Associated	1	Jun-21					
	COVID Hospital-Onset Probable Healthcare-Associated	0	Jun-21					
	COVID Hospital-Onset Definite Healthcare-Associated	0	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

Summary Indicators

Gateshead Health NHS Foundation Trust

Safe

	Measure	Latest period		Target	Latest 12 months	Variation	Assurance	Comment
SAFE	Medication errors per 1000 FCEs	9	Jun-21		8.8			A general upward trend over the past 18 months, levelling over the past four months
	Patient Falls per 1000 bed days	9.2	Jun-21		10.5			
	Trust Aqcuired Pressure Damage per 1000 bed days (Category 2 and above)	2.1	Jun-21		3.3			
	Potential under-reporting of patient safety incidents	37.6	Jun-21		42.7			
	Serious Incidents reported to StEIS	4	Jun-21		69			
	Patient Safety Alerts not completed by deadline	1	Jun-21	0				
	Escherichia Coli (E. coli) bacteraemia bloodstream infection (BSI)	168	Apr - Mar 21/22					
	Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemia infection rate	13.4	Apr - Mar 21/22					
	Care hours per patient day	8.67	May-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

Summary Indicators

Gateshead Health NHS Foundation Trust

Effective

	Measure	Latest period		Target	Latest 12 months	Variation	Assurance	Comment
EFFECTIVE	Summary Hospital level Mortality Indicator	1.00	Mar 20 - Feb 21					12 month figure, The Trust has a banding of 'As expected' for the most recent available 12 month period.
	Hospital Standardised Mortality Ratio	107.8	Apr-20 - Mar 21					12 month figure, The Trust is demonstrating 'More Deaths than Expected' for the most recent available period. The HSMR has fallen for a number of consecutive months moving from an outlier at the 99.8% control limit to 95% control limit.
	Crude Mortality - Inpatient Deaths	91	Jun-21		1070			
	Crude Mortality - Covid Deaths	1	Jun-21		217			
	Mortality Review Compliance	62.0%	Jun 20 - May 21					
	Potentially Avoidable Deaths	0.4% (3)	Jun 20 - May 21					
	Mortality Review Compliace - Learning Disability Deaths	86.6%	Jun 20 - May 21					
	Potentially Avoidable Deaths - Learning Disability Deaths (#/%)	7.7% (1)	Jun 20 - May 21					
	Long Length of Stay Patients	50.4	Jun-21		40.4			
	Readmissions within 30 days	9.5%	Jan-21		10.5%			Special cause variation (high - negative) for May 2020
	Pre procedure elective bed days	0.21	Jun-21		0.30			High against national median Q2 20/21 of 0.15

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

Summary Indicators

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	84.9%	Jun-21		86.6%			FFT in inpatient areas was launced 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 during July. Maternity is to use the Badger system at a later date however a numbe rof text message responses were received via the text message collection.
	Inpatient & day case scores from Friends & Family Test - % positive	96.2%	Jun-21		98.6%			
	Maternity scores from Friends & Family Test - % positive	100.0%	Jun-21		100.0%			
	Outpatient scores from Friends & Family Test - % positive	100.0%	Jun-21		100.0%			
	Community scores from Friends & Family Test - % positive	100.0%	Jun-21		100.0%			
	Mental Health scores from Friends & Family Test - % positive	100.0%	Jun-21		100.0%			
	Written Complaints rate per 1000 WTE	4.3	Jun-21					

Well Led

	Measure	Latest period		Target	Latest 12 months	Variation	Assurance	Comment
WELL-LED	Staff sickness	4.8%	Jun-21	4%	4.7%			June 2021 above target. Special cause variation - concern for April 2020. Target achived 3 out of 18 months
	Staff turnover	1.02%	Jun-21		1.38%			Special cause variation - concern for August 2020
	Appraisals	63.1%	Jun-21	85%	61.8%			Special cause variation - concern, shift in performance from October 2020 and consistently below target
	Core Training	69.6%	Jun-21	85%	74.7%			Special cause variation - concern. Recent performance below 18 month mean for the last 6 months. The last 3 months below the lower process limit. Consistently below target.
	Data Quality Maturity Index (DQMI) - MHSDS datset score	93.6%	Mar-21		89.5%			

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.

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

Gateshead Health NHS Foundation Trust

Category	Performance Indicator Information	PSF Trajectory	2019/20	2020/21 Performance Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Standard 2020/21	Trigger for Potential Support Need:- (2 consecutive months of non delivery of standard/PSF trajectory)*
Operational	Incomplete RTT Pathways - Waiting < 18 weeks	N	91.1%	70.5%	62.0%	53.0%	52.9%	63.6%	71.8%	76.7%	75.9%	74.7%	74.4%	74.2%	76.1%	69.0%	92%	
	Maximum Waiting Time 4 hours in A&E	Y	89.6%	91.7%	94.7%	98.4%	97.5%	94.7%	94.6%	85.5%	83.3%	86.2%	86.0%	90.4%	90.2%	91.4%	95%	
	62 day wait for 1st definitive treatments	N	76.7%	75.3%	41.0%	59.3%	69.4%	69.2%	74.1%	64.3%	67.2%	68.2%	61.5%	72.2%	79.2%	68.1%	85%	
	62 day wait for treatment (screening patients)	N	94.1%	77.8%	47.6%	0.0%	26.7%	45.5%	60.0%	96.6%	93.2%	92.3%	95.5%	90.2%	84.3%	76.4%	90%	
	Maximum 6-week wait for diagnostic procedures	N	98.8%	35.7%	32.5%	40.1%	53.4%	57.5%	61.2%	66.2%	61.8%	63.9%	64.6%	68.8%	72.1%	55.8%	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

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

Gateshead Health NHS Foundation Trust

Category	Performance Indicator Information	PSF Trajectory	2020/21	2021/22 Performance Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Standard 2021/22	Trigger for Potential Support Need:- (2 consecutive months of non delivery of standard/PSF trajectory)*
Operational	Incomplete RTT Pathways - Waiting < 18 weeks	N	69.0%	76.7%	80.3%											78.5%	92%	
	Maximum Waiting Time 4 hours in A&E	Y	91.4%	93.5%	91.3%	87.8%										90.7%	95%	
	62 day wait for 1st definitive treatments	N	68.1%	69.8%	74.1%											71.1%	85%	
	62 day wait for treatment (screening patients)	N	76.4%	88.1%	88.5%											85.1%	90%	
	Maximum 6-week wait for diagnostic procedures	N	55.8%	71.6%	70.8%											71.2%	99%	

Dashboard Key:

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

Operational Measures

Gateshead Health NHS Foundation Trust

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

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

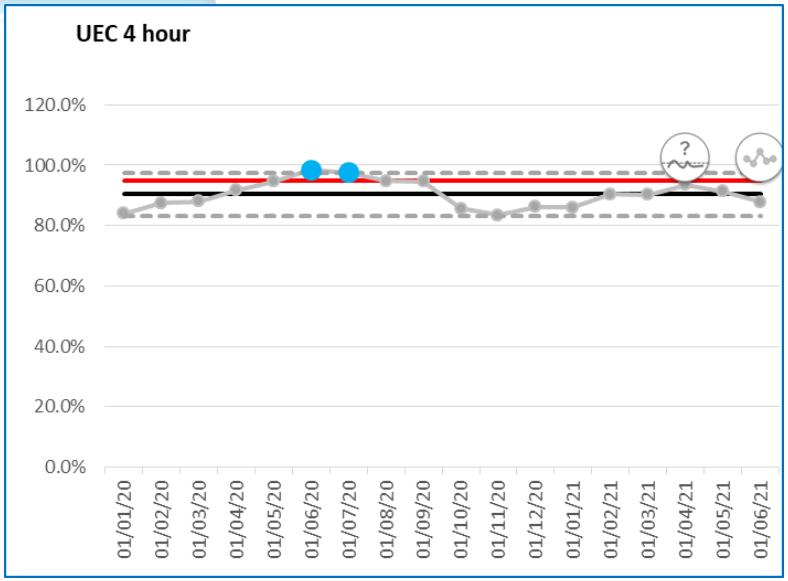
Pefrormance Measure	RO	Last Period		This Period		This Period Status	Variation	Assurance	Target (where applicable) or trajectory	Target type
Referral to treatment within 18 weeks	JBa	76.7%	Apr-21	80.3%	May-21	✕	H	F	92%	National
Referral to treatment Total Incomplete waiters	JBa	8995	Apr-21	9385	May-21		H		8,590	Activity and recovery monitoring
Referral to Treatment >52 week waiters	JBa	107	Apr-21	64	May-21		H		0	Activity and recovery monitoring
A&E seen within 4 hours	JBa	91.3%	May-21	87.8%	Jun-21	✕		?	95%	National
A&E attendances	JBa	7790	May-21	8394	Jun-21				10,268	Activity and recovery monitoring
Handover delays 30-60 minutes	JBa	4	May-21	22	Jun-21				0	National
Handover delays >60 minutes	JBa	0	May-21	2	Jun-21				0	National
Bed Occupancy	JBa	88.1%	May-21	91.6%	Jun-21				92%	National
Cancer 2 ww - first seen	JBa	91.4%	May-21	74.0%	May-21	✕		?	93%	National
Cancer 2ww to treatment within 62 days	JBa	69.8%	Apr-21	74.1%	May-21	✕		?	85%	National
Cancer 62 day treatment screening	JBa	88.1%	Apr-21	88.5%	May-21	✕		?	90%	National
Cancer waits over 104 days (all pathways)	JBa	33	Apr-21	23	May-21		H	?	0	Local monitoring
Diagnostic waits % within 6 weeks	JBa	71.6%	Apr-21	70.8%	May-21	✕		F	99%	National
Diagnostic waiters	JBa	5953	Apr-21	6063	May-21					National
Endoscopy waiters (subset of the above)	JBa	397	Apr-21	531	May-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



Combined impact analysis

Financial impact
No direct financial impact identified.

Quality impact
The reputation of the Trust could be impacted due to negative responses. Poor patient experience for those waiting longer than necessary.

Workforce impact
Pressurised working environments have the potential to adversely impact on staff wellbeing.

Operational performance impact
No direct operational impact identified.

Situation
The Trust continues to underachieve against the 4 hour standard, this is the eleventh consecutive month the Trust has failed the 4 hr target. In June the Trust saw 87.8% of the patients presenting through A&E within 4 hours, compared to 98.4 % in June 2020 .

Background
Activity levels for June at 81% of those of the comparable period in June 2019, pre-covid. Footfall and patient numbers are increasing with daily attendances averaging 72 more than June 2020 (35%)

Assessment
The impact of challenges within the 111 service are being seen in increases in attendances at ED. Staff isolation from test and trace tracking 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.

Actions
Several work streams are underway to improve performance:

- Talk before you Walk
- Telephone triage for Urgent Treatment Centre
- Project board established for Same Day Emergency Care
- Bed reconfiguration and modelling
- Review of options for POC testing to allow streaming of patients direct to surgical wards
- 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.

