MEETING OF THE BOARD OF DIRECTORS IN PUBLIC

Gateshead Health NHS Foundation Trust

Date: Wednesday 27th July 2022
Time: 9:30 am
Venue: Rooms 9&10, Education Centre/Teams

AGENDA

	TIME	ITEM	STATUS	PAPER
1.	9:30 am	**Welcome and Chair's Business**		
2.	9:33 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 Company Secretary on receipt of agenda, prior to the meeting*	Declaration	Verbal
3.	9:35 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.	9:40 am	**Minutes of the meeting held on 25 May 2022** To be agreed as an accurate record	Agree	Enclosure 4
5.	9:42 am	**Matters Arising / Action Log**	Update	Enclosure 5
6.	9:45 am	**Patient & Staff Story** • Patient journey – Yvonne Ormston	Assurance	Presentation
		ITEMS FOR DECISION		
7.	10.00 am	**Provider Collaborative Operating Model** To approve the proposed governance structure, presented By the Managing Director for NENC Provider Collaborative	Approval	Enclosure 7
8.	10:15 am	**Standing Financial Instructions** To approve the amendment to the public procurement thresholds, presented by the Company Secretary	Approval	Enclosure 8
9.	10:20 am	**Board Assurance Framework 2022/23** To approve the new framework, presented By the Company Secretary	Approval	Enclosure 9
		ITEMS FOR ASSURANCE		
10.	10:30 am	**Assurance from Board Committees** i. Finance and Performance Committee – 24 May 2022, 28 June 2022 and 26 July 2022 (verbal) ii. Quality Governance Committee – 22 June 2022 iii. Digital Committee – 13 June 2022 iv. POD Committee – 5 July 2022 v. Audit Committee – 7 July 2022	Assurance	Enclosure 10
11.	10:50 am	**Chief Executive's Update Report** To receive a briefing report from the Chief Executive	Assurance	Presentation
12.	11:05 am	**Governance Reports** i. **Organisational Risk Register** To receive the reports presented by the Chief Nurse	Assurance	Enclosure 12
13.	11:15 am	**Finance Update** To receive the report, presented by the Group Director of Finance and Digital	Assurance	Enclosure 13
14.	11:25 am	**Integrated Oversight Report** To receive the report, presented by the	Assurance	Enclosure 14

		Chief Operating Officer, Chief Nurse, Medical Director and Executive Director of People and Organisational Development		
15.	11:40 am	**Nurse Staffing Exception Report** To receive the report, presented by the Chief Nurse	Assurance	Enclosure 15
16.	11:50 am	**Freedom to Speak Up Guardian Report** To receive the report, presented by the FTSU Guardian	Assurance	Enclosure 16
17.	12:00 pm	**WRES and WDES 6 Monthly Report** To receive the report, presented by the Executive Director of People & Organisational Development	Assurance	Enclosure 17
		ITEMS FOR INFORMATION		
18.	12:10 pm	**Cycle of Business** To receive the cycle of business outlining forthcoming items for consideration by the Board, presented by the Company Secretary	Information	Enclosure 18
19.	12:15 pm	**Questions from Governors in Attendance** To receive any questions from governors in attendance		Verbal
20.	12:30 pm	**Date and Time of the next Meeting** The next scheduled meeting of the Board of Directors to be held in public will be Tuesday 27th September 2022 at 9:30am		Verbal
21.	12:30 pm	**Chair Declares the Meeting Closed**		Verbal
22.	12:30 pm	**Exclusion of the Press and Public** To resolve to exclude the press and public from the remainder of the meeting, due to the confidential nature of the business to be discussed		Verbal

Trust Board

Minutes of a meeting of the Board of Directors
held at 9.30 am on Wednesday 25th May 2022, in
Rooms 9&10, Education Centre, Queen Elizabeth Hospital and via MS Teams

Present:	
Mrs A Marshall	Chair
Mrs J Baxter	Chief Operating Officer
Mr A Beeby	Medical Director
Dr R Bonnington	Non-Executive Director
Mrs L Crichton-Jones	Executive Director of People & OD
Cllr M Gannon	Non-Executive Director
Mr A Moffat	Non-Executive Director
Mrs Y Ormston	Chief Executive
Mrs H Parker	Non-Executive Director
Mrs M Pavlou	Non-Executive Director
Mr A Robson	Managing Director QE Facilities
Mr M Robson	Vice Chair / Non-Executive Director
Mrs A Stabler	Non-Executive Director
In Attendance:	
Mr N Black	Chief Information Officer (22/60)
Miss J Boyle	Company Secretary
Ms R Bridger	Hatching Ideas (22/41)
Mrs L Heelbeck	Head of Midwifery (22/61)
Mrs K Mackenzie	Operational Director of Finance
Mrs A Maskery	Strategy Lead (22/41)
Dr K Roberts	Deputy Director of Nursing, Midwifery & Quality
Ms D Waites	Corporate Services Assistant
Governors and Members of the Public:	
Mrs H Adams	Staff Governor
Mr J Bedlington	Public Governor - Central
Mr L Brown	Public Governor - Western
Mr S Connolly	Staff Governor
Mr A Dougall	Public Governor – Eastern
Dr A Lowes	Staff Governor
Mrs A Kanyangu	Public Governor – Patient/Out of Area
Mr R Morrell	Staff Governor
Ms M Ndam	Staff Governor
Mr M Gill	NHS Providers (observing the meeting)
Member of the public	
Apologies:	
Mrs J Bilcliff	Group Director of Finance & Digital / Deputy Chief Executive
Mrs G Findley	Chief Nurse
Dr M Sani	Associate Non-Executive Director (NExT Placement)

Agenda Item	Discussion and Action Points	Action By
22/35	**CHAIR'S BUSINESS:** The meeting being quorate, Mrs A Marshall, Chair, declared the meeting open at 9.30 am and confirmed that the meeting had been convened in accordance with the Trust's Constitution and Standing Orders.	

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	She welcomed Mr M Gill, NHS Providers, who is observing the Board as part of the Board Development Programme, as well as the Trust's Governors and members of the public.	
22/36	**DECLARATIONS OF INTEREST:** Mrs A Marshall requested that Board members present report any revisions to their declared interests or any additional declaration of interest in any of the items on the agenda.	
22/37	**APOLOGIES FOR ABSENCE:** Apologies for absence were received from Mrs J Bilcliff, Mrs G Findley and Dr M Sani.	
22/38	**MINUTES OF THE PREVIOUS MEETING:** The minutes of the meeting of the Board of Directors held on Monday 30 March 2022 were approved as a correct record.	
22/39	**MATTERS ARISING FROM THE MINUTES:** The Board action log was updated accordingly and there were no additional matters arising from the minutes.	
22/40	**PATIENT AND STAFF STORY – ORGAN DONATION** The Board welcomed Dr A Lowes, Clinical Lead, who provided a presentation on Gateshead organ donation activity for 2021-2022 which included key quality and performance indicators, actions within the Trust over the past year and future plans. He highlighted that during 2021/22, the Trust facilitated 5 organ donors resulting in 12 patients receiving a life-saving or life-changing transplant. Funding has also been approved for memory boxes and comfort bags for relatives. He reminded the Board that Organ Donation Week takes place from 19th to 25th September 2022 this year and educational days for nursing staff in critical care and accident and emergency will be taking place. Plans are also in place to design and construct an organ donation memorial within the hospital grounds which will be accessible to all families of donors and a competition between local schools and colleges to design the memorial will take place and will be judged by a panel consisting of governors, clinical and non-clinical staff.	

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	Dr Lowes thanked Mrs A Stabler, Non-Executive Director, for her involvement in the working group and she highlighted that an update will be provided within the six-monthly mortality report going forward. It was noted that work will be undertaken to promote organ donation and share some of the positive outcomes that this has facilitated. Mrs Marshall thanked Dr Lowes for his presentation and also thanked all those involved in the work around organ donation.	
22/41	**TRUST STRATEGY 2022/23 – 2024/25** Ms R Bridger and Mrs A Maskery, presented the Trust Corporate Strategy and Behaviours Framework which have been developed through extensive engagement and consultation with 450 stakeholders including colleagues throughout the Trust, external partners, Senior Management Team, Council of Governors and Board of Directors. Ms Bridger highlighted that the Corporate Strategy maintains the five strategic aims that were in place during 2021/22 and the existing ICORE (Innovation, Care, Openness, Respect and Engagement) values, which continued to resonate with stakeholders, and identifies three key areas for strategic focus – patients, people and partners. Following a query from Mrs Y Ormston regarding the appointed Engagement Champions, Ms Bridger reported that these roles will continue, and will be a useful network going forward. Ms Bridger reported that the engagement from staff had been positive and they had demonstrated pride in their work, whilst also recognising the challenges faced during the pandemic. It was felt that it was important to continue this engagement with staff. Mrs A Stabler requested further information on measurements of success and how this would be reported back to the Board. Mrs Ormston reported that progress would be measured via the Corporate Objectives. Enabling strategies, such as the innovation strategy, would be aligned with the Corporate Objectives and support their achievement. Mrs J Baxter agreed that the engagement of staff was important and recognised how this results in better patient outcomes. She felt that it was important to demonstrate how staff have contributed to the delivery of the Strategy and Ms Bridger explained that staff engagement could be used effectively to bring the Corporate Strategy to life. Board Members reflected on the vision and whether this was aspirational enough. It was agreed that it was appropriate for the current time. The Board thanked everyone involved in the work and felt that it was important to maintain and embed a long-term future focus. After further consideration, it was:	

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	RESOLVED: to approve the Trust Corporate Strategy and Behaviours Framework. Ms Bridger and Mrs Maskery left the meeting.	
22/42	**TRUST OBJECTIVES 2022/23** Mrs Y Ormston, Chief Executive, presented the final version of the Trust Corporate Objectives for 2022/23 following the strategy session on the 27th April 2022 to discuss and review the draft Corporate Objectives and approach for 2022/23. She reminded the Board that one of its key roles is to set strategic aims and objectives for the organisation and to hold the organisation accountable for the delivery of these. The Board Assurance Framework (BAF) is a tool through which risks to the achievement of the corporate objectives of the organisation are managed by the Board committees and detailed action plans will be developed by each committee to ensure the delivery of these objectives. Mr M Robson felt that it may be beneficial to review the Committees terms of reference to ensure the relevant objectives and key topics have been identified. Miss J Boyle highlighted that topics such as health inequalities were not currently included in the terms of reference and therefore a review of Committee terms of reference and cycles of business would be conducted and come back to the Board for ratification. Following a query from Mr A Moffat regarding reporting back to Board and key performance indicators, Mrs Marshall confirmed that the Non-Executive Director Committee Chair and Executive Lead will ensure objectives are progressed through the Committee and a report will be presented to the Board on a quarterly basis. Miss Boyle confirmed that this already featured within the Board's cycle of business. Mrs L Crichton-Jones drew attention to Objective 2.3 - Development and Implementation of a Culture Programme and felt that it was important to also include recruitment within the detailed description of this objective. Following a query on next steps, it was clarified that Executive Leads should develop realistic detailed plans with timescales for the delivery of the objectives, in consultation with Committee chairs. After further discussion, it was: **RESOLVED:** i) to approve the Corporate Objectives and process for development of detailed action plans and monitoring arrangements via the allocated Board Committee ii) to agree that the Board Assurance Framework be developed via each Board Committee and be	JBoy JBoy

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	presented to July 2022 Board meeting for formal approval	
22/43	**ASSURANCE FROM BOARD COMMITTEES** **Finance and Performance Committee:** Mr M Robson, Chair of the Finance and Performance (F&P) Committee, noted that the Board had been appraised verbally of the key points from the March F&P meeting at the March 2022 Board of Directors' meeting which included the escalated issues relating to delayed discharges and the supply procurement report. Mr Robson also drew attention to the written assurance report relating to the extraordinary meeting which considered the financial plan submission prior to the extraordinary Board meeting in April 2022. He provided a verbal update from the meeting which took place yesterday (24th May 2022) and highlighted that there was one item for escalation which related to delayed discharges reported via the Integrated Oversight Report. He explained that poor performance figures had been reported within the emergency department relating to high trolley waits and high bed occupancy rates alongside continued staffing issues. The Trust and North Cumbria have been identified as outliers relating to delayed discharges and as a result the Integrated Care Board have instigated an external review. A regional bed review is also commencing. Mr Robson also highlighted the following key points: • QE Facilities (QEF) 6 monthly report – partial assurance provided. Further information has been requested in relation to the mask production and a report will be provided to the QEF Board. Some issues have also been identified in relation to Tyneside Surgical Services (TSS) and the proposed new business opportunity and it was felt that further consideration is required to consider the implications of this. Quarterly reports on QEF performance have now been requested. Following a query from Mrs M Pavlou regarding commercial decisions between the Trust and QE Facilities, Mr A Robson explained that the QEF Board works closely with the Trust Board and delegated authorities are in place to ensure discussions and decisions are considered in detail. He explained that a report will come back to the Board regarding TSS. • Month 1 Finance Report – a verbal report was provided and discussion took place around the continued staffing pressures resulting in high agency spend. Issues have also been raised in relation to elective recovery activity which had been collated manually. Trusts have been asked to resubmit plans to address pressures and inflation by 8th June 2022. Mrs Marshall queried whether this needed to come back to Board for approval however Mrs Mackenzie explained that she was awaiting feedback from discussions at the Integrated Care Board later today.	AR

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	• Supply Procurement Committee report – the review is being expanded and AuditOne are undertaking a best practice benchmarking exercise. **Quality Governance Committee:** Mrs M Pavlou, Non-Executive Director, chaired the last Quality Governance Committee meeting on 20th April 2022 on behalf of Mrs A Stabler. It was reported that there were no items for escalation however noting the main discussion that took place was around the Ockenden work and an in-depth report will be presented later in the meeting. Mrs Stabler highlighted that the Committee acknowledged that there had been no serious incident reports received in relation to maternity. **Digital Committee** Mr A Moffat, Chair of the Digital Committee, provided a brief verbal overview to accompany the narrative report and highlighted that an in-depth digital report will be presented later in the meeting. He noted that there were no specific matters to escalate to the Board however the following key points were discussed: • The Global Digital Exemplar (GDE) Programme closure report was accepted following approval and endorsement by NHS Digital. A rating of fully assured was awarded. • Key Performance Indicators – some concerns were raised in relation to the roll out therefore further work is taking place and a progress report will be presented at the next meeting. • An external cyber review is taking place and partial assurance was given as the related report and recommendations are yet to be received. **People and Organisational Development (POD) Committee** Dr R Bonnington, Chair of the POD Committee, provided a brief verbal overview to accompany the narrative report. She advised that there were no items to escalate to the Board however main discussions took place around workforce supply. A presentation was provided at the meeting highlighting the key areas of focus within each of the 'Heads of' portfolios and Dr Bonnington highlighted that the Committee were partially assured, understanding a recovery plan is required for core skills and appraisals. Mrs Marshall thanked the Committee Chairs for their reports and felt that these highlight the important issues regarding performance and staffing for the Board to consider for the rest of meeting. After consideration, it was: **RESOLVED**: to receive the reports for assurance	
22/44	**CHIEF EXECUTIVE'S UPDATE REPORT** Mrs Y Ormston, Chief Executive, gave a verbal update to the Board on the current issues:	

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	Operational Performance: Mrs Ormston drew attention to the key pressures reported during March and April in particular bed capacity and staffing issues. She reported that work continues to protect elective beds and monitor waiting lists. During this time, Covid patients rose to 100 however this has been reducing slowly and there are currently approximately 40 patients within the Trust. Pressures continue in relation to delayed discharges and the issues around domiciliary care capacity therefore this continues to impact on patient flow. Mrs Ormston felt that the Trust was performing well against the regional benchmarking report which indicates similar issues. **Recruitment** There remains a significant focus on recruitment following the detailed discussions at the last Board Strategy Session and a lot of programmes of work are underway. The Staffing Task and Finish Group are meeting fortnightly to progress these. **Equality, Diversity and Inclusion** Mrs Ormston reported that the Workforce Race Equality Standard (WRES) for 2021 was published in April and the Trust features in the top ten best performing trusts for 2 indicators. Mrs A Stabler reported that Annie Topping, NHS England, is leading on the WRES work and recently visited the Trust and felt that the staff were fully engaged in taking the work forward. **Provider Collaborative Development/ICS Framework** Mrs Ormston reported that the focus remains on elective recovery and diagnostic workstreams. Further appointments to the Integrated Care Board have been made and a development session for the Provider Collaborative and Integrated Care System will be taking place this week. Consultation on the Operating Model continues and will come to the Board for comment. The Board noted the update provided including the significant pressures and after further discussion, it was: **RESOLVED:** to receive the update for assurance.	
22/45	**GOVERNANCE REPORTS** **Organisational Risk Register (ORR)** Dr K Roberts, Deputy Director of Nursing, Midwifery and Quality, presented the updated ORR to the Board, noting that it had been subject to monthly scrutiny at the Executive Risk Management Group (ERMG). She highlighted that this report covers the period 12 March to 17 May 2022 and since the last report two risks have been closed. One risk has been escalated relating to the Trust's maternity estate and the potential impact on services. It has been noted that whilst plans to address some of the risk relating to the estate are being progressed, the recent release	

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	of Ockenden 2 requires a gap analysis to identify and consider any additional considerations. Mrs A Stabler highlighted that work is ongoing and further details will be provided within the Ockenden Report later in the meeting. After further discussion, it was: **RESOLVED:** to receive the report for assurance.	
22/56	**FINANCE UPDATE:** Mrs K Mackenzie, Operational Director of Finance, provided the Board with a summary of performance as at 31 March 2022 (Month 12) for the Group (inclusive of Trust and QE Facilities, excluding Charitable Funds). Mrs Mackenzie reported that for the period April to March, the Trust has reported a revenue surplus of £14.214m after adjustments for donated assets and gain/losses of asset disposal. This is an increase of £3.903m from the reported February surplus. For the same time period, the Trust has spent £13.274m of its capital programme, £1.3m below its forecast outturn of £14.573m. She highlighted some of the capital schemes including the surgical robot which will benefit patients and staff. Mr M Robson highlighted that discussions took place at the meeting around the positive staff benefits and a full capital report will be presented at the next meeting. Mrs A Marshall reminded the Board of the Annual Accounts submission timetable and highlighted that the Audit Committee will consider the accounts on 17 June 2022 prior to approval by the Board at the Extraordinary Board meeting on 20 June 2022 with the final submission date being 22 June 2022. The Board discussed the challenges moving into the next financial year and Mrs L Crichton-Jones felt that it was important to support managers with this. After further discussion, it was: **RESOLVED:** to receive the report for assurance and note the risks highlighted.	
22/57	**INTEGRATED OVERSIGHT REPORT:** Mrs J Baxter, Chief Operating Officer, introduced the Integrated Oversight Report (IOR) for March and April 2022. The paper has been	

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	discussed and received in-depth scrutiny by the various Board Committees. Mrs Baxter highlighted that April has been a difficult month and this has impacted on all performance and workforce targets. She reported that bed occupancy rates and trolley waits have been high and at one stage during the month, the full bed capacity protocol was enacted. Activity levels are below the planned 104% however plans are in place to recover this. There has been a deterioration in cancer waits with the biggest delays in gynae and urology however the Trust has a shared pathway with Newcastle and plans are in place to reduce waiting times. Discussions continue to take place within the Integrated Care System and a joint post is planned. There are also plans to re-visit the work carried out by the Emergency Care Improvement Support Team (ECIST) and review the operating model. Following a query from Mrs M Pavlou regarding delayed discharges, Mrs Baxter reported that this relates to social care issues however new domiciliary providers are planned to begin next week and discussions continue with the Local Authority. Mr M Robson raised a query on the impact of patients remaining in hospital longer than required and Mrs Baxter reported that there is evidence that this has an adverse effect on other conditions therefore being able to undertake assessments at home is beneficial to better understand required care packages. Mrs A Stabler highlighted that the Trust is still reporting OPEL level 3 during May and queried what impact this was having on quality and safety including staff. Mrs Baxter explained that there has been a significant impact on staffing levels therefore the de-escalation of additional beds is required as soon as possible. Mrs Stabler sought assurance that patient privacy and dignity was being maintained, and this was confirmed. Discussions are taking place in relation to transformation plans around the discharge process and the QEF transport team have been assisting with the surge on a short term basis. Mrs Stabler also queried the open patient safety alert highlighted within the report and Dr K Roberts explained that this will be closed off by the Patient Safety Team. The Board discussed the pressures on staff and Mrs Baxter explained that similar pressures were also being experienced across the region however protocols are in place and work continues with the Local Authority to review barriers to discharge. Mrs Ormston highlighted the importance of timely discharge to enable the closure of escalation beds to improve pressures on staff. Mrs Baxter reported that there have been improvements during the last few months and risks are being monitored via DATIX. Mr A Moffat recognised that the pressures on staff is not sustainable and sought assurance that alternatives for onwards care were being reviewed. Mrs Ormston emphasised that options were being explored including a Health and Social Care Academy and apprenticeship schemes. Mrs Baxter also highlighted that the Hospice at Home team	

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	has recently been expanded to further support discharges however long-term plans were required and a joint session with the Local Authority is planned. Dr Roberts reported that the extension of volunteering services is being looked at to support non-clinical teams. Mrs L Crichton-Jones reiterated that workforce supply including recruitment and retention is a top priority and this will be looked at via the People and OD Committee. A listening space for staff is being launched, which will provide a safe space for colleagues. Mrs M Pavlou queried whether there are any examples of best practice that the Trust could learn from. She also queried whether support could be given to families to provide them with the skills and knowledge to be able to care for their relatives at home, facilitating discharge, Mrs J Baxter confirmed that work is ongoing to support families and she also reported that the Trust is linking with County Durham and Darlington NHS Foundation Trust as they successfully resolved delayed discharge issues previously. The Board acknowledged the work being undertaken to address the pressures impacting on the Trust's performance and after consideration, it was: **RESOLVED:** to receive the report for assurance.	
22/58	**NURSE STAFFING ANNUAL CAPACITY AND CAPABILTIY REPORT INCLUDING MONTHLY EXCEPTION REPORT:** Dr K Roberts, Deputy Director of Nursing, Midwifery and Quality, presented the report which provides assurance to the Board on staffing, capacity planning and capability. She reported that the staffing establishments for the acute medical wards and emergency assessment areas have been reviewed using the safer nursing care staffing tool (SNCT) and is undertaken every 6 months. The use of SNCT has shown that the majority of wards have an appropriate level of staffing when all posts have been recruited to however Dr Roberts highlighted that wards are feeling ongoing pressure due to supply gaps therefore a review of staff absences has been undertaken and it is recommended that this requires an increase. She reported that a business case is being developed and this will be presented to the Senior Management Team for approval. Dr Roberts highlighted that the Trust is currently testing a tool for emergency department staffing and for community nursing and once the quality metrics are available, a paper will be presented to the Board for review. The Board also reviewed the exception report for April and recognised the continuing challenges. Dr Roberts explained that a staffing escalation protocol is now in operation across all areas and ongoing	GF/KR

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	concentrated work continues within the safe staffing Task and Finish Group to review staffing establishments, recruitment, managing sickness absence, recording and escalation of staffing challenges. Regular updates are shared with the Executive team. Following a query from Mrs Baxter in relation to whether agency usage was included in fill rates, Dr Roberts explained that some are included however this is reliant on whether this has been input onto Health Roster. She highlighted that this is being picked up in the Task and Finish Group to ensure fill rates include agency, overtime and bank hours. Mrs A Stabler, was assured by the levels of no harm however requested further understanding around low harm and Dr Roberts explained that this related to where patient care needs may be delayed however highlighted that this is difficult to quantify. She reported that this information is triangulated to identify unintended consequences. After consideration, it was: **RESOLVED:** to receive the report for assurance and note the work being undertaken to address the shortfalls in staffing	
22/59	**LEARNING FROM DEATHS 6 MONTHLY REPORT:** Mr A Beeby, Medical Director, provided an update on Mortality and Learning from Deaths over the last six months. This report was presented and discussed at the last Quality Governance Committee. Mr Beeby reported that the Trust's latest published SHMI (Summary Hospital-level Mortality Indicator) for November 2020 to October 2021 is 1.04 placing the Trust with the banding of deaths 'as expected'. The HSMR (Hospital Standardised Mortality Ratio) for Gateshead in the last 12 months (February 2021 to January 2022) is 115.9 placing the Trust with 'more deaths than expected' as calculated by the model however he asked the Board to recognise the need to triangulate all the information from the Medical Examiner work, mortality reviews, mortality alerts, Serious Incidents and complaints feedback. Mr Beeby explained that an increase in congestive heart failure crude mortality observed by the HSMR and by the Medical Examiner is influencing the HSMR and therefore the Trust has undertaken additional reviews. Mrs L Crichton-Jones highlighted the importance of learning and queried how this was fed back to teams and practitioners. Mr Beeby explained that themes are picked up at the Mortality and Morbidity Council and they ensure that they are reviewed by the relevant teams. Following further discussion, it was:	

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	RESOLVED: to receive the report for assurance.	
22/60	**SENIOR INFORMATION RISK OWNER REPORT AND DIGITAL UPDATE:** Mr N Black, Chief Digital Information Officer, provided an update on progress against the digital roadmap for the Trust and the clinical systems options outline business case, together with the Senior Information Risk Owner (SIRO) Annual Report. Mr Black informed the Board that NHSX has formally accredited the Trust as a 2022 digital leader after successfully fulfilling its commitments as part of the Global Digital Exemplar Programme. He also provided an update on progress against the digital roadmap for the Trust and the clinical systems options outline business case and highlighted some of the key achievements over the last 6 months both clinically and operationally, together with some of the assurances that have been provided to the Digital Committee. The SIRO report highlights that there has been some slippage of targets due to vacancy pressures and Mr Black drew attention to the main areas of risk which includes: • Malware such as ransomware compromising unpatched endpoints, servers, and equipment • System or technology change • Failure to manage information assets Mr Black reported that there have been 508 external attempts to access the Trust network and it therefore requires continuous system updates. Mr M Robson queried whether more publicity should be in place to highlight that protective software systems are working. Mr Black reported that the National Security Centre raises awareness and mitigations are then put in place however it remains a risk. Mr A Moffat felt that this links with the key performance indicators and overall strategic aims of the Digital Committee. The Board discussed the work around the outline business case to support further investment in Gateshead's Electronic Patient Record and Mrs Marshall requested further information on timescales. Mr Black explained that the final draft is expected to be shared at the Clinical Policy Group and Digital Transformation Group in June 2022 to ensure full clinical ownership and technical assurance of any decision. This will also feed into the refresh of the Digital Strategy which will be undertaken following the roll out of the new Trust Strategy and Vision. Mrs Ormston highlighted that discussions are taking place at ICS (Integrated Care System) level and some funding opportunities should be available. Mr M Robson felt that it was important to have clinical buy-in however wider engagement was also required and Mrs Ormston reported that	

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	wider teams were being engaged via the strategy work. Mrs A Stabler also felt that it was important to consider members of the community who do not access technology and ensure that they are supported to access services. Mr Moffat felt that it would be beneficial to have more in-depth discussions around timelines, etc and Miss J Boyle will look at planning this into a future Board Strategy Session. Following consideration, it was: **RESOLVED:** to receive the report and support the ongoing assurance through the Digital Committee Mr Black left the meeting.	JBoy
22/61	**OCKENDEN 2 UPDATE REPORT:** Mrs L Heelbeck, Head of Midwifery/Special Care Baby Unit, presented the report and informed the Board that the final Ockenden report was published in March 2022. Since then, the maternity team have performed a full gap analysis against each of the 15 immediate and essential actions (IEAs) within the service. Mrs Heelbeck explained that this will form part of the maternity services quality improvement strategy going forward and is aligned to the four key pillars: • Safe staffing levels • A well-trained workforce • Learning from incidents • Listening to families She drew attention to the key recommendations following the gap analysis and highlighted that the main risk identified relates to safe staffing, particularly the effect of covid absence and isolation combined with whole time equivalent (WTE) vacancies and the inability to recruit. A full nursing and midwifery service staffing review is currently underway including the review of the Midwifery Continuity of Carer (MCOC) strategy which has been paused as advised by NHS England and NHS Improvement until the staffing situation improves. A summarised report is expected to be completed and presented to the Chief Nurse by the end of May 2022. The Board reviewed the detailed gap analysis plan and Mrs Heelbeck advised that detailed actions plans have been developed for those areas highlighted in amber and are currently in progress. She explained that a lot of work is taking place in relation to training and workforce plans including a review of consultant job plans.	

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	Mrs Heelbeck also drew attention to the work which has taken place in relation to Clinical Governance Leadership and thanked Mrs A Stabler, Non-Executive Director Lead, for her involvement in this. Governance and reporting structures are now in place and a self-assessment tool is being completed and reported to the Trust's Safety Champions. Mrs Heelbeck concluded that a lot of work is taking place and confirmed that the Ockenden report has been shared with all staff and listening events to support staff are being planned. She reminded the Board that discussions took place via the Integrated Oversight Report at the last Board meeting in March 2022. The plan will also be externally reviewed by the North East and North Cumbria Local Maternity Services (NENC LMS). The Maternity Voice Partnership leads have also received a copy of the report, and the Trust will involve service users in the planning and implementation of the recommendations. Mrs Stabler acknowledged the work undertaken and thanked Mrs Heelbeck for this. She highlighted that NENC LMS will be visiting the Trust on 16th June 2022 and the Trust has been asked to provide a number of assurances prior to the visit. Mr A Beeby, Medical Director, highlighted that the Trust is well placed within the national context and already has robust assurances in place. The Trust will also continue to work with local partners and ensure women can make safe personalised choices about their care via public consultation events. Mrs Marshall thanked Mrs Heelbeck and the maternity team for their extensive work and encouraged the Board to review the full Ockenden report which highlights good learning for all. After further discussion, it was: **RESOLVED:** to acknowledge the Immediate and Essential Actions and received the report for assurance Mrs Heelbeck left the meeting.	
22/62	**QE FACILITIES 6 MONTHLY UPDATE REPORT** Mr A Robson, Managing Director of QE Facilities, provided a presentation to the Board and highlighted some of the workstreams which have taken place during Spring 2022. This included some of the work around key performance indicators and Mr Robson highlighted some of the transport and portering performance rates. He explained that reports are now presented to the Finance and Performance Committee and robust forecasting has also been presented for the coming year including efficiency delivery. Work continues around the mask manufacturing and BSI approval is expected by 15th June 2022.	

Agenda Item	Discussion and Action Points	Action By
	Mrs L Crichton-Jones felt that it would be useful for the Board to receive more information in relation to key risks and link the work around the living wage and QEF response to the staff survey with the People agenda and Mr Robson agreed to include this going forward. Following consideration, it was: **RESOLVED**: to receive the update for information and assurance.	AR to note for future reports
22/63	**WELL-LED REVIEW ACTION PLAN UPDATE:** Miss J Boyle, Company Secretary, provided the Board with an update on progress against the well-led action plan. She reported that there has been a significant increase in the number of complete actions, which now account for 81% of the total actions, compared to 65% when the plan was last presented to the Board. There has been some slippage due to capacity and operational pressures however there remains a commitment to complete the work and the remaining actions will be monitored via the Senior Management Team with escalation of any emerging issues to the Board via the Audit Committee. The Board noted that some of the actions relate to year-end activity therefore should be completed by September 2022. It was therefore agreed that the action plan should be monitored by SMT with a closure report presented at the September 2022 Board meeting. After consideration, it was: **RESOLVED:** to receive assurance that there will be a continued focus on addressing off-track and in progress actions and the plan will be monitored by the Senior Management Team with a closure report to the September 2022 Board meeting.	JBoy
22/64	**CYCLE OF BUSINESS:** Miss Boyle presented the cycle of business which outlines forthcoming items for consideration by the Board. This will provide advanced notice and greater visibility in relation to forward planning. Therefore the Board were encouraged to review the cycle of business ahead of the next meeting in July 2022 and it was: **RESOLVED:** to receive the cycle of business for information.	

Agenda Item	Discussion and Action Points	Action By
22/65	**QUESTIONS FROM GOVERNORS IN ATTENDANCE:** Mrs A Marshall invited those Governors in attendance to ask a question, noting that some questions had been received in advance. Mr S Connolly asked whether any skin transplants were undertaken and Mr A Lowes explained that there are some special tissue donations however work is ongoing to further educate and promote more awareness for organ and tissue donation. Mr Connolly queried whether expectant mothers were transferred via ambulance from maternity to the main hospital site and Mr A Beeby explained that an internal ambulance is used supplied via QEF Transport however most cases are dealt with within the unit. Mr Connolly was reassured that volunteers were being acknowledged during Executive walkabouts Mr J Bedlington thanked Mr Lowes for his presentation and was pleased that so many people have benefited from organ and tissue donation and felt that it was important to promote this to patients and families as well as the need to be given permission to proceed with organ donation. Mr Lowes highlighted that discussions had taken place at Board around staff engagement. He felt that it may be useful to look at internal surveys to capture the thoughts of staff including suggestions of improvements. Mrs Crichton-Jones highlighted that one of the Strategic Aims is to develop and implement a Culture Programme which will include discussions around improvement in the annual/pulse survey results. There is also work taking place around health and wellbeing and Equality, Diversity and Inclusion (EDI) with work also taking place on workforce supply. The Board agreed that it was important to develop organisational approaches and ensure discussions take place between managers and teams. Dr K Roberts reported that the matron forums are being restarted and will ensure leaders feedback to their teams. Mrs Marshall also felt that it was important to progress the “back to floor” work. Mrs Y Ormston felt that survey results and 1:1 meetings were a good source of feedback for staff and highlighted that the Strategy Engagement Champions will continue to support development work. The Joint Consultative Committee are also a good source of contact for staff however teams will continue to look at ways to further improve engagement mechanisms. Mrs Marshall thanked the Governors for their questions and attendance at the meeting.	

Agenda Item	Discussion and Action Points	Action By
22/66	**DATE AND TIME OF THE NEXT MEETING:** The next meeting of the Board of Directors will be held at 9:30 am on Wednesday 27th July 2022.	
22/67	**CLOSURE OF THE MEETING:** Mrs Marshall declared the meeting closed.	
22/68	**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
22/42	25/05/2022	Trust Objectives – to review Board Committee terms of reference, cycle of business and BAF to ensure relevant objectives and key topics are included	27/07/2022	JBoy	To come back to Board for ratification
22/43	25/05/2022	F&P Assurance Report – TSS report to come back to Board/F&P for discussion	27/07/2022	AR	
22/58	25/05/2022	Nurse staffing – quality metrics paper to be presented following the testing of new tool.	27/07/2022	GF/KR	Within Nurse Staffing paper
22/60	25/05/2022	SIRO/Digital report – to arrange a digital session via Board Strategy Session	27/07/2022	JBoy	To discuss with Nick Black
22/63	25/05/2022	Well Led Action Plan – to be monitored via SMT with a closure report to September Board	27/09/2022	JBoy	

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 7

Report Title:	**Provider Collaborative Operating Model**			
Name of Meeting:	Board of Directors			
Date of Meeting:	Wednesday 27th July 2022			
Author:	Matt Brown, Managing Director, NENC Provider Collaborative			
Executive Sponsor:	Yvonne Ormiston, Chief Executive			
Report presented by:	Matt Brown, Managing Director, NENC Provider Collaborative			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☒	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☐
	The Board is asked to approve the NENC Provider Collaborative governance arrangements including the formal Collaborative Agreement, which sets out how decisions are made, the Operating Model and its Ambitions Model.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☒
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Governance and associated documents have been developed and agreed by the Provider Collaborative's Leadership Board			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	As part of the new system architecture NHS Trusts are required to be part of provider collaboratives. These are non-statutory bodies designed to bring providers together to act at scale and in the interest of the wider population. This suite of documents: • Establishes the NENC Provider Collaborative as a collective decision making and delivery mechanism for the 11 Foundation Trusts in the ICS. It confirms that it will operate as a Provider Leadership Forum consisting of the 11 Chief Executives or the nominated representatives. Final authority for any decision remains with Trust Boards • The Operating Model sets out how the Collaborative will work and outlines the initial programmes that it will focus on noting that these will be linked to ICB objectives as well as areas where collectively the members feel joint action is required			

<table>
<tr><td></td><td colspan="6">• The Ambitions document which summarises the Collaboratives purpose, function and aims primarily for an external audience.</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="6">Members of the Trust Board are asked to:

1. Note the progress made on the development of the NENC Provider Collaborative
2. Note and formally approve the documents setting out the Collaboration Agreement, Operating Model and Our Ambition</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="5">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td colspan="5">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td colspan="5">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☒</td><td colspan="5">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☐</td><td colspan="5">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="6">SA4.1 Tackle our health inequalities
SA4.2 Work collaboratively as part of Gateshead Cares system to improve health and care outcomes to the Gateshead population</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 colspan="7">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td colspan="6">CEOL2 2880 - Risk that Place/ICS/ICP strategy and plans do not fully align with our objectives and aspirations to tackle health inequalities. (9)</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☐</td><td colspan="2">Not applicable
☒</td></tr>
</table>

NHS
North East and North Cumbria
Provider Collaborative

North East and North Cumbria Provider Collaborative Governance

Update for NHS Foundation Trust Boards

July 2022

1. Purpose

This report summarises the proposed formal work structure and governance for the North East and North Cumbria (NENC) Provider Collaborative, setting out how the 11 NHS Foundation Trusts (the Trusts) will operate, with the creation of a Provider Leadership Board (PLB), set out in the Ambition, Operating Model and Collaboration Agreement. There are separate arrangements for other collaboratives, such as those specifically for specialised mental health, learning disability and autism services.