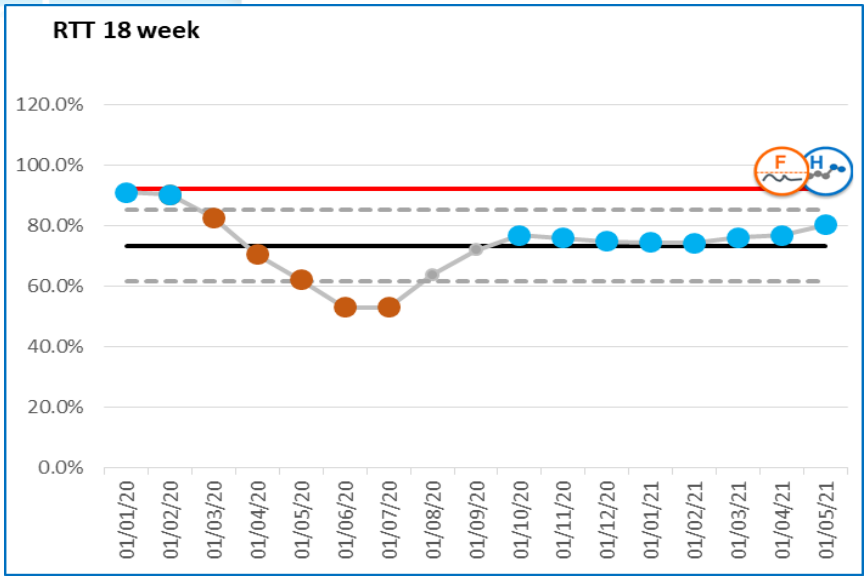
Recommendation
Finance & Performance Committee to receive updates from the weekly meetings and project boards.

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

May's reported performance of 80% is an improvement on 77% in April.

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 8 consecutive months above the 18 month mean triggering special cause variation for improvement.

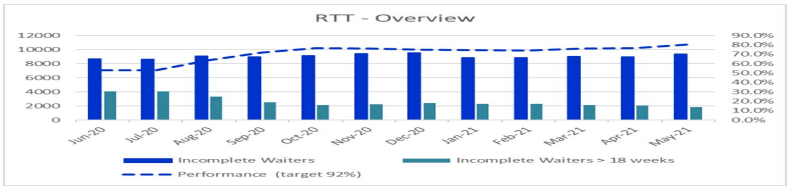
The indicator is highlighted to consistently fail based on current performance and variation.

Background

In March 2020 the Trust was required to cancel all non-urgent elective activity (NHSE/I) for a minimum of 3 months. Restart of elective recovery was well underway, seeing an upward improving trend; outbreaks and the circuit break have impacted on the ability to deliver Inpatient overnight stays.

Assessment

The indicator is flagging to consistently fail the target based on current performance and monthly variation. General Medicine 94.% and Geriatric Medicine 94% achieved the 18 week standard in May.



Actions

- Business Units are working towards achieving the expectations in the planning guidance Weekly prioritisation meetings 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.
- Secure additional support to validate waiting lists and baseline requirements for elective recovery
- Treatment cancellations by priority type are now sit-rep reportable.

Recommendation

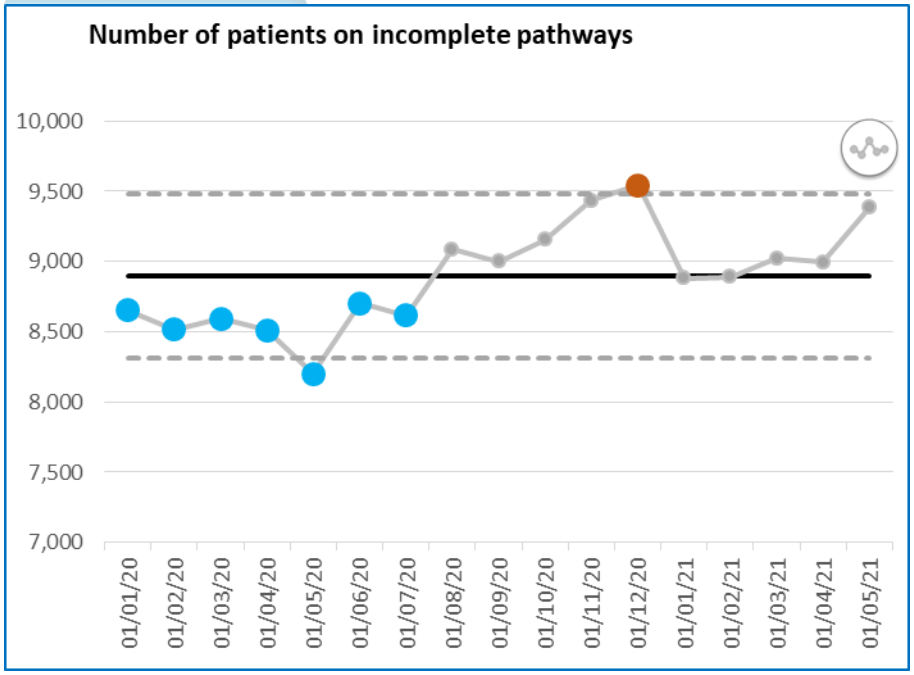
Finance & Performance Committee are to note that the above plans remain in place whilst current covid levels are maintained.

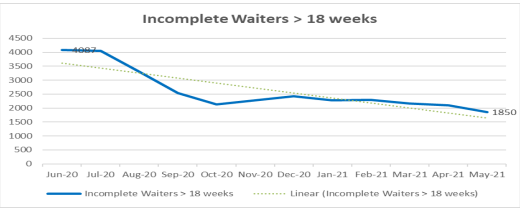
Report by exception: Responsive – Spotlight Number of patients on an incomplete pathway

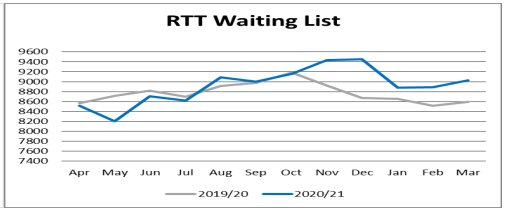
Detail on this measure is included as a significant shift is observed in the number of patients on an incomplete pathway

Gateshead Health NHS Foundation Trust

Responsive







Situation

A shift in the number of patients on an incomplete pathway is observed from August 2020. At the end of May 2021 there were 9385 patients on an incomplete pathway, an increase of 1186 patients on May 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 patient waiting longer than 18 weeks has fallen from 4,087 patients in Jun 20 to 1,850 in May 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 331 and 355 patients waiting longer than 18 weeks.

Actions

- Business Units are working towards achieving the expectations in the planning guidance & Accelerator programme
- Weekly prioritisation meetings 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 commence 21/06/21 in support of baselining validation capacity and supporting with the additional weekly waiting list requirements in support of gateway criterion and elective recovery

Recommendation

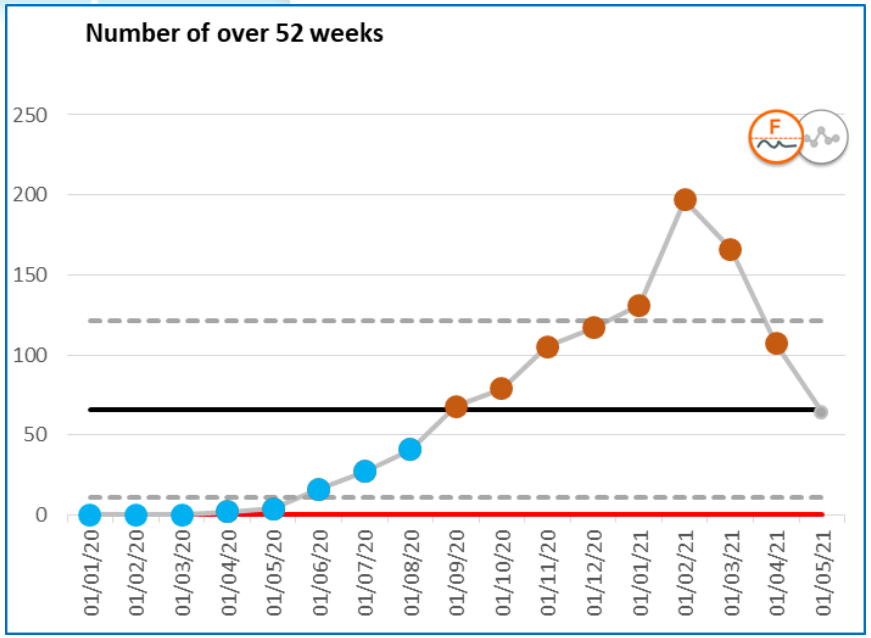
Finance & Performance Committee are to note that the above plans remain in place whilst current COVID levels are maintained.

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

Gateshead Health NHS Foundation Trust

Detail on this measure is included as the standard has not been met since May 2020 and special cause variation is identified

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 onwards. However common cause variation is displayed in May 2021.

Assessment

Following consecutive decreases the May figure is displaying common cause variation at 64 patients, just below the 18 month mean of 66. Weekly PTL data demonstrates a further reduction to 41 patients.

Monitoring and delivery meetings are in place to ensure the accelerator trajectory is managed and delivered, and any issues expedited.

	09-May	16-May	23-May	30-May	06-Jun	13-Jun	20-Jun	27-Jun	04-Jul
100 Gen Surg	15	17	17	14	12	13	11	10	9
101 Urology	9	8	8	7	7	6	6	5	5
110 T&O	55	42	39	33	32	28	26	20	18
300 Gen Med									
301 Gastro		1			1	4	3	3	3
320 Cardio	2	2	1						
340 Thoracic Med									
410 Rheumatology									
430 Geriatric Med									
502 Gynae	3	3	2	2	2	3	3	3	3
X01 Other	3	4	3	3	3	4	3	3	3
>52 weeks	**87**	**77**	**70**	**59**	**57**	**58**	**52**	44	41

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

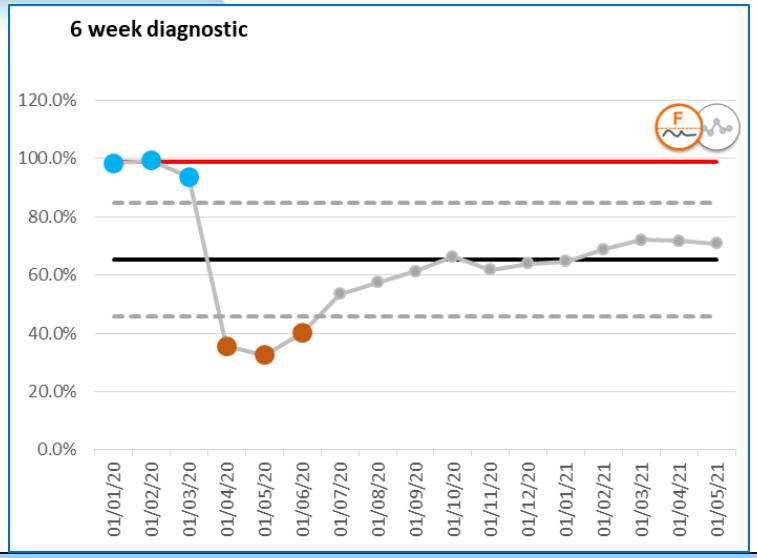
Finance & Performance Committee are to note that the above plans remain in place whilst current COVID-19 levels are maintained.

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

Detail on this measure is included as the standard has not been met since November 2019 and special cause variation triggered.

NHS Gateshead Health NHS Foundation Trust

Responsive



May 2021 Diagnostic Waits				
Procedure	Diagnostic waits 0 - < 6 weeks	Diagnostic waits 6 - < 13 weeks	Diagnostic waits 13 weeks +	Performance
Barium Enema	20	0	0	100.00%
CT	397	3	1	99.00%
MRI	253	0	0	100.00%
Non-obstetric ultrasound	1847	6	3	99.52%
Dexa	321	2	5	97.87%
Audiology	310	86	5	77.31%
Echocardiography	558	452	1190	25.36%
Peripheral Neurophysiology				
Urodynamics	68	3	2	93.15%
Colonoscopy	208	3	1	98.11%
Flexisigmoidoscopy	58	0	0	100.00%
Cystoscopy	74	4	4	90.24%
Gastroscopy	179	0	0	100.00%
Total	4293	559	1211	
Performance Percentage	70.81%	9.22%	19.97%	

Situation

The 6 week wait target has not been met since February 2020 with a significant reduction in performance observed from March 2020 onwards. May performance of 70.8% demonstrates four consecutive months above the 18 month mean.