Trust Boards are asked to note progress and confirm agreement to the proposed governance arrangements.

2. Context

National policy required that by the 1st July 2022 all NHS acute and mental health trusts are working as a provider collaborative with a requirement that they:

- Are formally convened with a focus on collaborative working to deliver local and national requirements
- Are established as a formal entity
- Have in place appropriate engagement and collective decision-making structures.

The intention of the legislation is that this supports closer system working and that it provides a basis for formal agreement between the Provider Collaborative and the Integrated Care Board (ICB) on jointly determined objectives and ways of working to deliver against those objectives.

Within NENC the 11 Foundation Trusts agreed to work together as a provider collaborative in September 2020. Since then, the Trusts have been developing working relationships, governance arrangements and determining areas for focus in the first instance. Though this work, the Provider Collaborative determined that this joint work would underpinned by four key documents:

1. A formal memorandum of agreement to be made between the Trusts, setting out how the Provider Collaborative will work, the **"Collaboration Agreement"**

2. A document setting out the aspiration and ambition that Trusts have together, as a form of prospectus, particularly designed for partners and stakeholders, in **"Our Ambition"**
3. A work programme which will need to evolve over time, setting out priorities and the mechanisms for operational delivery such as capacity, workstreams and meeting structures, the **"Operating Model"**
4. A documented agreement between the Provider Collaborative and the ICB, setting out a shared view on priorities, work areas for the Provider Collaborative to take forward on behalf of the ICB, accountabilities and resourcing, the **"Responsibility Agreement"**.

Since Summer 2021, the 11 Trusts have worked together to develop their governance model and wider approach through a series of facilitated workshops and along with specialist support from the legal firm Hill Dickinson to draft a governance structure.

3. Collaboration Agreement

The Collaborative Agreement includes as signatories all 11 Trust members of the Provider Collaborative, setting out the following key provisions:

- the overarching purpose and aims of the Collaborative and the status of the collaborative agreement;
- the proposed term of the agreement and arrangements for its regular review and updating;
- the principles of collaboration agreed between the Trusts, acknowledging each Trust's statutory duties and contractual obligations and the requirement for / ability of the Trusts to participate in other collaborative arrangements;
- the work programmes that have been agreed at the outset to be taken forward by the Collaborative and the resources the Trusts have agreed to commit (including to fund the Collaborative infrastructure (e.g. PMO)) etc;
- the governance arrangements to take forward the work programmes including the Provider Leadership Board and any sub-groups, together with terms of reference;
- a development plan setting out the key areas and priorities the Collaborative has agreed to focus on in further developing its governance and overall approach over the next 12-24 months;
- the process for resolving disagreements between the Trusts;
- the parameters of information sharing between the Trusts and dealing with conflicts of interest; and
- the process for members to terminate the arrangements, or for withdrawal of an individual Trust member and the process for admitting new members to the Collaborative.

The Collaboration Agreement sets out the governance approach, with a key vehicle for Provider Collaborative decision-making being the establishment of a 'Provider Leadership Board' (PLB). The Provider Leadership Board representation will be the Chief Executives of each of the 11 Trusts and is established as the overarching body, overseeing and directing the jointly agreed programme of work. Under this approach individual Trust boards would retain final decision-making authority with

each board giving their respective chief executive (or nominated organisational representative) delegated authority to make decisions as appropriate. Decisions would be made on a consensus basis.

A number of alternative approaches were considered that would see more formal delegation to the Provider Collaborative, but were not felt to be appropriate at this point. For reference, the key alternatives considered were Committees in Common (CiC) and Joint Committee (which are now permissible under the Health Act). In these approaches, formal decision making is delegated to organisational representatives with decisions taken in the CiC or Joint Committee binding on constituent organisations. In the provider leadership approach, final decisions rest with the individual organisations and this works on the basis that the partners trust agree formally to work together but individual trust boards retain full decision making powers.

The provider leadership model was felt to be appropriate as:

- It built from the existing model and work to date
- Allowed for a formalised decision making without becoming overly bureaucratic
- Was a flexible solution that could adjust to wider system working requirements as they evolve and emerge
- Was not restrictive, in that it would allow for growth and development into approaches which allowed for greater delegated authority, should the Trusts wish to evolve in that way over time.

The Collaboration Agreement sets out that the chair of the Provider Leadership Board would be one of the chief executives with a 24 month term of office, with a potential extension of a further 24 month term of office. The PLB Chair would be one of the two Integrated Care Board FT members and the tenure is aligned accordingly. A vice-chair would also be appointed, with the intention that the vice-chair is the successor to the chair, and a new vice-chair appointed by the Provider Leadership Board members. In January 2022, Ken Bremner was appointed as the chair and Lyn Simpson as the vice-chair.

4. Our Ambition

Our Ambition is intended to be a document that is externally facing, summarising how the Provider Collaborative seeks to deliver system priorities and how it will link, interface and work with other partners and stakeholders.

This document describes who the Provider Collaborative is, its role and what it seeks to achieve and how it will facilitate horizontal collaboration between Trusts. It highlights that the focus is at system level and therefore will complement and support work at place-level and with nested collaboratives, such as on a sub-regional basis. It recognises that there will be different partnership and collaborations at different levels in this system.

The Provider Collaborative will be one of a number of partnerships that the ICB will work with and through to deliver its overall aims and objectives. The role of the Provider Collaborative will be evolve over time in line with ICB requirements.

5. Operating Model

The Operating Model is intended to be a document that will evolve over time, setting out the key priorities for the Provider Collaborative and the way in which these will be taken forward operationally, including people, meeting and governance structures. The work programmes are structured around three broad areas of clinical, clinical support and corporate programmes, which is consistent with other, well-established provider collaboratives from around the country. The document sets out that the Provider Collaborative will have its own programmes and priorities as well as those agreed with the ICB.

The Provider Collaborative has set out to have a programme management approach with a particular focus over the next we months on:

- Clinical programmes, including
    - Elective and system recovery, reducing long waits for patients and taking forward the programme of transformation
    - Urgent and emergency care, supporting colleagues in local systems with collaborative solutions to pressures
    - Strategic approach to clinical services, tackling vulnerable services collectively such as issues with non-surgical oncology, supporting and leading clinical networks, and developing a strong model of clinical leadership
- Clinical support programmes, not least the development of the NENC Provider Collaborative Aseptics Manufacturing Hub and continuing to focus on collaborative opportunities for pathology and diagnostics
- Corporate programmes, where there are opportunities to make improvement by working together, particularly in seeking to take a more consistent, convergent approach to decisions affecting workforce and estates, while recognising the different circumstances for each organisation.

Programme reporting will be directly to the Provider Leadership Board, through Chief Executives taking on a Senior Responsible Officer role, supported by a programme management structure overseen by the Managing Director. Initial pump-priming resource to support the development of the collaborative and programme management capacity has come from NECS.

6. Integrated Care Board Working Arrangements (Responsibility Agreement)

The Collaborative Agreement, Operating Model and Our Ambition documents have been shared with the Integrated Care Board (ICB) and formally supported by the ICB Executive Team, prior to seeking final approval by FT Boards. The Provider Collaborative and the ICB are aligned on the intended priorities, governance approach and ways of working set out in these documents. However, it has not yet been possible to formally reflect this into a Responsibility Agreement, given the ICB has only been established in July 2022.

It was determined that the Collaboration Agreement, Operating Model and Our Ambition documents should be shared with Trust Boards for support and approval, whilst the Responsibility Agreement is developed. The Responsibility Agreement will be shared with Trust Boards once concluded and will document clearly shared priorities, governance, escalation, accountability and resourcing.

7. Recommendation

The FT Boards of the eleven NENC Provider Collaborative members are asked to:

- Note the progress made on the development of the NENC Provider Collaborative
- Note and formally approve the documents setting out the Collaboration Agreement, Operating Model and Our Ambition

Matt Brown

Managing Director

North East and North Cumbria Provider Collaborative

8th July 2022

Enclosures

- **Enc. A: Collaborative Agreement (MoU)**
- **Enc. B: Operating Model**
- **Enc. C: Ambitions Document**

Enclosure A

8TH JULY 2022

1. **COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST**
2. **CUMBRIA, NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST**
3. **GATESHEAD HEALTH NHS FOUNDATION TRUST**
4. **THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST**
5. **NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TUST**
6. **NORTH EAST AMBULANCE SERVICE NHS FOUNDATION TRUST**
7. **NORTH TEES AND HARTLEPOOL HOSPITALS NHS FOUNDATION TRUST**
8. **NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST**
9. **SOUTH TEES HOSPITALS NHS FOUNDATION TRUST**
10. **SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST**
11. **TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST**

COLLABORATION AGREEMENT

FOR THE NORTH EAST AND NORTH CUMBRIA PROVIDER COLLABORATIVE

No	Date	Version Number	Author
1	140322	1	Hill Dickinson (EV)
2	240322	2	Hill Dickinson (EV)
3	290422	3	PvCv (NS)
4	270622	4	PvCv (NS)
5	300622	5	PvCv (NS)
6	060722	6	PvCv (MB)

Contents

Overarching Note

This Collaboration Agreement is based on a memorandum of understanding approach to provide an overarching, non-legally binding, framework for collaboration between the Trust parties.

The Agreement sets out the current purpose, objectives, and initial priorities of the Collaborative. It also sets out its initial governance structure for the Trusts to come together to make aligned decisions in specific areas. The format of the Agreement is designed to work alongside existing services contracts held by the Trusts such as the NHS Standard Contract (the Services Contract), and does not affect or override any of the current Services Contracts in any way.

Some areas of the Agreement will need significant development around the nature and function of the Collaborative over time, as outlined in the Operating Model in Schedule 4. In particular, the Integrated Care Board (ICB) and Provider Collaborative have set out the need for a Responsibility Agreement, to define agreed areas of work, accountability, escalation and resourcing. This Responsibility Agreement will set out the part that the Provider Collaborative plays in the context of the wider system and will be developed throughout the Summer of 2022, following the formal establishment of the ICB.

The Integrated Care Board Executive team has supported the content of this Collaboration Agreement.

Date: **8th July 2022**

This **Collaboration Agreement** ("**Agreement"**) is made between:

1. **County Durham and Darlington NHS Foundation Trust** of Darlington Memorial Hospital Hollyhurst Road, Darlington, County Durham, DL3 6HX;

2. **Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust** of St. Nicholas Hospital, Jubilee Road, Gosforth, Newcastle upon Tyne NE3 3XT;

3. **Gateshead Health NHS Foundation Trust** of Queen Elizabeth Hospital, Sheriff Hill, Gateshead NE9 6SX;

4. **The Newcastle Upon Tyne Hospitals NHS Foundation Trust** of Freeman Hospital, Freeman Road, High Heaton, Newcastle upon Tyne, NE7 7DN;

5. **North Cumbria Integrated Care NHS Foundation Trust** of NCIC Trust HQ, Pillars Building, Cumberland Infirmary, Infirmary Street, Carlisle, CA2 7HY;

6. **North East Ambulance Service NHS Foundation Trust** of Bernicia House, Goldcrest Way Newburn Riverside, Newcastle upon Tyne, NE15 8NY;

7. **North Tees and Hartlepool Hospitals NHS Foundation Trust** of Hardwick Road, Hardwick, Stockton-on-Tees TS19 8PE;

8. **Northumbria Healthcare NHS Foundation Trust** of 7, Northumbria House, Cobalt Business Park, 8 Silver Fox Way, Newcastle upon Tyne NE27 0QJ;

9. **South Tees Hospitals NHS Foundation Trust** of The James Cook University Hospital, Marton Road, Middlesbrough, Cleveland, TS4 3BW;

10. **South Tyneside and Sunderland NHS Foundation Trust** of Sunderland Royal Hospital, Kayll Road, Sunderland, SR4 7TP;

11. **Tees, Esk and Wear Valleys NHS Foundation Trust** of Trust Headquarters, West Park Hospital, Edward Pease Way, Darlington, Durham, DL2 2TS,

together referred to in this Agreement as the "**Trusts**" and "**Trust**" shall be construed accordingly.

BACKGROUND

1. The white paper published by the Department of Health and Social Care in February 2021[1] (the "**White Paper**") builds on the NHS Long Term Plan vision of integrated care

[1] *Integration and Innovation: working together to improve health and social care for all* (Integration and Innovation:

and sets out the key components of a statutory integrated care system ("**ICS**"). One of these components is a provider collaborative, a partnership arrangement involving two or more trusts working across multiple places to realise the benefits of mutual aid and working at scale. The Health and Care Bill 2021 implements proposals from the White Paper with effect from 1 July 2022, including new mechanisms to enable provider NHS trusts to make joint decisions.

2. Guidance[2] states that provider collaboratives should have a shared purpose and effective decision-making arrangements to:

   (a) reduce unwarranted variation and inequality in health outcomes, access to services and experience;

   (b) improve resilience by, for example, providing mutual aid; and

   (c) ensure that specialisation and consolidation occur where this will provide better outcomes and value.

3. The Trusts have been working together informally as a provider collaborative since 2020 (the "**Collaborative"**). With the NHS North East & North Cumbria Integrated Care Board ("**ICB**") established on 1 July 2022 pursuant to the Health & Care Bill, there is a need for the Collaborative to formalise its governance arrangements and ways of working to ensure it can be proactive in setting its relationship with the ICB, and other stakeholders, moving forward.

4. Aligned to the Collaborative's agreed purpose, the Trusts have agreed to undertake several initial programmes of work that they will pursue through the Collaborative governance (see Schedule 3). The Trusts have also agreed a plan for the further development of the Collaborative from the Commencement Date, as detailed in the Operating Model in Schedule 4.

5. This Agreement provides an overarching governance framework for the Trusts to work and make decisions together on matters within the remit of the Collaborative. The framework set out is intended to enable, and not prevent, smaller groups of Trusts to come together on specific programmes of work where it makes sense for them to do so.

6. While, through this Agreement, the Trusts are documenting their agreed governance arrangements for the Collaborative as at the Commencement Date, the governance

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working together to improve health and social care for all (publishing.service.gov.uk)

[2] *Working together at scale: guidance on provider collaboratives* (NHS England, August 2021)

model is likely to evolve over time as the Trusts develop their working relationships further and as the ICB's operating model develops. A Responsibility Agreement will be developed to define the relationship between the ICB and the Collaborative. New governance mechanisms will become available when the Health & Care Bill becomes law, including the ability for the Trusts to form joint committees with each other, and with the ICB. The Collaborative will also need to evolve to be capable of receiving, delivering and providing assurance to the ICB on the exercise of any ICB functions delegated to or commissioned from the Collaborative, alongside any existing programmes agreed by the Trusts. It is therefore anticipated that this Agreement will be reviewed and updated regularly by agreement of the Trusts.

OPERATIVE PROVISIONS

1. DEFINITIONS AND INTERPRETATION

1.1 In this Agreement, capitalised words and expressions shall have the meanings given to them in Schedule 1.

1.2 In this Agreement, unless the context requires otherwise, the following rules of construction shall apply:

1.2.1 a person includes a natural person, corporate or unincorporated body (whether or not having separate legal personality);

1.2.2 a reference to a "**Trust**" includes its personal representatives, successors or permitted assigns;

1.2.3 a reference to a statute or statutory provision is a reference to such statute or provision as amended or re-enacted. A reference to a statute or statutory provision includes any subordinate legislation made under that statute or statutory provision, as amended or re-enacted;

1.2.4 any phrase introduced by the terms "**including**", "**include**", "**in particular**" or any similar expression shall be construed as illustrative and shall not limit the sense of the words preceding those terms; and

1.2.5 a reference to writing or written includes faxes and e-mails.

2. PURPOSE AND EFFECT OF THE AGREEMENT

2.1 The Trusts have agreed to work together to form a single voice and act in concert to bring further improvements to care in their combined areas of operation. The Trusts

wish to record the basis on which they will collaborate with each other in this Agreement and intend to act in accordance with its terms.

2.2 This Agreement sets out:

2.2.1 the agreed purpose, strategic objectives and principles of the Collaborative;

2.2.2 the initial Key Delivery Priorities for the Collaborative;

2.2.3 the governance structures the Trusts will put in place;

2.2.4 the programme management arrangements for the Collaborative;

2.2.5 the respective roles and responsibilities of the Trusts; and

2.2.6 a plan for the further development of the Collaborative for 2022/23, which the Trusts will work together to implement through this Agreement.

2.3 The Trusts agree that, notwithstanding the good faith consideration that each Trust has afforded the terms set out in this Agreement, this Agreement shall not be legally binding. The Trusts enter into this Agreement intending to honour all their obligations to each other.

3. ACTIONS TAKEN PRIOR TO AND POST THE COMMENCEMENT DATE

3.1 Each of the Trusts acknowledges and confirms that as at the date of this Agreement it has obtained all necessary authorisations to enter into this Agreement.

4. DURATION

4.1 This Agreement shall commence on the Commencement Date and will continue for the Initial Term, unless and until terminated in accordance with its terms.

4.2 On the expiry of the Initial Term this Agreement will expire automatically without notice unless, no later than 6 months before the end of the Initial Term, the Trusts agree in writing that the term of the Agreement will be extended for a further term to be agreed between the Trusts ("**Extended Term**").

4.3 The Trusts will review progress made by the Collaborative against the Key Delivery Priorities and the terms of this Agreement no later than 12 months following the Commencement Date and at such intervals thereafter as the Trusts may agree, but at least annually. The Trusts may agree to vary the Agreement to reflect developments as appropriate in accordance with Clause 16 (*Variations*).

5. THE COLLABORATIVE PURPOSE, OBJECTIVES AND PRIORITIES

5.1 The Trusts have agreed that the common purpose for the Collaborative is to bring together the Trusts in order to:

5.1.1 improve the health and wellbeing of the North East and North Cumbria population, with particular focus on improving health inequalities that exist within the region;

5.1.2 optimise the delivery, quality and efficiency of local health and care services provided by the Trusts; and

5.1.3 support the Trusts by taking the necessary collaborative, or where possible, collective, action, including mutual aid and support,

the "**Collaborative Purpose**".

5.2 The Trusts have agreed to work together to perform their obligations under this Agreement in order to achieve the Collaborative Purpose, and more specifically, have agreed the following objectives for the Collaborative:

5.2.1 development of a strategic approach to clinical services focusing on vulnerable services and a strategic response to clinical networks and associated cross system working arrangements;

5.2.2 delivery of elective recovery (covering inpatient, diagnostics and cancer) to meet or exceed national benchmarks, standards and targets;

5.2.3 delivery of urgent care standards and requirements across providers and local systems to reduce variation and improve consistency of response;

5.2.4 building capacity and capability in clinical support services to achieve appropriate infrastructure in place to deliver strategy clinical aims; and

5.2.5 establishing and delivering appropriate corporate strategies to enhance integration and tackle variation including approaches to collective planning, rationalised and aligned estates / capital processes and development of underpinning approaches to workforce,

(the "**Objectives**").

5.3 The Trusts have agreed a number of Key Delivery Priorities for 2022/23 in pursuit of the Objectives, as set out in Schedule 3. The Trusts will agree any changes to the Key Delivery Priorities during the NHS financial year 2022/23 if required, and will review and refresh the Key Delivery Priorities in any event in advance of each new NHS financial year.

5.4 Each programme of work within a Key Delivery Priority will be sponsored by a Trust Chief Executive as Senior Responsible Owner ("**SRO**"). SRO roles will be distributed across the Trust Chief Executives. Each SRO will be responsible to the Provider Leadership Board for the planning and delivery of their work programme and will be supported by the Programme Management Office.

5.5 The Trusts acknowledge and confirm that the success of the Collaborative will depend on the Trusts' ability to effectively co-ordinate and combine their expertise, workforce, and resources as providers in order to deliver the Key Delivery Priorities and achieve the Objectives.

5.6 Each Trust acknowledges that in order to achieve the Collaborative Purpose, it will need to collaborate with the other Trusts to provide mutual aid and solve challenges in line with the Collaborative Principles. Where practicable, the Trusts will work together to agree a joint plan for tackling such challenges which will also set out the agreed roles and responsibilities of each Trust.

5.7 The work of the Collaborative will be in the context of the Integrated Care System, in close partnership with the ICB, and will conducted in line with statutory and legislative requirements, such as the guidance on service change in the NHS[3].

6. THE COLLABORATIVE PRINCIPLES

6.1 The aim of this Clause 6 is to identify the high level collaborative principles which underpin how the Trusts will work together for the delivery of the Objectives and Key Delivery Priorities under this Agreement and to set out key factors for the success of the Collaborative.

6.2 The principles referred to in Clause 5.1 are that the Trusts will work together in good faith and, unless the provisions in their individual Services Contract(s) or this Agreement state otherwise, through the Collaborative the Trusts will:

6.2.1 look to provide mutual aid and support to each other in pursuit of the Collaborative Purpose and Objectives;

6.2.2 make collective decisions that speed up service changes and transformation, whilst ensuring that these are discussed with system partners, as relevant; and compliant with statutory and legislative requirements

[3] *Planning, assuring and delivering service change for patients* (NHS England, amended May 2022)

6.2.3 challenge and hold each other to account through agreed systems, processes and ways of working;

6.2.4 act collaboratively and in good faith with each other in accordance with Guidance, the Law and Good Practice to achieve national priorities and the Objectives having at all times regard to the welfare of the population of the North East and North Cumbria;

6.2.5 actively promote a culture that facilitates integrated working and empowers staff to work collaboratively with other Trust staff to deliver better outcomes for the population of the North East and North Cumbria;

6.2.6 ensure strong clinical leadership is built into the Collaborative governance and work programmes;

6.2.7 engage with and involve the population and wider stakeholders in the ICB area in relation to the work of the Collaborative, primarily through each Trust's membership of place-based partnerships within the ICB area;

6.2.8 support each other (informally and publicly) in taking decisions in the best interests of the North East and North Cumbria population;

6.2.9 take responsibility for and manage the risks in delivering the Key Delivery Priorities together as a Collaborative;

6.2.10 promote and develop a co-operative and high performing culture, and way of working across the Collaborative:

(i) that promotes and drives co-operation, innovation and continuous improvement;

(ii) where information is shared;

(iii) where communication is honest and respectful; and

(iv) which is founded upon ethical and responsible behaviour and decision making,

without losing sight of each Trust's corporate and statutory accountability;

together these are the "**Collaborative Principles**".

7. PROBLEM RESOLUTION AND ESCALATION

7.1 The Trusts agree to adopt a systematic approach to problem resolution between them on matters which relate to the Collaborative which recognises the Collaborative Principles, the Objectives and Key Delivery Priorities (set out in Clauses 5 and 6).

7.2 If a problem, issue, concern or complaint comes to the attention of a Trust in relation to the Key Delivery Priorities or any matter within the scope of this Agreement, such Trust shall notify the other Trusts and the Trusts each acknowledge and confirm that they shall then seek to resolve the issue by a process of discussion between the relevant affected Trusts.

7.3 Save as otherwise specifically provided for in this Agreement, any dispute arising between the Trusts out of or in connection with this Agreement will be resolved in accordance with Schedule 5 (*Dispute Resolution*).

7.4 If any Trust receives any formal inquiry, complaint, claim or threat of action from a third party (including, but not limited to, claims made by a supplier) in relation to the Key Delivery Priorities or other work of the Collaborative, the Trust will liaise with the Provider Leadership Board as to the contents of any response before a response is issued.

8. OBLIGATIONS AND ROLES OF THE TRUSTS

8.1 Each Trust acknowledges and confirms that:

8.1.1 it remains responsible for performing its obligations and functions for delivery of services to the Commissioners in accordance with its Services Contract(s);

8.1.2 it will be separately and solely liable to the Commissioners for the provision of services under its own Services Contract; and

8.1.3 the intention of the Trusts is to work together with each other, and with the Commissioners, to achieve better use of resources and better outcomes for the population of the North East and North Cumbria initially in respect of the Key Delivery Priorities and to create a collaborative culture in, and between, their organisations.

8.2 Each Trust undertakes to co-operate in good faith with the others to facilitate the proper performance of this Agreement and in particular will:

8.2.1 use all reasonable endeavours to avoid unnecessary disputes and claims against any other Trust;

8.2.2 not interfere with the rights of any other Trust and its servants, agents, representatives, contractors or sub-contractors (of any tier) on its behalf in

performing its obligations under this Agreement nor in any other way hinder or prevent such other Trust or its servants, agents, representatives, or sub-contractors (of any tier) on its behalf from performing those obligations; and

8.2.3 (subject to Clause 8.3) assist the other Trusts (and their servants, agents, representatives, or sub-contractors (of any tier)) in performing those obligations so far as is reasonably practicable.

8.3 Nothing in Clause 8.2 shall:

8.3.1 interfere with the right of each of the Trusts to arrange its affairs in whatever manner it considers fit in order to perform its obligations under this Agreement in the manner in which it considers to be the most effective and efficient; or

8.3.2 oblige any Trust to incur any additional cost or expense or suffer any loss in excess of that required by its proper performance of its obligations under this Agreement.

8.4 Each of the Trusts severally undertakes that it shall:

8.4.1 subject to the provisions of this Agreement, comply with all Laws applicable to it which relate to the Key Delivery Priorities; and

8.4.2 inform the Provider Leadership Board as soon as reasonably practicable if at any time it becomes unable to meet any of its obligations and in such case inform, and keep the Provider Leadership Board informed, of any course of action to remedy the situation recommended or required by NHS England, the Secretary of State for Health and Social Care or other competent authority,

provided that, to avoid doubt, nothing in this Clause shall in any way fetter the discretion of the Trusts in fulfilling their statutory functions.

8.5 The Trusts have not agreed to share risk or reward between them under this Agreement and any future introduction of such provisions will require additional legally binding provisions to be agreed between the relevant Trusts.

9. COLLABORATIVE PROGRAMME MANAGEMENT RESOURCE

9.1 The Trusts have agreed that the Collaborative will be supported by a programme management office ("**PMO**"). The PMO will support each SRO in respect of the work programmes and Key Delivery Priorities. The initial PMO structure is set out in Schedule 4 (*Operating Model*).

9.2 For the financial year 2022/23, PMO costs will be met through a financial contribution to the Collaborative from the NHS North East Commissioning Support Unit. The Trusts acknowledge that the funding of the PMO and any other proposed supporting infrastructure for the Collaborative for NHS financial year 2023/24 and beyond will need to be discussed and agreed by the Trusts and may comprise or include financial or other resource contributions from the Trust members of the Collaborative.

10. REPORTING REQUIREMENTS

10.1 Each of the Trusts will during the Term:

10.1.1 promptly provide to the PMO or to any other Trust involved in the delivery of the Key Delivery Priorities, such information about their work in respect of such Key Delivery Priorities and such co-operation and access as the PMO or other Trust may reasonably require from time to time in line with the Collaborative Principles, provided that if the provision of such information, co-operation or access amounts to a change to this Agreement then it will need to be proposed as such to the Provider Leadership Board and the variation procedure set out in Clause 16 will apply; and

10.1.2 identify and obtain all consents necessary for the fulfilment of its obligations in respect of the Key Delivery Priorities,

limited in each case to the extent that such action does not cause a Trust to be in breach of any Law, its obligations under Clause 12 (*Information Sharing and Conflicts of Interest*) Clause 17 (*Confidentiality*) or any legally binding confidentiality obligations owed to a third party.

11. GOVERNANCE

11.1 The Trusts all agree to establish the Provider Leadership Board ("**PLB**"). For the avoidance of doubt the PLB shall not be a committee of any Trust or any combination of Trusts.

11.2 The PLB is the group responsible for leading and overseeing the Trusts' collaborative approach to the Key Delivery Priorities and working in accordance with the Collaborative Principles. The PLB may establish supporting and/or task and finish groups to take forward programmes in respect of the Key Delivery Priorities as appropriate, ensuring a strong clinical voice and involving input from a range of functions across the Trusts. The PLB will have other responsibilities as defined in its terms of reference set out in Schedule 2 (Provider Leadership Board – Terms of Reference).

11.3 The PLB will invite the Chairs of each Trust's board to a meeting of the PLB at 6 monthly intervals in order to brief the Chairs on the Collaborative's work and progress against the Objectives and Key Delivery Priorities.

11.4 The Trusts will communicate with each other clearly, directly and in a timely manner to ensure that the members of the PLB are able to make effective and timely decisions.

11.5 The Trusts will ensure appropriate attendance from their respective organisations at all meetings of the PLB and that their representatives act in accordance with the Collaborative Principles.

11.6 The Trusts acknowledge that they each participate in other collaborative arrangements outside of the Collaborative, including with other providers on a sector basis, and at place level. The Trusts will work together to ensure that the governance arrangements under this Agreement are streamlined and do not unnecessarily duplicate decision-making arrangements in other collaboratives.

12. INFORMATION SHARING AND CONFLICTS OF INTEREST

12.1 The Trusts will provide to each other all information that is reasonably required in order to deliver the Key Delivery Priorities and achieve the Objectives.

12.2 The Trusts have obligations to comply with competition law. The Trusts will therefore make sure that they share information, and in particular Competition Sensitive Information, in such a way that is compliant with competition law and, accordingly, the PLB will ensure that the exchange of Competition Sensitive Information will be restricted to circumstances where:

12.2.1 it is essential;

12.2.2 it is not exchanged more widely than necessary;

12.2.3 it is subject to suitable non-disclosure or confidentiality agreements which include a requirement for the recipient to destroy or return it on request or on termination or expiry of the Agreement; and

12.2.4 it may not be used other than to achieve the Collaborative Purpose and Objectives under this Agreement in accordance with the Collaborative Principles.

12.3 The Trusts acknowledge that it is for each Trust to decide whether information is Competition Sensitive Information but recognise that it is normally considered to include any internal commercial information which, if it is shared between Trusts who are

providers, would allow them to forecast or co-ordinate commercial strategy or behaviour in any market.

12.4 The Trusts will make sure the PLB establishes appropriate non-disclosure or confidentiality agreements between and within the Trusts so as to ensure that Competition Sensitive Information and Confidential Information are only available to those Trusts who need to see it for the purposes of the better delivery of the Key Delivery Priorities and Objectives and for no other purpose whatsoever so that they do not breach competition law.

12.5 It is accepted that the involvement of the Trusts in this Agreement may give rise to situations where information will be generated and made available to the Trusts, which could give them an unfair advantage in competitions or which may be capable of distorting such competitions (for example, disclosure of pricing information or approach to risk may provide one Trust with a commercial advantage over a separate Trust). The Trusts therefore recognise the need to manage the information referred to in this Clause 12.5 in a way which maximises their opportunity to take part in competitions operated by the Commissioners by putting in place appropriate procedures, such as appropriate non-disclosure or confidentiality agreements in advance of the disclosure of information.

12.6 Where there are any Patient Safety Incidents or Information Governance Breaches relating to the Key Delivery Priorities, for example, the Trusts shall ensure that they each comply with their individual Services Contract and work collectively and share all relevant information for the purposes of any investigations and/or remedial plans to be put in place, as well as for the purposes of learning lessons in order to avoid such Patient Safety Incident or Information Governance Breach in the future.

12.7 The Trusts will:

12.7.1 disclose to each other the full particulars of any real or apparent conflict of interest which arises or may arise in connection with this Agreement or the delivery of the Key Delivery Priorities, immediately upon becoming aware of the conflict of interest whether that conflict concerns the Trust or any person employed or retained by them for or in connection with the delivery of the Key Delivery Priorities or Objectives;

12.7.2 not allow themselves to be placed in a position of conflict of interest or duty in regard to any of their rights or obligations under this Agreement (without the prior consent of the other Trusts) before they participate in any decision in respect of that matter; and

12.7.3 use best endeavours to ensure that their representatives on the PLB and other Collaborative governance groups also comply with the requirements of this Clause 12 when acting in connection with this Agreement.

12.8 The Trusts shall comply with their obligations under the Data Protection Legislation.

13. TERMINATION, EXCLUSION AND WITHDRAWAL

13.1 The PLB may resolve to terminate this Agreement in whole where:

13.1.1 a Dispute cannot be resolved pursuant to the Dispute Resolution Procedure;

13.1.2 automatically and immediately where there exists just one Trust that remains party to this Agreement; or

13.1.3 where the Trusts agree for this Agreement to be replaced by a formal legally binding agreement between them.

Exclusion

13.2 A Trust may be excluded from this Agreement on written notice from all of the remaining Trusts in the event of a material or a persistent breach of the terms of this Agreement by the relevant Trust which has not been rectified within 30 calendar days of notification issued by the remaining Trusts or which is not reasonably capable of remedy. In such circumstances this Agreement shall be partially terminated in respect of the excluded Trust.

Voluntary withdrawal of a Trust

13.3 Any Trust may withdraw from this Agreement by giving at least 60 calendar days' notice in writing to the other Trusts.

Consequences of termination / exclusion / withdrawal

13.4 Where a Trust is excluded from this Agreement, or withdraws from it, the excluded Trust shall procure that all data and other material belonging to any other Trust shall be delivered back to the relevant Trust, deleted or destroyed as soon as reasonably practicable and confirm to the remaining Trusts when this has been completed.

14. INTRODUCING NEW PROVIDERS

14.1 Additional providers may become parties to this Agreement on such terms as the Trusts will jointly agree, acting at all times in accordance with the Collaborative

Principles. Any new provider will be required to agree to the terms of this Agreement before admission.

15. CHARGES AND LIABILITIES

15.1 Except as otherwise provided, the Trusts shall each bear their own costs and expenses incurred in complying with their obligations under this Agreement, including in respect of any losses or liabilities incurred due to their own or their employees' actions.

15.2 Except as otherwise provided, no Trust intends that any other Trust shall be liable for any loss it suffers as a result of this Agreement.

16. VARIATIONS

16.1 The provisions of this Agreement may be varied at any time by a Notice of Variation signed by the Trusts in accordance with this Clause 16.

16.2 If a Trust wishes to propose a variation to this Agreement ("**Variation**"), that Trust must submit a draft notice setting out their proposals in accordance with Clause 16.3 (a "**Notice of Variation**") to the other Trusts and the Chair of the PLB to be considered at the next meeting (or when otherwise determined by the Trusts) of the PLB.

16.3 A draft Notice of Variation must set out:

16.3.1 the Variation proposed and details of the consequential amendments to be made to the provisions of this Agreement;

16.3.2 the date on which the Variation is proposed to take effect;

16.3.3 the impact of the Variation on the achievement of the Key Delivery Priorities and Objectives; and

16.3.4 any impact of the Variation on any Services Contracts.

16.4 The PLB will consider the draft Notice of Variation and either:

16.4.1 accept the draft Notice of Variation (all Trusts consenting), in which case all Trusts will sign the Notice of Variation;

16.4.2 amend the draft Notice of Variation, such that it is agreeable to all Trusts, in which case all Trusts will sign the amended Notice of Variation; or

16.4.3 not accept the draft Notice of Variation, in which case the minutes of the relevant PLB shall set out the grounds for non-acceptance.

16.5 Any Notice of Variation of this Agreement will not be binding unless set out in writing and signed by or on behalf of each of the Trusts.

17. CONFIDENTIAL INFORMATION

17.1 Each Trust shall keep in strict confidence all Confidential Information it receives from another Trust except to the extent that such Confidential Information is required by Law to be disclosed or is already in the public domain or comes into the public domain otherwise than through an unauthorised disclosure by a Trust. Each Trust shall use any Confidential Information received from another Trust solely for the purpose of delivering the Key Delivery Priorities and complying with its obligations under this Agreement in accordance with the Collaborative Principles and for no other purpose. No Trust shall use any Confidential Information received under this Agreement for any other purpose including use for their own commercial gain in services outside of the Key Delivery Priorities or to inform any competitive bid for any elements of the Key Delivery Priorities without the express written permission of the disclosing Trust.

17.2 To the extent that any Confidential Information is covered or protected by legal privilege, then disclosing such Confidential Information to any Trust or otherwise permitting disclosure of such Confidential Information does not constitute a waiver of privilege or of any other rights which a Trust may have in respect of such Confidential Information.

17.3 The Parties agree to procure, as far as is reasonably practicable, that the terms of this Clause 17 (*Confidential Information*) are observed by any of their respective successors, assigns or transferees of respective businesses or interests or any part thereof as if they had been party to this Agreement.

17.4 Nothing in this Clause 17 (*Confidential Information*) will affect any of the Trusts' regulatory or statutory obligations, including but not limited to competition law.

18. INTELLECTUAL PROPERTY

18.1 In order to meet the Collaborative Purpose and Objectives each Trust grants to each of the other Trusts a fully paid up non-exclusive licence to use its existing Intellectual Property provided under this Agreement insofar as is reasonably required for the sole purpose of the fulfilment of that Trusts' respective obligations under this Agreement.

New Intellectual Property

18.2 If any Trust creates any new Intellectual Property through the operation of the Collaborative, the Trust which creates the new Intellectual Property will grant to the other Trusts a fully paid up non-exclusive licence to use the new Intellectual Property for the sole purpose of the fulfilment of that Trusts' obligations under this Agreement.

19. FREEDOM OF INFORMATION

19.1 If any Trust receives a request for information relating to this Agreement or the Integrated Services under the Freedom of Information Act 2000 or the Environmental Information Regulations 2004, it shall consult with the other Trusts before responding to such request and, in particular, shall have due regard to any claim by any other Trust to this Agreement that the exemptions relating to commercial confidence and/or confidentiality apply to the information sought.

20. NOTICES

20.1 Any notice or other communication given to a Trust under or in connection with this Agreement shall be in writing addressed to that Trust at its principal place of business or such other address as that Trust may have specified to the other Trust in writing in accordance with this Clause, and shall be delivered personally, or sent by pre-paid first class post, recorded delivery or commercial courier.

20.2 A notice or other communication shall be deemed to have been received: if delivered personally, when left at the address referred to in Clause 20.1; if sent by pre-paid first class post or recorded delivery, at 9.00 am on the second Operational Day after posting; or, if delivered by commercial courier, on the date and at the time that the courier's delivery receipt is signed.

21. NO PARTNERSHIP

21.1 Nothing in this Agreement is intended to, or shall be deemed to, establish any partnership between any of the Trusts, constitute any Trust the agent of another Trust, nor authorise any Trust to make or enter into any commitments for or on behalf of any other Trust except as expressly provided in this Agreement.

22. COUNTERPARTS

22.1 This Agreement may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this Agreement, but all the counterparts shall together constitute the same agreement. The expression "counterpart" shall include any executed copy of this Agreement scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment. No counterpart shall be effective until each Trust has executed at least one counterpart.

23. GOVERNING LAW AND JURISDICTION

23.1 This Agreement, and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims), shall be governed by, and construed in accordance with, English law, and, subject to Clause 6, the Trusts irrevocably submit to the exclusive jurisdiction of the courts of England.

Signed by .....

for and on behalf of **COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST** [ ]

Signed by .....

for and on behalf of **CUMBRIA, NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST** [ ]

Signed by .....

for and on behalf of **GATESHEAD HEALTH NHS FOUNDATION TRUST** [ ]

Signed by .....

for and on behalf of **THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST** [ ]

Signed by	.....
for and on behalf of **NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST**	[ ]
Signed by	.....
for and on behalf of **NORTH EAST AMBULANCE SERVICE NHS FOUNDATION TRUST**	[ ]
Signed by	.....
for and on behalf of **NORTH TEES AND HARTLEPOOL HOSPITALS NHS FOUNDATION TRUST**	[ ]
Signed by	.....
for and on behalf of **NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST**	[ ]
Signed by	.....
for and on behalf of **SOUTH TEES HOSPITALS NHS FOUNDATION TRUST**	[ ]

Signed by for and on behalf of **SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST**	..... [ ]
Signed by for and on behalf **TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST**	..... [ ]

SCHEDULE 1

Definitions and Interpretation

1 The following words and phrases have the following meanings in this Agreement:

Agreement	this collaboration agreement incorporating the Schedules
Collaborative	the provider collaborative formed by the Trusts and as detailed pursuant to this Agreement
Collaborative Principles	the collaborative principles for the Collaborative as set out in Clause 6.2
Collaborative Purpose	the common purpose for the Collaborative as set out in Clause 5.1
Commencement Date	1 April 2022
Commissioners	Pre 1 July 2022: Clinical commissioning groups in the North East and North Cumbria ICS area Post 1 July 2022: the ICB
Competition Sensitive Information	Confidential Information which is owned, produced and marked as Competition Sensitive Information by one of the Trusts and which that Trust properly considers is of such a nature that it cannot be exchanged with the other Trusts without a breach or potential breach of competition law. Competition Sensitive Information may include, by way of illustration, trade secrets, confidential financial information and confidential commercial information, including without limitation, information relating to the terms of actual or proposed contracts or sub-contract arrangements (including bids received under competitive tendering), future pricing, business strategy and costs data, as may be utilised, produced or recorded by any Trust, the publication of which an organisation in the same business would reasonably be able to expect to protect by virtue of business confidentiality provisions

Confidential Information	all information which is secret or otherwise not publicly available (in both cases in its entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business methods, in all cases whether disclosed orally or in writing before or after the date of this Agreement, including Commercially Sensitive Information and Competition Sensitive Information;
Data Protection Legislation	all applicable Laws relating to data protection and privacy including without limitation the UK GDPR; the Data Protection Act 2018; the Privacy and Electronic Communications Regulations 2003 (SI 2003/2426); the common law duty of confidentiality and the guidance and codes of practice issued by the Information Commissioner, relevant Government department or regulatory in relation to such applicable Laws
Dispute	any dispute arising between two or more of the Trusts in connection with this Agreement or their respective rights and obligations under it
Dispute Resolution Procedure	the procedure set out in Schedule 5 (*Dispute Resolution Procedure*) to this Agreement
Extended Term	has the meaning set out in Clause 4.2
Good Practice	has the meaning set out in the Services Contracts
Guidance	any applicable health or social care guidance, guidelines, direction or determination, framework, code of practice, standard or requirement to which the Trusts have a duty to have regard (and whether specifically mentioned in this Agreement or not), to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Trust by a Commissioner and/or any relevant regulatory body
ICB	NHS North East and North Cumbria Integrated Care Board, expected to be established on 1 July 2022
IG Guidance for Serious Incidents	NHS Digital's Checklist Guidance for Information Governance Serious Incidents Requiring Investigation June 2013,

	available at Data Security and Protection Toolkit - NHS Digital
Information Governance Breach	an information governance serious incident requiring investigation, as defined in the IG Guidance for Serious Incidents
Initial Term	3 years from the Commencement Date
Intellectual Property	patents, rights to inventions, copyright and related rights, trade marks, business names and domain names, goodwill, rights in designs, rights in computer software, database rights, rights to use, and protect the confidentiality of, Confidential Information and all other intellectual property rights, in each case whether registered or unregistered and including all applications and rights to apply for and be granted, renewals or extensions of, and rights to claim priority from, such rights and all similar or equivalent rights or forms of protection which subsist or will subsist now or in the future in any part of the world
Key Delivery Priorities	the priorities of the Collaborative, the initial priorities being those set out in Schedule 3, as may be amended from time to time by a Notice of Variation
Law	(a) any applicable statute or proclamation or any delegated or subordinate legislation or regulation; (b) any enforceable EU right within the meaning of section 2(1) European Communities Act 1972; (c) any applicable judgment of a relevant court of law which is a binding precedent in England; (d) Guidance; and (e) any applicable code in each case in force in England and Wales, and "Laws" shall be construed accordingly

NHS Standard Contract	the NHS Standard Contract as published by NHS England from time to time
Notice of Variation	has the meaning set out in Clause 16.2
Objectives	the objectives for the Collaborative as set out in Clause 5.2, as may be amended from time to time
Operational Days	a day other than a Saturday, Sunday or bank holiday in England
Patient Safety Incident	any unintended or unexpected incident that occurs in respect of a Service User, during and as a result of the provision of the Services, that could have led, or did lead to, harm to that Service User
Programme Management Office or PMO	the programme management office for the Collaborative, as further described in Clause 9.1 and Schedule 4 (*Operating Model*)
Operating Model	Document that describes how the Collaborative will work summarised in in Schedule 4 (*Operating Model*)
Provider Leadership Board or PLB	the group established by the Trusts pursuant to Clause 11.1, the terms of reference for which are set out in Schedule 2 (*Governance*)
Senior Responsible Owner or SRO	a Trust Chief Executive responsible for the planning and delivery of a work programme pursuant to a Key Delivery Priority
Services	the services provided, or to be provided, by a Trust to a Commissioner pursuant to its respective Services Contract which may include services which are the subject of one or more Key Delivery Priorities for the Collaborative
Services Contract	a contract entered into by one of the Commissioners and a Trust for the provision of Services, and references to a Services Contract include all or any one of those contracts as the context requires
Service User	a patient or service user for whom a Commissioner has

	statutory responsibility and who receives Services under any Services Contract
Term	the Initial Term of this Agreement plus any Extended Term(s) agreed in accordance with the terms of this Agreement
UK GDPR	has the meaning given to it in section 3(1) (as supplemented by section 205(4) of the Data Protection Act 2018
Variation	a proposed variation to this Agreement, effected in accordance with Clause 16
White Paper	has the meaning set out in Background paragraph 1.

SCHEDULE 2

Governance

Terms of Reference for the Provider Leadership Board

NORTH EAST AND NORTH CUMBRIA PROVIDER COLLABORATIVE PROVIDER LEADERSHIP BOARD Terms of Reference	
Version	**1.0**
Implementation Date	**1 April 2022**
Review Date	**1 April 2023**
Approved By	**Trust boards**
Approval Date	**8 July 2022**

REVISIONS			
Date	**Section**	**Reason for Change**	**Approved By**

1.	Purpose	The purpose of the Provider Leadership Board ("PLB") is to provide strategic leadership of the North East and North Cumbria Provider Collaborative (the "Collaborative") in setting its strategic direction and

		priorities. The PLB will oversee the delivery of the Collaborative Purpose, Objectives and Key Delivery Priorities (as set out in the Agreement and Operating Model).
2.	Status and authority	The PLB is established by the Trusts, each of which remains a sovereign organisation, to provide a governance framework for the further development of collaborative working between the Trusts in line with the Collaborative Principles. The PLB is not a separate legal entity, and as such is unable to take decisions separately from the Trusts, or bind any one of them; nor can one Trust 'overrule' any other on any matter. As a result, the PLB will operate as a place for discussion of issues with the aim of reaching consensus between the Trusts to make recommendations and proposals to statutory Trust boards as necessary. The PLB will function through engagement and discussion between its members so that each of the Trusts makes a decision in respect of, and expresses its views about, each matter considered by the PLB. The decisions of the PLB will, therefore, be the decisions of the individual Trusts, the mechanism for which shall be authority delegated by the individual Trusts to their members on the PLB. Each Trust will ensure that their designated member: - is appointed to attend and represent their Trust on the PLB with such authority as is agreed to be necessary for the PLB to function effectively in discharging its responsibilities as set out in these terms of reference which is to the extent necessary, recognised in the relevant Trust's respective scheme of delegation - has equivalent delegated authority to the designated representatives of all other Trusts comprising the PLB (as confirmed in writing and agreed between the Trusts); and - understands the status of the PLB and the limits of their responsibilities and authority.
3.	Accountability	The PLB is accountable to each of the boards of the Trusts.
4.	Responsibilities	The PLB is responsible for leading the Trusts' collaborative approach to the Collaborative Objectives and Key Delivery Priorities working in

		accordance with the Collaborative Principles, in line with the terms of the Agreement. The PLB members will make decisions together at PLB meetings in respect of the Key Delivery Priorities, including in relation to recommendations from supporting/working groups as may be established by the PLB from time to time. The PLB will also be responsible for developing the Trusts' collaborative approach across the North East and North Cumbria and beyond the initial Key Delivery Priorities. When making decisions together at PLB meetings, the PLB members will act in line with the Collaborative Principles and their respective obligations under the Agreement. The PLB may establish working groups and/or task and finish groups to support its agreed functions.
5.	Membership and attendance	The PLB will include the following members: - The Chief Executive or nominated deputy from each Trust signatory to the Agreement as notified to the PLB from time to time. It is important that members or their deputies commit to attending PLB meetings. Where a member cannot attend a meeting, the member may nominate a named deputy to attend, provided that the member gives reasonable notice of the deputy attending to the chair. Deputies must be able to contribute and make decisions on behalf of the Trust they are representing. The PLB may invite others to attend, observe and/or participate in PLB meetings, as agreed by the members from time to time. Such attendees shall not participate in decision-making or count towards the quorum.
6.	Quorum	The PLB will be quorate if eight (8) of the Trust members of the PLB, one of whom is the chair, are present.
7.	Chairing arrangements	Meetings of the PLB will be chaired by a member, initially selected by a vote of attending members at the first meeting of the PLB and thereafter on an agreed schedule where the chair is rotated to each member in turn with each carrying out the role for a twenty four (24) month period, with a potential extension for a further twenty four

		months (to align with ICB representative requirements). The successor chair in line with the agreed schedule will be the vice-chair for the preceding twenty four (24)month period to their appointment as chair.
8.	Decision making	The PLB will aim to achieve consensus wherever possible. Each member of the PLB will be representing their appointing Trust and will only make decisions at the PLB in respect of their own Trust in accordance with any delegated authority. Not all decisions within the remit of the PLB will affect all of the Trusts. Where this is the case, and the members of the PLB agree which of the Trusts are affected by a decision, then the relevant decision will be taken by the members of the affected Trusts, with the aim of achieving consensus.
9.	Conduct of business	Meetings of the PLB will be held monthly or such other frequency as may be agreed between the Trusts. Meetings may be held by telephone or video conference. Members of the PLB may participate (and count towards quorum) in a face-to-face meeting via telephone or video-conference. Any member may call extraordinary meetings of the PLB at their discretion subject to providing at least five working days' notice to PLB members. Circulation of the meeting agenda and papers via email will take place at least five working days prior to the meeting from the Chair. In the event members wish to add an item to the agenda they must notify the Chair. Requests made less than 7 working days before a meeting may be included on the agenda at the discretion of the Chair. The PLB will have administrative support from the Programme Management Office of the Collaborative to: - take minutes of the meetings and keep a record of matters arising and issues to be carried forward; and - maintain a register of interests of PLB members. Draft minutes of PLB meetings will be sent to the Trust's representative members within 14 days of each meeting. Approval of the minutes of the previous meeting of the PLB will be a standing

		item on each meeting agenda. It will be the members' responsibility to disseminate minutes and notes from the PLB inside their respective Trusts.
10.	Conflicts of interest	The members of the PLB must refrain from actions that are likely to create any actual or perceived conflicts of interests. PLB members must disclose all actual, potential or perceived conflicts of interest to the Chair in advance of each meeting to enable appropriate management arrangements to be put in place and ensure that such conflicts are managed in adherence with their organisation's conflict of interest policies and statutory duties. All members are required to uphold the Nolan Principles and all other relevant NHS requirements applicable to them. If there is any conflict between these terms of reference and the Agreement, the latter will prevail.
11.	Review	These terms of reference will be reviewed on an annual basis.

SCHEDULE 3

Key Delivery Priorities for 2022/23

The Trusts have identified the initial Key Delivery Priorities for the Collaborative (as may be agreed and amended from time to time) below.

The inclusion of any additional Key Delivery Priorities under this Schedule may only be made with the mutual written consent of all the Trusts.

NENC PvCv will:

- Optimise the resource available for healthcare (by collectively organising, managing and deploying workforce where appropriate, utilising the full NHS estate to best effect, sharing risk and gains financially to deliver an overall balanced position etc)
- Standardise pathways and interventions to reduce unwarranted clinical variation, thereby achieving improved outcomes for patients and more efficient use of the capacity available
- Leverage the assets within the PC that Trusts offer to attract inward investment (e.g. AHSC, Centre for Ageing, BRC, TREE, innovation appetite and opportunity) but this needs to be part of a coherent approach playing to the academic strengths of the member Trusts
- Facilitate data sharing to enable the NHS and care resource to be targeted more closely to need; to reduce inequalities and improve the equity of patient outcomes across the ICS and to enable prediction and prevention of health and care demand.
- Support member Trusts individually in their role as anchor institutions with the PvCV acting as a bridge aid economic recovery and the prevention agenda (through providing employment opportunities, local procurement and commitment to overall NE achievement of carbon net zero)

Given this overarching approach the PvCv will operate across four strategic objectives (underpinning work for 2022-25):

<u>Clinical Programmes</u>

1. Development of strategic approach to clinical services focusing on vulnerable services and a strategic response to clinical networks and associated cross system working arrangements

2. Delivery of elective recovery (covering inpatient, diagnostics and cancer) to meet or exceed national benchmarks, standards and targets

3. Delivery urgent care standards and requirements across providers and local systems to reduce variation and improve consistency of response

<u>Clinical Support Programmes</u>

4. Building capacity and capability in clinical support services to achieve appropriate infrastructure in place to delivery strategic clinical aims

<u>Corporate Programmes</u>

5. Establish and deliver appropriate corporate strategies to enhance integration and tackle variation including approaches to collective planning, rationalised and aligned estates/capital process and development of underpinning approaches in workforce.

Provider Collaborative Development

6. To continue to build capacity and capability within and across the PvCv to meet ongoing requirements.

NENC Key Delivery Priorities for 2022/23

Key delivery priority	How will we deliver it?	Q in which it will be achieved?	How will we know it has been achieved?	Current Delivery Mechanism
Clinical Programmes				
Strategic Objective 1				
1. Strategic Approach to Clinical Services *Development of strategic approach to clinical services focusing on vulnerable services and a strategic response to clinical networks and associated cross system working arrangements*	Working with ICB to develop overarching clinical strategy/approach in line with system priorities. Focus action on agreed risk/vulnerable areas (e.g. Clinical Oncology)	Tbc	Overarching clinical aligned clinical strategy in place. Agreed action delivered for identified areas: non-surgical medical oncology revised arrangements in place with evaluation complete by q4 22/23 with view to sustainable system approach for 23/24	Range of groups support clinical strategy with ICS/B focus through Optimising Health group. Specific mechanisms targeted for work include Cancer Alliance. Clinical Networks range of responsibility/accountability arrangements linked to commissioning.
Strategic Objective 2				
2. Elective recovery *Delivery of elective recovery (covering inpatient, diagnostics and cancer) to meet or exceed national benchmarks, standards and targets*	Working through established COOs and associated mechanism formally brought under PvCv (with ICB agreement). Elective Board established	In line with national milestones	Performance in line (or exceeding) national milestones Development of elective centres, management of waiting list and associated innovations	SRO leadership from PvCv. Elective Board reporting to ICB established with operational delivery through PvCv COOs group. Requirement to establish mechanism for longer term transformation. (Note linkages to wider system groups e.g. 'Waiting Well'.
Strategic Objective 3				
3. Urgent Care *Delivery urgent care standards and requirements across providers and local systems*	Working through established locality and system groups PvCv will take overview through SRO putting in place action at system levels as necessary	In line with national milestones	Performance in line (or exceeding) national milestones	SRO lead from PvCv Established locality structure feeding through to ICP and system level group

Key delivery priority	How will we deliver it?	Q in which it will be achieved?	How will we know it has been achieved?	Current Delivery Mechanism
to reduce variation and improve consistency of response				
Clinical Support Programmes				
Strategic Objective 4: *Building capacity and capability in clinical support services to achieve appropriate infrastructure in place to delivery strategic clinical aims*				
1.Clinical Support Services – Diagnostics & Pathology	Establish working groups under auspices of agreed SRO	Tbc	Delivery in line with plans	Program developed under Optimising Health with CEO SRO leadership for specific elements
2.Clinical Support Services – Aseptics Pharmacy	Time limited project group established to lead work	Q2 – delivery of outline business case Q4 – Full service model & plan	Agreement of approach to aseptic services across provider collaborative Plan and delivery of revised (agreed) model	Project established under auspices of PvCv with SRO leadership in place
Corporate Support Programmes				
Strategic Objective 5: *Establish and deliver appropriate corporate strategies to enhance integration and tackle variation including approaches to collective planning, rationalised and aligned estates/capital process and development of underpinning approaches in workforce.*				
1.Corporate Strategy – assessment of requirements	Review of existing mechanism to establish opportunities, requirements and potential approaches with development of agreed programme	Q2 – Delivery of proposal	Establishment of work programme with clear reporting and associated requirements	Tbc
2.Corporate strategy – Estates/finance/planning	Establishment of agreed approach to capital prioritisation, finance and planning to deliver collective	As per agreed milestones	As per agreed outcomes	SRO for Capital/Estates work established, agreed planning approach for 22/23.

Key delivery priority	How will we deliver it?	Q in which it will be achieved?	How will we know it has been achieved?	Current Delivery Mechanism
	response			
Provider Collaborative Development				
1. Establish the collaborative as a vehicle for our joint work with appropriate governance, methods of working (with CEOs leading work streams) and a resource plan	Formalisation of PvCv as a Provider Leadership Forum with associated governance arrangements	Q1 22/23	Sign off by PvCv with updates agreed via constituent Trust boards	
2. Development of appropriate programme management structures and support to deliver programmes (including reporting and associated oversight)	Identification of resource needs and requirements on a rolling basis (noting some elements will link to existing programmes, require support as part of ICS changes as well as utilisation of internal resource)	Rolling implementation based on agreed programmes and support Established reporting and associated structures	Clear, accountable SRO arrangements for programmes agreed for the PvCv delivery with agreed support implemented	

SCHEDULE 4

Operating Model

The Operating Model is the overarching document that describes what the Collaborative is, its purpose and how it works. Along with the Collaborative's Ambitions document the Operating Model has two core functions/purposes to provide:

1. A summary of what the Collaborative is, how it works and its membership in order to support discussion and agreement of the role the Collaborative will play in the NENC integrated care system as well as facilitating the agreement of the specific system objectives the Collaborative will be leading on and supporting. This is detailed in the Operating Plan but also set out in the Ambitions document.
2. Detail on the mechanism and approaches the Collaborative will use describing the programmes and detailing the specific requirements for delivery.

The Operating Model recognises that the Collaborative's role within the NENC ICS has three dimensions:

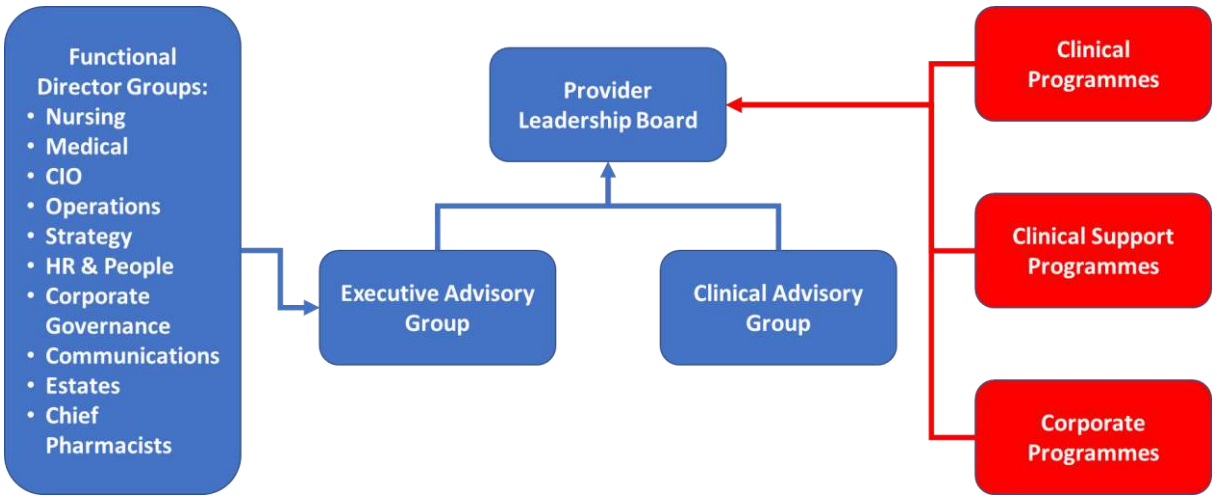
- Where the PvCv is leading on agreed objectives, with delegated authority and responsibility from the ICB
- Where the PvCv is working jointly, in partnership with ICB; working through existing mechanisms and/or groups (either leading or supporting) or as a joint committee of the ICB

It is recognised that depending on the issue, objective and requirement there may be different approaches needed for delivery

- In addition to the work to delivery ICS objectives there will be elements of the PvCv work that reflects the member's needs, requirements and priorities.

The following graphic summarises the PvCv operational model (as at April 2022), with full details found in the Operating Model and Ambitions document

Figure 1: Summary of NENC Provider Collaborative Operating Model



SCHEDULE 5

Dispute Resolution Procedure

1 Avoiding and Solving Disputes

1.1. The Trusts commit to working co-operatively to identify and resolve issues to mutual satisfaction so as to avoid so far as possible dispute or conflict in performing their obligations under this Agreement. Accordingly, the Trusts shall collaborate and resolve differences between them in accordance with Clause 7 (*Problem Resolution and Escalation*) of Agreement prior to commencing this procedure.

1.2. The Trusts believe that:

1.2.1. by focusing on the Collaborative Principles;

1.2.2. being collectively responsible for all risks; and

1.2.3. fairly sharing risk and rewards,

they will reinforce their commitment to avoiding disputes and conflicts arising out of or in connection with the Key Delivery Priorities.

1.3. The Trusts shall promptly notify each other of any dispute or claim or any potential dispute or claim in relation to this Agreement (each a "**Dispute**") when it arises.

1.4. The Provider Leadership Board shall seek to resolve any Dispute to the mutual satisfaction of each of the Trusts involved in the Dispute.

1.5. The Provider Leadership Board shall deal proactively with any Dispute in accordance with the Collaborative Principles and this Agreement so as to seek to reach a unanimous decision. If the Provider Leadership Board reaches a decision that resolves, or otherwise concludes a Dispute, it will advise the Trusts involved in the Dispute of its decision by written notice.

1.6. The Trusts agree that the Provider Leadership Board may determine whatever action it believes is necessary including the following:

1.6.1. if the Provider Leadership Board cannot resolve a Dispute, it may select an independent facilitator to assist with resolving the Dispute; and

1.6.2. the independent facilitator shall:

1.6.2.1. subject to the provisions of this Agreement, be provided with any information they request about the Dispute;

1.6.2.2. assist the Provider Leadership Board to work towards a consensus decision in respect of the Dispute;

1.6.2.3. regulate their own procedure and, subject to the terms of this Agreement, the procedure of the Provider Leadership Board at such discussions;

1.6.2.4. determine the number of facilitated discussions, provided that there will be not less than three and not more than six facilitated discussions, which must take place within 20 Operational Days of the independent facilitator being appointed; and

1.6.2.5. have their costs and disbursements met by the Trusts involved in the Dispute equally or in such other proportions as the independent facilitator shall direct.

1.6.3. If the independent facilitator cannot resolve the Dispute, the Dispute must be considered afresh in accordance with this Schedule 5 and only after such further consideration again fails to resolve the Dispute, the Provider Leadership Board may decide to:

1.6.3.1. terminate the Agreement; or

1.6.3.2. agree that the Dispute need not be resolved.

ENCLOSURE B

NHS Provider Collaborative
North East and North Cumbria ICS

North East and North Cumbria
Provider Collaborative

Operating Model

May 2022

Operating Model

The eleven FTs in North East and North Cumbria (NENC) have set out how they will work together as the NENC Provider Collaborative, along with their purpose, principles and objectives in a memorandum of understanding ("Collaboration Agreement").

This document is intended to supplement the Collaboration Agreement with some more specific operational practicalities.

Provider Leadership Board

As set out in the Memorandum of Understanding, the eleven Foundation Trusts across North East and North Cumbria have agreed to establish a Provider Leadership Board (PLB), which is the group responsible for leading and overseeing the Trusts' collaborative approach to the Key Delivery Priorities and working in accordance with the Collaborative Principles.

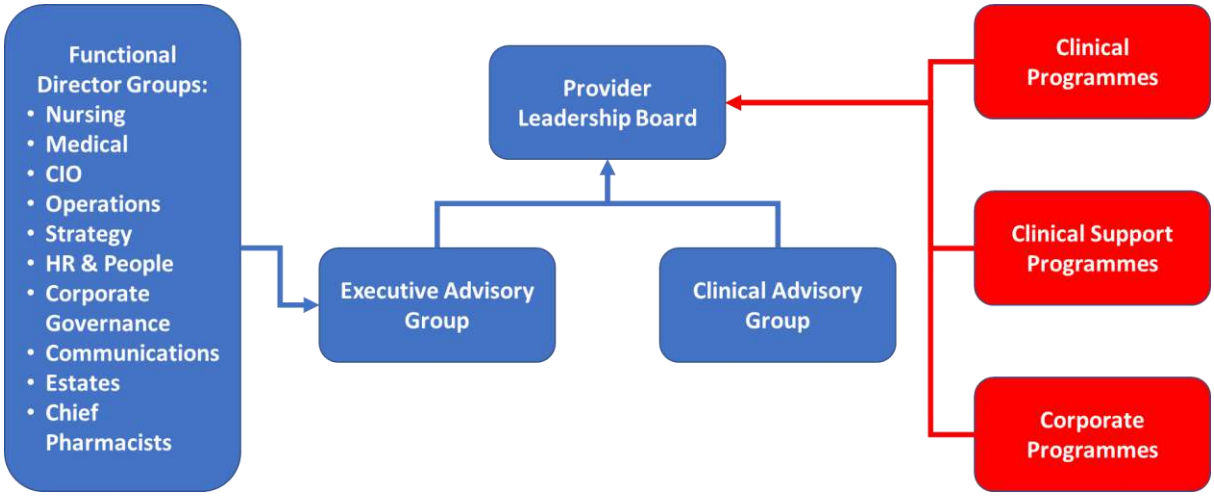
The PLB features all 11 CEOs and it is anticipated that CEOs will keep FT Boards regularly updated, supported by periodic written papers from the Provider Collaborative. The MoU sets out that Chairs of the FT Boards should be invited to meetings of the PLB at 6 monthly intervals, to discuss the work programme and progress with delivery.

The PLB may establish supporting and/or task and finish groups to take forward programmes in respect of the Key Delivery Priorities as appropriate, ensuring a strong clinical voice and involving input from a range of functions across the Trusts.

The Provider Collaborative determined that subgroups would be necessary to deliver key functions and the work programme. There is, however, a clear risk of overlap with the ICS and particularly the previous clinical advisory machinery established to support commissioning. As a consequence, this will need to be considered iteratively in the context of broader conversations with the ICB team. It was also noted that the subgroup structure should be mindful of bureaucratic burden.

For now, it is proposed that the programmes of work report directly to the Provider Leadership Board and that it is supported by an Executive Advisory Group and a Clinical Advisory Group. The Provider Leadership Board has been established, with the Executive and Clinical Advisor Groups to be put in place during Summer 2022.

In addition, the PLB will be strongly supported by nested collaboratives, such as those for mental health and at sub-regional geographies, to ensure decision making, direction and delivery take place at the right levels.



Clinical Advisory Group

The purpose of the Clinical Advisory Group is to ensure that the Provider Collaborative has strong clinical leadership and a constant focus on the key areas of collective clinical concern. The Clinical Advisory Group would draw on and provide a point of escalation for clinical networks.

Membership would need to feature clinical leads from all FTs with good medical, nursing and AHP leadership. Initial conversations with the ICB have suggested that this could be a joint body with the ICB, co-chaired by clinical leadership from within the Provider Collaborative and the ICB Medical Director, to align clinical input across the ICS. In this case, having wider clinical views, such as from general practice and community pharmacy, could support broader transformational work and enable the group to support both the Provider Collaborative and the ICB. PCN clinical leaders would be key in this.

As the ICB develops, consideration can be given as to whether it is feasible for this group to drive the strategic approach to clinical services, and the opportunity to align clinical groups generally, including the ICS Optimising Health Services Group. It should also be noted that the role and responsibility of the Provider Collaborative in the development of the ICS clinical strategy still needs to be worked through and agreed with the ICB and partners.

Executive Advisory Group

The purpose of the Executive Advisory Group is to provide a mechanism for strategic clarity across and through the Provider Collaborative FTs, making sure that a full range of functional perspectives are considered throughout the work programmes. The Executive Advisory Group will provide a sounding board and point of professional escalation for Managing Director and PMO on programmes and projects, facilitating quick access to appropriate functional expertise, in addition to being tasked with the delivery of specific projects.

This creates a mechanism to check and challenge proposals going to Provider Leadership Board, in addition to a coordinated approach to identifying risks or opportunities for collaborative work.

It is anticipated that membership of this group would be the chairs of the directors' networks, including a Director of Nursing, Medical Director, CIO, COO, Director of Finance, Director of Planning & Performance, Director of Workforce, Director of Corporate Governance, Director of Communications, Director of Estates and Chief Pharmacist.

Work Programme

Each programme of work within a Key Delivery Priority will be sponsored by a Trust Chief Executive as Senior Responsible Owner ("SRO"). SRO roles will be distributed across the Trust Chief Executives. Each SRO will be responsible to the Provider Leadership Board for the planning and delivery of their work programme and will be supported by the Programme Management Office. It is anticipated that Provider Collaborative SROs will lead some of the ICS workstreams, where appropriate.

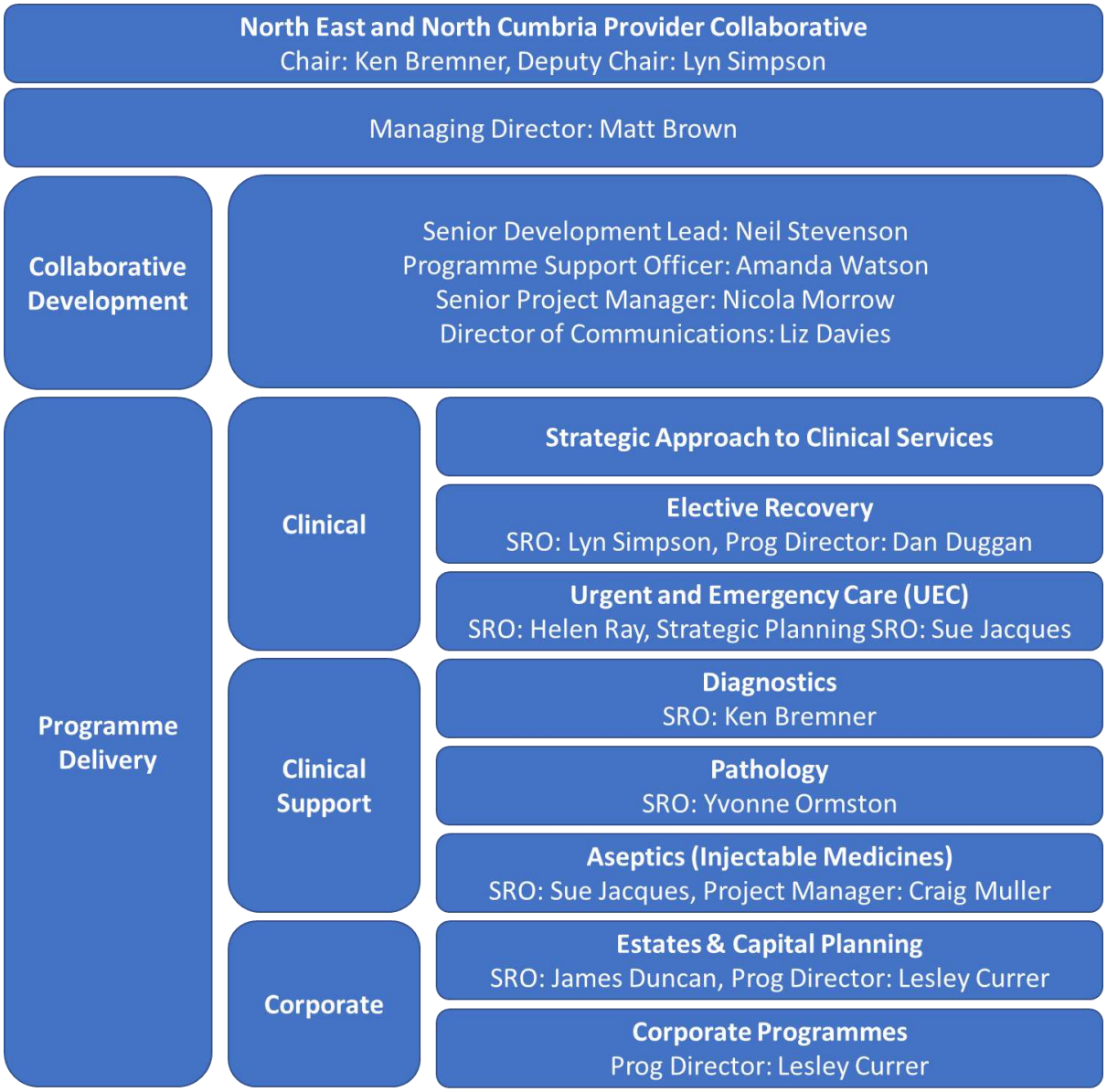
The SRO will effectively work as a Chair for the supporting programme infrastructure, with a dedicated programme management support and it is intended that there should be a designated Programme Director for each Key Delivery Priority. The Programme Director should work extremely closely with the SRO to ensure progress, direction, reporting and communication. The governance structure will be different for each Key Delivery Priority.