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, Echo-cardiology still remains a particular area of concern accounting for 93 % of the patients waiting over 6 weeks – and current performance at 25% of patients seen within 6 weeks. Activity levels for echo-cardiology have fallen from Pre-covid 2019/20 levels: March (94%) to 54% in April and 61% in May.

Despite the long waits RTT cardiology performance target has demonstrated an upward trend since July – with RTT performance at 83%.

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

- The Echocardiology business case for the 3rd diagnostic room has been approved
- Estates work is to start imminently; a workforce staffing plan is in place to support additional activity.
- Weekly management of audiology referrals.

Recommendation

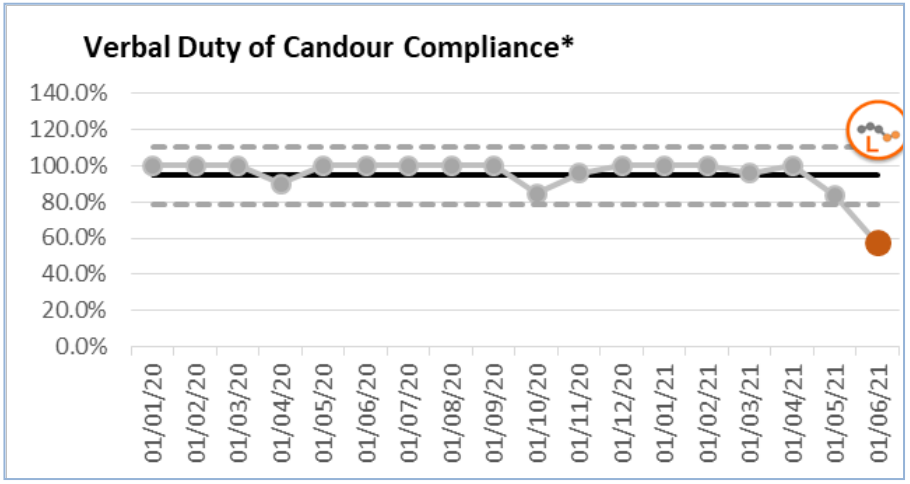
Review recovery plans with detailed discussion and scrutiny at Finance & Performance Committee

Report by exception: Responsive – Duty of Candour Verbal Compliance

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

NHS Gateshead Health NHS Foundation Trust

Responsive



Situation

Verbal Duty of Candour compliance is displaying special cause variation for concern in June 2021 with compliance at 57.1% (8 of 14 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

For June 2021 compliance is at is at 57.1**%** The apparent reasoning for the significant decline in the compliance rate in June 2021 is due to recent significant pressures due to staff isolation and the increased clinical pressures the Trust are experiencing. You will note from the above only 6 incidents are showing as non-compliant; however 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 with no avail due to all staff self-isolating. The Legal team have attempted to review all available records. Those records not reviewed are due to the patient still being admitted.

The Covid pandemic continues to impact on the Trusts ability to update systems with duty of candour information in a timely manner.

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. It is worth highlighting that following discussions with the business units it appears that in some instances incidents are assigned to incorrect handlers which is causing a delay in the Duty of Candour process and actions being assigned to incorrect individuals. This has been highlighted to the Patient Safety Team.

Recommendation

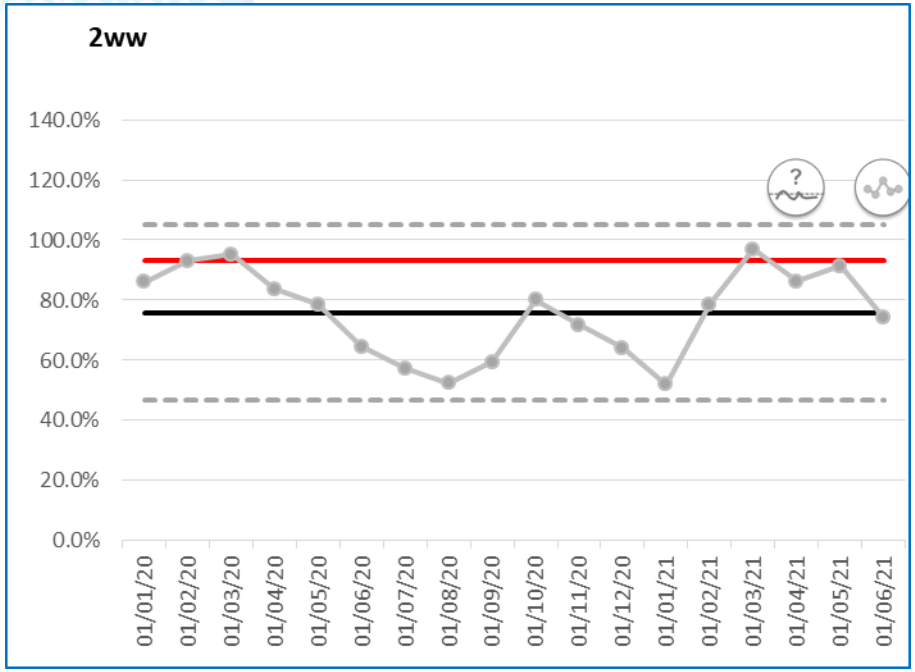
To be reviewed and discussed at the Quality Governance Committee

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.

NHS Gateshead Health NHS Foundation Trust

Responsive



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

Situation

Cancer two week: June's performance was below the 93% performance target at 74 % and slightly below the 18 month mean of 76%. 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

June saw referral rates increase across most tumour sites with a total of 1235 patients referred on a two week wait pathway. This is a 41% increase in comparison to June 2019 data.

Assessment

The breast service showed a drop in performance to 64% against the 93% performance standard. However, the number of breast referrals remain above average with 586 referrals in June. This is a 47.2 % increase in comparison with June 2019. Gynaecology achieved a performance of 95% despite a increase in referral numbers to 124. (42.5% increase in referrals in comparison to June 2019). The lung pathway is beginning to show some improvement with an increase in June performance to 39% in comparison to Mays performance of 14%.

Actions

- Within the lung team there has been some changes in relation to the respiratory clinicians inpatient responsibilities alongside the support of the navigator role which is proving effective. The team have also undertaken extra weekend clinics to support with the referral numbers.
- Within gynaecology changes are being made to the referral pathway in line with the rapid diagnostic project which will assist in capacity planning and expedite appointments
- LGI cancer navigator post has commenced in late June which will assist in pathway management.

Recommendation

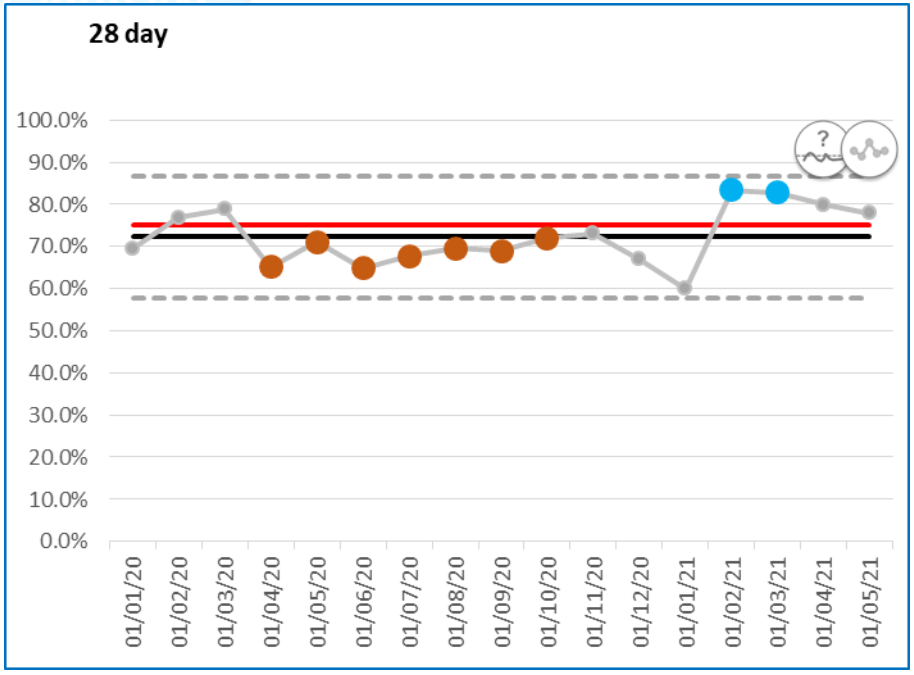
Detailed discussion and scrutiny at Finance & Performance Committee

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

Gateshead Health NHS Foundation Trust

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

Responsive



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

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 four consecutive months with May compliance at 77.30%.

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:

Cancer 28 day Faster Diagnosis Standard	**77.30%**
Suspected Breast Cancer	94.62
Suspected Testicular Cancer	80%
Suspected Lung Cancer	50%
Suspected Urological Cancers (Excluding Testicular)	70.69%
Suspected Upper Gastrointestinal Cancer	66.37%
Suspected Gynaecological Cancer	58.20%
Suspected Haematological Malignancies excluding acute leukemia	60%
Suspected Lower Gastrointestinal Cancer	38.85%

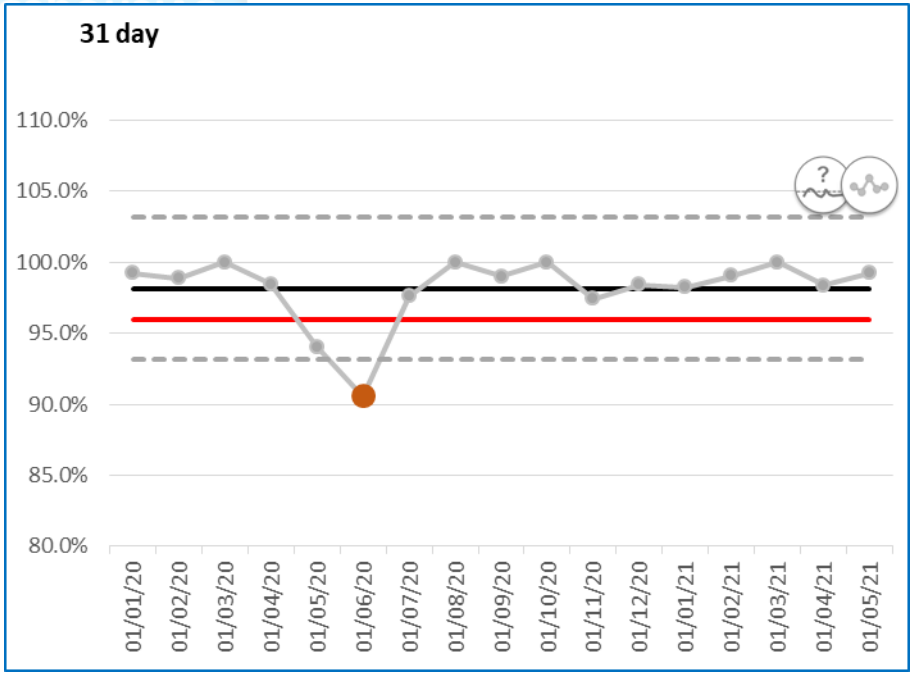
Actions
Ongoing review of each tumour site to optimise performance against this standard.

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 two of the last 18 months (Jun-20 and Jul-20) Special cause variation (low) identified in Jun-20.

The target was achieved in May 2021 with compliance at 99.2% 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 This target was achieved despite pressures placed on services due to Covid.

Actions Ongoing review

Combined impact analysis

Financial impact

Quality impact

Workforce impact

Operational performance impact

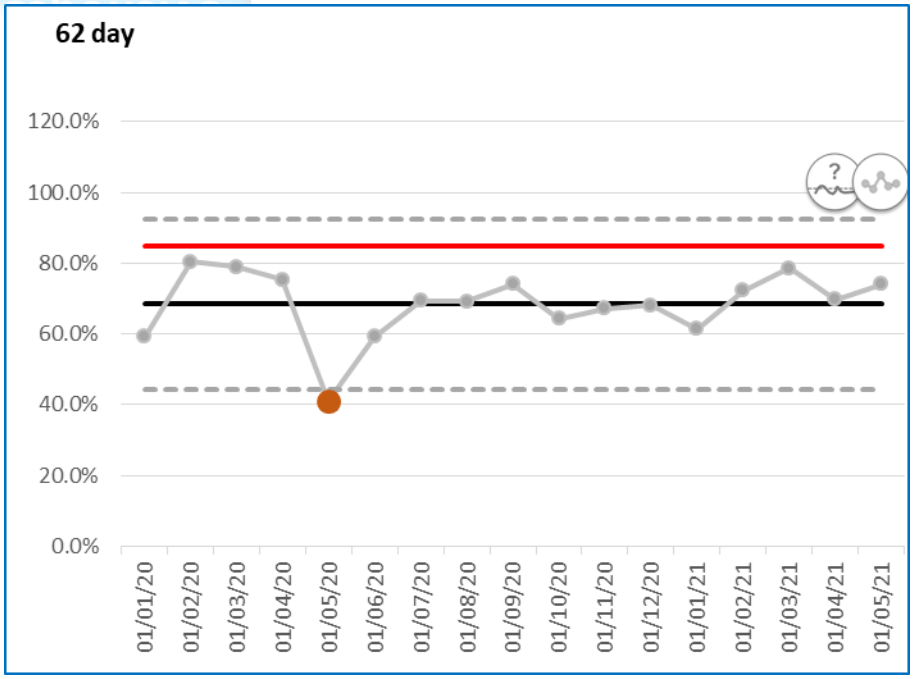
.

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

.

Situation

Cancer 62 day compliance has not met the standard since October 2019. May performance is 74.1% against a performance standard of 85%. This is an increase on the previous months performance and demonstrates four months above 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. Breast and UGI achieved the performance standard of over 85%. There are sustained pressures across the other tumour sites with particular pressure within the gynaeoncology service. Treatments although below planned levels have increased from 59 in April to 67 in May.

Actions

Ongoing weekly 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 prioritisation of gynaeoncology cases.
Extra weekend theatre lists to support with gynaeoncology surgical requirements.
Ongoing tender process to support with chemotherapy expansion plan

Recommendation

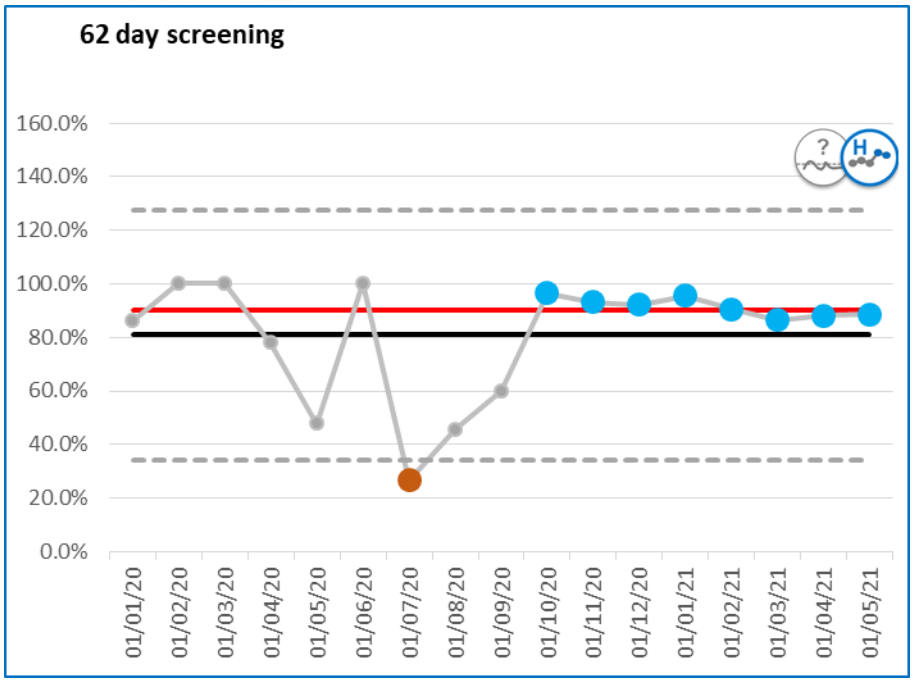
Detailed discussion and scrutiny at Finance & Performance Committee

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

Gateshead Health NHS Foundation Trust

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

Responsive



Situation
Performance was below target between March and October 2020 (with the exception of June 2020). The target has been recently achieved for 5 consecutive months from October 2020 to February 2021 and 8 consecutive points above the mean triggering special cause variation for improvement.

May compliance is below the target at 88.5% against a 90% target.

Assessment Performance against this target has returned to pre-covid levels.

Actions Ongoing review

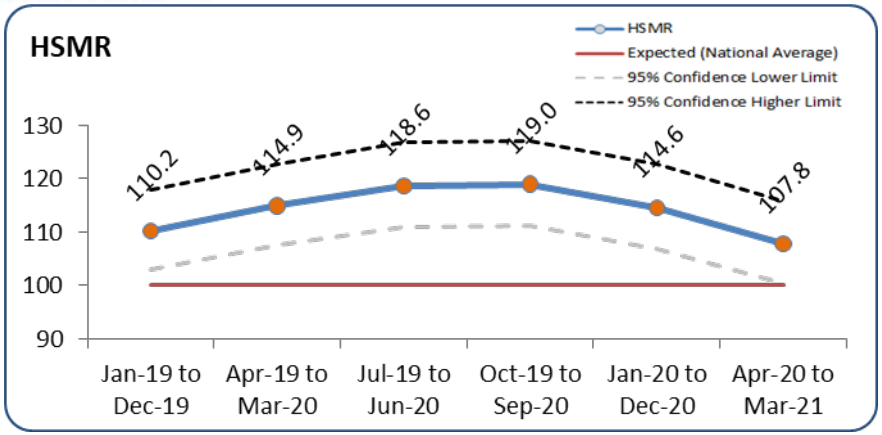
Recommendation
Detailed discussion and scrutiny at Finance & Performance Committee

Report by exception: Effective – Hospital Standardised Mortality Ratio

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

NHS Gateshead Health NHS Foundation Trust

Effective



Combined impact analysis

Financial impact

No direct financial impact yet identified.

Quality impact

No direct quality impact yet identified.

Workforce impact

No direct workforce impact yet identified.

Operational performance impact

No direct operational performance impact identified.

Situation - HSMR is above expected value. The Trusts HSMR has increased to 'Higher than Expected' levels since the period Jul-18 to Jun-19 to date. The HSMR has fallen for a number of consecutive months moving from an outlier at the 99.8% control limit to 95% control limit.

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

Assessment - The mortality indicators show the Trust deaths relative to the expected deaths per the statistical models for HSMR and SHMI. For the Trust the two mortality indicators are diverging. However, recent HSMR results are showing slight improvement towards the 'as expected' banding.

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

Following a n external review by the North East Quality Observatory (NEQOS), no specific cause for the high HSMR, or concern about quality of care, has been identified.

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

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

Actions - NEQOS to present the findings to the Trust Board . Date is still to be confirmed liaison required with Trust Secretary to get this on the agenda and then it will be presented to the CCG

- 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.

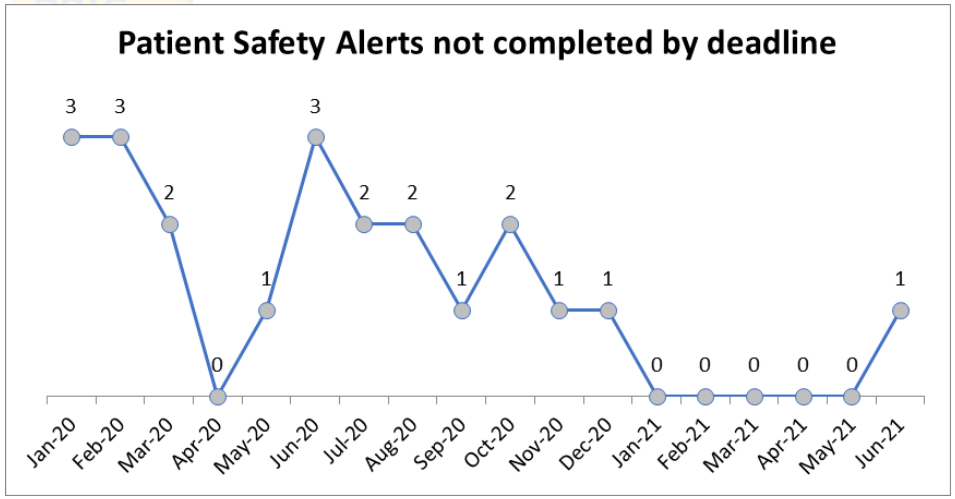
Recommendation - Continue to inform & note actions undertaken at Mortality and Morbidity steering group and Quality Governance Committee via the Integrated quality report and Mortality Paper.

Report by exception: 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 June 2021: Ongoing

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

Information regarding the existing LocSSIPs has been collated.
The progress of this safety alert was discussed at the Medicine Business Unit Safecare meeting in June and confirmation of compliance is awaited from the identified leads for the alert.

Recommendation

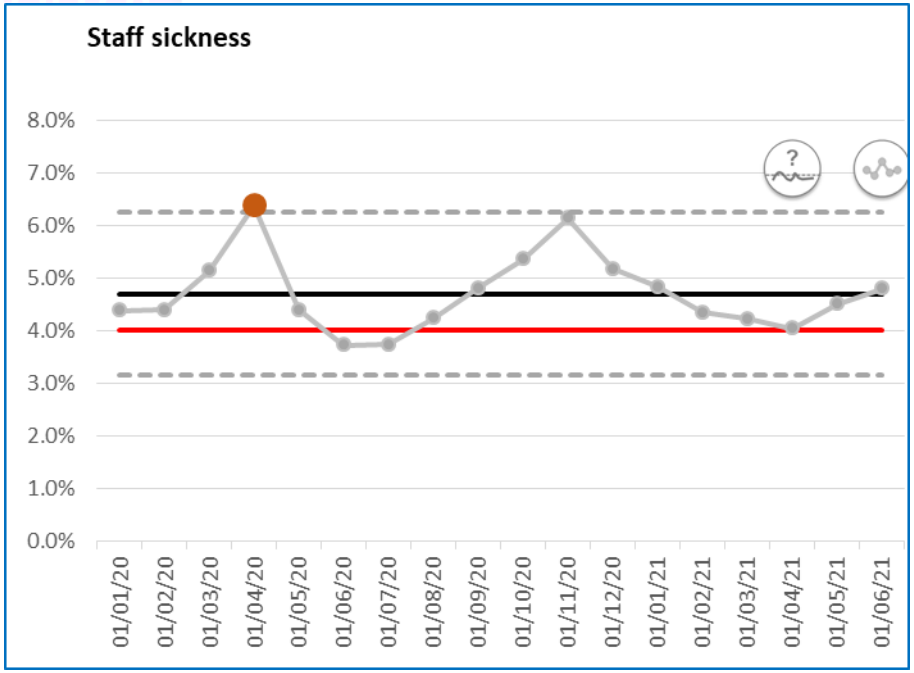
Discussion for information at Quality Governance Committee

Report by exception: Well led – Sickness Absence

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

Gateshead Health NHS Foundation Trust

Well Led



Combined impact analysis

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

Quality impact
No direct quality impact yet identified.