These teams will be supported by a general pool of project management capacity and a small core collaborative team.

Each of the five Key Delivery Priorities will report to the Provider Leadership Board on a monthly basis, using a programme highlight report, to be distributed one week before the meeting. This will focus on progress, key risks and issues for escalation. The Provider Leadership Board will ensure clear objectives and scope under each Key Delivery Priority.

The Managing Director will work closely with the SROs and Programme Directors to ensure oversight and coordination across the Key Delivery Priorities.

The following chart reflects the capacity specifically deployed by Provider Collaborative, but there are other people from the system involved in the work programmes already, such as in supporting the UEC, diagnostics and pathology ICS programmes.



Clinical Programmes – Strategic Approach to Clinical Services

It is proposed that this programme is focussed on developing a strategic approach to clinical services across North East and North Cumbria, supporting nested collaborative working. This should focus initially on tackling vulnerable services, unwarranted clinical variation and providing coordination & escalation for clinical networks. The output of this programme should be heavily informed by population health management and help guide strategic decision making on collaborative opportunities and challenges around estates, technology and workforce.

Programme infrastructure needs to be developed for this Key Delivery Priority. It is proposed that the governance for this has two forums, one clinically-led focussed on the clinical challenges and solutions through the Clinical Advisory Group, one managerially-led focussed on the corporate governance support required.

Clinical Programmes – Elective

The elective programme has a duality of focus, on the performance management aspects of elective recovery in the here and now, particularly on long waits, alongside the transformation requirements for the years ahead. In doing so, the programme seeks to tackle health inequalities, particularly of access and outcomes.

A Strategic Elective Care Board has been in established to take this work forward, with oversight of performance management, clinically-led transformation programmes, independent sector strategy, strategic productivity and collaborative opportunities (eg capitalising on GIRFT and Model Hospital) and ensuring connection to the broader programmes such as waiting well and health literacy.

Clinical Programmes – Urgent and Emergency Care

In 2022/23, the UEC Network has prioritised the long-term plan, operating guidance and national 10-point recovery plan. Specific priorities focus on UEC operating models, including community care, digital and hospital discharge.

Governance arrangements are being revised with the establishment of a UEC Board, which will provide NENC oversight, leadership on winter planning, assurance to ICB and direct connection with LADBs for place-based delivery.

Clinical Support Programmes

There are a number of key strands of work under Clinical Support programmes, particularly around diagnostics and pathology. In addition, a steering group with dedicated project management is overseeing the development of a business case for aseptics (injectable medicines) production facility for the Provider Collaborative.

The NENC Diagnostic Programme Board reports directly into the Optimising Health Services Group, then into the ICS Management Group, with a dotted line to the Provider Collaborative. The Pathology Network Board reports into the Diagnostic Programme Board.

Corporate Programmes

There are a range of active, and potential, work programmes across the Corporate Key Delivery Priority, including work on strategic planning for capital and estates. There is great potential here to make efficiencies but also to harness and maximise the many assets that exist across North East and North Cumbria. The intention is to adopt a series of evidence based programmes designed to get added value for every pound spent. These might include in the short term - redesigning and standardising care pathways, optimising sites, optimising workforce, supporting staff with cost of living pressures, adoption of innovation at pace and scale, sharing and adoption of best practice, but could also include in the longer term policies on workforce, digital innovation, back office support cost reduction, taking a rigorous approach to anchor institution development and so forth.

It is proposed that specific programme infrastructure is established for the Key Delivery Priority, with oversight, identification of opportunities and challenges through the Executive Advisory Group.

Provider Collaborative Leadership and Management Resource

The Managing Director will be accountable to the Chief Executives through the Chair of the Provider Leadership Board and will oversee the collaborative team and Programme Management Office. This team will include a secretariat function to provide administration and support across all Provider Collaborative programmes, specific programme management capacity, transformation resource, analytical capacity and communications and engagement resource. The Provider Collaborative is keen to ensure that access to, and shared leadership of, quality improvement capability.

Access to data has been determined to be a key element of being able to deliver the evidence based programmes required, in particular the use of cross system, multi sectoral data to allow benchmarking and analysis of warranted and unwarranted variation. It is anticipated that much of this will come through FTs, with analytical support from NECS and NEQOS, supported by other sources such as GIRFT and Model Hospital.

The PMO will be accountable to the Managing Director, who will have oversight across all Key Delivery Priorities.

The collaborative team will have a combination of specific staff and seconded staff, both clinical and managerial, to meet programme requirements. For the majority of collaborative programmes, the team will work with FTs to support them in delivery.

The Provider Collaborative team will need to develop over time, in line with resourcing, and alongside the Integrated Care Board (ICB).

It is expected that there will be a phased development of resources in line with increase in development and responsibilities. In the first instance, a sum of £400k has been allocated from NECS for the Provider Collaborative to draw down in 21/22, with a further £500k in 22/23.

In future years, there will need to be consideration of future funding arrangements, depending on the extent of allocated funding from either NECS or the ICB, likely to be as part of negotiation of the Responsibility Agreement. The Provider Collaborative has expressed a desire for FTs to engage collective capacity and an appetite for subscription or other contribution models.

The Development of the Provider Collaborative, including both OD and governance, will be led by the Chair and Vice-Chair. This will explicitly seek to take a strategic approach to talent management and development of a culture of collaboration.

NENC Provider Leadership Board Chair and Deputy

The Chair and Deputy Chair will act as convenors for the Collaborative, bringing together Chief Executives from the constituent FTs through the Provider Leadership Board, in line with the working arrangements set out in the Collaborative Agreement.

The Chair and Deputy will work with colleagues identifying issues for consideration and action by the Collaborative, facilitating discussion across the Collaborative to reach collective agreement on agreed action and ensuring appropriate assurance mechanisms are in place to ensure timely delivery. This will be achieved through distributed leadership, ensuring that all Chief Executives are appropriately involved in and leading Collaborative programmes. The Chair and Deputy will Provide direction, oversight and support to the Managing Director.

The position of Chair/Deputy will be elected from the constituent members and it is expected that the Chair will serve a tenure of 12-15 months. The Deputy will then step into the role of Chair, with a new Deputy nominated.

Senior Responsible Officer (SRO)

To deliver the Collaborative's work programme, a distributed leadership model will be enacted, with a Chief Executive fulfilling the Senior Responsible Officer (SRO) role in leading and facilitating delivery of agreed programmes.

The SRO will effectively act as Chair for the programme, with a designated programme director, and be responsible for ensuring that a programme or project meets its objectives and delivers the projected benefits. The SRO will act as the visible owner of the programme and the key leader in driving forward.

Managing Director

The Managing Director is responsible for leading the foundation and development of the Provider Collaborative through the establishment of governance arrangements and working infrastructure, including staffing/resourcing. The Managing Director will lead the development and delivery of the agreed work programme in line with the priorities established by the Provider Leadership Board.

The MD will ensure the leadership, development and success of the Collaborative's work programme and its contribution to the NENC ICS, coordinating the Collaborative as a membership organisation, working closely and fairly with all its constituent Trusts and ensuring it is established as a credible, robust and respected membership organisation across the North East and North Cumbria.

Programme Director

The Programme Director will work to the Programme SRO to oversee and ensure every aspect of programme delivery, from conception to implementation. Responsibilities include developing and

deploying the project team, securing appropriate resources to support delivery, developing the programme business case and milestones and ensuring that the programme meets the objectives and requirements to agreed timescales and resources. The Managing Director will have oversight of the Programme Directors.

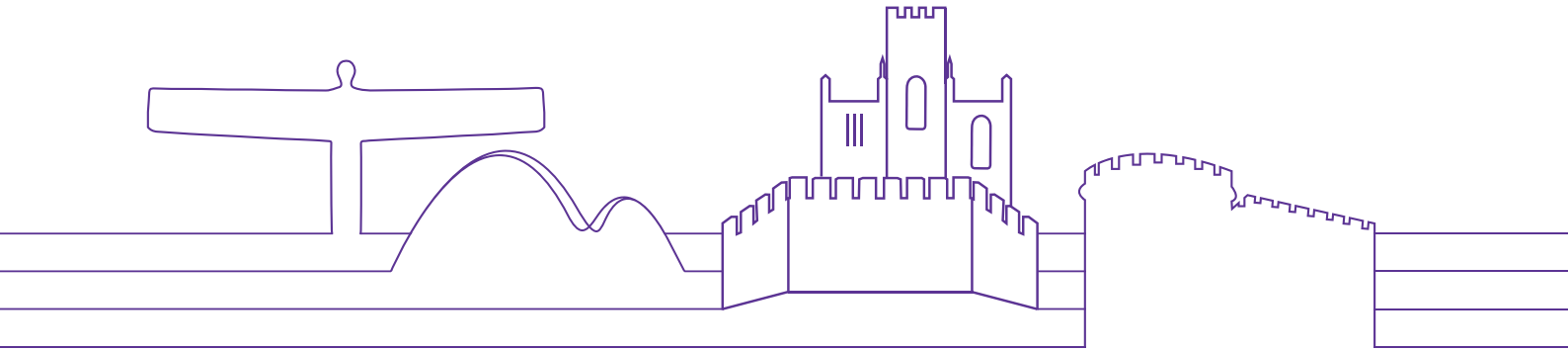
Enclosure C

North East and North Cumbria
Provider Collaborative

WORKING TOGETHER TO IMPROVE HEALTH, WEALTH AND WELLBEING

Setting out our ambitions for the future

May 2022



WHO ARE WE?

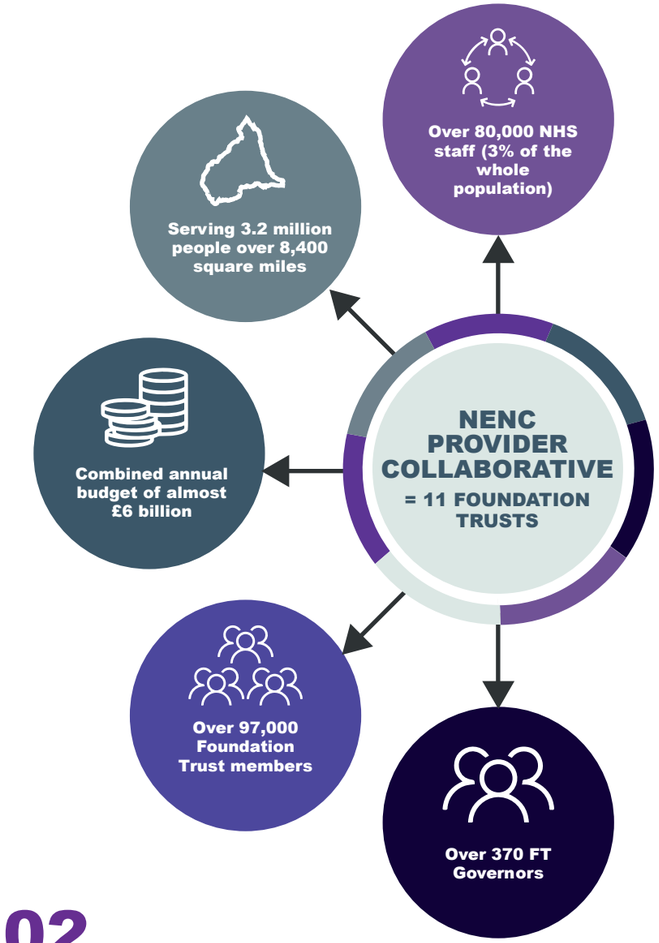
The North East and North Cumbria (NENC) Provider Collaborative is a formal partnership of all 11 NHS Foundation Trusts (FTs)* in the region. Together we cover the entire geographical footprint of the Integrated Care System and, between us, we provide the vast majority of all secondary NHS care services with millions of patient interactions every single day. This includes:

- **Community care and mental health services**
- **Acute hospital services and highly specialist care**
- **Ambulance, patient transport and emergency response services**

Our workforce is the largest in the region and we are major employers within our communities providing significant opportunities for local people. We are very proud of our strong track record, over many years, for providing some of the very best care, patient outcomes and organisational performance across the whole NHS. But we know there is more to do and especially as we recover from the impact of the pandemic.

Through the NENC Provider Collaborative our collective focus now is to ensure we consistently provide the highest quality of care right across our region and the best possible experience for our staff. Given the sheer size and scale of our organisations, we also have a significant role to play in improving the overall health, wealth and wellbeing of the local population.

OUR IMPACT



NENC Provider Collaborative Members:

- Northumbria Healthcare NHS Foundation Trust
- Newcastle upon Tyne Hospitals NHS Foundation Trust
- Gateshead Health NHS Foundation Trust

- South Tyneside and Sunderland NHS Foundation Trust
- County Durham and Darlington NHS Foundation Trust

- North Tees and Hartlepool NHS Foundation Trust
- South Tees Hospitals NHS Foundation Trust

- North Cumbria Integrated Care NHS Foundation Trust

- North East Ambulance Service NHS Foundation Trust
- Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
- Tees, Esk and Wear Valleys NHS Foundation Trust

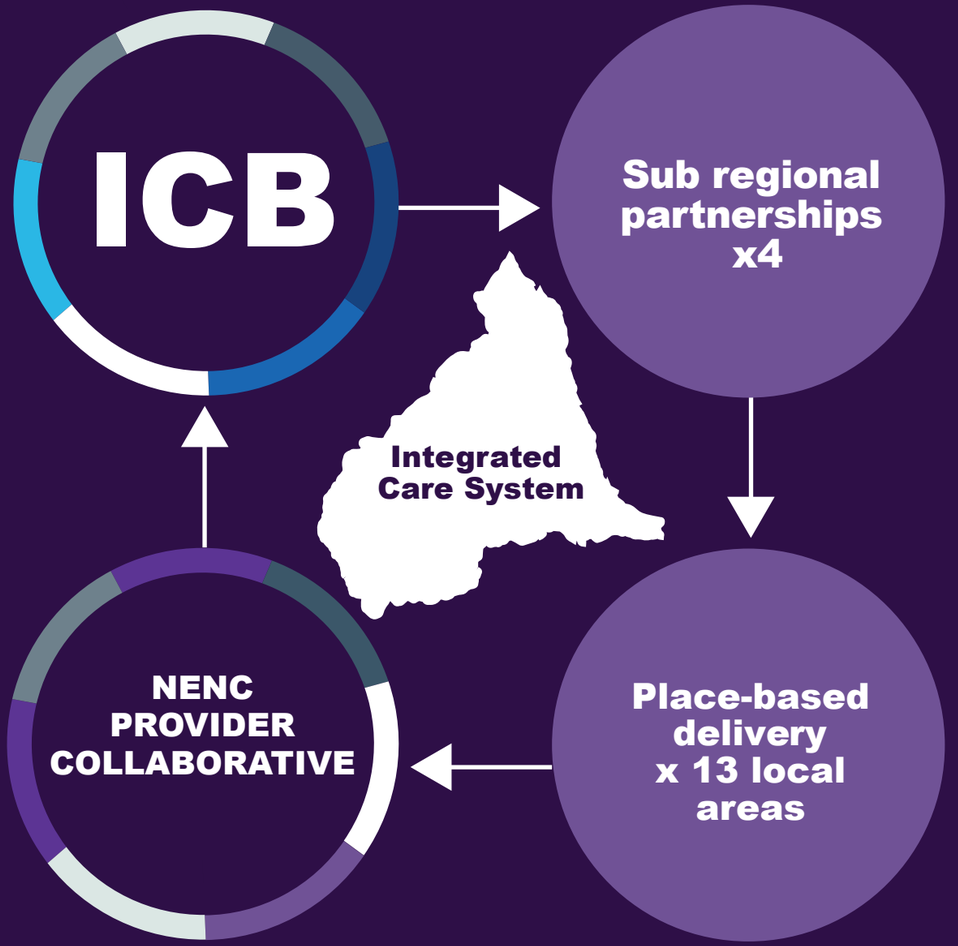
WHAT IS THE ROLE OF PROVIDER COLLABORATIVES?

Provider Collaboratives are an important part of our new system architecture. By July 2022, all NHS Foundation Trusts and NHS Trusts are expected to be part of one or more formal Provider Collaboratives, working together to agree plans for the future and deliver benefits at scale.

Our region was one of the first in England to form a Provider Collaborative ahead of national requirements. Since September 2019 all 11 of our NHS Foundation Trusts have been working together formally to discuss and address many challenges facing us all and, most importantly, to start to plan together as one for the future.

As a collective, we believe we have to continue to think differently about the way we deliver services if we want to be one step ahead and able to face the challenges, as well as the opportunities, the future presents to us.

The NENC Provider Collaborative now provides us with the formal mechanism for us to make collective decisions, to coordinate action on important issues and take forward programmes to improve health and care through collaboration. We will act on behalf of, and take decisions that represent the views of our 11 FTs collectively, rather than being a separate formal entity in our own right. We are a key component of how our new Integrated Care System will work.



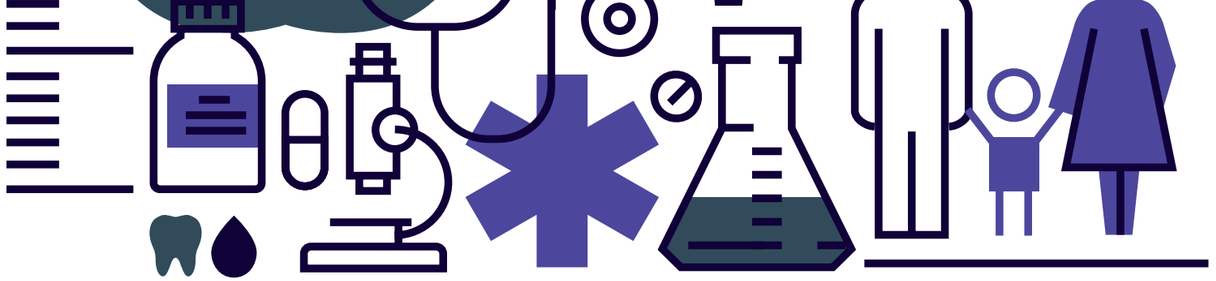
WHAT DO WE WANT TO ACHIEVE?

Our ambition as the NENC Provider Collaborative is simple:

“We want to further improve the quality of care across our Integrated Care System and use our influence to support the wider determinants of health, wealth and wellbeing across the region. We seek nothing less than for patients and the wider population within the North East and North Cumbria to have the highest possible standards of physical and mental health outcomes and positive life experiences.”

As major anchor organisations within our local communities, we recognise that we have a wider responsibility and impact across our Integrated Care System. Not only in the way we offer and deliver health and care services, but also in how we employ staff, how we procure goods and how we do business locally and achieve value for money.

As a NENC Provider Collaborative, we commit to doing all that we can to take collective action to improve health and health care services and support wider economic recovery, providing employment opportunities and local procurement.



We will work in partnership with the Integrated Care Board and share the same strategic objectives to:

Improve outcomes in population health and healthcare by focusing on improving health inequalities that exist within the region.

Tackle inequalities in outcomes, experience and access by optimising the delivery, quality and efficiency of local health and care services provided through our 11 FTs.

Enhance productivity and value for money by taking necessary collaborative. action, including mutual aid and support.

Help the NHS support broader social and economic development by providing opportunities and harnessing our collective strength to influence change.

OUR PRINCIPLES AND WAYS OF WORKING

We have ten principles which outline how we will work together. These will guide everything we do. They will help us to develop an even stronger culture of collaboration between our 11 NHS Foundation Trusts.

1.	**We will support each other and provide mutual aid in times of pressure.**
2.	**We will make shared decisions to speed up transformation and change.**
3.	**We will challenge each other and hold each other to account.**
4.	**We will always act in good faith and in the best interests of the people we serve.**
5.	**We will empower staff to work with other Trust staff to improve care.**
6.	**We will make sure there is strong clinical leadership and governance in all of our work.**
7.	**We will actively involve staff, patients, the public and wider stakeholders.**
8.	**We will show solidarity when making decisions for the local population.**
9.	**We will take responsibility for delivering on agreed priorities and manage risks together.**
10.	**We will promote a high performing culture of teamwork, innovation and continuous improvement. To do this we will share information, communicate honestly and respectfully and act ethically with responsible behaviour and decision making.**

KEY PRIORITIES

We have identified five key delivery priorities which will form the focus of our work in 2022/23 and beyond. This will be via three programmes of work:

Clinical Programmes

1. To develop a strategic approach to clinical services encompassing acute, mental health, learning disabilities and community. This will focus on vulnerable services and thinking about a strategic response to clinical networks and associated cross system working arrangements.

2. To deliver on elective recovery including all service aspects of inpatient, diagnostics and cancer care, as well as mental health and learning disabilities. Our aim is to meet or exceed national benchmarks, standards and targets.

3. To deliver urgent care standards (including ambulance standards) and requirements across all NENC providers and local systems to reduce variation and improve consistency of response.

Clinical Support Programmes

4. To build capacity and capability in clinical support services (in particular diagnostic capacity) to ensure appropriate infrastructure is in place to deliver the above clinical priorities.

Corporate Programmes

5. To support the wider ICS in sustainable transformation, establishing and delivering appropriate corporate strategies to enhance integration and tackle variation. This will include approaches to collective planning, rationalised and aligned estates/capital processes, the development of underpinning approaches in workforce and a commitment to the ICS green strategy.

WORKING AS PART OF THE WIDER ICS

In our role as the NENC Provider Collaborative we will take collective responsibility for the delivery of agreed service improvements and standards across FTS in the North East and North Cumbria. These will be agreed with the ICB.

We will facilitate horizontal collaboration between FTs, but that work will in no way reduce the primacy of place or hamper provider organisations playing full roles within their relevant place based partnerships. We recognise the crucial importance of place-based working, where our FTs work closely with local communities and partner organisations.

There will also be different collaborative arrangements (see page 12) where individual FTs will continue to work with each other on a geographical or sectoral basis All of this good work will not stop. Our role is not to cut across any of this, but to act as an enabler.

Our strength as the NENC Provider Collaborative will be through operating as a whole system collaborative when a response is best done once, together and at scale. This might be because the issue is complex, there is a need for critical mass, or requires standardisation to reduce unwarranted variation across multiple FTs.

To work effectively with the ICB we need to agree responsibilities as to how we can best contribute to the overall success of the ICS and meet the strategic objectives we all share.

We believe the NENC Provider Collaborative is best placed to lead on the priority areas identified on page 9. This includes:

- **Action to deliver recovery, specifically in tackling long waits in elective care and other services** with the development of longer term transformation solutions.
- **Addressing system level action to bring the urgent care system back to pre-pandemic levels of performance and above.**
- **Taking forward a strategic approach to clinical service development,** particularly where there are service vulnerabilities, or opportunities, that require at-scale consideration. This would include discussion and agreement around Clinical Networks and formal hosting and/or leadership arrangements.
- **Opportunities for at-scale solutions and strategic improvements to unwarranted variation or inefficiencies** within and across the 11 FTs (see page 7).

WORKING WITH HEALTH AND CARE PARTNERS

As the NENC Provider Collaborative, we are just one of a number of partnership arrangements that will work with the ICB to deliver the overall aims and objectives of the Integrated Care System. These are shown opposite.

We may interact with these other collaboratives acting as the NENC Provider Collaborative, or as individual FTs, depending on the nature of discussions taking place. However we collaborate, we want to interact and support the work of others as we collectively strive to plan, deliver and transform health and health care services for the future in our region.

DRIVING INNOVATION & IMPROVEMENT

As NENEC providers we have a high appetite for innovation and will seek a coherent approach which plays to the academic, commercial and industrial strengths of our FTs.

As part of this we will support and drive the development of research and continue our close working with vital partners. This includes working with Health Education England, education partners and professional bodies to provide high quality education and training, recruiting and retaining the workforce of today and attracting the workforce of tomorrow.

We aim to go much further than our role in directly improving health and delivering healthcare. We aim to capitalise on the substantial opportunities we have across our organisations and with our partners.

Academic Health Sciences Network	**North East Quality Observatory System**	**Biomedical Research Centre**
Academic Health Sciences Centre	**Universities of Northumbria, Newcastle, Durham, Sunderland and Teesside**	**NIHR Applied Research Collaborative**

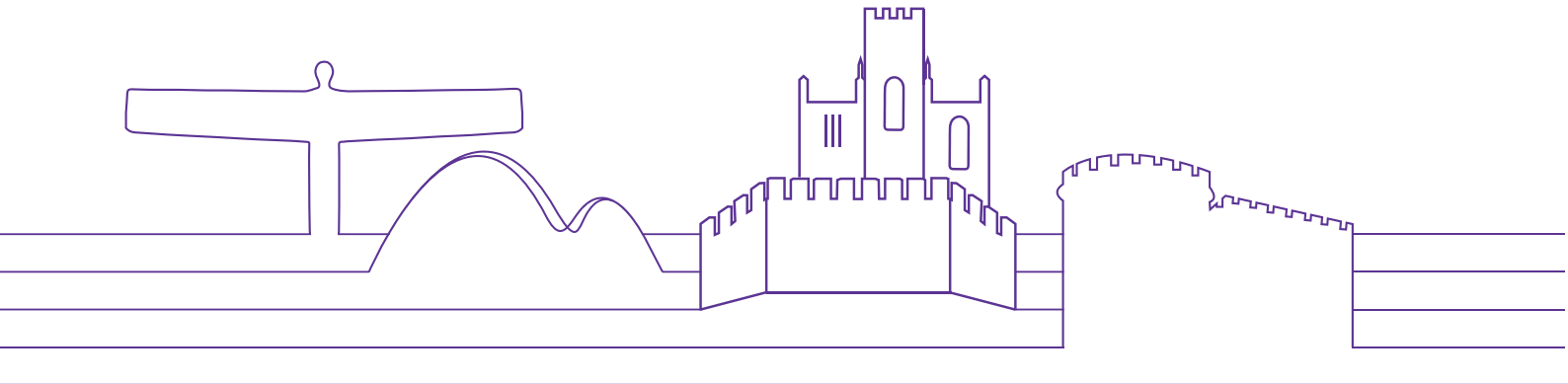
WHAT NEXT?

This document sets out our aspirations for the future and the ways of working we have developed so far as the NENC Provider Collaborative.

As work gathers pace towards our new structures and system architecture coming into place formally from July 2022, we will speak to partners about the role of the NENC Provider Collaborative and where you think we can add value to drive forward innovation and improvement.

In the coming months, we will work with the ICB to jointly agree how we can best support the delivery of ICS objectives and best use our skills and capabilities as we strive to maximise the flexibilities and freedoms of the new Health Bill when enacted. We recognise this can be achieved in several ways and we want to agree the appropriate mechanism, recognising that the basis of this working relationship will flex issue by issue.

We look forward to involving and engaging with you all along the way and building on the strengths of our relationships here in the North East and North Cumbria.



www.northeastnorthcumbria.nhs.uk/who-we-are/provider-collaborative

Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 8

Report Title:	**Standing Financial Instructions**			
Name of Meeting:	Board of Directors			
Date of Meeting:	27 July 2022			
Author:	Jennifer Boyle, Company Secretary			
Executive Sponsor:	Jacqueline Bilcliff, Group Director of Finance and Digital / Deputy Chief Executive			
Report presented by:	Jennifer Boyle, Company Secretary			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☒	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☐
	To update the Standing Financial Instructions (SFIs) to reflect changes to the Public Procurement Thresholds.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☒
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	-			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	• The Public Procurement Thresholds were revised in January 2022. It is therefore necessary to amend the SFIs to reflect the new thresholds. • A full review of the SFIs is about to commence, with a view to a further paper being presented to Board in September outlining other potential changes for consideration.			
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Board is requested to review and approve the proposed amendment to the SFIs.			

Trust Strategic Aims that the report relates to:	**Aim 1** ☐	We will continuously improve the quality and safety of our services for our patients			
	Aim 2 ☐	We will be a great organisation with a highly engaged workforce			
	Aim 3 ☒	We will enhance our productivity and efficiency to make the best use of resources			
	Aim 4 ☐	We will be an effective partner and be ambitious in our commitment to improving health outcomes			
	Aim 5 ☐	We will develop and expand our services within and beyond Gateshead			
Trust corporate objectives that the report relates to:	**SA3.2** Achieving financial sustainability				
Links to CQC KLOE	Caring ☐	Responsive ☐	Well-led ☒	Effective ☒	Safe ☐
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks and DATIX reference)	None				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

APPENDIX 1 – Proposed Changes to the SFIs

Proposed amendments:

DELEGATED AREA	SPECIFICS/ VALUES	AUTHORITY DELEGATED TO	NOTES
4. Quotation and Tendering Recorded on the Tender registered held in the Procurement Department **4.1 Expenditure**	From £1,000 to £9,999 From £10,000 up to £49,999 From £50,000 up to the Sterling thresholds ~~(UK procurement thresholds) £122,976 (as at 16/8/2021)~~ (for the application of the Public Contract Regulations) Public Procurement thresholds from 1st Jan 2022 (Inc. VAT): Supplies and services - £138,760 Works - £5,336,937 Light Touch Regime - £663,540 Concession Contracts - £5,336,937	2 verbal quotes 3 quotations (electronic) Formal tender process (electronic) advertised on Contract finder	All elements of expenditure refer to the cumulative cost over the whole life of the contract, and all limits are exclusive of VAT.
4.2 Specific Circumstances In certain very specific circumstances (as stated in the Standing Financial Instructions) the CEO, D of F&I or nominated deputy may waive the quotation process and the CEO or D of F&I may waive the tender process.	Over UK procurement threshold (£122,976 as at 16/08/2021) Waiving of Standing Orders Up to £150,000 per annum Waiving of Standing Orders Over £150,000	Above thresholds are subject to Public Procurement Process Supply and Procurement Committee CEO through ~~CMT~~ SMT	Chairman's action can be sought in exceptional circumstances between Supply and Procurement Committee Trust SFIs are superseded by Public Procurement Regulations if the limit is over the threshold which may be the case for some awards over £150k.

Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 9

<table>
<tr><td>Report Title:</td><td colspan="4">Board Assurance Framework 2021/22</td></tr>
<tr><td>Name of Meeting:</td><td colspan="4">Board of Directors</td></tr>
<tr><td>Date of Meeting:</td><td colspan="4">27 July 2022</td></tr>
<tr><td>Author:</td><td colspan="4">Jennifer Boyle, Company Secretary
Executive Directors</td></tr>
<tr><td>Executive Sponsor:</td><td colspan="4">Gillian Findley, Chief Nurse</td></tr>
<tr><td>Report presented by:</td><td colspan="4">Jennifer Boyle, Company Secretary</td></tr>
<tr><td rowspan="2">Purpose of Report
Briefly describe why this report is being presented at this meeting</td><td>Decision:
☒</td><td>Discussion:
☐</td><td>Assurance:
☐</td><td>Information:
☐</td></tr>
<tr><td colspan="4">This report provides an opening position for the Board Assurance Framework 2021/22 based on the corporate objectives approved at the May 2022 Board meeting. It is presented to the Board of Directors for approval.</td></tr>
<tr><td>Proposed level of assurance – <u>to be completed by paper sponsor</u>:</td><td>Fully assured
☐
No gaps in assurance</td><td>Partially assured
☒
Some gaps identified</td><td>Not assured
☐
Significant assurance gaps</td><td>Not applicable
☐</td></tr>
<tr><td>Paper previously considered by:
State where this paper (or a version of it) has been considered prior to this point if applicable</td><td colspan="4">Executive Directors</td></tr>
<tr><td>Key issues:
Briefly outline what the top 3-5 key points are from the paper in bullet point format

Consider key implications e.g.
• Finance
• Patient outcomes / experience
• Quality and safety
• People and organisational development
• Governance and legal
• Equality, diversity and inclusion</td><td colspan="4">• A new format BAF has been designed for 22-23 in response to feedback from the Board and Internal Audit.
• The BAF will be reviewed by the Board on a quarterly basis, with the Board committees reviewing their related extracts at each meeting.
• The Board is requested to approve the opening position, noting that this is a dynamic document which will be continually updated during the year.
• The BAF utilises the following RAG-ratings when considering progress against action plans to address gaps in controls and assurances:

<table>
<tr><th>Key</th><th>Description</th></tr>
<tr><td></td><td>Not yet started</td></tr>
<tr><td></td><td>Started and on track no risks to delivery</td></tr>
<tr><td></td><td>Plan in place with some risks to delivery</td></tr>
</table></td></tr>
</table>

		Off track, risks to delivery and or no plan/timescales and or objective not achievable			
		Complete			
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Board is requested to approve the opening position of the BAF, noting that it will be under continuous review and update at the relevant Board committees.				
Trust Strategic Aims that the report relates to:	**Aim 1** ☒	We will continuously improve the quality and safety of our services for our patients			
	Aim 2 ☒	We will be a great organisation with a highly engaged workforce			
	Aim 3 ☒	We will enhance our productivity and efficiency to make the best use of resources			
	Aim 4 ☒	We will be an effective partner and be ambitious in our commitment to improving health outcomes			
	Aim 5 ☒	We will develop and expand our services within and beyond Gateshead			
Trust corporate objectives that the report relates to:	This relates to all corporate objectives, assisting in the management and mitigation of risks which may pose a risk to delivery.				
Links to CQC KLOE	Caring ☐	Responsive ☐	Well-led ☒	Effective ☐	Safe ☐
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks and DATIX reference)	Risks identified on the BAF itself.				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

§

Quality Governance Committee BAF (SA1.1, SA1.2, SA4.1)

Strategic objective:	SA1.1 Continue to improve our maternity services in line with the wider learning from the Ockenden review						
Executive Owner:	Chief Nurse						
Board Committee Oversight:	**Quality Governance Committee**						
Date of Last Review:	N/a – this is the opening position for 2022/23						
Summary risk							
This is a risk that the Trust is unable to implement the recommendations and improvement actions outlined in the Ockenden reviews due to resource capacity, impacting upon the quality of maternity services and a decline in performance against the maternity metrics in the IOR.	*Risk score graph will appear here once 2 reviews have been completed by the Quality Governance Committee*	**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		2	4	8	2	4	8
Links to risks on the ORR:	COO 2879 - Risks relating to the trusts Maternity estate that have the potential to impact on the delivery of safe maternity services (8) COO 2869 - Unintended harm to patients, due to the impact of reduced services, delayed treatment and pathway starts (16) POD 2764 - Workforce - Risk of not having the right people in right place at the right time with the right skills. (16)						

Controls		**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Maternity workforce plans developed, with some specialist roles already appointed to		Vacancies in midwifery posts remain, although recruitment is ongoing	Chief Nurse	October 2022	In the process of recruiting students due to quality in September 2022	**On track**
Face to face training has resumed		Third Midwifery Continuity of Care team not yet in place	Chief Nurse	June 2022	Roll-out delayed to June to enable support to the acute unit due to pressures.	**On track**
Estates strategy in place and work commenced on maternity estates improvements		Maternity and neonatal records not yet fully integrated and digitised	Chief Nurse	March 2023	Neonatal Badger implementation has begun	**On track**
Action plans in place for Maternity Incentive Scheme and Ockenden						
Gap analysis undertaken against Ockenden reports						

Assurance (Level 1: Operational Oversight)		Gaps in assurance and corrective action	Owner	Timescale	Update	Action status
Performance is monitored within the department at governance meetings						
Maternity forms part of the Surgery Quality Oversight Meetings where performance is overseen by the exec team						
Action plans for Maternity Incentive Scheme and Ockenden monitored at Maternity and SBU Safecare						
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Ockenden assurance report to Board in March – Ockenden one year on						
Maternity metrics now feature in the IOR which is reported to every Quality Governance Committee and Board Meeting.						
Maternity assurance report presented at every Quality Governance Committee meeting						
Ockenden assurance report to Board in May 2022						
Patient safety walkabouts with Executive Directors and Non- Executive Director held monthly						
Assurance (Level 3 – external)						
Feedback received from regional team regarding Ockenden evidence submission						
Maternity Voices Partnership provide regular feedback to the unit on patient experience						
Friends and Family test score results are positive and provide good assurance over the quality of care						

Strategic objective:	SA1.2 Continuous Quality improvement Plan						
Executive Owner:	Chief Nurse						
Board Committee Oversight:	Quality Governance Committee						
Date of Last Review:	N/a – this is the opening position for 2022/23						
Summary risk							
Pressures on performance, people and finance, coupled with changes in the local and national health economy and structures may place significant risk on the ability of the Trust to achieve national quality standards and deliver the Quality requirements	*Risk score graph will appear here once 2 reviews have been completed by the Quality Governance Committee*	**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		3	4	12	2	4	8
Links to risks on the ORR:	COO 2869 - Unintended harm to patients, due to the impact of reduced services, delayed treatment and pathway starts (16) POD 2764 - Workforce - Risk of not having the right people in right place at the right time with the right skills. (16) COO 2868 - Further waves of Covid may impact on the ability to deliver key performance targets and recovery plans (16)						

Controls	**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Gap analysis undertaken against CQC standards	Quality strategy in development	Chief Nurse	December 2022		**On track**
Core standards action plan has been developed	Nursing strategy in development	Chief Nurse	September 2022		**On track**
Clinical audit programme in place					
Quality Governance Committee and sub-groups in place					
Equality and Quality Impact Assessment (EQIA) programme in place					
Transformation and Quality Improvement Programme in place					
Datix and incident reporting systems in place to record risks and incidents and capture learnings					
Assurance (Level 1: Operational Oversight)	**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**

SafeCare meetings in each operational business unit						
Quality is a key component of the Quarterly Oversight meetings						
Compliance Manager is in post and has action plan for compliance						
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
IOR includes quality metrics mapped to the key lines of enquiry – reviewed by the Quality Governance Committee and Board bi-monthly						
Patient and staff stories presented to Board at every meeting						
Clinical audit outcomes reported to Quality Governance Committee						
Assurance (Level 3 – external)						
CQC process audit by AuditOne – outcome awaited						
AuditOne audits from 2021/22 – NICE Guidance (good) and Duty of Candour (good)						

Strategic objective:	SA4.1 Tackle our health inequalities						
Executive Owner:	Medical Director						
Board Committee Oversight:	Quality Governance Committee						
Date of Last Review:	N/a – this is the opening position for 2022/23						
Summary risk							
There is a risk that due to competing pressures (such as financial constraints and the need to meet national operational targets) the Trust does not deliver on its health inequalities action plan, resulting in continued decline in health within the local population	*Risk score graph will appear here once 2 reviews have been completed by the Quality Governance Committee*	**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		5	2	10	4	2	8
Links to risks on the ORR:	POD 2759 - We are not able to appropriately support the health and wellbeing needs of our workforce (12) CEOL2 2880 - Risk that Place/ICS/ICP strategy and plans do not fully align with our objectives and aspirations to tackle health inequalities. (9)						

Controls		**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Health Inequalities Lead and SRO identified		Health Inequalities action plan in development	Deputy Director of Corporate Services and Transformation	September 2022	Priority areas identified to support production of action plan	**On track**
Health Inequalities Board established with members including the Director of Public Health for Gateshead		Embed role of Chief Operating Officer as a key member of the Gateshead Cares System Board	Chief Operating Officer	December 2022		**On track**
Waiting lists record deprivation score index and data sets also record ethnicity		Lack of knowledge and expertise. Maintain strong links with ICS team and Gateshead Director of Public Health	Medical Director	December 22		**On track**
Trust engagement in Making Every Contact Count						
Engagement in Gateshead Cares System Board						
Engagement with Gateshead Citizens' Advice to provide support to patients and staff						

Assurance (Level 1: Operational Oversight)		Gaps in assurance and corrective action	Owner	Timescale	Update	Action status
		IOR does not yet include health inequalities metrics	Deputy Director of Performance and Planning	September 22		
		Health Inequalities Board reporting to SMT not yet fully established	Deputy Director of Corporate Services and Transformation	August 22	Formal reporting to start following next meeting	**On track**
		Reports to Board on agreements and collaborations required as a result of partnership working with Gateshead system	Chief Operating Officer	September 2022	Minutes of System Board to be shared via the Reading Room	**On track**
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Presentations to the Board of Directors on health inequalities by the Trust lead, ICS lead and Director of Public Health for Gateshead – provides assurance over commitment and progress to-date						
Reports to Board on the Citizens' Advice collaboration and outcomes – last report November 2021						
Assurance (Level 3 – external)						

Strategic objective:	SA4.2 Work collaboratively as part of Gateshead Cares system to improve health and care outcomes to the Gateshead population						
Executive Owner:	Chief Operating Officer						
Board Committee Oversight:	Quality Governance Committee						
Date of Last Review:	N/a – this is the opening position for 2022/23						
Summary risk							
There is a risk that health and care outcomes for the population of Gateshead are not improved, so the Gateshead Care priorities and action plan fail to collectively deliver (noting the Trust's ability to influence but not fully control the outcomes)	*Risk score graph will appear here once 2 reviews have been completed by the Quality Governance Committee*	**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		4	3	12	2	3	6
Links to risks on the ORR:	CEOL2 2880 - Risk that Place/ICS/ICP strategy and plans do not fully align with our objectives and aspirations to tackle health inequalities. (9) COO 2869 - Unintended harm to patients, due to the impact of reduced services, delayed treatment and pathway starts (16) COO 2868 - Further waves of Covid may impact on the ability to deliver key performance targets and recovery plans (16)						

Controls	**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Joint session planned with the system to review priorities and set objectives for 22/23	Membership of Gateshead Cares Board does not include representatives from areas such as education and housing, which contribute towards health outcomes. Note this is not in control of the Trust	N/a	N/a	N/a	N/a
Senior representation secured at Gateshead Cares meetings	Greater visibility of GHFT's new strategy required. The Chief Operating Officer will seek to ensure this is considered as part of the agenda	COO	September 2022	On September 2022 agenda	**On track**
Trust developed strong relationships with key stakeholders and can influence the agenda					
Assurance (Level 1: Operational Oversight)	**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
	A requirement to include updates on partnership working on the SMT and Exec Team cycles of business	COO / Co Sec	September 2022	On SMT draft cycle of business. Exec team cycle of business being developed	**On track**

Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Assurance (Level 3 – external)						

People and OD Committee BAF (SA2.1, SA2.2, SA2.3)

Strategic objective:	SA2.1 Protect and understand the health and well-being of our staff by looking after our workforce						
Executive Owner:	Executive Director of People and OD						
Board Committee Oversight:	People and OD Committee						
Date of Last Review:	N/a – this is the opening position for 2022/23						
Summary risk							
There is a risk that the Trust is unable to provide appropriate levels of support to staff from a health and wellbeing perspective due to resource and capacity constraints and an increase in demand post-pandemic.	Risk score graph will appear here once 2 reviews have been completed by the XX Committee	**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		3	4	12	2	4	8
Links to risks on the ORR:	POD 2759 -We are not able to appropriately support the health and wellbeing needs of our workforce (12)						

Controls	**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Health and wellbeing programme Board	Delivery of the HWB Strategy	AV	Mar 23		**On track**
Health and wellbeing team established	Launch and promote Listening space	KG	Dec 22		**On track**
Health and wellbeing conversations launched for all staff	Deliver Flu campaign	CH	Jan 23		**Not Started**
Partnership with Gateshead Citizen's Advice to provide additional support to staff	Grow Health and Wellbeing ambassador network	DJ	Jan 23		**Not Started**
	Reduction in sickness absence	CS	Dec 22		**On track**
Assurance (Level 1: Operational Oversight)	**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
POD Quality Meeting	Compliance with health and wellbeing conversations unknown	DJ	Aug 23		**Not Started**

Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Health and wellbeing metrics reported to POD Committee						
Health and wellbeing metrics reported in IOR at Board						
Assurance (Level 3 – external)						

Strategic objective:	SA2.2 Growing and developing our workforce						
Executive Owner:	Executive Director of People and OD						
Board Committee Oversight:	People and OD Committee						
Date of Last Review:	N/a – this is the opening position for 2022/23						
Summary risk							
Risk of not having the right people in right place at the right time with the right skills due to lack of workforce capacity, resources and expertise across the organisation	Risk score graph will appear here once 2 reviews have been completed by the People and OD Committee	**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		4	4	16	2	4	8
Links to risks on the ORR:	2764 - Risk of not having the right people in right place at the right time with the right skills.						

Controls	**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Task and finish group established to coordinate all strands of work relating to staffing	Retention Strategy	FC	Mar 23		**On track**
International recruitment	Comprehensive Workforce Plans	FC	Mar 23		**On track with some risk**
Recruitment process streamlined (RPIW)	E-Rostering to Medical Workforce	PM	Mar 23		**On track with some risk**
Managing Well	Apprenticeship Strategy	SN	Aug 23		
Assurance (Level 1: Operational Oversight)	**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
POD Supply Meeting	BU Dashboard	LH	Sep 23		**On track**
	Medical Staffing Dashboard	LH	Sep 23		**On track**
	Nurse/HCSW Dashboard	LH	Sep 23		**On track**
Assurance (Level 2: Reports / metrics seen by Board / committee etc)					

POD Metrics to POD Commitee						
POD Portfolio Board						
Assurance (Level 3 – external)						
Returns to NHSE/i						

Strategic objective:	SA2.3 Development and Implementation of a Culture Programme (2-3 year Programme)						
Executive Owner:	Executive Director of People and OD						
Board Committee Oversight:	People and OD Committee						
Date of Last Review:	N/a – this is the opening position for 2022/23						
Summary risk							
There is a risk that the Trust's culture does not reflect the organisational values.	Risk score graph will appear here once 2 reviews have been completed by the People and OD Committee	**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		3	4	12	2	4	8
Links to risks on the ORR:							

Controls	**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Trust-wide engagement programme that resulted in the launch of a new vision and behaviour framework.	Programme Manager to be confirmed. Risk being raised at June Transformation Board, with suggested mitigations.	LF	July 2022		**On track**
Trust values have been reviewed as part of the wider engagement programme and remain the same.	Change Team not yet formed and awaiting agreement at Board to change the approach away from a board set-up to a team set-up.	TBC (PM)	July 2022		**On track**
Agreement to establish a Culture Programme, overseen by the Transformation Board and sponsored by the CEO.	Detailed project plan for Stage 1 and 2 required.	LG	August 2022		**On track**
SRO agreed and confirmed.					
Agreement to deliver the NHSE Culture & Leadership Programme.					
Existing team of Cultural Ambassadors that can support the programme.					
Assurance (Level 1: Operational Oversight)	**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
	Operational Oversight to be agreed	YO	July 2022		**On track**
Assurance (Level 2: Reports / metrics seen by Board / committee etc)					

Transformation Board						
POD Portfolio Board						
Assurance (Level 3 – external)						

Finance and Performance Committee BAF (SA3.1, SA3.2, SA5.1)

Strategic objective:	SA3.1 – Improve the productivity and efficiency of our operational services through the delivery of the new operating model and associated transformation plans						
Executive Owner:	Chief Operating Officer						
Board Committee Oversight:	Finance and Performance Committee						
Date of Last Review:	N/a – opening position						
Summary risk							
There is a risk that the Trust is unable to deliver to the require standards against the responsive indicators within the Integrated Oversight Report due to capacity and demand and workforce pressures, lack of progress with associated transformation plans and the response to Covid	Risk score graph will appear here once 2 reviews have been completed by the Finance and Performance Committee	**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		3	5	15	3	3	9
Links to risks on the ORR:	MEDIC 2982 – risk of delayed transfers of care and increased hospital lengths of stay (16) CEOL2 3029 - Risk of further waves/continued endemic Covid, which could impact operational delivery across the whole Trust. (16) COO 2879 - Risks relating to the trusts Maternity estate that have the potential to impact on the delivery of safe maternity services (12) COO 2744 - Risk of low or inadequate staffing to operate effective and efficient service provision as a result of covid surge and response. (16)						

Controls	**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
PMO team in place and supporting operational business units in transformation projects					
Elective and Planned Care Recovery Programme Board in place					
Winter and Surge weekly planning meetings in place					
Expansion of the Hospice at Home team to support discharges					
Assurance (Level 1: Operational Oversight)	**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Chief Operating Officer meets with senior team on a weekly basis for performance meetings	Operational business unit governance structures in place but query whether there is consistency – review underway	Company Secretary / Head of	September 22		**On track**

			Quality & Patient Exp.			
Weekly meetings with the local authority to review discharges and challenges						
Transformation Programme Board meets fortnightly to review progress in respect of the new operating model workstream						
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Quarterly Oversight Meetings in place						
Integrated Oversight Report reviewed at Board committees, with F&P Committee reviewing responsiveness domain and undertaking deep dives where required.						
Transformation Board meets monthly with a suite of project update reports to provide assurance over key related workstreams, such as the new operating model						
Assurance (Level 3 – external)						
External review of discharges underway – outcome not yet available						
ECIST review undertaken						
External review of waiting list integrity provided good assurance						

Strategic objective:	SA3.2 Achieving financial sustainability						
Executive Owner:	Group Director of Finance and Digital						
Board Committee Oversight:	Finance and Performance Committee						
Date of Last Review:	N/a – opening position						
Summary risk							
There is a risk that the Trust does not achieve its financial and capital plans due to the challenging level of CRP, increasing inflation and risk around achievement of ERF.	Risk score graph will appear here once 2 reviews have been completed by the Finance and Performance Committee	**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		5	4	20	3	3	12
Links to risks on the ORR:	-						

Controls	**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Agreed budgets in place for each business unit reconciled to balanced position and agreed financial plan.	Finance team not yet fully established and therefore support is prioritised to 'core business' – recruitment underway	Group Director of Finance	December 2022		**On track**
Financial accountability framework in place	Cost reduction programme in development but plans not yet fully formulated	Group Director of Finance	August 2022	Workshop held with SMT on 30/06	**On track**
Regular meetings with ICS to discuss system position, required actions and inflationary pressures	New business case process is still embedding	Group Director of Finance	September 2022	Keep under review with regular feedback from SMT to business case owners to enhance quality and scrutiny prior to SMT presentation	**On track**
Target CRPs agreed for all business units and included in agreed budgets	SFIs and scheme of delegation require updating to reflect changes in the governance structure and decision-making	Group Director of Finance / Company Secretary	September 2022		**On track**
New business case process launched in April 22.	Increased use of waivers during the pandemic. A review is being undertaken by the Operational Director of Finance to strengthen controls.	Group Director of Finance	September 2022		**On track**

Oversight meetings in place with each business unit to hold to account, CRP and accountability framework key item			Group Director of Finance	August 2022		
Close monitoring of activity information and assessment of ERF achievement						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Month end finance closure and related procedures		ICS regional DOF meetings not happening – therefore regional position is unknown	Group Director of Finance	TBC	Dependent upon external developments – will be kept under review	**Not yet started**
Monthly budget meetings held between business units and assigned financial management support leads		System Oversight Framework external monitoring and assurance arrangements not yet defined	Group Director of Finance	TBC	Dependent upon external developments – will be kept under review	**Not yet started**
Oversight / hold to account meetings		Specific reporting line for CRP achievement / assurance not identified.	Group Director of Finance	August 2022	Discussions underway re: role of Transformation Board	**On track**
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Achievement against revenue and capital plan reviewed for assurance at Finance and Performance Committee						
Revenue and capital report received for assurance at Board of Directors						
Assurance (Level 3 – external)						
Internal audits provide assurance over financial systems and controls – accounts receivable (good), accounts payable (reasonable), capital planning and monitoring (good), waivers (reasonable).						
ICS monitoring framework						

Strategic objective:	SA5.1 We will look to utilise our skills and expertise beyond Gateshead						
Executive Owner:	QEF Managing Director						
Board Committee Oversight:	Finance and Performance Committee						
Date of Last Review:	N/a – opening position						
Summary risk							
There is a risk that the Group will miss opportunities to utilise skills and expertise to generate income for reinvestment in patient care and staff wellbeing, resulting in increased pressures on existing funding.	Risk score graph will appear here once 2 reviews have been completed by the Finance and Performance Committee	**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		3	3	9	2	3	6
Links to risks on the ORR:	POD 2759 - We are not able to appropriately support the health and wellbeing needs of our workforce (12) CEOL2 3029 - Risk of further waves/continued endemic Covid, which could impact operational delivery across the whole Trust. (16)						

Controls	**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Regular meetings in place with external partners to discuss opportunities	Trust commercial strategy in development	QEF MD	October 2022		**On track**
Monthly strategy meeting in place in QEF to discuss opportunities					
QEF commercial strategy in place					
Assurance (Level 1: Operational Oversight)	**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Weekly senior management meetings in QEF with reporting to QEF Board					
Commercial divisions within QEF report to QEF Board on progress made					
Assurance (Level 2: Reports / metrics seen by Board / committee etc)					
QEF quarterly reporting to F&P Committee					

QEF reporting to Board twice per year						
Assurance (Level 3 – external)						

Digital Committee BAF (SA1.3)

Strategic objective:	SA1.3 Digital where it makes a difference						
Executive Owner:	Group Director of Finance and Digital						
Board Committee Oversight:	Digital Committee						
Date of Last Review:	N/a - this is the opening position						
Summary risk							
There is a risk that the Trust is not able to access / utilise digital technologies to greatest effect impacting upon the ability to drive improvements in service provision and patient care and increasing the risk of critical system failure.	*Risk score graph will appear here once 2 reviews have been completed by the Digital Committee*	**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		3	5	15	1	5	5
Links to risks on the ORR:	1636 – risk of exposure to critical cyber vulnerabilities - 10						

Controls		**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Digital strategic roadmap and portfolio plan in place based on workforce planning metrics		Digital strategy not yet fully in place - in development	Chief Digital Information Officer	September 2022	Digital strategy refresh underway aligned to corporate objectives	**On track**
Digital re-prioritisation and engagement exercise in place to ensure digital transformation plan is realistic based on current resource		Work ongoing to improve access to business intelligence to inform performance reporting	Chief Digital Information Officer	September 2022	Project group established alongside a PID	**On track**
Digital Transformation and Digital Assurance Groups in place		Workforce capacity tracker to inform planned delivery of digital initiatives – in development	Chief Digital Information Officer	September 2022	Current planned digital delivery work continues and will be informed by new planned dates in line with re-prioritisation exercise.	**On track**
Significant stakeholder engagement to seek views on digital aspirations and challenges within the Trust to inform future developments		Digital Communications and Engagement strategy to be refreshed	Chief Digital Information Officer	November 2022	Comms and Engagement Strategy was developed to support GDEFF programme, this will be revisited and socialised to	**Not Started**

					ensure stakeholders are able to inform future developments	
Engagement of Channel 3 Consulting to lead options appraisal and the outline business case development for further development of the electronic patient record (EPR).		Clinical safety resource and refreshed best practice process not yet fully in place – in development	Chief Digital Information Officer/Nominated Exec Lead (Clinical)	October 2022	Draft outline business case developed to highlight resource need which will follow Trusts new business case process. Safehands commissioned to support review of best practice process.	**On track**
Clinical Safety resource in place to oversee and manage best practice process						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Review of outline business case for EPR to be undertaken by Clinical Policy Group to ensure full clinical ownership and technical assurance.		Digital KPIs in development to enhance the assurance to Digital Committee	Chief Digital Information Officer	August 2022	Workshops held in May and June. New template and worked example shared with Digital Committee in June 22.	On track
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Digital roadmap reviewed by Digital Committee at each meeting						
Strategic objectives update report reviewed by Digital Committee						
Information governance KPIs reported to Digital Committee						
SIRO report presented to Board						
AuditOne recommendations – progress report presented to Digital Committee						
Assurance (Level 3 – external)						
AuditOne reports – Docstore It General Controls (reasonable), Cyber Incident Response Planning (reasonable), Health Information Exchange (good), Outpatient Digital Programme (substantial), DSP Toolkit follow-up (moderate).						
Global Digital Exemplar Fast Follower accreditation						

Gateshead Health
NHS Foundation Trust

Assurance Report Agenda Item: 10i

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	Finance and Performance Committee – 24.05.2022			
Name of Meeting:	Board of Directors			
Date of Meeting:	27th July 2022			
Author:	Mrs K Mackenzie			
Executive Lead:	Mrs J Bilcliff and Mrs J Baxter			
Report presented by:	Mr M Robson, Chair of Committee			
Matters to be escalated to the Board:	Delayed Discharges and Local Authority			
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	<u>QE Facilities 21/22 Review</u> The Committee received an update highlighting the consolidated position, internal / statutory reporting metrics and variances. It was agreed that a summary report would be included for comparison and the report to be brought to the Committee quarterly instead of six months. The Committee discussed mask production, vesting certificates and QEF reconsidering due diligence processes when considering business opportunities. Noted partial assurance. <u>Integrated Oversight Report</u> Context was given in relation to April being the hardest month of the pandemic so far, with particular pressure in unscheduled care. The Committee received partial assurance due to the extraordinary amount of 12 hour trolley waits, fill rates across the hospital, the Elective Recovery Programme and two week wait performance for cancer. The Committee were also made aware of the process of a harm assessment report on patients who had to stay longer in hospital than needed resulting from LA related delayed discharges <u>Financial Revenue Reports - Month 1</u> The Committee noted that there was no formal report for month 1 this will be brought to the next Committee in June as part of the cumulative report. The Committee were informed that finance are undertaking urgent educational pieces across the business units in relation to the wider Trust financial position and received a partial assurance, noting the requirement for further submissions of plan.			

	<u>Financial Revenue Reports - Month 12</u> The Committee received full assurance, noting a draft £14.2m revenue surplus. The Committee noted a capital spend of £9m and recognised that a number of capital schemes were not completed in the last financial year so will impact 2022/23. <u>Supply Procurement Committee Update</u> The Committee received partial assurance and noted that there is a process in place of reviewing the Supply Procurement Committee. <u>Organisational Risk Register Extract Review</u> The Committee reviewed the extract and was fully assured that the appropriate risks were captured and being managed effectively. <u>Board Assurance Framework (BAF)</u> The Board Assurance Framework was updated accordingly. <u>Finance and Performance Committee Cycle of Business 2022/23</u> The Cycle of Business was updated accordingly.				
Recommended actions for Board	The Board is requested to note the assurances and risks identified by the Committee and be mindful of this when reviewing and discussing related agenda items.				
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:	As outlined in the Finance Report paper on the agenda.				
Links to Risks (identify significant risks and DATIX reference)	Risks identified on the Organisational Risk Register at the time of the meeting include: • 2868 – risks of further waves of Covid impacting upon the delivery of the new operating model (16)				
People and OD Implications:	Workforce planning assumptions will form part of the annual plan submission.				
Links to CQC KLOE	Caring ☒	Responsive ☒	Well-led ☒	Effective ☒	Safe ☒

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

Gateshead Health
NHS Foundation Trust

Assurance Report

Agenda Item: 10i

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	Finance and Performance Committee (28 June 2022)			
Name of Meeting:	Trust Board			
Date of Meeting:	27 July 2022			
Author:	Miss J Boyle			
Executive Lead:	Mrs J Bilcliff and Mrs J Baxter			
Report presented by:	Mr M Robson, Chair of Committee			
Matters to be escalated to the Board:	No items identified for escalation			
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	<u>Urgent and Emergency Care Performance Update</u> The Committee received an informative update on the current action plan to improve Urgent and Emergency Care Performance against the new A&E standards which were introduced on 1 April 2022. The Committee received partial assurance and agreed that a deep dive report would be prepared for the Board and then this would be escalated to the Local Authority Overview & Scrutiny Committee. <u>Integrated Oversight Report</u> The Committee received a report which covers the reporting period for April and May 2022. The Committee noted the key areas of pressures within the report and received partial assurance given the challenging environment and impact on performance. <u>2022/23 Plan</u> The Committee received a verbal update on the 2022/23 Plan and noted that it has been highlighted and made explicit to the ICS the level of risk inherent in the planned financial position. The Committee were not assured on this item given the level of risk identified in both performance and financial terms. <u>Financial Revenue Reports</u> The Committee received a report and noted that for the period April to May the Trust has reported a revenue deficit of £2.696m after adjustments for donated assets and gain/losses of asset disposal. The Committee were not assured on this item given the distance from plan. <u>Supply Procurement Committee Update</u>			

<table>
<tr><td></td><td colspan="6">The Committee were not assured on this item however, the Committee noted that the Supply and Procurement Committee are challenging appropriately.

<u>Transformation Board Update</u>
The Committee received a report and noted that there was ongoing work on the Transformation Portfolio. Capital figures also need to be refreshed following the agreement of plans. The Committee agreed partial assurance.

<u>Capital Plan</u>
The Committee received a report and noted that a full review of the Capital Plan has been undertaken by the Executive Team. The Committee received full assurance on the capital plan and agreed that this would remain as a quarterly agenda item, however, if there was any progress to report this would be highlighted to the Committee sooner.</td></tr>
<tr><td>Recommended actions for Board</td><td colspan="6">The Board is requested to note the assurances and risks identified by the Committee and be mindful of this when reviewing and discussing related agenda items.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:
(Including reference to any specific risk)</td><td>Aim 1
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☒</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">As outlined in the Finance Report paper on the agenda.</td></tr>
<tr><td>Links to Risks (identify significant risks and DATIX reference)</td><td colspan="6">Risks identified on the Organisational Risk Register include:
FIN 2873 - Risk that the Trust is unable to form a suitable capital plan and programme due to reduced levels of CDEL available. (9)
FIN 2874 - Risk that we are unable to formulate a coherent financial plan due to uncertainty surrounding the financial framework. (3)</td></tr>
<tr><td>People and OD Implications:</td><td colspan="6">Workforce planning assumptions will form part of the annual plan submission.</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

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Gateshead Health
NHS Foundation Trust

Assurance Report

Agenda Item: 10ii

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☒
Committee Reporting Assurance:	Quality Governance Committee June 2022			
Name of Meeting:	Trust Board			
Date of Meeting:	July 2022			
Author:	Mrs A Stabler, Non-Executive Director			
Executive Lead:	Mr A Beeby, Medical Director			
Report presented by:	Mrs A Stabler, Non-Executive Director			
Matters to be escalated to the Board:	No escalation required.			
Executive Summary:	**Items received for assurance:** **Integrated Oversight Report** The Committee acknowledged ongoing operational pressure as well as demand on the emergency department and surgical specialities. It was noted that plans were in place to establish the course and find a fix for the following points of weakness: • Duty of Candour verbal compliance rates • Readmission compliance Based on the above, the Committee agreed that a partial level of assurance had been provided from this report. **Serious Incident Report** The Committee acknowledged a total of 34 serious incidents were open, 14 of which were complex cases and breaching the 60day target. It was noted that all 14 were aligned to a SI panel and would be completed by the end of August 2022. The Committee agreed a full level of assurance had been provided from this update noting a robust plan is in place to get SI reporting back on track. **Nurse Staffing Exception Report** The Committee acknowledged that May 2022 continued with significant staffing challenges due to vacancies and focused work around the recruitment of retention of staff is ongoing. It was noted that further work was required on managing absence.			

	The Committee agreed that a partial level of assurance had been provided from this report. **Maternity Continuity of Care Update Report** The Committee received the above report to support the ask to postpone the role out of the second phase of the Continuity of Care Team following an in-depth review of staff staffing carried out by the Head of Midwifery. The Committee agreed with the recommendation to fully maintain one team, step back from the second team to do a hybrid mixed model and pause the role out of the third and fourth team until spring 2023 following the appointment of additional staff. The Committee agreed that a full level of assurance had been provided from this report. **June 2022 Ockenden Visit Feedback** The Committee acknowledged that follow the recent visit from the regional team to review the seven immediate essential actions and the resulting in positive feedback for the maternity team. It was noted that the seven immediate Ockenden actions had been embedded in practice, however further work was required regarding documentation and audit. The Committee agreed that a full level of assurance had been provided from this presentation. **Quality Account Close Down Report** The Committee acknowledged that the out of the nine Quality Account priorities, four were fully achieved and need no further monitoring; one is not being taken forward at this time due to changing priorities; with the one relating to building patient and relative career involvement being delivered through board transformation work. The Committee noted that the ongoing actions from the final three will be monitored at Safecare, Risk and Patient Safety Council and at the Trust's Transformation Board. The Committee agreed a full level of assurance had been provided from this report. **Medicines Quarterly Report** The Committee acknowledged the excellent prescribing turnaround times, demonstrating efficient operational services. The Committee agreed a partial level of assurance had been provided from this report noting the lack of narrative around not meeting the medicines reconciliation target.

<table>
<tr><td></td><td colspan="6">Cancer Patient Experience Survey Results 2020
The Committee acknowledged the positive results of the above survey results and noted the 2021 results were due to be received in July 2022. The action plans from these will be developed and monitored via the Mortality Council.

The Committee agreed a full level of assurance had been received from this report.

Equality & Quality Impact Assessment Progress Report
The Committee acknowledged that a total of 17 EQIAs had been created which have been reviewed by the Chief Nurse and Medical Director.

The Committee agreed a partial level of assurance had been provided from this progress report as this is the first of its kind and does not provide full assurance that the correct process is in place.

Items received by the Committee for information:

• Cancer Services Annual Report
• Palliative Care Annual Report
• Mental Health Act Compliance Minutes – April 2022</td></tr>
<tr><td>Recommended actions for Board</td><td colspan="6">Board are asked to note the work of the committee and the assurances received and note the areas of risk identified but note the actions in place to resolve.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to: (Including reference to any specific risk)</td><td>Aim 1
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<tr><td>Financial Implications:</td><td colspan="6">None to Note</td></tr>
<tr><td>Links to Risks (identify significant risks and DATIX reference)</td><td colspan="6">ORR Risks, 2879 – Maternity, 2779 CQC Compliance/ Improvement, 2868 – Further wave of Covid, 2880</td></tr>
<tr><td>People and OD Implications:</td><td colspan="6">Gaps in workforce in nursing, midwifery and mental health.</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
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Trust Diversity & Inclusion Objective that the report relates to	**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: 10

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	Digital Committee Assurance Report from Meeting held on 20 June 2022			
Name of Meeting:	Board of Directors			
Date of Meeting:	27 July 2022			
Author:	Mr A Moffat, Chair of the Digital Committee			
Executive Lead:	Mrs J Bilcliff, Group Director of Finance and Digital			
Report presented by:	Mr A Moffat, Chair of the Digital Committee			
Matters to be escalated to the Board of Directors:	No specific matters to escalate to the Board for further action.			
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	**<u>Strategic Aims and Objectives / Strategy and Transformation Roadmap</u>** The report provided a good level of assurance with the percentage progress updated, however slippage related to capacity/resourcing issues continued to be noted. The review of workload priorities is underway to ensure the finite resource capacity is focussed on the appropriate deliverables; this work was reported as ongoing. A rating of partial assurance was awarded. **<u>Service Key Performance Indicators</u>** KPI development work continues, aimed at providing digital performance assurance. Moving forward detailed review of digital KPIs will be undertaken on an ongoing basis by the Digital Assurance Group and escalated to the Digital Committee as appropriate. It was noted that the SMT now also have visibility of digital KPI performance and those items escalated to the Digital Committee. A rating of partial assurance reflects the performance against KPIs reported and acknowledges that some further development work is required. **<u>Cyber Update</u>** Significant progress has been made with patching and other cyber risks, however there are some outstanding actions relating to the external Cyber review undertaken by Dionach. A rating of partial assurance has been given as the actions in the report have yet to be completed.			

<table>
<tr><td></td><td colspan="6"><u>Internal Audit Reports</u>
There are four outstanding audit actions, none of which are overdue against amended lengthened delivery dates, however due to fairly extensive delays in anticipated completion, a rating of partial assurance was awarded.

Digital Strategy
The Channel 3 clinical systems outline business case <u>has been shared</u> with SMT and the Executive for comment prior to formal submission to the business case process. The business case is to be shared with the Committee in August. A rating of full assurance was awarded.

Sub-Group Reporting
<u>Assurance reports were</u> received from the Digital Transformation Group and the Digital Assurance Group. As no gaps in assurance were identified, full assurance was awarded.</td></tr>
<tr><td>Recommended actions for the Board of Directors</td><td colspan="6">The Board is requested to take assurance from the work of the Committee and note the assurances, actions and decisions of the Committee in framing related items on the Board agenda.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:
(Including reference to any specific risk)</td><td>Aim 1
☒</td><td colspan="5">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☐</td><td colspan="5">We will be a great organisation with a highly engaged workforce</td></tr>
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<tr><td>Aim 5
☐</td><td colspan="5">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Financial Implications:</td><td colspan="6">None to note</td></tr>
<tr><td>Links to Risks (identify significant risks and DATIX reference)</td><td colspan="6">There are no significant risks on Datix relating to the business conducted at this meeting.</td></tr>
<tr><td>People and OD Implications:</td><td colspan="6">None to note.</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☐</td><td>Responsive
☐</td><td>Well-led
☒</td><td>Effective
☐</td><td colspan="2">Safe
☒</td></tr>
<tr><td>Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)</td><td>Obj.1
☐</td><td colspan="5">The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance between working life and personal commitments</td></tr>
</table>

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

Gateshead Health
NHS Foundation Trust

Assurance Report

Agenda Item: 10iv

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	People and OD Committee – July 2022			
Name of Meeting:	Trust Board			
Date of Meeting:	27 July 2022			
Author:	Ferne Clements, Head of People Planning, Performance & Quality			
Executive Lead:	Lisa Crichton-Jones, Director of People & OD			
Report presented by:	Ruth Bonnington, Non-Executive Director			
Matters to be escalated to the Board:	No items identified for escalation			
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	The key agenda items discussed were as follows: **Trust Vision/Values/Strategic Update** A presentation was delivered providing an overview of the Trust Vision, Values and Strategic Update with a focus on the People and OD Strategic Objectives. The committee were fully assured. **Growing the workforce – *Absence & Supply*** The committee were partially assured reflecting the amount of work underway but further work required to understand more detail about other professional groups. **People Plan** The Committee were fully assured that we are on track to deliver. **People & OD Metrics** A presentation was shared highlighting the key areas of focus within each of the 'Heads of' portfolios. The committee were partially assured, understanding there were metrics still in development. **Guardian of Safeworking Q4** The Guardian of Safeworking presented the quarter 4 report. The committee were partially assured due to lack of progress on the Junior Doctor mess.			