Workforce impact
Less workforce available.

Operational performance impact
No direct operational performance impact identified.

Situation Special cause variation is observed in April 2020 when the Trust's sickness absence rate was at 6.3%. Current performance of 4.8% 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. There have been increasing rates of sickness absence, Covid App track and trace absence, and the impact of different working arrangements on teams as a result of an increasing number of staff who have to care for children sent home from school as a result of Covid bubble isolation.

Assessment
It was positive that short term absence reduced and only operational Business Units had sickness absence rates over the 4% target for the month of May: Medicine & Elderly (6.42%) Community (4.67%) CSS (4.44%) and Surgical Services (4.43%). However absence rates have been increasing throughout June and this has placed extreme pressure on those remaining at work as a result.

Actions
A Workforce Cell has been stood up very recently to identify and implement urgent support to staff and services. There is a focus on Health & Wellbeing, Communication and the flexible deployment of staff. The HR helpline has been introduced and steps taken to manage absence from work due to the Covid 19 App and track and trace system. This will enable staff to return to work in as timely a manner as practicable and support colleagues and services. However pressure is expected to continue to build during the summer.

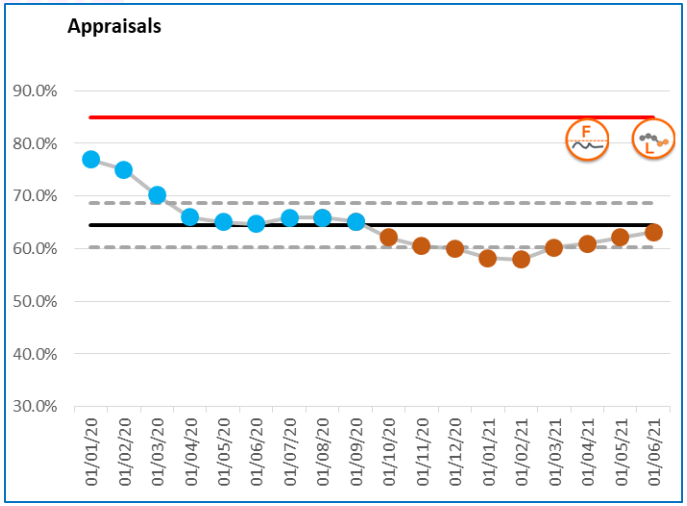
Recommendation
Continued scrutiny through HR committee

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 9 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. During the pandemic staff, understandably, did not have the time to carry out appraisals due to the increased volume of pandemic-response work.

Assessment

Compliance rates are monitored via ESR and reported to business units as part of the suite of workforce metrics that are produced. Current compliance is 62.1% against an 85% target representing an increase from 60.9% in April.

Actions

POD began distributing weekly reports to line managers in June, which provide the full details of staff who have outstanding Appraisals. The information can be used to monitor progress and inform decisions about undertaking staff appraisals in a fair and appropriate manger. In addition line managers are expected to use the reports to check and correct any inaccurate information in ESR, to ensure that the data reported is accurate.

Recommendation

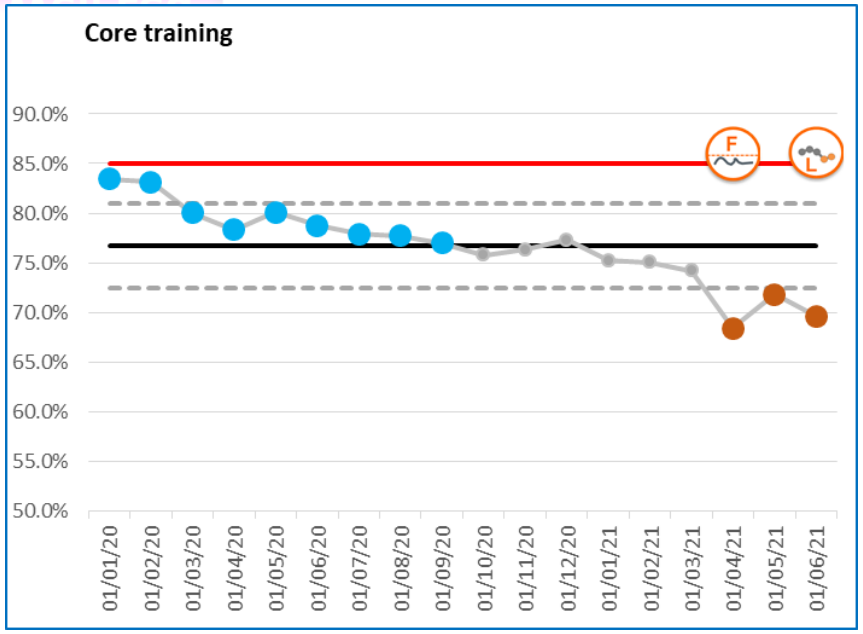
Continued scrutiny through HR committee and SMT

Report by exception: Well led – Core training

Gateshead Health NHS Foundation Trust

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

Well Led



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

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

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

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

Situation
A shift in core skills compliance is observed from September 2020 with special cause variation (low) triggering for the last 3 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 with a number of courses cancelled and social distancing has meant that it is still difficult to return to face to face delivery of training.

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 69.6% against an 85% target, an decrease from 71.8% in May.

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.

Recommendation
Continued scrutiny through HR committee and SMT .

Appendices

Reporting Changes

Introduction to SPC

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

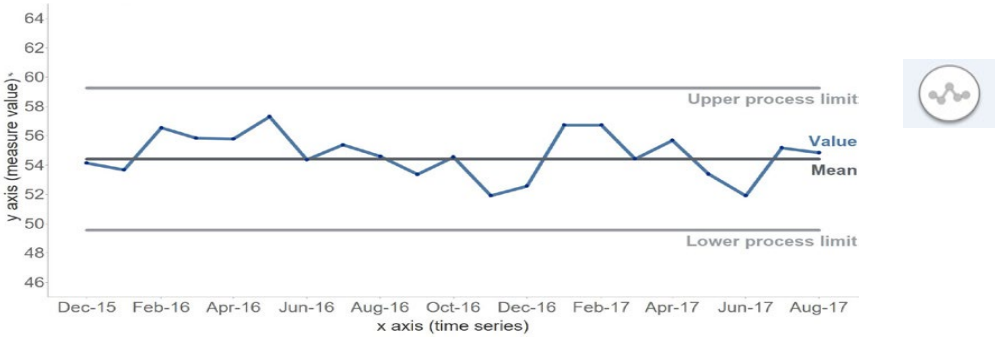
Gateshead Health NHS Foundation Trust

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'.

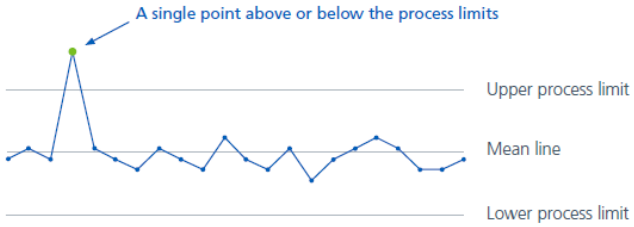
Integrated Oversight Report

Using SPC to identify special cause variation

Gateshead Health NHS Foundation Trust

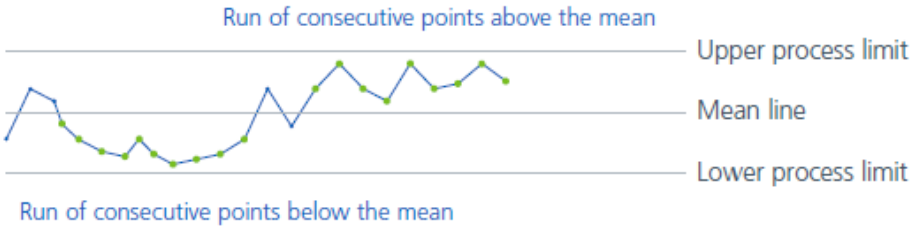
A single point outside the control limits

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.



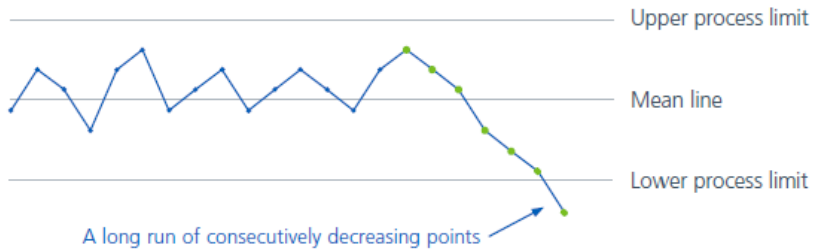
Consecutive points above or below the mean line

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.



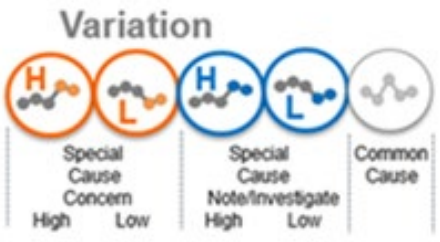
Integrated Oversight Report

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: 14

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Report Title:	**Healthcare Associated Infection (HCAI) Performance Report**			
Name of Meeting:	Trust Board			
Date of Meeting:	July 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 objectives for 2021/22 have not yet 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 2021/22 we note common cause variation in the rates of all mandatory reportable infections. For Q1 2021/22 there have been zero (**0**) norovirus outbreaks and zero (**0**) 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.			

<table>
<tr><td></td><td colspan="5">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. For Q1 2021/22 the Trust has identified– zero (0) indeterminate; two (2) probable and zero (0) definite hospital onset healthcare associated cases. GHNFT has reported zero (0) nosocomial COVID cases during April 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 objectives for 2021/22 have not yet 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 2021/22 we note common cause variation in the rates of all mandatory reportable infections.

For Q1 2021/22 there have been zero (**0**) norovirus outbreaks and zero (**0**) COVID-19 outbreaks.