<table>
<tr><td></td><td colspan="6">Freedom To Speak Up Report
Additional information required to understand how/when concerns will be actioned/closed. Therefore, the committee were Partially assurance.</td></tr>
<tr><td>Recommended actions for Board</td><td colspan="6">Note main assurances against the strategic People and OD themes detailed and key associated risks.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to: (Including reference to any specific risk)</td><td>Aim 1
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<tr><td>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">No significant new financial implications to highlight to the Board.</td></tr>
<tr><td>Links to Risks (identify significant risks and DATIX reference)</td><td colspan="6">Three risks from the organisational risk register were reviewed:
2764 – Right People, Right place, Right skills – 16
2765 – Leadership and OD – 12
2759 – Health & Wellbeing – 12</td></tr>
<tr><td>People and OD Implications:</td><td colspan="6">As set out</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☒</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
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Gateshead Health
NHS Foundation Trust

Assurance Report

Agenda Item: 10v

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	Audit Committee Assurance Report from Meeting held on 7 July 2022			
Name of Meeting:	Board of Directors			
Date of Meeting:	27 July 2022			
Author:	Miss J Boyle, Company Secretary			
Executive Lead:	Mrs J Bilcliff, Group Director of Finance and Digital			
Report presented by:	Mr A Moffat, Chair of the Audit Committee			
Matters to be escalated to the Board of Directors:	The Audit Committee recommended the Annual Report and Accounts to the Board for formal ratification.			
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	<u>Executive Risk Management Group – Update</u> The Committee received the update report and noted that it was agreed to move these meetings to a bi-monthly cycle. The Committee were fully assured and noted the ongoing work that was being undertaken. The Committee ratified the revised Terms of Reference. <u>External Audit Progress (Final Accounts) Report</u> The Committee received a detailed update from External Audit relating to the year end Audit. The Committee received full assurance and was able to recommend the annual accounts and annual report to the Board for signature and completion. <u>Internal Audit Plan</u> The Committee received the Internal Audit Plan which is not yet finalised; it was agreed that any final amendments were needed from the Executive team subject to full ratification but that a number of audits could commence in the meantime. As such the Committee were partially assured. <u>Internal Audit Progress Report</u> The Committee received the Progress Report and noted the key issues. The Committee agreed to invite a number of Directors to the September committee to discuss outstanding actions. The Committee were partially assured. <u>Internal Audit Charter</u>			

	The Committee received the Internal Audit Charter and noted that a couple of minor changes have been made. An additional section has been added in Appendix 1. The Committee received full assurance. <u>Counter Fraud Progress Report</u> The Committee received the report and noted the five key items that have been identified for the Audit Committee's attention within this report. The Committee were fully assured and were pleased with modifications and content within the Counter Fraud Progress Report. <u>Counter Fraud Annual Plan</u> The Committee noted the new format of the Counter Fraud Annual Plan and the Committee were partially assured. <u>Compliance with Standards of Business Conduct Policy</u> The Committee noted that plans are in place to update the policy and launch a new system of conflicts of interest which should increase levels of compliance. The Committee were partially assured and noted that there is still work to do. <u>Schedule of Losses and Special Payments</u> The Committee approved the losses and special payments register for the period 1 January 2022 to 31 March 2022 and were fully assured.				
Recommended actions for the Board of Directors	The Board is requested to take assurance from the work of the Committee and note the assurances, actions and decisions of the Committee in framing related items on the Board agenda.				
Trust Strategic Aims that the report relates to: (Including reference to any specific risk)	**Aim 1** ☒	We will continuously improve the quality and safety of our services for our patients			
	Aim 2 ☐	We will be a great organisation with a highly engaged workforce			
	Aim 3 ☒	We will enhance our productivity and efficiency to make the best use of resources			
	Aim 4 ☐	We will be an effective partner and be ambitious in our commitment to improving health outcomes			
	Aim 5 ☐	We will develop and expand our services within and beyond Gateshead			
Financial Implications:	None to note				
Links to Risks (identify significant risks and DATIX reference)	There are no significant risks on Datix relating to the business conducted at this meeting.				
People and OD Implications:	None to note.				
Links to CQC KLOE	Caring	Responsive	Well-led	Effective	Safe

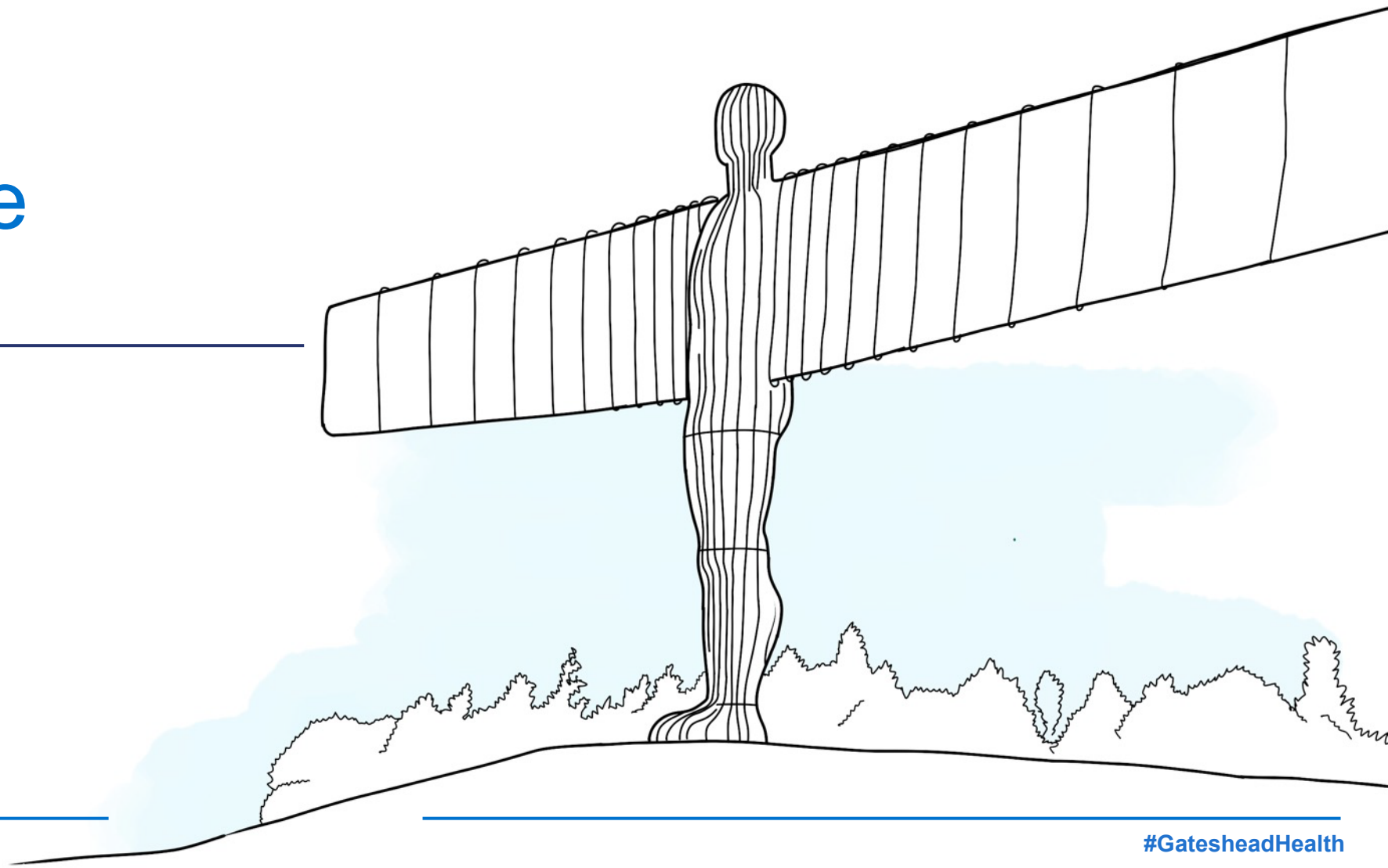
	☐	☐	☒	☐	☒
Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)	**Obj.1** ☐	The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance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

NHS
Gateshead Health
NHS Foundation Trust

Chief Executive Update

Yvonne Ormston MBE

July 2022

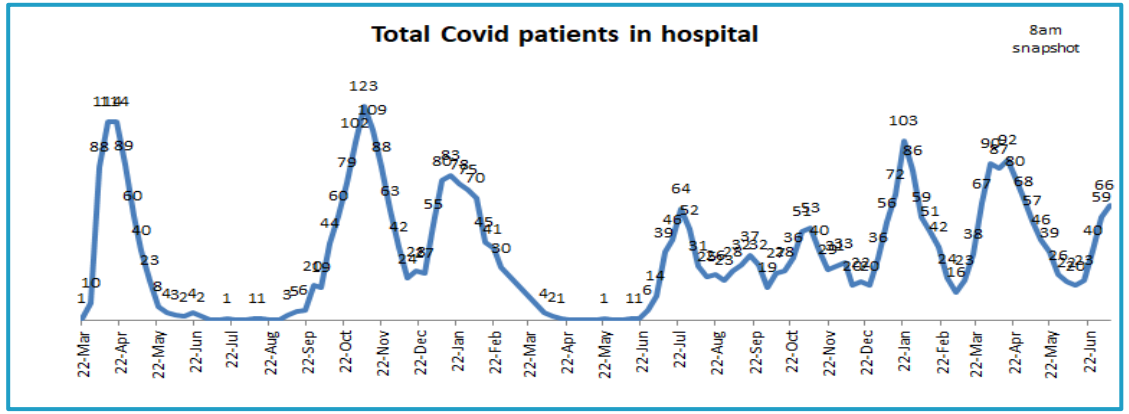


Operational performance

Operational performance

Urgent and emergency care

- Higher levels of attendances in June.
- 4-hour performance at 77.1% (May: 77.9%)
- Bed occupancy increased to 94.4% (May: 92.8%)
- Delayed discharges still a significant issue. There has been an increase in the average daily patient delay rate from an average of 44.2 patients per day in April to 43.6 patients per day in June.
- This is the equivalent of 2 general and acute wards of patients residing in hospital.
- Ambulance delays seen a significant improvement but remain high compared to historic levels.



A&E Indicators	Apr-22	May-22	Jun-22	Q1
Attendances: Type 1	5431	6098	6090	11546
Attendances: Type 3	3323	3618	3569	6941
Total Attendnaces	8754	9716	9659	18470
Total Breaches	2164	2148	2212	4312
Trust total % seen in 4 hours	75.3%	77.9%	77.1%	77%
National Rank (acute Trusts)*	23rd	20th		
12 Hour Trolley waits (target 0)	71	4	11	86
Volume in Department > 12 hours	252	108	193	553
A&E> 12 Hours waits (target <2%)	2.9%	1.1%	2.0%	3.0%

Ambulance Arrivals & Handover Delays	Apr-22	May-22	Jun-22	Q1
% within 15 minute target	52.6%	52.4%	53.9%	53.30%
Ambulance handovers within 30-60 minutes	72	26	40	138
Ambulance handover delays > 60 minutes	62	10	17	89

Performance benchmarking

Gateshead Health NHS Foundation Trust

Indicator	Gateshead Health Performance	View	Position
A&E 4 hour waiting time	77.9%	May	20th / 139 NHS Providers
Latest weekly PTL: patients waiting > 104 weeks	0	w/e 26th June	Joint 1st /8 Providers in ICS
Latest weekly PTL: patients waiting > 52 weeks	73	w/e 26th June	3rd / 8 Providers in ICS
Latest weekly PTL: patients waiting > 62 days for cancer treatment	57	w/e 26th June	1st / 8 Providers in ICS
62-day backlog as % of waiting on the list (612)	9.3%	w/e 26th June	69 (top 20 under NHSE/I scrutiny

Latest update:

- On Sunday 17th July during the heatwave we achieved 91% performance, the second best performance in the North East and Yorkshire.

Our People

5th cohort completed Managing Well

First 2 cohorts of Leading Well filled (Sept start)

Physiotherapy team win education award for ‘outstanding’ training and mentoring of students from Northumbria University

Continued focus on health and wellbeing

- listening space launch
- Schwartz rounds recommenced

Domestic Recruitment

International Recruitment

Longer term strategic supply pipelines

General updates

Provider Collaborative / ICS / ICB

Provider Collaborative Prospectus and Operating Model to be considered at signed off at each provider Board.

On agenda of today's meeting.

Other key updates

Submitted consultation responses to the following draft documents produced by NHS England:

- Draft code of governance for NHS provider Trusts
- Draft addendum to your statutory duties on Governor duties
- Draft guidance on good governance and collaboration

Annual report and accounts submitted to NHS England. Value for money certification expected by the end of this month.

Planning for our Annual General Meeting, which will be held on Wednesday 28 September

General Update

- Visits:
  - People and Organisational Development Team
  - Children's Outpatient Department
  - National Volunteers Week Celebratory event
  - A&E visit
- Meetings
  - NHS Systems Leader webinar
  - Pathology Network development workshop
  - Pathology Network Board meeting
  - Pathology Collaboration meeting
  - ICB recruitment panel
  - Provider Collaborative Board
  - Fortnightly ICS Chief Executive calls
  - IHI Conference
  - Meeting regarding mask production
  - Provider CEOs' meeting on operational pressures
  - Meetings with external companies on discharge
  - Roundtable discussion on delivery and continuous improvement review
  - CEO strategic session with the ICB
  - Objective-setting with Executive Directors
  - Meeting with Sarah Gorman, Edberts House
  - Chaired National Health & Care Women's Network Panel
  - North & NC ICP Meeting
  - Director of Finance recruitment meetings
- Planning and Development
  - SMT and EMT Development
  - Clinical Policy Group time-out
  - Board Strategy session

Board of Directors

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 12i

Report Title:	Organisational Risk Register			
Name of Meeting:	Board of Directors			
Date of Meeting:	27th July 2022			
Author:	Kendra Marley, Corporate Risk Manager			
Executive Sponsor:	**Gill Findley, Chief Nurse**			
Report presented by:	**Gill Findley, Chief Nurse**			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☐
	To ensure the Board and Committees are clearly sighted on those risks that have an organisational -wide impact, the organisational risk register is compiled by the Executive Risk Management Group of those risks that impact on the delivery of strategic aims and objectives. This includes risks included within the Board Assurance Framework (BAF) as well as risks identified by the Group for inclusion as having an organisational impact and impact on delivery of strategic aims and objectives. The supporting report shows the risk profile of the ORR, includes a full register, and provides details of review compliance, and risk movements.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☒ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	The attached report is now received in the Executive Team Meeting each week, and bi-monthly at the Executive Risk Management Group.			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety*	A new strategic risk relating to pandemic activity has been added to the ORR and as a result two covid related risks removed. Additionally one risk relating to staffing levels and covid/surge activity was closed being merged into a similar existing BAF and ORR risk. A third risk relating to leadership and OD strategy was reduced from 12 to 9 following the development of the Leading Well agenda.			

<table>
<tr><td>

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

</td><td colspan="5">A review of strategic risks was undertaken at a Board strategy session in June 2022. The risks will be reviewed and agreed at the Executive Risk Management Group and changes reflected in the ORR to the Board in September 2022.

Risk and action review compliance is consistent, and this is reflective of the improvements being observed across the wider trust registers.</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="5">The Board are asked to:

• Review the risks and actions and discuss and seek further information relating to risks as appropriate.
• Take assurance over the ongoing management of risk.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="4">We will continuously improve the quality and safety of our services for our patients</td></tr>
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<tr><td>Aim 5
☒</td><td colspan="4">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="5">Each risk is linked to a corporate objective, see report.</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☐</td><td>Responsive
☐</td><td>Well-led
☒</td><td>Effective
☐</td><td>Safe
☐</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td colspan="5">Included in report</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☐</td><td>Not applicable
☒</td></tr>
</table>

Organisational Risk Register

Executive Summary

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

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

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

This report covers the period 17th May 2022 to 19th July 2022 (extraction date for this report).

Organisational Risk Register - Movements

One new risk has been added to the ORR in the period;

- Risk 3029 - *There is a risk that there will be further waves of Covid, or continued endemic Covid, which could have an effect across the whole Trust (and the wider health and social care system) leading to workforce shortages, operational pressures because of the need to segregate covid positive patients, cancellation of some elective work, difficulty maintaining flow of care for patients presenting acutely and deflection from Trust "business as usual" activities and development / improvement work.*

This is a new strategic risk relating to Covid, and as a result 2 existing risks related to Covid have been removed from the ORR. These are:

- Risk 2869 - *There is a risk of unintended harm to patients, due to the impact of reduced service provision, delayed treatment and pathway starts as a result of Covid 19. This may result in patients accessing treatment who are more unwell than otherwise would have been, longer stays in hospital and longer recovery periods. (16)*
- Risk 2963 - *Risk that uncertainty relating to next steps for covid vaccine for NHS staff - staff may leave roles/ employment impacting on service delivery and further staff pressures/ wellbeing, impact on recruitment. (9)*

A third risk relating to covid and impact on the new operating model has been retained on the ORR as agreed by the Executive Risk Management Group.

One risk has been reduced;

- Risk 2765 POD - *No Leadership and OD strategy in place across the trust.* Current risk rating reduced from 12 to 9 with the introduction of the Leading Well approach.

One risk has been closed, having been merged into risk 2868 which is on the BAF and ORR;

- Risk 2744 COO - *Risk of low or inadequate staffing to operate effective and efficient service provision as a result of covid surge and response.*

A review of strategic risks was undertaken at a Board strategy session in June 2022. The risks will be reviewed and agreed at the Executive Risk Management Group and changes reflected in the ORR to the Board in September 2022.

Risk and action review compliance is consistent, and this is reflective of the improvements being observed across the wider trust registers.

Recommendations

The Board are asked to:

- Review the risks and actions and discuss and seek further information relating to risks as appropriate.
- Take assurance over the ongoing management of risk.

Organisational Risk Register Report

Reporting Period: 17-May-2022 to 19-Jul-2022

Comparison Date: 17-May-2022

Gateshead Health NHS Foundation Trust

Risk Profile (Current/Managed)

Competency - 1

POD 2765 - No Leadership and OD strategy in place across the trust (9)

Resources - 1

POD 2764 - Workforce - Risk of not having the right people in right place at the right time with the right skills. (16)

Wellbeing - 1

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

Business Continuity - 1

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

Digital - 1

COO 2945 - Risk of ineffective and inefficient management of services due to availability and access to appropriate and timely BI. (12)

Effectiveness - 1

MEDIC 2982 - Risk of delayed transfers of care and increased hospital lengths of stay (16)

Safety - 2

CEOL2 3029 - Risk of further waves/continued endemic Covid, which could impact operational delivery across the whole Trust. (16)

COO 2879 - Risks relating to the trusts Maternity estate that have the potential to impact on the delivery of safe maternity services (12)

Compliance - 2

CEOL2 2964 - There is a risk that there is insufficient and formal oversight on the 4 GP practices currently hosted by the trust (16)

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

Delivery of Objectives - 2

COO 2868 - Further waves of Covid may impact on the ability to deliver key performance targets and recovery plans (16)

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

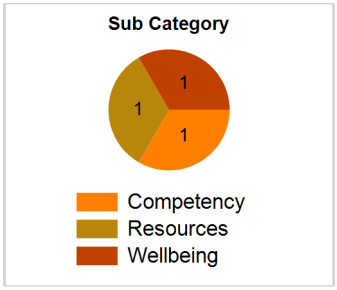
Organisational Risk Register Report

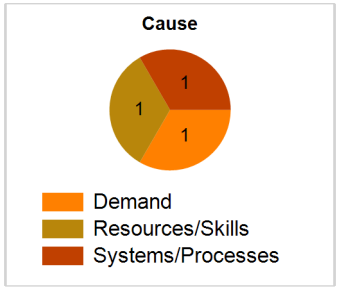
Reporting Period: 17-May-2022 to 19-Jul-2022

Comparison Date: 17-May-2022

Gateshead Health NHS Foundation Trust

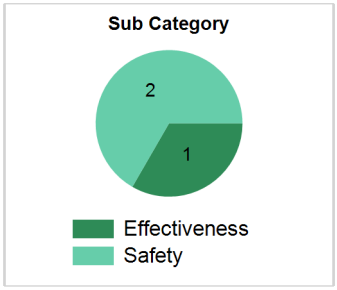
People & Resources

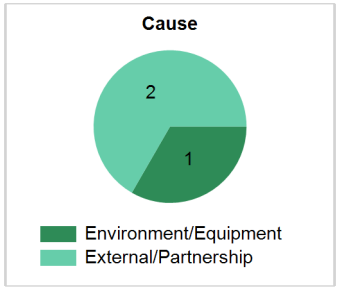




Risk Sub Cat	Risk Cause	No. Risks
Competency	Systems/Processes	1
Resources	Resources/Skills	1
Wellbeing	Demand	1

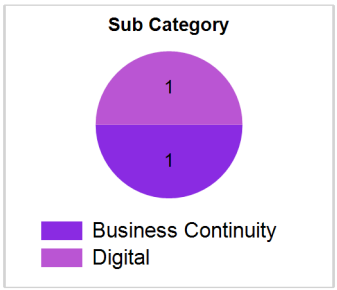
Quality Outcomes

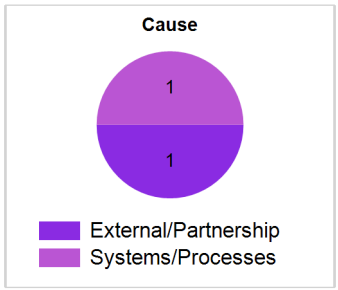




Risk Sub Cat	Risk Cause	No. Risks
Effectiveness	External/Partnership	1
Safety	Environment/Equipment	1
	External/Partnership	1

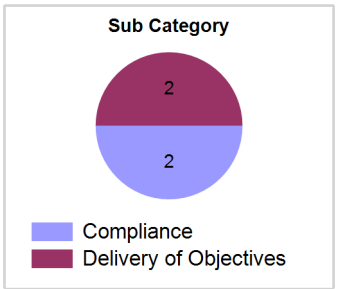
Finance & Efficiency

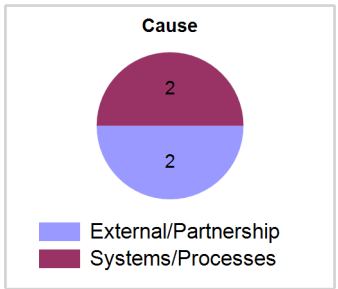




Risk Sub Cat	Risk Cause	No. Risks
Business Continuity	External/Partnership	1
Digital	Systems/Processes	1

Regulation & Compliance, Reputation





Risk Sub Cat	Risk Cause	No. Risks
Compliance	Systems/Processes	2
Delivery of Objectives	External/Partnership	2

Key: **CRR** - Current Risk Rating **PRR** - Previous Risk Rating
IRR - Initial Risk Rating **TRR** - Target Risk Rating

Organisational Risk Register Report

Reporting Period: 17-May-2022 to 19-Jul-2022

Comparison Date: 17-May-2022

Gateshead Health NHS Foundation Trust

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

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR
2764 17/11/2020 Ferne Clements People and OD Human Resources 28/07/2022 BAF HRC ORG 2.3P Develop a trust wide approach to strategic workforce planning	Risk of not having the right people in right place at the right time with the right skills due to lack of workforce capacity, resources and expertise across the organisation to support workforce planning resulting in failure to deliver current and future services that are fit for purpose.	20	Task and finish group established to coordinate all strands of work relating to staffing International recruitment on track Domestic recruitment actively pursued and monitored Over recruiting to HCSW positions to fill some of the Registered Nurse vacancies Recruitment process streamlined (RPIW) Refreshed dataset provided to The Whole System Partnership on 01 March 2022. (to enable workforce planning) Health and Care academy development being overseen by Transformation Board. Updates provided on a monthly basis. SMT discussions on longer term strategic supply pipelines for Registered Nurses have commenced, inc Registered Nurse degree apprentices and Trainee Nurse Associates.	16	Workforce planning to be scoped and future resource identified.	Ferne Clements 31/07/2022	8
2868 27/04/2021 Thomas Knox Chief Operating Officer EPRR & Site Resilience 08/08/2022 BAF COO EPRR FPC ORG QGC 3.8P Deliver the Operational transformation programme to improve productivity and efficiency of service delivery and recovery post covid	Further waves of covid impact on staffing levels and the delivery of the new operating model and associated transformation plans therefore impacting on key performance and recovery plans.	20	EPRR incident response and surge plans in place Reconfiguration from previous waves and learning applied. Workforce management plans in place and monitoring of staff absences available Current model for managing covid within the clinical environment is being changed in line with national guidance. Annual review and establishment of safe nursing staffing levels. 2.Safe staffing report (nursing)produced and forecasting robust. 3.Workforce bank in place (see linked risk) 4.Expanded Agency usage (process for approval) 5.Critical staff payment offer approved and in place. 6.Workforce absence etc captured via ESR/ healthroster 7.New operating model aligns staffing requirements to activity and service plans. 8. Volunteers - recruitment and use 9.Deployment Hub to improve use of available resources	16	Review of temporary staffing solutions	Joanne Baxter 31/07/2022	6
					triangulations of incidents and low staffing	Shelley Dyson 31/07/2022	
					active recruitment to vacanices	Lisa Crichton-Jones 30/09/2022	
					international recruitment programme	Lisa Crichton-Jones 30/09/2022	
					De-escalation	Nicola Bruce (Completed 28/06/2022)	

Key: **CRR** - Current Risk Rating **PRR** - Previous Risk Rating **IRR** - Initial Risk Rating **TRR** - Target Risk Rating

Organisational Risk Register Report

Reporting Period: 17-May-2022 to 19-Jul-2022

Comparison Date: 17-May-2022

Business Intelligence

NHS Gateshead Health NHS Foundation Trust

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR
2964 28/10/2021 Jacqueline Bilcliff Chief Executive Office Chief Executive Office 16/06/2022 BU_DIR ORG 2.5 Strengthen approaches to people related quality, performance and governance measures	There is a risk that there is insufficient and formal oversight on the 4 GP practices currently hosted by the trust resulting in clinical, quality, financial and people risks not being sufficiently understood or mitigated against	16	Some informal oversight by Medical Director / Chief Nurse and COO.	16	Longer term strategy for primary care / GP practices under consideration.	Jacqueline Bilcliff 30/06/2022	6
2982 06/12/2021 Amy Muldoon Medical Services Medical Services - Divisional Management 08/08/2022 BU_DIR COO ORG 3.8P Deliver the Operational transformation programme to improve productivity and efficiency of service delivery and recovery post covid	description: Increased risk of delay in transfer to community due to lack of social care provision and intermediate care beds. Risk of: patients remaining in hospital when medically optimised creating risk to these patients as well as other patients as bed capacity not able to meet demand. Due to: there is currently increased numbers of patients awaiting POC up to 30 patients in medical wards. This delay adds significant pressures to acute bed availability, escalation beds being required and significant risk of problems with flow through hospital impacting A&E breach standards and risk of patients being delayed within ambulances. Resulting in: patient harm or death, patients deconditioning and increased risk of failed discharge secondary to this. Staff health and wellbeing, job dissatisfaction and poor performance due to pressures.	20	Daily meeting with LA to examine capacity in out of hospital system and match with demand for discharges. Target discharges of 40 per week to keep pace with demand. Monitoring of Delayed transfers of care twice weekly meeting Escalation of delays of care to the community BU and social services at twice weekly meetings. Monitoring of any levels of harm - Datix incidents. Monitoring of Breach levels and times. Monitoring of Ambulance delays. Monitoring increased LOS of medically optimised patients. Escalation of patients requiring social services support raised weekly at Discharge Systems group which includes Social services management and CCG representative. Medically Optimised meeting 2x week, passed to IPC/CCG ECIST work Pilot on 2 wards re improving discharges. Further social care provision for discharge purchased and in place from beginning of June 2022	16	RPIW to unblock obstacles to same day discharge	Joanna Clark 31/08/2022	9
					System leadership post for discharge created and to be recruited to	Joanna Clark 31/10/2022	

Organisational Risk Register Report

Reporting Period: 17-May-2022 to 19-Jul-2022

Comparison Date: 17-May-2022

Business Intelligence

NHS Gateshead Health NHS Foundation Trust

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR
3029 04/04/2022 Mr Andrew Beeby Chief Executive Office Medical Directorate 04/05/2022 BU_DIR ORG	There is a risk that there will be further waves of Covid, or continued endemic Covid, which could have an effect across the whole Trust (and the wider health and social care system) leading to workforce shortages, operational pressures because of the need to segregate covid positive patients, cancellation of some elective work, difficulty maintaining flow of care for patients presenting acutely and deflection from Trust "business as usual" activities and development / improvement work.	20	Business continuity and EPRR governance and resilience plans Staffing resilience and backup Service delivery plans IPC planning/ escalation/ reduction of PPE/ distancing Estate flexibility and planned escalation/ covid wards	16			8
2759 16/11/2020 Amanda Venner People and OD Human Resources 28/09/2022 BAF HRC ORG 2.1P Establish a post covid health and well being programme to incorporate; The development of a hwb strategy, roll out of HWB conversations, the continuing arrangement for a Trust Testing Track & Trace & vaccine service and a review of the OH service	Risk that we are not able to appropriately support the health and wellbeing needs of our workforce due to insufficient capacity to support these needs resulting in backlog of Occupational Health work and slow turn around times for management referrals, counselling and proactive management of staff HWB. Resulting in reduced resilience levels low, with mental and physical health needs emerging, potentially resulting in higher levels of absence and turnover and safety incidents as well as an inability to deliver of the relevant HWB aspects of the NHS people plan.	16	Health and Wellbeing team established with Regional funding secured to fund the team until June 2023. Partnered with Talk Works to provide talking therapies and counselling services to reduce waiting times for counselling and psychological support services. Occupational health referral systems(self referral and management referral)and process in place. Occupation Health external review completed, with improvement plan now being implemented. Occupational Health Metrics discussed at POD Quality meeting. Physio appointed 24/7 catering/vending solution now in place and usage is positive Schwartz rounds commenced	12	Engagement on HWB Strategy to be undertaken during May 2022, with strategy finalised and agreed in June 2022	Amanda Venner 01/07/2022	8
					Listening Space	Amanda Venner 31/07/2022	
					Relaunch Health and wellbeing check ins	Amanda Venner 31/08/2022	
					Increase the number of Mental Health first aiders	Amanda Venner 30/09/2022	

Information supporting clinical excellence

RLDatix

Key: **CRR** - Current Risk Rating **PRR** - Previous Risk Rating
IRR - Initial Risk Rating **TRR** - Target Risk Rating

Organisational Risk Register Report

Reporting Period: 17-May-2022 to 19-Jul-2022

Comparison Date: 17-May-2022

Business Intelligence

Gateshead Health NHS Foundation Trust

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR
2779 01/07/2020 Jane Conroy Nursing, Midwifery & Quality Quality Governance 05/08/2022 BAF ORG QGC 1.10P Develop Route Map to CQC Outstanding	The Trust fails to meet the CQC Fundamental Standards resulting in potential regulatory action, harm to patients, decline in ratings, and resulting reputational damage.	16	CQC readiness action plan Inspection action plans Nursing Strategy and Safe Staffing planning & delivery Governance Framework Risk Management systems and processes Health & Safety Governance and processes NICE guidance governance processes Learning Disability Support processes Cancer Services delivery plans Scheduled audits of operational safety elements.	12	Ensure any areas of improvement from last inspection are in place	Jane Conroy 05/08/2022	6
					Develop a route map to Outstanding	Jane Conroy 05/08/2022	
2879 29/04/2021 Helen Routh Chief Operating Officer 08/08/2022 BAF ORG QGC 1.1P Implementation of the recommendations of the Ockenden report on Maternity Services	There are risks relating to the trusts Maternity estate that have the potential to impact on the delivery of safe maternity services and the ability to satisfactorily address actions from local and national requirements (HSIB/ Ockenden/ Continuing Care/ Birthrate Plus.	20	Ockenden Compliance Report – Assurance Assessment tool separate specific risks on register (see linked risks) Quality and safety of services monitored	12	Gap Analysis of Ockenden 2 requirements	Lesley Heelbeck 31/07/2022	4
					Agree a plan to mitigate current risk	Kate Hewitson 01/08/2022	
					Deliver the full project plan for a new maternity build in collaboration with QEF	Joanne Baxter 20/10/2022	
2945 14/09/2021 Debbie Renwick Chief Operating Officer Planning & Performance 08/08/2022 BU_DIR ORG 3.8P Deliver the Operational transformation programme to improve productivity and efficiency of service delivery and recovery post covid	Risk of ineffective and inefficient management of services due to availability and access to appropriate and timely business intelligence to deliver and improve services	15	Programme of work established to work on improving access to BI and improve board reporting along with service line access to quality performance and workforce data Project Manager appointed to lead on this work with support from NECS. Programme involves 3 projects Static reporting – Look back - this is what we achieved Live reporting – this is how we are doing now and where we need to intervene to prevent poor performance Forecasting – these are the trends to be able to plan services much more effectively to meet demand the later two points need further development Some BI available in sitreps and excel format	12	• Assess what is currently available and set up in yellow fin under relevant business units	Michael Smith 31/07/2022	4
					• Work with the BU managers looking at what is available and start to build what is needed and get rid of what is not used/helpful	Debbie Renwick 31/08/2022	
					• Improve data quality by working with teams and provide resilience to teams doing the RTT etc	Debbie Renwick 30/09/2022	
					project groups established and PID developed and plans developed for delivery	David Thompson 30/09/2022	

Organisational Risk Register Report

Reporting Period: 17-May-2022 to 19-Jul-2022

Comparison Date: 17-May-2022

Gateshead Health NHS Foundation Trust

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR
1636 10/11/2014 Dianne Ridsdale Digital IT 07/09/2022 DIGC MDMG ORG	UCRF R01/R03/R20/R23 Malware such as Ransomware Compromising Unpatched Endpoints, Servers, Equipment or due to Lack of Hardened Build Standards. There is a risk of potential exposure to published critical cyber vulnerabilities. Laptops, workstations and medical devices compromised by ransomware or botnets, due to endpoints being susceptible to compromise through the use of obsolete, old, or unpatched operating systems and third party software, including Java. Endpoints often not monitored for patch status. Endpoints compromised more easily through dangerous browser plugins (such as Java, Flash), or unsupported browsers. Servers compromised by ransomware, due to servers susceptible to compromise through the use of obsolete, old, or unpatched operating systems and software. Servers often not monitored for patch status. Due to failure to maintain all Digital assets, including installing Operating system patches, AV patches or other software and hardware updates across the IT estate, including network equipment and medical devices. Resulting in potential harm to patients, data leaks, impacts on service delivery.	25	AV on all end points AV up to date ATP in place site wide NHSD & Microsoft group policy templates Ongoing updates routinely planned as they are released Patching regime	10	Complete Cyber Essential Plus Accreditation	Jon Potts 31/05/2022	5
					Manage replacement of End of life Network Hardware	Jon Potts 30/07/2022	
2765 17/11/2020 Laura Farrington People and OD Workforce Development 30/09/2022 BAF HRC ORG 2.4P Develop a leadership and OD Strategy with clear outcomes	Leaders in the organisation may not lead with an expected level of competence due to lack of leadership and OD strategy.	20	Head of Leadership, OD & Staff Experience in post, with wider OD team now in position. Leadership & OD Programme Board underway, with Exec sponsor in place. POD Committee updated via wider POD Strategic update. Leading Well approach agreed by SMT in May 2022	9	Initial Roll out and review of the leading well programme	Laura Farrington 31/08/2022	8
					Pilot of Leading Well 3 day programme	Laura Farrington 31/10/2022	
					Leadership & OD Strategy	Laura Farrington 31/12/2022	

Key: **CRR** - Current Risk Rating **PRR** - Previous Risk Rating
IRR - Initial Risk Rating **TRR** - Target Risk Rating

Organisational Risk Register Report

Reporting Period: 17-May-2022 to 19-Jul-2022

Comparison Date: 17-May-2022

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR
2880 30/04/2021 Mr Andrew Beeby Chief Executive Office Medical Directorate 16/08/2022 BAF ORG QGC 4.3P Strong partner working at place, ICP, ICS levels and beyond to manage population health and tackle health inequalities - Appoint a consultant in Public Health jointly with LA & CCG	Risk that Place/ICS/ICP strategy and plans do not fully align with our objectives and aspirations to tackle health inequalities. Due to slightly different aims and objectives, or ways of doing things. Slow or no progress against health inequalities.	12	Being involved with ICS / ICP / Place in the development of work (co-production) Health Inequalities Board established.	9			6
							12

Changes in CRR - Current/Managed Risks

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note	PRR
2765 17/11/2020 Laura Farrington People and OD Workforce Development 30/09/2022 BAF HRC ORG 2.4P Develop a leadership and OD Strategy with clear outcomes	No Leadership and OD strategy in place across the trust	20	Head of Leadership, OD & Staff Experience in post, with wider OD team now in position. Leadership & OD Programme Board underway, with Exec sponsor in place. POD Committee updated via wider POD Strategic update. Leading Well approach agreed by SMT in May 2022	9	Initial Roll out and review of the leading well programme Pilot of Leading Well 3 day programme Leadership & OD Strategy	Laura Farrington 31/08/2022 Laura Farrington 31/10/2022 Laura Farrington 31/12/2022	8	Current Controls updated	12
									1

Key: CRR - Current Risk Rating; IRR - Initial Risk Rating; PRR - Previous Risk Rating; TRR - Target Risk Rating

Organisational Risk Register Report

Reporting Period: 17-May-2022 to 19-Jul-2022

Comparison Date: 17-May-2022

Gateshead Health NHS Foundation Trust

Risks Moved to Managed in Period

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

Risks Closed in Period

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due / (Open Actions)	TRR	Closure Details	PRR
2744 01/07/2020 Joanne Baxter Chief Operating Officer EPRR & Site Resilience 16/06/2022 BU_DIR COO ORG 3.8P Deliver the Operational transformation programme to improve productivity and efficiency of service delivery and recovery post covid	Risk of low or inadequate staffing to operate effective and efficient service provision as a result of covid surge and response.	20	1.Annual review and establishment of safe nursing staffing levels. 2.Safe staffing report (nursing)produced and forecasting robust. 3.Workforce bank in place (see linked risk) 4.Expanded Agency usage (process for approval) 5.Critical staff payment offer approved and in place. 6.Workforce absence etc captured via ESR/ healthroster 7.New operating model aligns staffing requirements to activity and service plans. 8. Volunteers - recruitment and use 9.Deployment Hub to improve use of available resources	16			6	merged into risk 2868 (BAF and ORR)	16
1									

Risks Added in Period

Key: CRR - Current Risk Rating; IRR - Initial Risk Rating; PRR - Previous Risk Rating; TRR - Target Risk Rating

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note / Date Added to ORR
3029 04/04/2022 Mr Andrew Beeby Chief Executive Office Medical Directorate 04/05/2022 BU_DIR ORG	There is a risk that there will be further waves of Covid, or continued endemic Covid, which could have an effect across the whole Trust (and the wider health and social care system) leading to workforce shortages, operational pressures because of the need to segregate covid positive patients, cancellation of some elective work, difficulty maintaining flow of care for patients presenting acutely and deflection from Trust "business as usual" activities and development / improvement work.	20	Business continuity and EPRR governance and resilience plans Staffing resilience and backup Service delivery plans IPC planning/ escalation/ reduction of PPE/ distancing Estate flexibility and planned escalation/ covid wards	16			8	31-05-2022
								1

Risks Removed in Period

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note / Date Removed from ORR
2869 27/04/2021 Helen Routh Chief Operating Officer EPRR & Site Resilience 16/06/2022 COO 3.8P Deliver the Operational transformation programme to improve productivity and efficiency of service delivery and recovery post covid	There is a risk of unintended harm to patients, due to the impact of reduced service provision, delayed treatment and pathway starts as a result of Covid 19. This may Result in patients accessing treatment who are more unwell than otherwise would have been, longer stays in hospital and longer recovery periods	20	Detailed elective recovery plans have been developed and are underway Additional capacity is being facilitated to reduce waiting times Clear trajectory to reduce long waiters Clinical review of those long waiters	16	work with newly appointed public health consultant and gateshead system to determine health inequalities	Andrew Beeby 30/06/2022	8	Full plans in place, no current impact on achievement of plan, however risk remains in terms of wider pressures within patient pathways relating to outpatients and diagnostic capacity. 31-05-2022
					deliver the planned and elective recovery transformation plan	Helen Routh 26/09/2022		
					delivery trajectory to address all 52 week waiters	Helen Routh (Completed 16/05/2022)		

Organisational Risk Register Report

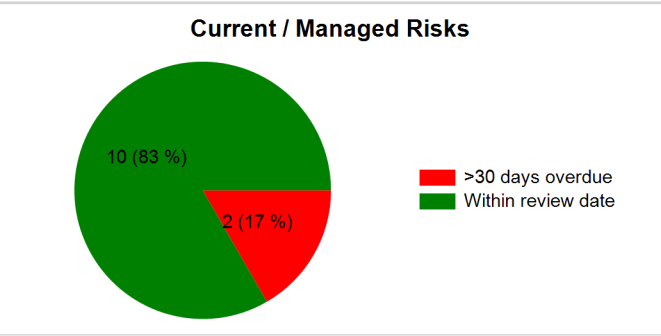
Reporting Period: 17-May-2022 to 19-Jul-2022

Comparison Date: 17-May-2022

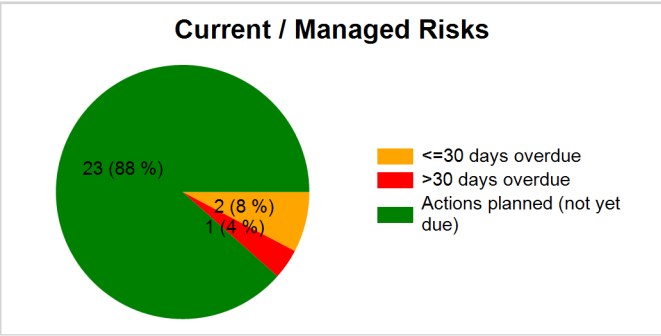
Gateshead Health NHS Foundation Trust

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note / Date Removed from ORR
2963 28/10/2021 Amanda Venner People and OD Human Resources 24/08/2022 BU_DIR 2.3P Develop a trust wide approach to strategic workforce planning	Risk that uncertainty relating to next steps for covid vaccine for NHS staff - staff may leave roles/ employment impacting on service delivery and further staff pressures/ wellbeing, impact on recruitment.	9	Current vaccination program and known % of staff vaccinated New recruits asked for vaccination status Current progress and project plan known Agreed process for discussing vaccination status, redeployment/ other options POD Lead assigned	9	Task and finish group to complete actions below	Laura Farrington (Completed 08/06/2022)	4	Risk wording updated 31-05-2022
								2

Risk Review Compliance



Risk Action Compliance



Movements in CRR

				CRR		
BU	Service Line	ID	Risk Description	May-2022	Jun-2022	Today
Chief Executive Office	Chief Executive Office	2964	There is a risk that there is insufficient and formal oversight on the 4 GP practices currently hosted by the trust	16	16	16

Key: **CRR** - Current Risk Rating **PRR** - Previous Risk Rating
IRR - Initial Risk Rating **TRR** - Target Risk Rating

Organisational Risk Register Report

Reporting Period: 17-May-2022 to 19-Jul-2022

Comparison Date: 17-May-2022

Gateshead Health NHS Foundation Trust

				CRR		
BU	Service Line	ID	Risk Description	May-2022	Jun-2022	Today
Chief Executive Office	Medical Directorate	2880	Risk that Place/ICS/ICP strategy and plans do not fully align with our objectives and aspirations to tackle health inequalities.	9	9	9
		3029	Risk of further waves/continued endemic Covid, which could impact operational delivery across the whole Trust.	16	16	16
Chief Operating Officer		2879	Risks relating to the trusts Maternity estate that have the potential to impact on the delivery of safe maternity services	12	12	12
	EPRR & Site Resilience	2868	Further waves of Covid may impact on the ability to deliver key performance targets and recovery plans	16	16	16
	Planning & Performance	2945	Risk of ineffective and inefficient management of services due to availability and access to appropriate and timely BI.	12	12	12
Digital	IT	1636	UCRF R01/R03/R20/R23 - Malware such as Ransomware Compromising Unpatched Endpoints, Servers and Equipment	10	10	10
Medical Services	Medical Services - Divisional Management	2982	Risk of delayed transfers of care and increased hospital lengths of stay	16	16	16
Nursing, Midwifery & Quality	Quality Governance	2779	The Trust fails to meet the CQC Fundamental Standards.	12	12	12
People and OD	Human Resources	2759	We are not able to appropriately support the health and wellbeing needs of our workforce	12	12	12
		2764	Workforce - Risk of not having the right people in right place at the right time with the right skills.	16	16	16
	Workforce Development	2765	No Leadership and OD strategy in place across the trust	12	9	9

Key: **CRR** - Current Risk Rating **PRR** - Previous Risk Rating
IRR - Initial Risk Rating **TRR** - Target Risk Rating

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 13

Report Title:	**Consolidated Finance Report – Part One**			
Name of Meeting:	Trust Board			
Date of Meeting:	27th July 2022			
Author:	Mrs Jane Fay, Assistant Director of Finance – Strategic Finance			
Executive Sponsor:	Mrs Jacqueline Bilcliff, Group Director of Finance			
Report presented by:	Mrs Jacqueline Bilcliff, Group Director of Finance			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☐
	The purpose of this paper is to provide assurance against corporate objectives and address financial risks			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Finance & Performance Committee			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	For the period April to June 22 the Trust has reported an actual deficit of £2.887m after adjustments for donated assets and gain & losses of asset disposal. This is an increase of £0.192m from the deficit reported at the end of May. The reported deficit is an adverse variance of £3.679m from the Trust's planned surplus totalling £0.792m. For the period April to June 22 the Trust has spent £0.961m of its approved annual capital programme totalling £9.326m.			
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The recommendation to Board is to receive the report, discuss the potential implications and record partial assurance as a direct consequence of the reported year to date position.			

	To note the summary of performance as at 30th June 2022 (Month 3) for the Group (inclusive of Trust and QE Facilities, excluding Charitable Funds).				
Trust Strategic Aims that the report relates to:	**Aim 1** ☒	We will continuously improve the quality and safety of our services for our patients			
	Aim 2 ☐	We will be a great organisation with a highly engaged workforce			
	Aim 3 ☒	We will enhance our productivity and efficiency to make the best use of resources			
	Aim 4 ☐	We will be an effective partner and be ambitious in our commitment to improving health outcomes			
	Aim 5 ☐	We will develop and expand our services within and beyond Gateshead			
Trust corporate objectives that the report relates to:					
Links to CQC KLOE	Caring ☐	Responsive ☐	Well-led ☒	Effective ☐	Safe ☐
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks and DATIX reference)					
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐		**No** ☐	**Not applicable** ☒	

1. Introduction

1.1 The purpose of this report is to provide a summary of financial performance as at 30th June 2022 (month 3) for the Group (inclusive of the Trust and QE Facilities, excluding Charitable Funds).

2 2022-23 Financial Framework

2.1 The financial framework for 2022-2023 is underpinned by the following principles:

- A continuation of the block contract values agreed in H2 2021-22 with an inflation uplift of 1.7% inclusive of a 1.1% efficient target and an additional 0.7% for excess inflation announced as part of the second round of financial planning.
- Activity growth of 2.3%
- System funding inclusive of specific allocations for COVID, urgent care capacity and maternity investment funding
- The continuation of the Elective Recovery Fund (ERF) to support activity recovery in addition to system financial envelopes, with indicative ERF's baselines included in funding proposals to achieve financial thresholds equivalent to 104% of weighted 19-20 activity baselines
- Additional funding streams outside of system envelopes to fund COVID pathology testing and vaccination programmes
- An Integrated Care Board requirement to achieve a breakeven position

2.2 The Trust's 2022-2023 financial plan reports a surplus of £1.610m inclusive of the achievement of £10.939m cost reduction programme (CRP) target and elective recovery fund (ERF) income totalling £6.226m.

2.3 Reporting for June is against the Trust's 2022-2023 revised financial plan submission.

3 Income and Expenditure

3.1 The Trust has reported a deficit of £2.545m for the period April to June 2022 prior to an adjustment for donated assets, profit / losses on disposal of assets and the net impact of donated PPE from DHSC, and an adjusted deficit of £2.887m.

3.2 This is an adverse variance of £3.679m against the revised June 22 plan as detailed on the Trust Statement of Comprehensive Income (SOCI) presented in Table 1 which is based on a surplus of £0.792m.

3.3 For the month of June 2022 the Trust has reported actual income of £28.960m, resulting in a June adverse variance of £0.531m from the NHSEI plan mainly due to the Trust not achieving ERF income following the non-achievement of June 22 target ERF financial baseline.

3.4 Total year to date income is £88.238m and an adverse variance of £0.232m from the year-to- date plan. The £0.232m variance is mainly due to the non-achievement of £1.560m ERF income offset by £0.442m non-recuring funding for specific developments not included in the Trusts plan, more income than planned for pass through drugs & devise £101k and the provision of primary care services £70k.

3.5 For the month of June 2022 the Trust has reported actual operating expenditure of £29.054m resulting in a June adverse variance of £0.246m from the NHSEI plan mainly due to the non-achievement of the CRP target for June.

3.6 Total year to date operating expenditure is £89.945m and an adverse variance of £3.524m from the year-to-date plan. Of the total operating expenditure £0.820m is directly attributable to the Trust's response to the COVID-19 pandemic.

STATEMENT OF COMPREHENSIVE INCOME

June 22-23

	NHSE APRIL - MARCH 23 REVISED ANNUAL PLAN					VARIANCE		
	Annual Plan	Plan In Month	Actual In Month	Plan to Date	Actual to Date	Variance (Actual - Plan)		Previous Month Variance
	£000's	£000's	£000's	£000's	£000's	£000's		£000's
Operating								
Operating Income from Patient Care activities								
Income From NHS Care Contracts	(320,909.0)	(26,741.0)	(26,445.7)	(80,223.0)	(79,341.3)	881.7		994.3
Income From Local Authority Care Contracts	(90.0)	(7.0)	(13.7)	(21.0)	(41.3)	(20.3)		(13.5)
Private Patient Revenue	(735.0)	(61.0)	(41.0)	(183.0)	(158.7)	24.3		4.3
Injury Cost Recovery	(290.0)	(24.0)	(44.4)	(72.0)	(98.8)	(26.8)		(6.4)
Other non-NHS clinical revenue	(850.0)	(71.0)	(85.9)	(213.0)	(178.6)	34.4		49.3
Total Operating Income From Patient Care activities	**(322,874.0)**	**(26,904.0)**	**(26,630.7)**	**(80,712.0)**	**(79,818.8)**	**893.2**		**1,027.9**
Other Operating Income								
Education and Training Income	(7,631.0)	(636.0)	(387.6)	(1,908.0)	(2,465.9)	(557.9)		(287.7)
R&D Income	(527.0)	(44.0)	(59.0)	(132.0)	(219.2)	(87.2)		(72.2)
Top up Income	-	-	-	-	-	-		
Funding outside of System Envelope	(3,910.0)	(326.0)	(369.1)	(978.0)	(637.9)	340.1		(259.4)
Other Income	(18,609.0)	(1,551.0)	(1,513.5)	(4,650.0)	(4,668.4)	(18.4)		(464.0)
Donations & Grants Received	(366.0)	(30.0)	-	(90.0)	(427.6)	(337.6)		(367.6)
Total Other Operating Income	**(31,043.0)**	**(2,587.0)**	**(2,329.2)**	**(7,758.0)**	**(8,419.0)**	**(661.0)**		**(1,978.8)**
Total Operating Income	**(353,917.0)**	**(29,491.0)**	**(28,959.9)**	**(88,470.0)**	**(88,237.7)**	**232.3**		**(950.9)**
Operating Expenses								
Employee Expenses - Substantive	221,172.0	18,212.0	17,676.4	54,613.0	53,774.3	(838.7)		(331.1)
Employee Expenses - Bank	7,150.0	641.0	724.4	1,935.0	3,466.4	1,531.4		1,448.0
Employee Expenses - Agency	3,653.0	344.0	1,019.4	1,040.0	2,803.3	1,763.3		1,087.9
Employee Expenses - Other	1,187.0	99.0	70.3	297.0	207.3	(89.7)		(33.0)
Total Employee Expenses	**233,162.0**	**19,296.0**	**19,490.4**	**57,885.0**	**60,251.3**	**2,366.3**		**2,171.9**
Purchase of Healthcare - NHS bodies	6,076.0	506.0	444.9	1,518.0	1,667.700	149.7		210.8
Purchase of Healthcare - Non NHS bodies	2,348.0	196.0	352.4	588.0	826.893	238.9		82.5
Purchase of Social Care	-	-	-	-	-	-		-
NED's	188.0	16.0	14.4	48.0	41.445	(6.6)		(5.0)
Supplies & Services - Clinical	24,096.0	2,009.0	1,901.3	6,027.0	6,128.518	101.5		209.2
Supplies & Services - General	3,225.0	269.0	256.8	807.0	658.734	(148.3)		(136.1)
Drugs	18,339.0	1,529.0	1,810.5	4,587.0	5,251.324	664.3		382.9
Research & Development expenses	-	-	(0.2)	-	2.777	2.8		2.9
Education & Training expenses	1,089.0	91.0	103.2	273.0	513.282	240.3		228.1
Consultancy costs	143.0	12.0	3.8	36.0	110.872	74.9		83.1
Establishment expenses	3,209.0	268.0	305.1	804.0	826.986	23.0		(14.1)
Premises	17,041.0	1,420.0	1,610.1	4,260.0	4,915.746	655.7		465.7
Transport	1,628.0	136.0	136.5	408.0	383.645	(24.4)		(24.9)
Clinical Negligence	7,923.0	660.0	660.3	1,980.0	1,980.711	0.7		0.5
Operating Leases	2,604.0	217.0	27.8	651.0	135.242	(515.8)		(326.5)
Other Operating expenses	3,967.0	331.0	297.5	993.0	1,020.962	28.0		61.4
Cost Improvement Programme	-	-	-	-	-	-		-
Reserves	-	-	-	-	-	-		-
Operating Expenses included in EBITDA	**325,038.0**	**26,956.0**	**27,414.9**	**80,865.0**	**84,716.2**	**3,851.2**		**3,392.2**
Depreciation & Amortisation - Purchased / Constructed	8,238.0	687.0	640.4	2,061.0	1,884.487	(176.5)		(129.9)
Depreciation & Amortisation - Donated / Granted	366.0	30.0	28.6	90.0	85.772	(4.2)		(2.8)
Depreciation & Amortisation - Finance Leases	13,569.0	1,130.0	1,130.1	3,390.0	3,390.352	0.4		0.2
Impairment & Revaluation	61.0	5.0	(184.7)	15.0	- 206.162	(221.2)		(31.5)
Restructuring Costs			-		-	-		-
Operating Expenses excluded from EBITDA	**22,234.0**	**1,852.0**	**1,614.4**	**5,556.0**	**5,154.4**	**(401.6)**		**(164.0)**
Total Operating Expenses	**347,272.0**	**28,808.0**	**29,029.3**	**86,421.0**	**89,870.6**	**3,449.6**		**3,228.3**
(Profit)/Loss from Operations	**(6,645.0)**	**(683.0)**	**69.5**	**(2,049.0)**	**1,632.9**	**3,681.9**		**2,277.4**
Non Operating								
Non-Operating Income								
Finance Income	(105.0)	(9.0)	(37.524)	(27.0)	(97.9)	(70.9)		(42.3)
Total Non-Operating Income	**(105.0)**	**(9.0)**	**(37.5)**	**(27.0)**	**(97.9)**	**(70.9)**		**(42.3)**
Non-Operating Expenses								
Finance Costs	589.0	49.0	43.3	147.0	204.4	57.4		63.1
Gains / (Losses) on Disposal of Assets	-	-	-	-	-	-		-
PDC dividend expense	3,156.0	263.0	247.6	789.0	742.8	(46.3)		(30.8)
Total Finance Costs (for non-financial activities)	**3,745.0**	**312.0**	**290.9**	**936.0**	**947.2**	**11.2**		**32.3**
Other Non-Operating Expenses								
Misc. Other Non-Operating expenses			-		-	-		-
Total Non-Operating Expenses	**3,745.0**	**312.0**	**290.9**	**936.0**	**947.2**	**11.2**		**32.3**
(Surplus) / Deficit Before Tax	**(3,005.0)**	**(380.0)**	**322.9**	**(1,140.0)**	**2,482.2**	**3,622.2**		**2,267.3**
Corporation Tax	1,395.0	116.0	(103.4)	348.0	63.2	(284.8)		(65.3)
(Surplus) / Deficit After Tax	**(1,610.0)**	**(264.0)**	**219.4**	**(792.0)**	**2,545.4**	**3,337.4**		**2,202.0**
(Surplus) / Deficit After Tax from Continuing Operations	**(1,610.0)**	**(264.0)**	**219.4**	**(792.0)**	**2,545.4**	**3,337.4**		**2,202.0**
Remove capital donations / grants I&E impact	-	-	(28.6)	-	341.8	341.8		370.4
Gain on disposal of assets	-	-	-	-	-	-		
Impairements - AME	-	-	-	-	-	-		
Loss on disposal of DHSC assets	-	-	-	-	-	-		
Remove net impact of consumables donated from other DHSC bodies			-		-	-		
Adjusted Financial Performance (Surplus) / Deficit	**(1,610.0)**	**(264.0)**	**190.9**	**(792.0)**	**2,887.2**	**3,679.2**		**2,572.4**
Adjusted Financial Performance (Surplus) / Deficit	**(1,610.0)**	**(264.0)**	**190.9**	**(792.0)**	**2,887.2**	**3,679.2**		**2,572.4**

Table 1: Trust Statement of Comprehensive Income

4 Cost Reduction Programme (CRP)

4.1 Included in the Trust's 2022-23 financial plans is an annual CRP requirement of £10.939m with £3.293m planned to be achieved by June 22. At this stage in the financial year no schemes have been actioned with work on going to identify schemes in the coming months.

5 Cash and Working Balances

5.1 Group cash as at 1st April 2022 totalled £55.586m. The cash position of £47.047m as at 30th June is equivalent to an estimated 49.29 days operating costs and represents a £0.766m increase from May 2022.

5.2 The liquidity metric has deteriorated by 1.39 days against May to +10.84 days driven by a £1.414m reduction in the working capital balance, however this is 1.97 days better than Plan (8.87 days).

5.3 The balance sheet is presented in Table 2.

Table 2 – Statement of Position

Statement of Position - June 2022

	2022/2023 May 2022 Group £000's	2022/2023 June 2022 Group £000's	Movement from Prior Month £000's	2022/2023 June 2022 QEF £000's	2022/2023 June 2022 FT £000's
Assets					
Non-Current Assets					
Investments	80	80	0	80	16,824
Property, Plant and Equipment, Net	135,116	136,817	1,701	1,309	135,508
Trade and Other Receivables, Net	1,917	2,012	95	814	1,198
Finance Lease - Intragroup				42,047	0
Trade and Other Receivables - Intragroup Loan	0	0	0		11,668
Total Non Current Assets	137,112	138,909	1,796	44,249	165,199
Current Assets					
Inventories	4,649	4,809	160	2,569	2,240
Trade and Other Receivables - NHS	12,349	14,579	2,230	484	14,094
Trade and Other Receivables - Non NHS	5,848	5,536	(312)	777	4,759
Trade and Other Receivables - Other	0	0	0		0
Prepayments	6,511	5,726	(785)	439	5,287
Cash and Cash Equivalents	46,281	47,047	767	7,616	39,431
Other Financial Assets - PDC Dividend	488	488	0		488
Accrued Income	2,985	3,276	291	1,875	1,401
Finance Lease - Intragroup				525	0
Trade and Other Receivables - Intragroup Loan					3,104
Total Current Assets	88,396	81,462	2,351	14,284	70,806
Liabilities					
Current Liabilites					
Deferred Income	9,273	9,600	326	213	9,387
Provisions	3,959	3,959	0	320	3,639
Current Tax Payables	4,743	4,450	(293)	392	4,059
Trade and Other Payables - NHS	2,323	2,659	336	1,034	1,625
Trade and Other Payables - Other	9,797	10,571	773	2,143	8,427
Trade and Other Payables - Capital	319	(307)	(627)	0	(307)
Other Financial Liabilities - Accruals	32,673	33,913	1,240	8,468	25,444
Other Financial Liabilities - Borrowings FTFF	999	999	0	0	999
Other Financial Liabilities - PDC Dividend	495	743	248	0	743
Other Financial Liabilities - Intragroup Borrowings	0	0		3,104	0
Finance Lease - Intragroup	0	0		0	525
Total Current Liabilities	73,867	66,585	2,003	15,673	54,540
NET CURRENT ASSETS (LIABILITIES)	14,529	14,877	348	(1,389)	16,266
Non-Current Liabilities					
Deferred Income	2,036	2,018	(18)	1,719	299
Provisions	3,123	3,123	0	0	3,123
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	11,668	0
Other Financial Liabilities - Borrowings FTFF	13,011	13,011	0	0	13,011
Finance Lease - Intragroup				0	42,047
Total Non-Current Liabilities	18,169	18,152	(18)	13,387	58,480
TOTAL ASSETS EMPLOYED	**133,472**	**135,634**	**2,162**	**29,473**	**122,985**
Tax Payers' and Others' Equity					
PDC	145,470	145,470	0	0	145,470
Taxpayers Equity	0	0	0	0	0
Share Capital	0	0	0	16,824	0
Retained Earnings (Accumulated Losses)	(21,892)	(19,731)	2,162	20,611	(40,342)
Other Reserves	0	0	0	0	0
Revaluation Reserve	9,795	9,795	0	0	9,795
Misc Reserve	99	99	0	0	99
TOTAL TAXPAYERS EQUITY	133,472	135,634	2,162	37,436	115,023
TOTAL ASSETS EMPLOYED	**133,472**	**135,634**	**2,162**	**37,436**	**115,023**

6 Capital

6.1 The Trust's 2022-2023 CDEL limit had been set at £8.419m, with contributions from capital grants of £0.427m and donated assets of £0.480m increasing capital resources to £9.326m as summarised in the below table: -

CDEL	£000's
Net Depreciation*	7,605
Internal Cash	464
Donation - Decarbonisation	427
Donated Assets	480
PDC	350
Total	9,326

* After Principal Loan Repayments of £0.999m

6.2 Capital spend up to the 30th of June was £0.961m, £0.700m below plan. Expenditure in the period was in respect of the Maternity Theatre, building maintenance and schemes from the 2021/22 programme which were carried forward.

7 Risk

7.1 There are a number of risks that must be noted alongside consideration of the financial position:

- activity is not delivered in line with planned trajectories, leading to reduced access to ERF funding.
- efficiency requirements cannot be achieved due to ongoing operational pressures resulting from COVID and demand on unscheduled care.
- financial mitigations (Trust and ICB) assumed in plan are not realised in line with expected figures.
- cost implications associated with safer staffing tool, not yet quantifiable.
- capacity to deliver efficiency requirements, change in financial framework/direction and ability to deliver transformation impact on delivery of financial plan.
- capital schemes are not in place in a timely basis to enable capacity required to manage surge.
- the capital plan may be impacted by short notice, non-recurrent funding made available nationally.

Jacqueline Bilcliff, Group Director of Finance
18th July 2022

Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 14

Report Title:	**Integrated Oversight Report**			
Name of Meeting:	Board of Directors			
Date of Meeting:	27th July 2022			
Author:	Deborah Renwick and IOR Reporting Leads			
Executive Sponsor:	Joanne Baxter			
Report presented by:	Joanne Baxter			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☐
	To summarise performance in relation to key NHS standards, requirements and KLOE's to outline the risks and recovery plans associated with COVID -19. This report covers the reporting period of May and June 2022.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☒ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Chief Operating Officer's Senior Management Team Trust Senior Management Team			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	Key points highlighted in the IOR: **<u>Safe (pages 8-10 of IOR)</u>** 5 Serious Incidents were STEIS reportable in June and are currently under review. **<u>Effective (pages 11-12 of IOR)</u>** Readmission rates are increasing (subject to deep dive). Hospital Standardised Mortality Ratio (HSMR) continues to show more deaths than expected for this indicator, however no new data has been able to be provided this month as it is not available until later in Jul-22. **<u>Responsive (pages 13-24 of IOR)</u>** **UEC:** Front of house performance measures shown below despite an increase in attendances through ED: • 4-hour performance is at 77.1% (last month's performance of 77.9% placed the Trust 20th top quartile) • 11 patients waited longer than 12 hours to be admitted • 12 hour waits in department to discharge increased to 198 • Ambulance delays 40: 30-60 and 17: >60 mins			

<table>
<tr><td></td><td colspan="2">

- Bed occupancy increased to 94.4%

Indicative activity levels are below planned levels with combined elective activity at 96%.

- Day cases: 112%
- Elective inpatients: 78%.
- New outpatient attendances: 99%
- Follow-up attendances: 97%
- Diagnostics 110%

RTT: Performance Pressures include:

- Higher referral rates across surgical specialties
- Increases in the patients waiting for treatment 52 & 72 week waiters are above planned levels
  - 71 52w in May, indicative 73 in June
- May RTT <18 weeks waiters at 75.9%
- June RTT <18 week waiter's indicative at 74%

Diagnostics: DM01 6-week performance at 79%. Pressures in Audiology and echocardiology continue

Cancer: Performance measures:

- Higher referral rates in breast
- 2week wait performance at 89.7%
- Faster Diagnostic Standard at 69.4%
- 62-day cancer 67.2% (April)*
- Overall, 62-day waiters are in line with trajectory 57 against a plan of 75
- Weekly PTL on 5/6/22: sharp increase to 71

Duty of candour: Verbal and written duty of candour are demonstrating downward trends.

Well led (pages 25-28 of IOR)
Workforce pressures continue although sickness absence levels improved to 5.2% (May).

Benchmarking (page7 of this report)
The Trust remains in a relatively strong position against available benchmarking data.

</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="2">This report seeks to provide assurance in respect of the priority objectives to 3.8 deliver operational transformation to improve productivity and efficiency.

The recommendations to the Board are to receive this report, discuss the potential implications and record as limited/partial assurance as a direct consequence of the impact on activity recovery, long waiting times and performance.</td></tr>
<tr><td rowspan="3">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td>We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td>We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td>We will enhance our productivity and efficiency to make the best use of resources</td></tr>
</table>

	Aim 4 ☒	We will be an effective partner and be ambitious in our commitment to improving health outcomes
	Aim 5 ☐	We will develop and expand our services within and beyond Gateshead
Trust corporate objectives that the report relates to:	3.8 (F&P) Deliver operational transformation to improve productivity & efficiency 3.9 (F&P) Develop smart integrated reporting framework	

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

Risks / implications from this report (positive or negative):			
Links to risks (identify significant risks and DATIX reference)	• Activity & Elective Recovery (2560, 2884,2869) • Emerging increase in referrals rates – Breast, T&O and urology) • UEC performance and flow • Ambulance Delays • 12 Hour Trolley waits • Cancer rising referral rates (breast) Gynae transfers • Workforce fatigue and health and well being • Staffing and workforce gaps in key areas (2956, 2942, 2514, 2946, 2938, 2953, 1675) • Backlog reduction: Cancer – Urology, Gynaecology (2514), LGI Echocardiology (2730) • Outpatient capacity to see patients face to face • Maternity pressures (1675)		
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒

INTEGRATED OVERSIGHT REPORT – JULY COMMITTEES

1. Introduction

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

IOR section	Area	Data Item	Reporting Period	Data Quality Sign Off
Safe, high-quality care	Safe	SI's	Reported June	***
	Safe	Open Safety alerts	June	***
	Safe	Reporting Safety incidents	June	***
	Effective	HMSR	October 19 to Feb 22	***
	Effective	SHMI	Sept 19 to Jan 22	***
	Effective	Long Lengths of Stay	June CDS	***
	Maternity	All sub-set standards	June	***
Responsive	Responsive	Community	June	**
	Responsive	A&E	Submitted June	***
	Responsive	2 week waits		**
	Responsive	RTT	May (provisional) Early indications for June	**
	Responsive	Cancer		**
	Responsive	Diagnostics		**
	Recovery	Activity	June: Draft reporting/baseline construction	**
Well Led	People and workforce	Sickness, Appraisals, training	May	***
	*** Signed off Unlikely to change, ** Subject to validation * snapshot position			

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

Quality Governance Committee:

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

People & OD:

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

Finance & Performance Committee:

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

2. Key issues & findings

2.1 Safe

2.1.1 **Trust level SI's (page 8):** Five incidents have been reported in June, which is below average for the last 18 months. Themes include falls and test results. There was one maternity SI's were reported in June.

2.1.2 **Patient Safety Alerts (page 9):** One open patient safety alert**.**

2.1.3 **Infection Prevention & Control (page 10):** During the reporting month June Covid infections in hospital started to increase and continued to do so into July – volumes peaked at. The Trust has reported 5 C.Difficle infections and 11 E.Coli infections in Q1. There have been no MRSA infections.

2.2 Effective

2.2.1 **HMSR (page 11):** Continues to show more deaths than expected with an HSMR of 113.7 for the rolling period of Mar-21 to Feb-22. The SHMI is at 1.02 and is within expected range. IOR (pg.20) provides a summary of the findings from Q3 and Q4 Learning from Deaths Report.

2.2.2 **Readmission Rates (page 12): T**his quality measure looks at the number of patients who were readmitted with 30 days is now triggering concern. Readmission rates are an imperfect absolute measure as readmissions can occur due to avoidable or unavoidable reasons. It is likely that the increase is due to the changes in recoding from ambulatory care to SDEC. A further deep dive is now in progress to understand the clinical reasons contributing to the increase whilst extracting the extremely valuable learning from patient level reviews.

2.3 Responsive

2.3.1 **Urgent and Emergency Care (pages 13-14):** Attendances through ED in June continues to see higher levels of attendances. In June, with increases in activity levels front of house, there have been some challenges across the suite of performance measures. Highlights include:

- 4 hour performance is at 77.1% (slight deterioration from last month 77.9)
- 11 patients waiting longer than 12 hours to be admitted (May:4)
- 12 hour waits in department from arrival to discharge deteriorated to 198 (May:108)
- Ambulance delays reported: 40 between 30-60mins and 17 delays >60 mins (May: 26/10)
- Bed occupancy levels increased from 92.8% in May to 94.4% in June.

2.3.2 The hospital remains under pressure with ED, Urgent and Emergency Care and Community continuing to care for patients with increased acuity. Delayed discharges constrained by (i) limited care packages in the community and (ii) reduced capacity in nursing homes, and (iii) limited access to residential homes has continued through Q1. The average daily patient delay rate increased slightly from 44.2 in April to 46.2 in May, fell slightly to 43.6 in June. The Trust is still experiencing significant volumes of beds blocked, circa 2 General & Acute wards of patients residing in hospital who are medically optimised and are fit to go home. Out of area discharges also remain problematic.

The number of patients in hospital with longer lengths of stay remain above average levels. Difficulties experienced in maintaining patient flow manifest in 'blockages' in the front of house and delays allocating specialty beds.

Winter bed escalation plans were instigated early this year and the Trust continues to operate with winter or escalation beds open alongside full capacity protocols to cope with the peaks and beds blocked with patients no longer meeting the criteria to reside.

2.3.3 **Community Teams (page 15):** Continue to support secondary care services by keeping patients in their own home. Community teams, including children's services saw 39,596 patients in June (averaging 1,319 per day). The Rapid Response team responded to 66 two-hour crisis response referrals and achieved an indicative compliance rate of 64.14% for patients referred within 2 hours. The target is to achieve a 70% compliance rate by Q3.

2.3.4 **Elective activity and recovery (pages 16-17):** The expectation is to reach 104% of activity of the 2019/20 plan. June (draft) combined **elective activity is at 96%** of 2019/20 baseline activity, which is below planned levels although much improved from April's overall activity levels of 92%. Overnight elective activity improved 78% of baseline year. Day case treatments have improved from 103% in May to 112% in June and Outpatient attendances are at 99% for new 97% follow-up attendances. National and regional concerns have been raised about the activity levels and pressures in Q1 with similar pressures replicated across the ICS.

Patient Initiated Follow-up (PIFU) attendances remain static at 2% and the Trust achieved 25% of remote outpatient appointments against the transformational requirement of 25%.

Diagnostic activity levels improved across all modalities to 110% of baseline year. Echocardiology activity is at 73% remains below planned levels and colonoscopies improved to 130% and CT at 131% of pre-covid levels.

2.3.5 **RTT (page 18):** Continued focus on increasing capacity to reduce patient backlogs and waiting times.

Reduced activity levels in Q1 and increased referrals particularly in surgical specialties have increased the number of patients waiting for hospital treatment from 10,957 waiting at the end of March to 11,563 at the end of June* *indicative*. Weekly reviews of the PTL demonstrate a week on week increase of patients waiting and a corresponding growth in over 52-week waiters, increasing from 52 at the end of April to 71 in May and 73 in June(unvalidated).

Performance measures demonstrate that circa 75% of our patients are waiting less than 18 weeks, performance is above the 61.7% national position.

Clinical prioritisation continues with a particular focus on patients with long waits or who continue to choose to wait longer for care, where offers for care and treatment have repeatedly been declined. The Trust is now following guidance which involves individualised patient level risk management involving joint reviews with GPs for on-going patient management and care. Weekly patient level reviews continue to with a focus on long waiters and proactive care management.

2.3.6 **Diagnostics (page 19):** Finalised performance for the Trust improved from 75.1% in April to 78.7% in May. Modalities achieving the standard are CT (99.5), barium enema (100%) and non-obstetric ultrasound at 99.6%.

Challenged modalities and pressures continue in: Audiology 57.6% (May 56.7) and echo-cardiology performance at 38.4% (May 32.6%), the Trust will not achieve the echocardiology improvement trajectory to eliminate long waiters by the summer. Operational teams continue to review all options to reduce waiting times.

2.3.7 **Cancer (pages 20-23):** Continued focus on clinical prioritisation and increasing capacity to reduce patient backlogs and waiting times.

At the end of June, the Trust reported 66 patients waiting longer than 62 days, (representing an in month decrease of 14 patients from 80). The Trust continues to support the ICS wide provision of cancer services and difficulties persist in gaining access to treatments across shared pathways.

Performance against **62-day cancer treatment** target declined from to 67.2% in April to 34.5% in May, Breast achieved the standard with performance at 91.7%, service pressures continue across all other tumour sites.

In June performance against the 2week standard has remained stable at 88.4%. Increases in breast referrals continue to cause pressure in this high-volume tumour group. Particular capacity pressures are evident in lung 2, accounting for 80% of the patients waiting 3 weeks or more.

The trust is performing well in the 31day standard measuring treatment from diagnosis.

The Trust did not achieve the **Faster diagnostic standard** in April and May with performance at 73.4% and 69.3% and against the 75% target. ** Gynaecology, Upper GI, Lower GI, and urological tumour sites are challenged. Early indications demonstrate Trust level compliance in June at 75.5%

2.3.8 **Verbal Duty of Candour (page 24):** Duty of Candour compliance in June is sitting just below 80%, triggering a cause for concern, this figure is after several initiatives to ensure that DOC has been undertaken for all cases meeting the notifiable Safety incident criteria. The reason for the remaining low compliance is due to the small numbers involved June only 5 incidents met the criteria 4 have been completed (80%)- the 5th is an IT incident spanning multiple patients and as yet the harm level for the SI is unknown and has therefore been set at moderate until any harm is identified.

2.4 Well Led

2.4.1 **Workforce (pages 25-27):** Sickness absence levels (in May) improved to 5.2% from 6.1% in April. Trust level appraisal compliance increased to 62.4% but continues below the 85% target. Core training data also continues to display special cause variation and is outside of expected levels with performance at 74.9% (improvement from 68.5% in April).

2.4.2 **Data Quality Maturity Index (page 28):** Displaying special cause variation, caused by two fields in the mental health dataset. Further investigative work is underway to understand the issues and re-submit year to date activity. A business case is in the pipeline to support the Business Unit to proactively manage the data issues and waiting lists.

2.5 Maternity

2.5.1 **Maternity (pages 29-35):** Going forward this section will have a dedicated maternity report out with the IOR.

Total number of births continue within expected range. Smoking at time of delivery remains high at 12% against the 5% target and breast feeding at discharge remains a concern, although the trajectory is demonstrating early signs of improvement. Babies admitted directly to SCBU > 37 week gestation is at 2.8 % and within normal range, whilst the pre-term birth rate at 7.9 % is within expected levels.

The current reporting arrangements are under review in line with Okenden 2 requirements.

2.6 Benchmarking

2.6.1 The Trust remains in a relatively strong position against available benchmarking data below the ‘reading room’ contains a wider set of productivity benchmarking data.

Indicator	*QEH Performance*	*View*	*Position*
A&E 4 hour waiting time	77.9%	May	20th / 139 NHS Providers

Latest weekly PTL: patients waiting > 104 weeks	0	w/e 26th June	Joint 1st /8 Providers in ICS
Latest weekly PTL: patients waiting > 52 weeks	73	w/e 26th June	3rd / 8 Providers in ICS
Latest weekly PTL: patients waiting > 62 days for cancer treatment	57	w/e 26th June	1st / 8 Providers in ICS
62-day backlog as % of waiting on the list (612)	9.3%	w/e 26th June	69 (top 20 under NHSE/I scrutiny

3. Recommendations

3.1 The Board are recommended to note the content of this report, in summary:

I. Pressures in discharging patients continue to impact on the Trust's ability to maintain patient flow, escalation beds are still open across the site challenging the clinical operating model and staffing models are stretched. Additional beds are open over and above planned levels which will ultimately impact on Trust expenditure. Readmission rates are also higher than expected levels and work is underway to understand the increasing trends.