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

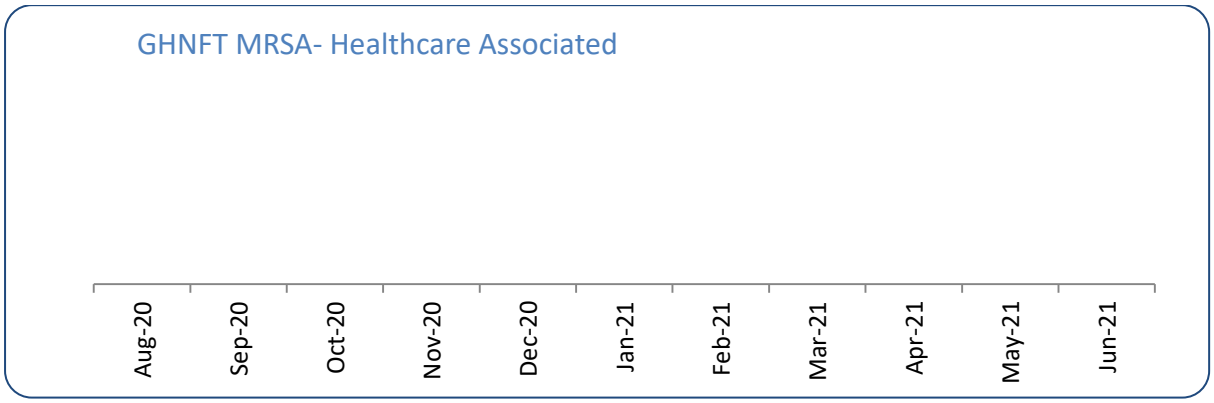
- Community-Onset – First positive specimen date <=2 days after admission to Trust;
- Hospital-Onset indeterminate Healthcare-Associated (HOIHA)– First positive specimen date 3-7 days after admission to trust;
- Hospital-Onset probable Healthcare-Associated (HOPHA) - First positive specimen date 8-14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

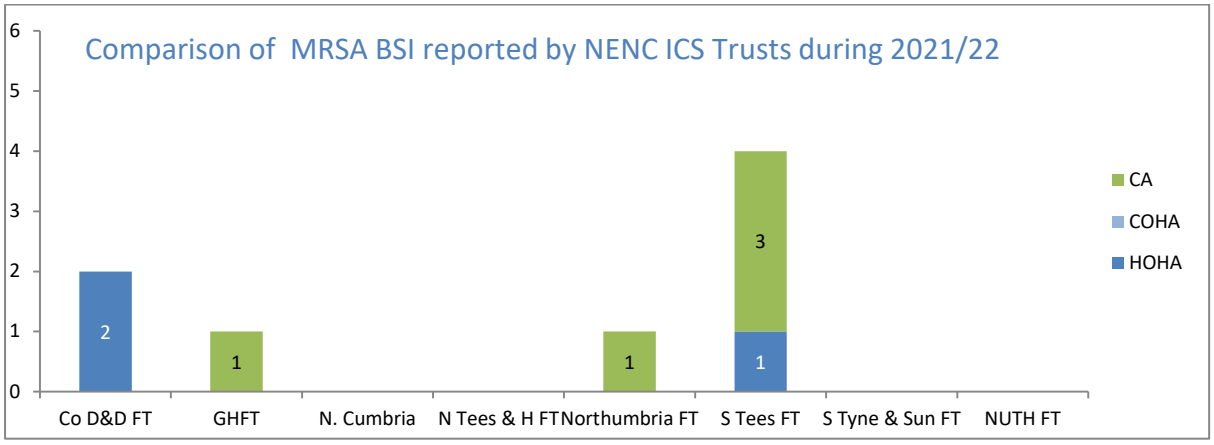
The Trust reports the number of COVID-19 positive in-patients via SitRep and investigates and reports all identified nosocomial COVID-19 cases and COVID-19 outbreaks. For Q1 2021/22 the Trust has identified– zero (**0**) indeterminate; two (**2**) probable and zero (**0**) definite hospital onset healthcare associated cases. GHNFT has reported zero (**0**) nosocomial COVID cases during April 2021

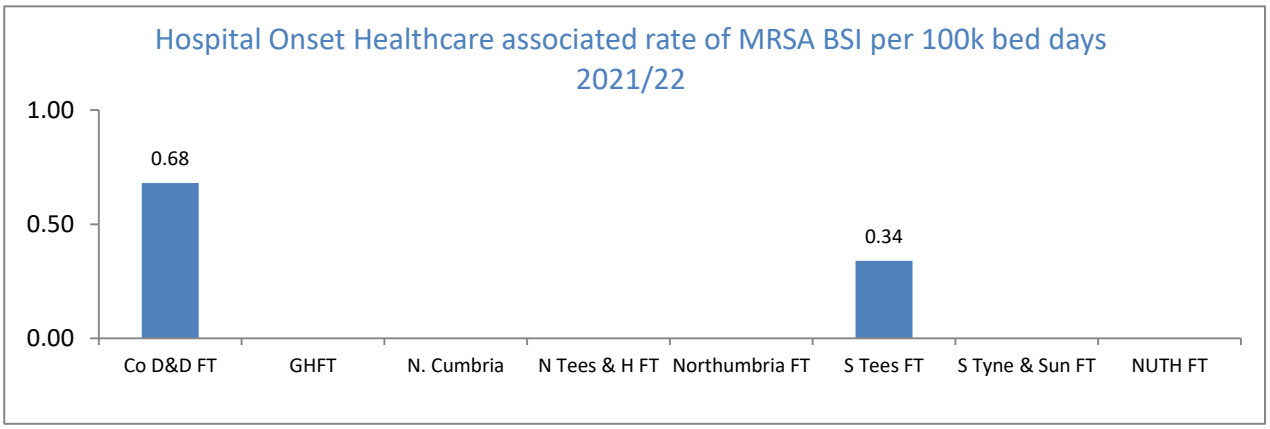
2.0 MANDATORY HCAI SURVEILLANCE

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

During Q1 2021 GHNFT has reported zero (**0**) healthcare associated MRSA BSI and one (**1**) community associated MRSA BSI.





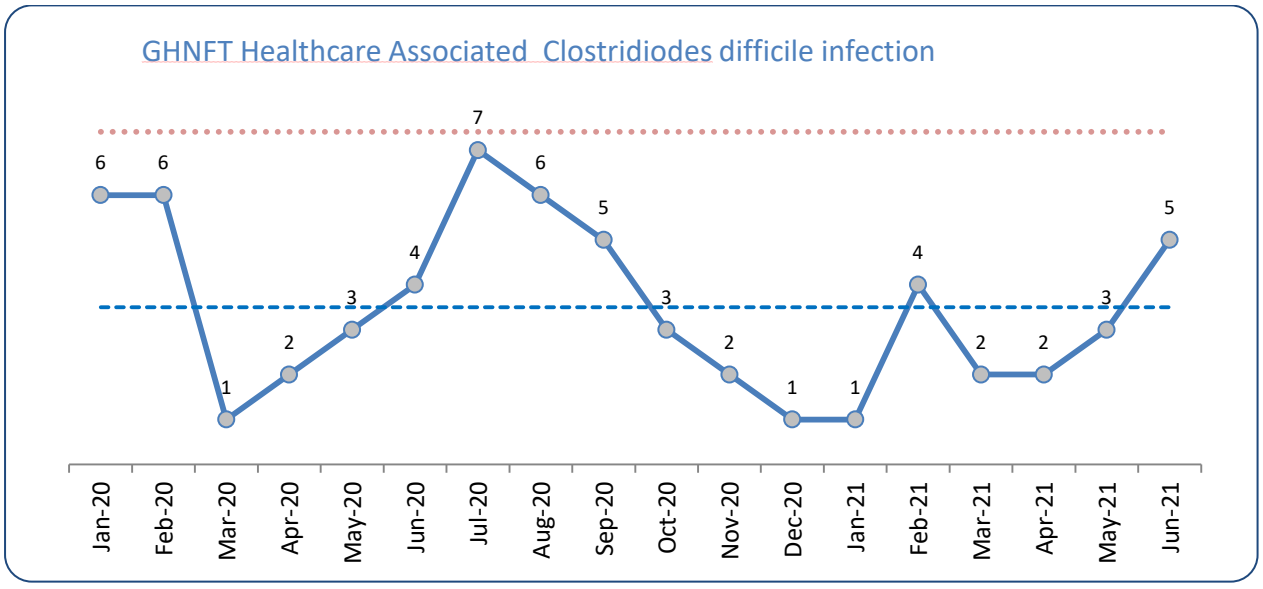


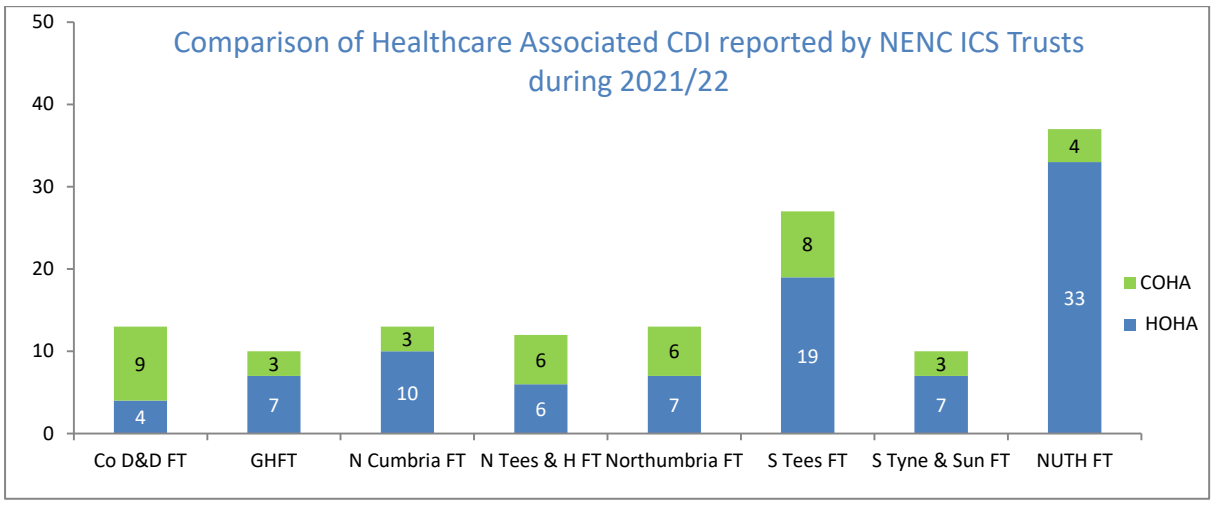
2.2 *Clostridioides difficile* Infection (CDI)

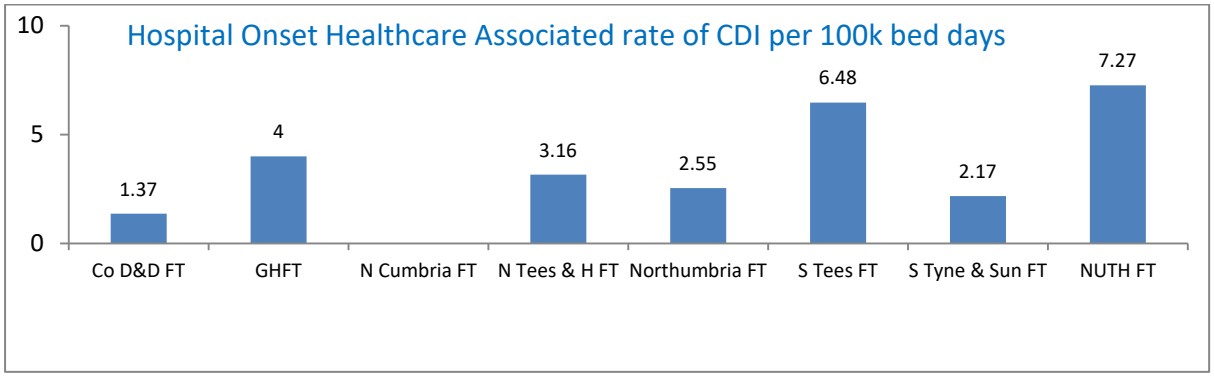
Clostridiodies difficile infection (CDI) is an unpleasant, and potentially severe or fatal infection that occurs mainly in elderly and other vulnerable patient groups, especially those who have been exposed to antibiotic treatment. Reduction of CDI continues to present a key challenge to patient safety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

From April 2020 the financial sanctions and the associated appeals process for CDI cases were discontinued.

For Q1 2021/22, GHNFT has reported ten (**10**) CDI healthcare associated samples, seven (**7**) hospital onset healthcare associated (HOHA) and three (**3**) community onset healthcare associated (COHA). These cases have been subjected to internal review and no lapses in care identified.

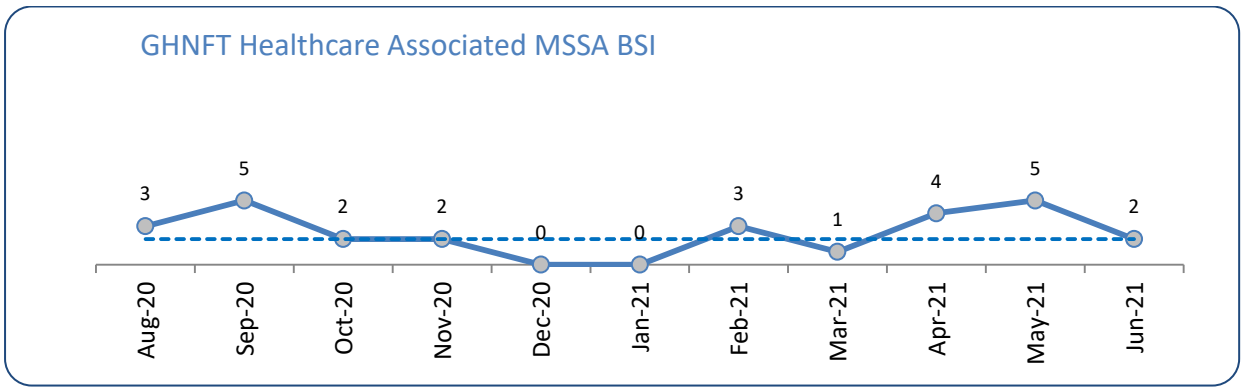


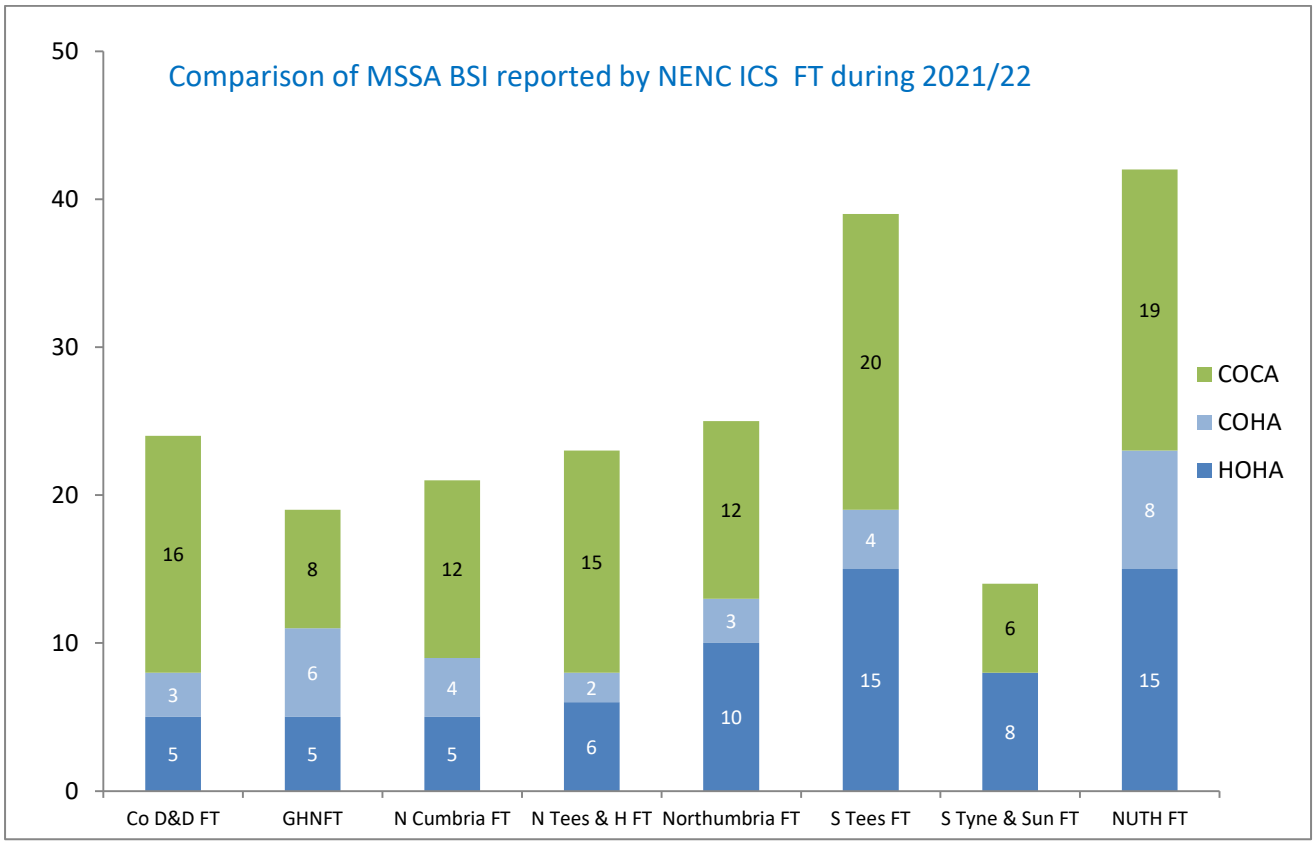


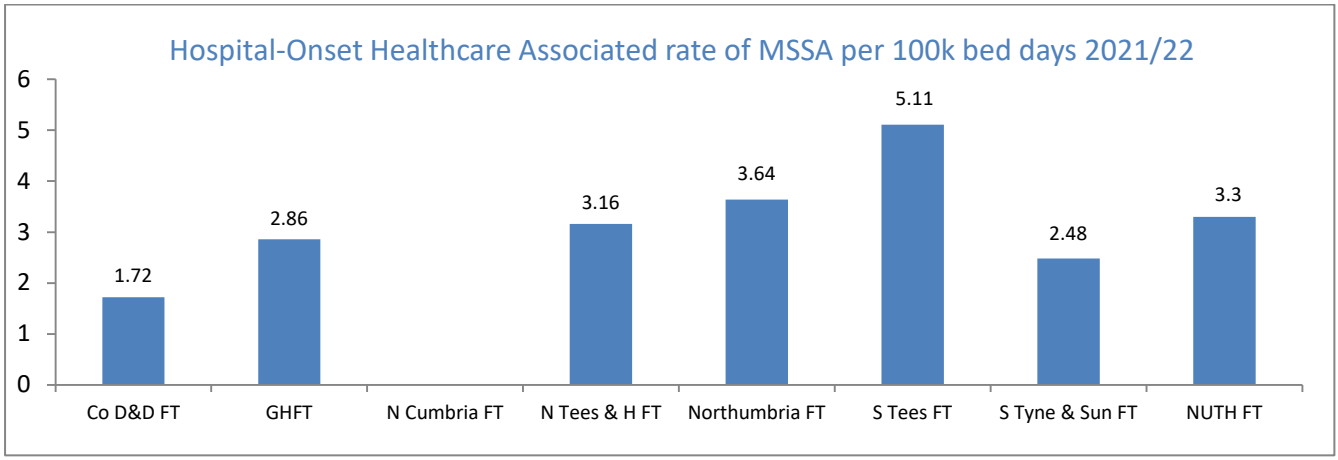


2.3 Meticillin Sensitive *Staphylococcus aureus* (MSSA) Blood Stream Infections (BSI)

For Q1 2021/22 GHNFT has reported eleven (**11**) healthcare associated MSSA BSI – five (**5**) HOHA and six (**6**) COHA - and eight (**8**) community associated cases.







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

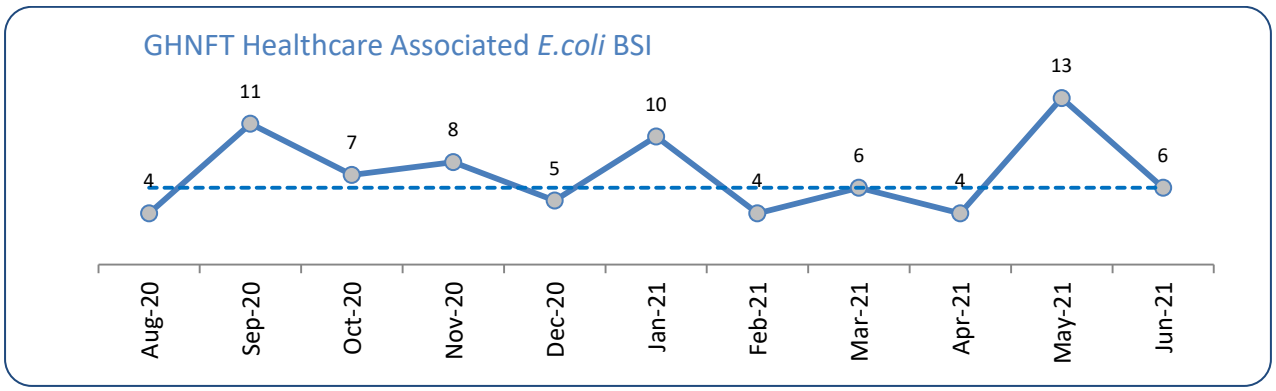
The anticipated Gram-negative BSI reporting objectives for 2021/22 have not been published.

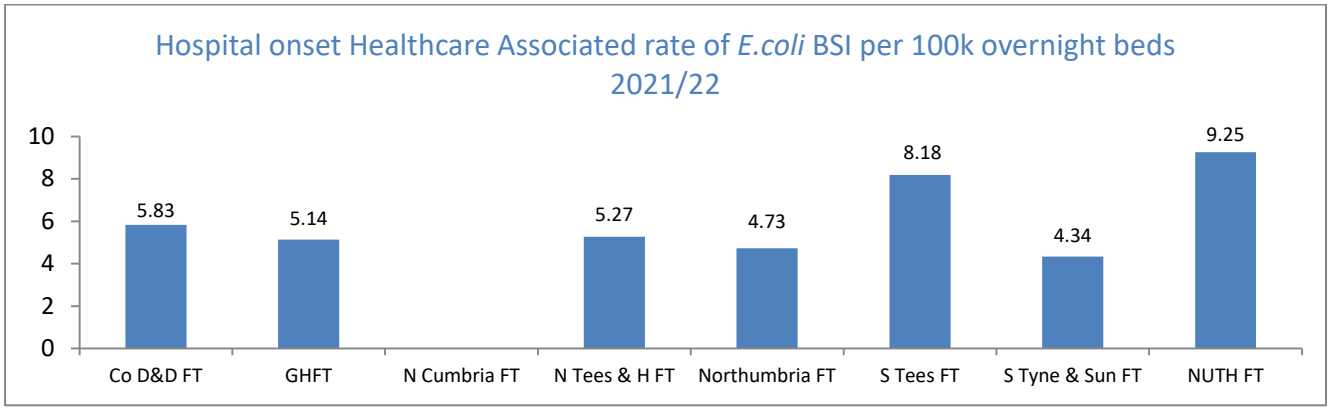
The following data representing *E. coli*, *Klebsiella* species and *Pseudomonas aeruginosa* blood stream infections (BSI) and demonstrate that the main proportion of BSI occur within the primary and social care environment.

3.1 Escherichia coli BSI (*E. coli*)

E.coli bacteria are frequently found in the intestines of humans and animals. There are many different types of E.coli, and while some live in the intestines quite harmlessly, others may cause a variety of diseases. E.coli BSI presents a huge challenge across the community and social care sector as well as within the hospital environment

For Q1 2021/22 GHNFT reported twenty three (**23**) healthcare associated E.coli BSI – nine (**9**) HOHA and fourteen (**14**) COHA – and forty (**40**) community associated cases.

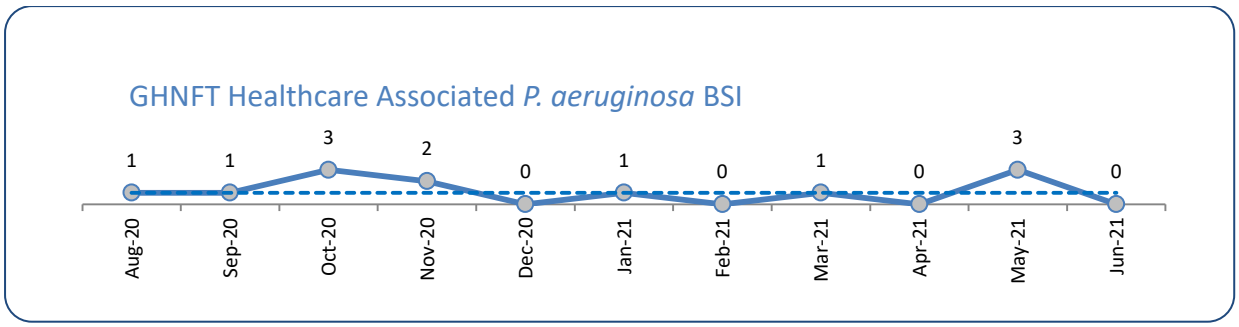


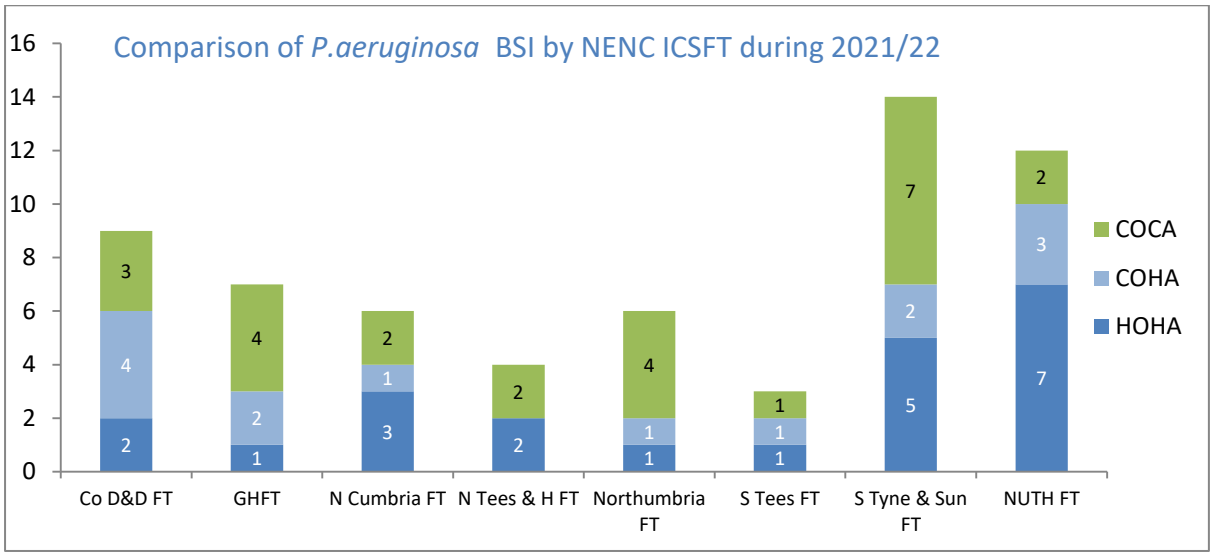


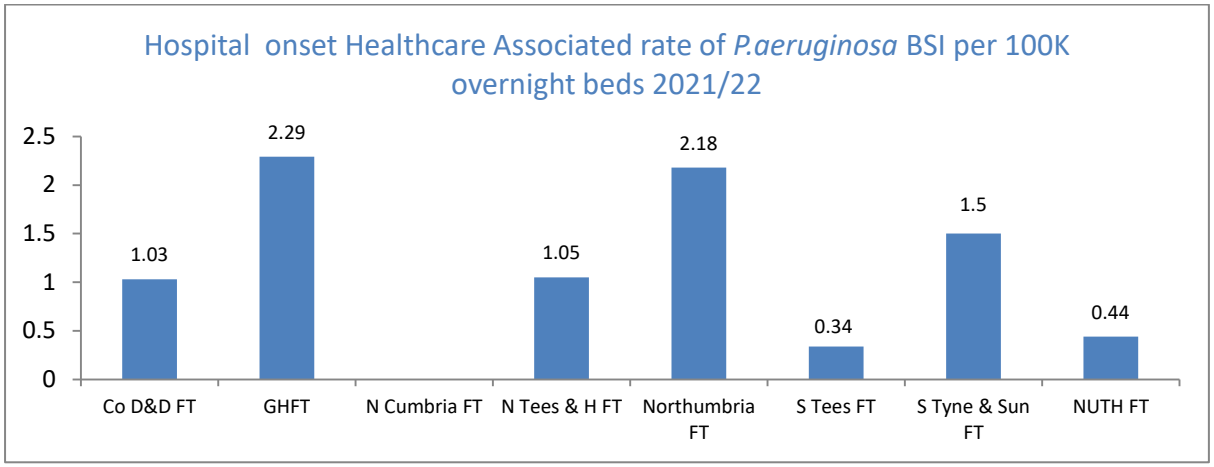
3.2 *Pseudomonas aeruginosa* BSI

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

For Q1 2021/22 GHNFT has reported three (**3**) healthcare associated *Pseudomonas aeruginosa* BSI - one (**1**) HOHA and two (**2**) COHA - and four (**4**) community associated cases.



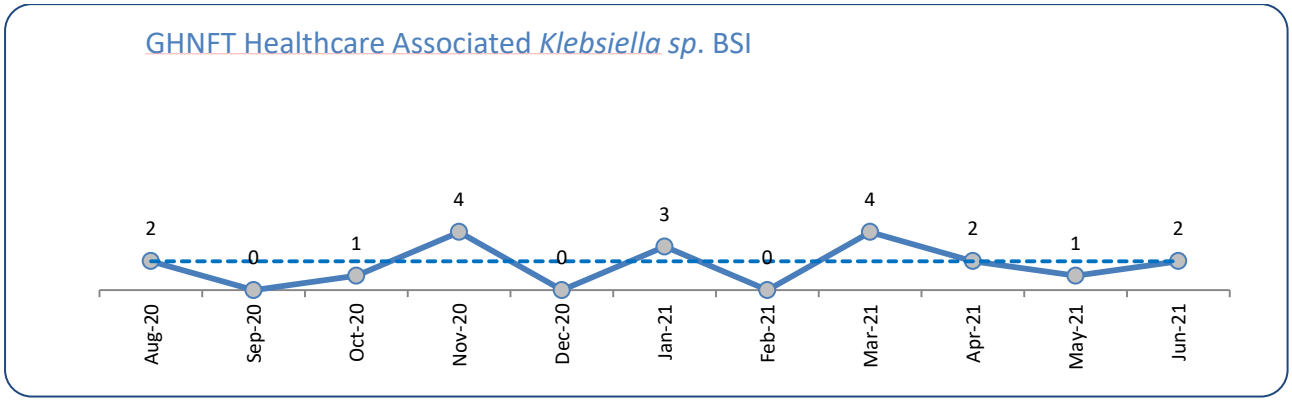


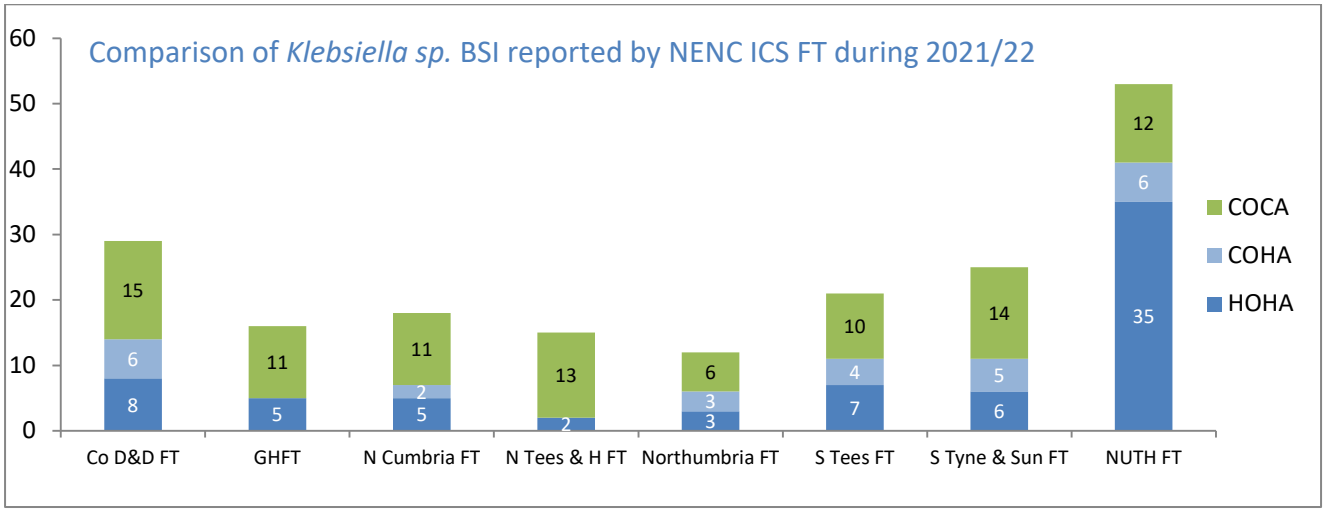


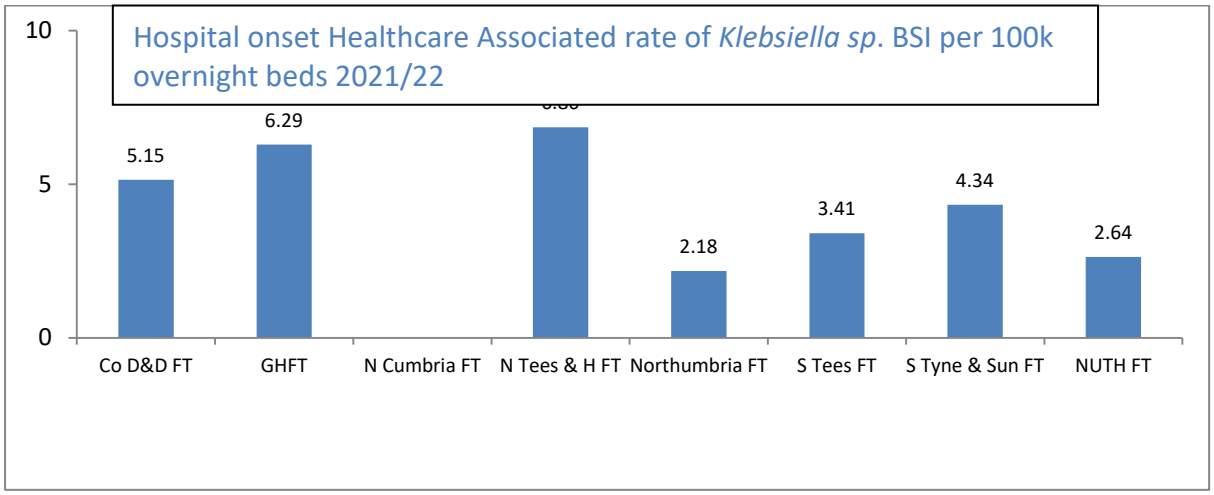
3.3 *Klebsiella species* BSI

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

For Q1 2021/22 GHNFT has reported five (**5**) healthcare associated *Klebsiella sp.* BSI – five (**5**) HOHA and zero (**0**) COHA – and eleven (**11**) 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**
HOiHA	**0**	**0**	**0**										**0**
HOpHA	**0**	**1**	**1**										**2**
HOdHA	**0**	**0**	**0**										**0**
Total	**0**	**1**	**1**										

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 zero (**0**) COVID outbreaks during Q1 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**									
21/22 Non clinical setting	**0**	**0**	**0**									
Total	**0**	**0**	**0**									

Louise Caisley
Head of Infection Prevention and Control