II. Whilst activity levels have improved overall on last month's reported position, indicative elective activity levels in June continue below plan; this position is also replicated across the ICS. Lower levels of activity combined with increased referral rates have impacted on waiting lists with an increase in RTT long waiters and challenged cancer pathways continue to demonstrate pressures.

III. The Trust is unlikely to achieve the 104% value attributed to ERF, (elective recovery funding) assumed in the financial plan.

IV. Pressures are bubbling across diagnostic modalities, and services continue to review options for recovery. Prolonged reduced levels of activity in echocardiology have increased the volume of patients awaiting test, the summer target in the improvement trajectory is at risk.

V. Despite footfall through A&E increasing the Trust has sustained positive movements across the suite of UEC measures and remains in the top quartile for A&E performance.

Gateshead Health NHS Foundation Trust

Integrated Oversight Report

July 2022

Data: May/June 2022

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NHS
Gateshead Health
NHS Foundation Trust

Note: Press *Ctrl+click* on the page number, to go to the page in the report

CQC Rating

Gateshead Health NHS Foundation Trust

Overall rating for this trust	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Outstanding
Are services responsive?	Good
Are services well-led?	Good
Are resources used productively?	Requires improvement

KLOE Summary: Indicators triggering concern or displaying Special Cause Variation

Gateshead Health NHS Foundation Trust

Indicators triggering variation or failing targets are summarised below – with spotlights referenced within the report.
All indicators are now detailed in the appendices of this report.

Safe
1 of 8 applicable indicators triggering SPC/underachieving against targets

Responsive
20 of 32 applicable indicators triggering SPC/underachieving against targets

Effective
3 of 5 applicable indicators triggering SPC/underachieving against targets

Well Led
10 of 13 applicable indicators triggering SPC/underachieving against targets

Caring
0 of 1 applicable indicators triggering SPC/underachieving against targets

Maternity
4 of 5 applicable indicators triggering SPC/underachieving against targets

KLOE Summary

Gateshead Health NHS Foundation Trust

Safe

Total number of **Trust reportable SI's: 5** are reported in month, open and under investigation
One maternity Serious Incident reported in June-22
There is currently **one open patient safety alerts** not completed by deadline
No Never Events in the past 18 months

Effective

The Trust **Hospital Standardised Mortality Ratio** (HSMR) continues to shows more deaths than expected for this indicator. **As last month - no new data available until later in Jul-22**
The **Summary Hospital Level Indicator** (SHMI) shows deaths within the expected range. **As last month - no new data available until later in Jul-22**
The **Long Length of stay greater than 21 days indicator** has triggered special cause variation. There was an improvement in the average number of Long stay patients (LOS 21+) from 83.6 in May to 67.8 in June.

Caring

There are **no caring indicators triggering concern**.

Responsive

See next slide for details

Well Led

Core training performance increased to 74.9%
Appraisals remains broadly the same as last month at 62.4%
Sickness Absence rates 5.2% in May, above target however below the 18 month average

Maternity

Includes an progress against Ockenden compliance, SI update and a sub-set of indicators taken from the maternity dashboard.
Breast feeding at time of discharge and Smoking at delivery currently triggering concern as target consistently not achieved.

KLOE Summary

Responsive

NHS Gateshead Health NHS Foundation Trust

UEC: June 22 Performance against the 4 hour standard is 77.10%. Overall activity remains (6.68%) below pre-covid levels. Footfall through UEC decreased slightly to 9,659 in June from 9,716 attendances in May. June activity is on average 42 attendances per day more than last year (15.1% increase). The latest national benchmarking data (May – performance of 77.9%) places the Trust at 20th of 139 Type 1 providers. The Trust reported 40 30-60 minute and 17 over 60 minute ambulance delays in June. The Trust also reported 11, 12 hour waits from decision to admit to leaving ED and 193, 12 hour waits in the ED (from registration to left department).

RTT: May 22 Performance against the 18 week standard is 75.85% with an increase of patients on the RTT waiting list from 11.336 to 11,542 and an increase to 71 patients waiting over 52 weeks, five of which were over 78 weeks.

Cancer: 2ww Cancer referrals remain higher than pre-pandemic levels which creates challenge in achieving the 2 Week Wait Standard. The indicative Trust position against the target in June is 88.4%, below the 93% standard. In June 1,125 Two week wait referrals were received which shows an increase of 1.9% in comparison to the same period last year and up by 23.2% on the same period in 2019.

Cancer Faster Diagnostics Performance is at 69.3% in May. Historically Trust was achieving this target – performance deterioration from March 2022. Performance Risks across all specialties - Particularly challenged specialties include Lung, Gynae, Lower GI and Urology. Implementation of Best Practice Timed Pathways is underway

Cancer: 62 day treatments The Trusts position against the 62 day standard showed a significant decrease in performance in May reporting performance at 36.9% with only Breast tumour site above the performance standard of 85%.

Diagnostics: The Trust failed the diagnostic standard in May reporting 78.73% of patients seen with 6 weeks of referral. Echocardiography continues to be the main challenge at 38.37% and Audiology is also reported below target at 57.07% and highlighted as an area of concern.

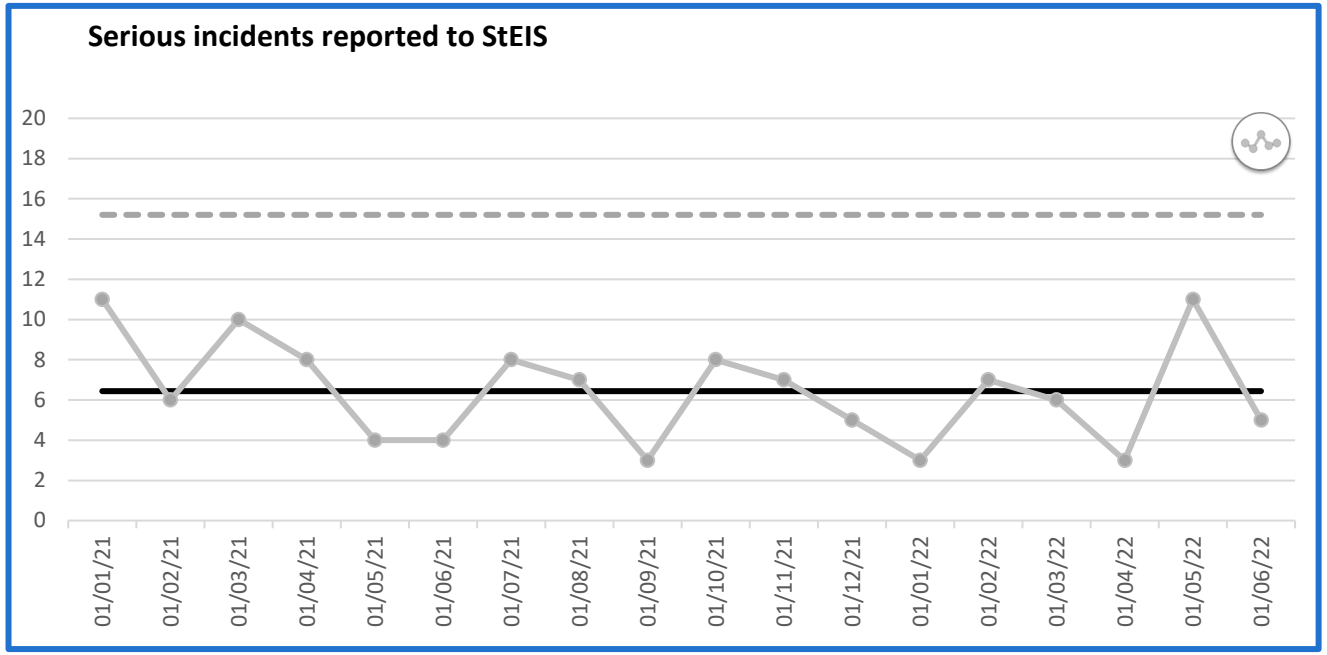
Duty of candour: Verbal compliance with Duty of candour was 80.0% (4 of 5) in June 2022 triggering a cause for concern. This figure is after a number of initiatives to ensure that DOC has been undertaken for all cases meeting the notifiable safety incident criteria

The following section includes detailed reports for a range of key measures, reported for each domain. These metrics might include indicators triggering concern or displaying Special Cause Variation and spotlights requested specifically by Committee or Board.

Safe - Serious Incidents reported to StEIS

Safe

NHS Gateshead Health NHS Foundation Trust



Aim: to ensure SI's are identified, reported and investigated appropriately. Identifying and sharing learning to prevent future occurrence.

Operational Definition: Serious Incidents and never events as defined NHS Improvement's Never Events Policy and framework (Jan 2018) reported on to STEIS.

Health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified.
Serious Incidents include acts or omissions in care that result in; unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm - including those where the injury required treatment to prevent death or serious harm, abuse.

Consequence: of Failure: Patient safety, quality, Trust reputation, scrutiny from regulators.

There were 5 SI's declared in June – themes are listed below:

- 2 x Fall on same level - cause unknown
- 1 x Test results / reports - failure / delay to receive
- 1 x Diagnosis - delay / failure
- 1 x Diagnosis - incorrect

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

Detail on this measure is included as there are patient safety alerts currently open which were not completed by the deadline in the last 18 months

Safe

Gateshead Health NHS Foundation Trust

Background
The Central Alerting system produces a range of alerts, and the Trust receives these via a central email address for review, appropriate circulation and action. Previously on this report only those labelled as National Patient Safety Alerts have been reported on, and tracked for completion in the graph.

In the graph, NatPSA remaining open beyond timescales for completion the deadline was 25th November 2022. No assurance has been identified that this alert can be closed to date. This information is drawn from the National MHRA site.

NatPSA/2021/009/NHSPS Infection risk when using FFP3 respirators with valves or Powered Air Purifying Respirators (PAPRs) during surgical and invasive procedures.

NB it should be noted that the information above is derived from a national data base and is not congruent with the information held in Ulysses at a Trust level**

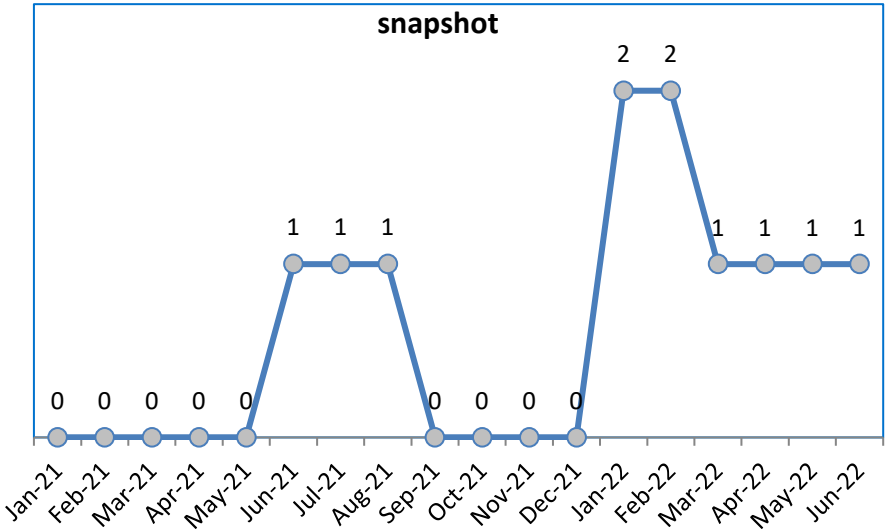
A full review of the Ulysses system shows other types of alert that remain open, n=36, with 16 being overdue. 17 alerts do not have a specified completion date. A full paper describing these has been produced for Risk and Patient Safety Council this month. It is believed that several of these alerts have been completed but not closed within the system and work remains ongoing to clarify and rectify this.

There have been 6 alerts received in June 2022, 4 have been closed , 2 medication alerts remain open but within timescales

2 x MHRA alerts
3 x Drug alerts
1 x National Patient Safety Alert

Recommendation
Reconciliation of internal and national databases, determination of what types of alerts require reporting for the IOR going forward

Number of NHS England or NHS Improvement patient safety alerts outstanding in most recent monthly snapshot

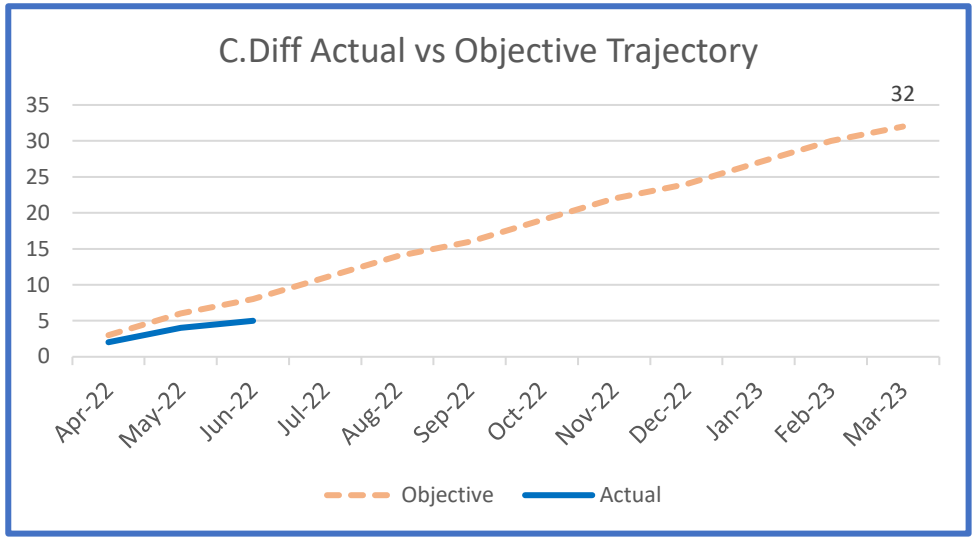


Source: https://www.cas.mhra.gov.uk/Help/AlertComplianceData.aspx

Safe – Infection Prevention & Control

Safe

Gateshead Health NHS Foundation Trust



Aim: to reduce the incidence of healthcare acquired infections

Operational Definition: Healthcare-associated infections (HCAIs) developed as a direct result of healthcare interventions or from being in contact with a healthcare setting

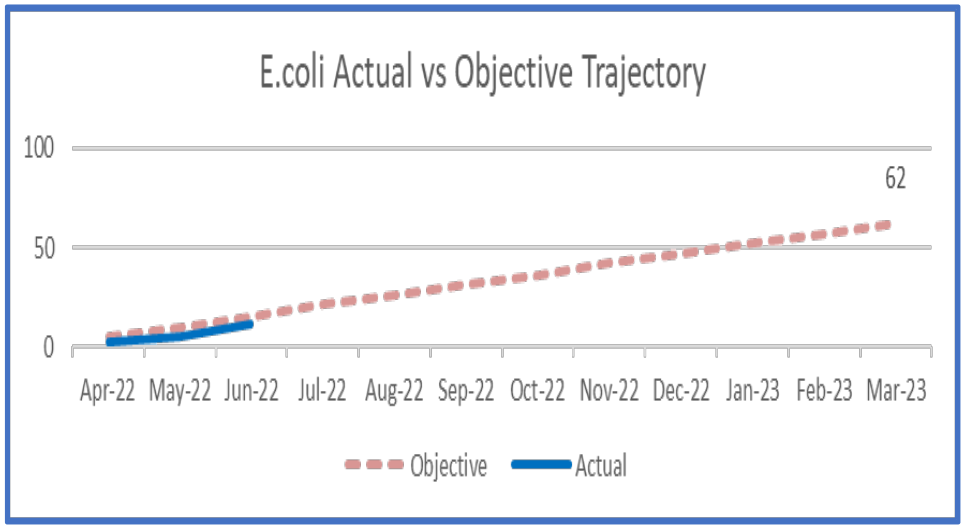
Consequence: Patient safety, quality, patient experience

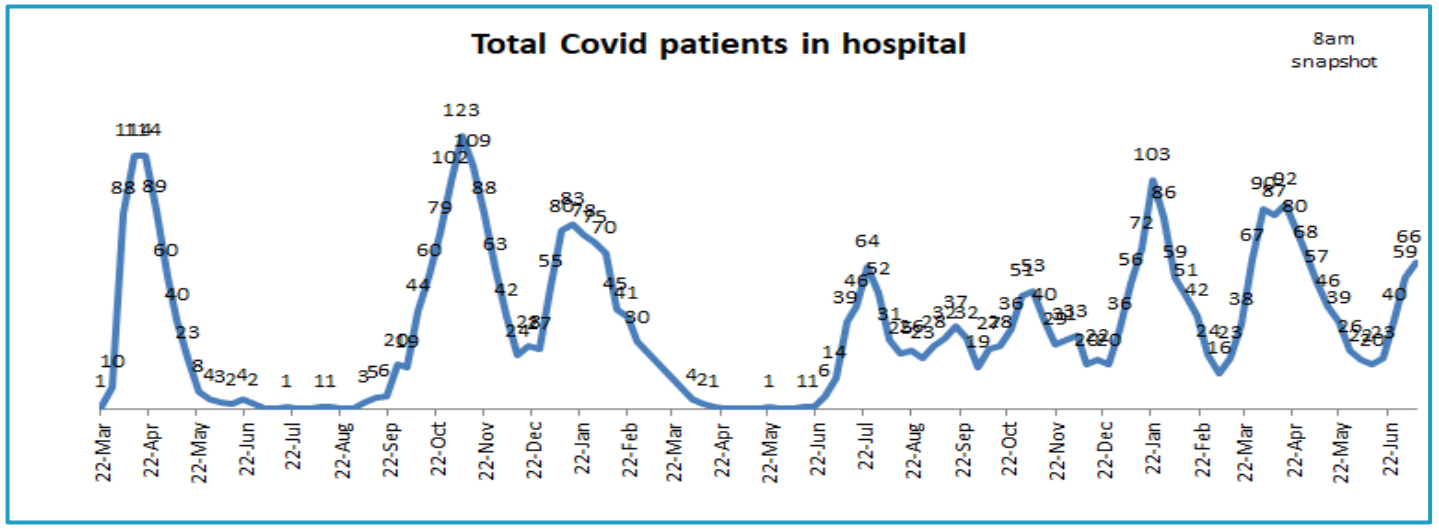
Covid: Graph illustrates the decrease in number of patients who tested positive for Covid from May to June. Although Covid cases are on the increase throughout June.

C.Diffiicile: 5 infections to date against a trajectory if 8.

E.Coli: 11 Ecoli infections to date in 2022-23

MRSA: Zero MRSA infections have been reported to date against a zero tolerance in this measure.



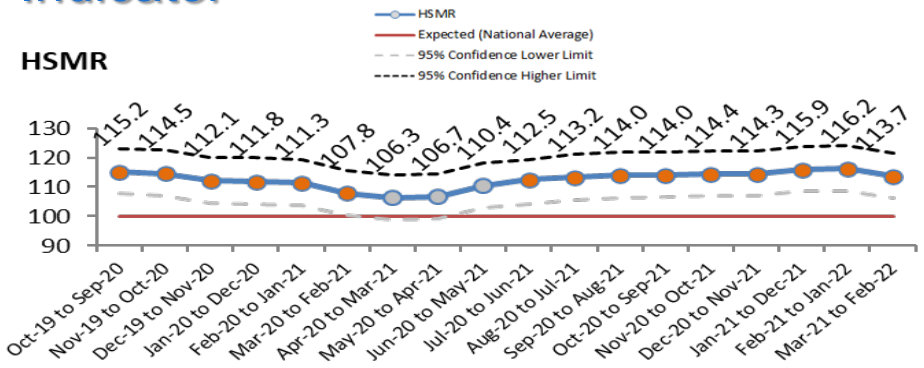


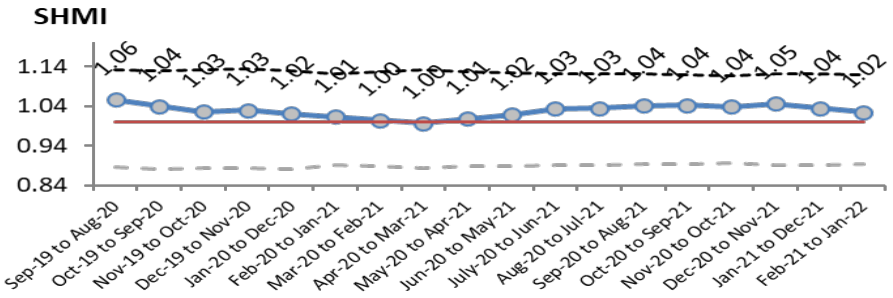
Report by exception: Effective – Hospital Standardised Mortality Ratio and Summary Hospital-Level Mortality Indicator

Situation – Position remains the same as last month as new data is not available until later in July 2022

Effective

Gateshead Health NHS Foundation Trust





Deaths 01/06/2021 to 30/05/2022

Deaths in scope	Deaths reviewed by Medical Examiner	Deaths reviewed by Ward Team	Learning Disability Deaths reviewed at Mortality Council	Severe Mental Illness deaths reviewed at Mortality Council	Patients received a Mortality Council Review
1195	99.8%	44.9%	52.9%	7.3%	5.3%

The scores below relate to reviews undertaken by either the Ward Based Team and /or Mortality Council.
Mortality Council review score supercedes Ward Based Team review score where both have taken place.

Hogan 1 - Definitely Not Preventable	Hogan 2 - Slight Evidence of Preventability	Hogan 3 - Possibly Preventable (Less than 50:50)	Hogan 4 - Probably preventable (more than 50:50)	Hogan 5 - Strong Evidence Preventable	Hogan 6 - Definitely Preventable	Potentially avoidable deaths
96.8%	2.8%	0.4%	0.0%	0.0%	0.0%	0.0%

NCEPOD Score 1 Good Practice	NCEPOD Score 2 Room for improvement - Clinical Care	NCEPOD Score 3 Room for Improvement - Organisational Care	NCEPOD Score 4 Room for Improvement Clinical and Organisational Care	NCEPOD Score 5 Less Than Satisfactory	NCEPOD score 6 Insuficient data
87.0%	2.1%	9.1%	1.6%	0.0%	0.2%

The Trust HSMR is 113.7 and remains with a banding of 'More Deaths than Expected' for the most recent available period. The SHMI is 1.02 and remains with a banding of 'As Expected'

Background - The HSMR and SHMI are measurement tools that considers observed hospital deaths (and deaths within 30 days of discharge for the SHMI) with the an expected number of deaths based on certain risk factors identified in the patient group. The HSMR is risk adjusted on palliative care coding whereas the SHMI is not.

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

Recent analysis of data from HED , the Trusts benchmarking provider identified the Trust as having a lower depth of coding score for deceased patients when compared to the national figures (this means patients have fewer diagnosis codes recorded on average). The Trust also has a relatively low comorbidity score for Congestive Heart Failure patients, comorbidity score is used in the case mix adjustment when calculating expected deaths. Conversely the Trust's comorbidity score is higher than the national score when considering all diagnostic groups. This information has been shared with the clinical coding department for further investigation.

Mortality review data for the last 12 months demonstrates that 96.8% of deaths reviewed were definitely not preventable. Cases scoring more than Hogan 1 are subject to a review at Mortality Council, the majority of these cases are also patient safety incidents and would go through the Trusts Serious Incident Panel. Since the inception of the Medical Examiner Service in September 2020, they review all deaths and escalate cases for additional investigations i.e. Mortality Council, patient safety investigation.

Actions

- Potential issues identified with clinical coding shared with the clinical coding team for further investigation.
- Task & Finish Group set up to incorporate the Medical Examiner Review into the level 1 process. A large proportion of deaths are expected and well managed, particularly in the Medical Business Unit. Changing the process will release capacity and allow the ward teams to concentrate their efforts on reviewing the deaths where is the most learning and areas for improvement. First meeting took place on 16th February, very well attended, agreement to change process and action plan development to achieve this. Action plan is on track, work ongoing with the systems to ensure capture of data and allow for reporting. Medical Examiner reviews will now be reported in terms of level 1 reviews.
- Two additional Mortality Council meetings have been scheduled to review heart failure deaths – 15 cases have been reviewed 12 x Hogan 1 and 3 x Hogan 2. 7 x NCEPOD 1, 4 x NCEPOD 3 and 4 x NCEPOD 4. Learning identified in terms of NCEPOD 3 and 4's was 1) delays in discharges as a result of delays in obtaining social care packages, 2) recognition of patient dying, 3) reduced access to obtaining ECHOs and telemetry and appropriateness of placing patients in wards were there is limited access to monitoring 4) ECGs not documented within patient notes 5) Senior decision making and handover 6) Referrals to heart failure team – completed reviews undertaken and action plan developed
- Explore the use of HIE to ensure all comorbidities are captured more efficiently in the initial clerking document in order to be coded appropriately, lead for Great North Care Record, he is going to take it back to the HIE – completed full access to HIE is available
- Review the admission document to ensure all differential diagnoses can be added and coded appropriately. Completed September 2021

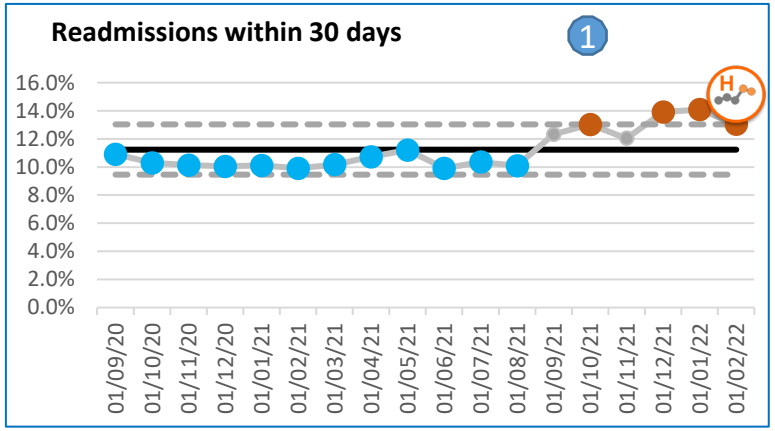
Recommendation - Continue to inform & note actions undertaken at Mortality and Morbidity steering group and Quality Governance Committee via the Integrated Oversight Report and Mortality Paper.

Report by exception: Readmissions within 30 days

Situation – Position remains the same as last month as new data is not available until later in July 2022

Effective

NHS Gateshead Health NHS Foundation Trust

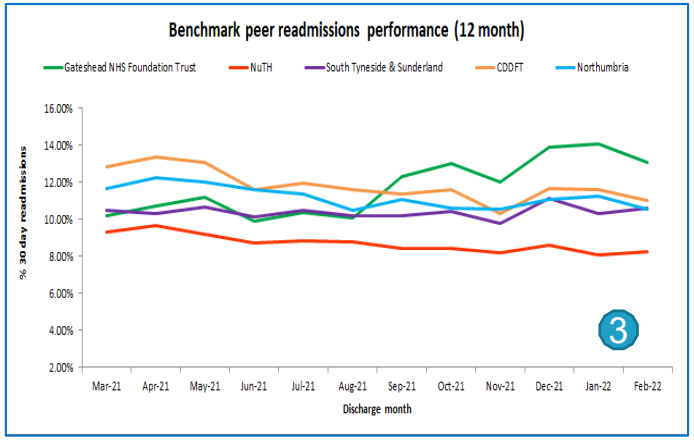


TRUST

Lower than GHFT
Higher than GHFT

	Gateshead NHS Foundation Trust			NuTH	S'Tyneside & S'land	CDDFT	Northumbria
	Discharges	Re-admissions	%age				
Mar-21	4807	489	10.17%	9.29%	10.48%	12.82%	11.69%
Apr-21	4632	497	10.73%	9.65%	10.32%	13.36%	12.24%
May-21	4603	516	11.21%	9.17%	10.68%	13.09%	12.03%
Jun-21	4993	495	9.91%	8.72%	10.15%	11.63%	11.59%
Jul-21	4644	481	10.36%	8.86%	10.50%	11.95%	11.36%
Aug-21	4361	440	10.09%	8.76%	10.19%	11.62%	10.48%
Sep-21	5226	644	12.32%	8.42%	10.19%	11.39%	11.09%
Oct-21	5079	662	13.03%	8.41%	10.41%	11.58%	10.60%
Nov-21	5156	621	12.04%	8.21%	9.79%	10.30%	10.54%
Dec-21	5043	702	13.92%	8.62%	11.14%	11.68%	11.05%
Jan-22	4664	657	14.09%	8.10%	10.33%	11.63%	11.26%
Feb-22	4535	592	13.05%	8.24%	10.59%	11.01%	10.56%

2



Situation
Special cause variation (high) observed in 30 day readmissions for October 2021 and December 2021 to February 2022.

Background
Emergency readmissions – where patients are readmitted to hospital in an emergency within 30 days of discharge – are frequently used as a measure of poor patient outcomes. However, it is not this simple. Some emergency readmissions may result from potentially avoidable adverse events, but others may be due to unrelated or unforeseen causes of admission. Some may relate to changes in the way that hospitals run services – for example, through the increased use of frailty and ambulatory care units. And others might be a consequence of our ageing population and the increase in the number of people living with multiple chronic conditions. Despite the complications in interpreting what this means for the quality of care, publishing data on emergency readmissions is the first step in understanding why they are happening. The measure considers the % of patients who are readmitted as an emergency within 30 days of discharge. It is calculated by dividing the total number of patients readmitted as an emergency within 30 days of discharge, by the total number of discharges per month.

Assessment
% of readmissions has been above the mean since September 21. Most recent month has seen reduction to 13.05%, having been around 14% in previous 2 months (chart 1). Charts 2 and 3 show our benchmarked performance against some other local Trusts (the ones we have data for). Until September GHFT were benchmarking favourably, however in September there was a significant jump that other Trusts did not.

Most recent data shows Surgery accounts for 48.4% of discharges, and 35.5% if readmissions, while Medicine accounted for 47.7% of discharges and 63.2% of readmissions, meaning medicine account for a disproportionate high number of re-admissions. Both General Medicine and General Surgery have account for the most discharge and re-admission activity, have proportionately more re-admissions that discharges and have seen their proportion of re-admissions each month increase since September, most notably in General Medicine.

Specialities accounting for the top 5 highest proportion of readmissions: General Medicine - discharge percentage 22.6%, accounting for 42.6% of all readmissions, General Surgery - discharge percentage 12.0%, accounting for 17.9% of readmissions ,Gastroenterology - discharge percentage 11.5%, accounting for 6.4% of readmissions,, Paediatrics - discharge percentage 9.1%, accounting for 3.5% of readmissions, Clinical oncology - discharge percentage 9.0%, accounting for 5.2% of readmissions.

Recommendation
More work to be undertaken to understand the reasons behind the headline performance figures. Work is being undertaken to identify what may have impacted to cause the sudden increase seen in September. Trending data has been developed to identify speciality areas which have and continue impacting performance, in order do focussed analysis for those specialities. And audit deep work will be undertaken with audit and operational staff to help better understand the influencing factors. Then subsequently agree any actions for improvement.

UEC Measures

Responsive

Gateshead Health NHS Foundation Trust

NHSI SOF Operational Performance & National Operational Standards

1. % of patients who spend 4 hours or less in A&E (target 95%)
2. National rank 4-hr performance our of all trusts
3. No. of attendances
4. No of ambulance delays
5. No of waits in department > 12 hours
6. No of waits in department waiting longer than 12 hours for a bed

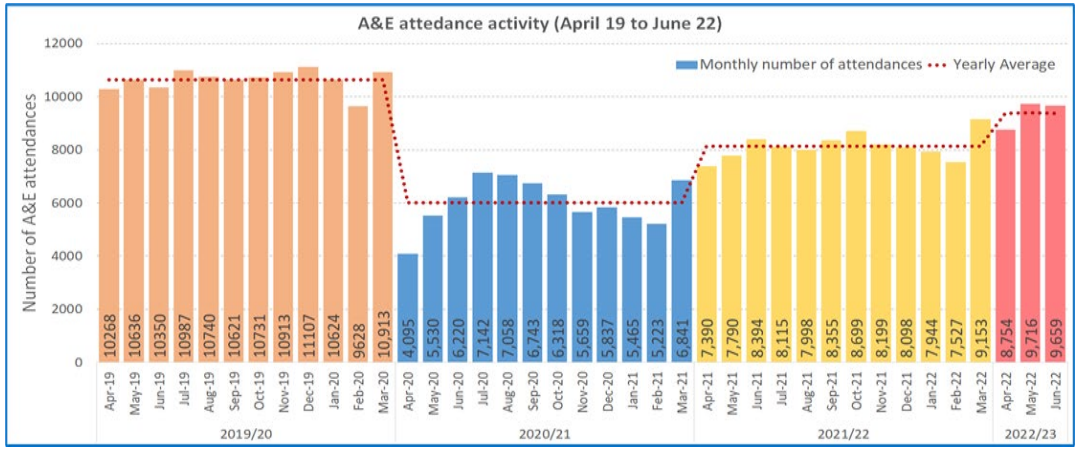
A&E Indicators	Apr-22	May-22	Jun-22	Q1
Attendances: Type 1	5431	6098	6090	11546
Attendances: Type 3	3323	3618	3569	6941
Total Attendnaces	8754	9716	9659	18470
Total Breaches	2164	2148	2212	4312
Trust total % seen in 4 hours	75.3%	77.9%	77.1%	77%
National Rank (acute Trusts)*	23rd	20th		
12 Hour Trolley waits (target 0)	71	4	11	86
Volume in Department > 12 hours	252	108	193	553
A&E> 12 Hours waits (target <2%)	2.9%	1.1%	2.0%	3.0%

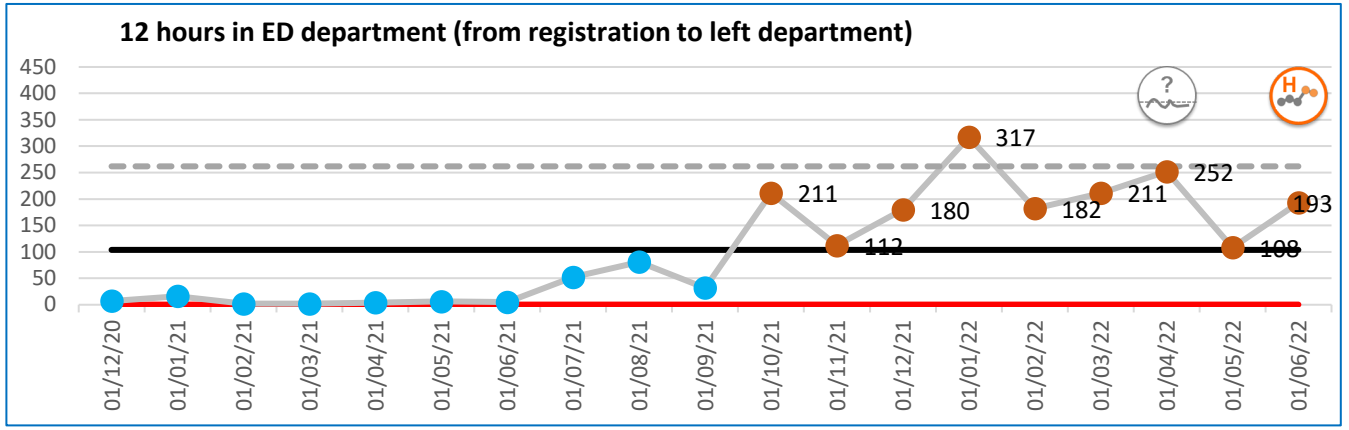
Context:

- Urgent and Emergency Care remains under pressure with increasing and sustained activity levels
- Footfall for the last 3 months is gradually moving towards pre-pandemic levels
- Last 2 months more than 9600 attendances each month – May was 9716, June 9659
- Average for last 3 months was 9376, compared to 8208 for the 3 months prior to that, and 7858 same period last year
- As a result of significant daily pressure in the 8 days prior, GHFT moved back to Opel 3 on the 28th June

Performance

- A&E 4hour performance at 77.10%, slight deterioration on previous month
- While we meet the target for 12 hr dept times, overall time in the department remains high, (non-admitted 2 hours 30 minutes, admitted 7 hours 45 minutes)
- 11 x 12 hour trolley breaches recorded in the month, on the 28th June, linked to site pressures mentioned above. No previous breaches since the 4th May.
- Bed occupancy levels are high averaging 94.4% in June
- Ambulance delays have seen significant improvement from previous month but remain high: 40 at 30-60 mins and 17 > 60 mins Volume of patients in the department who are in longer than 12 hours is high 193 2.0% of the total attendances (pre-pandemic levels were at zero or the exception).





UEC Ambulance Handover Delays

Responsive

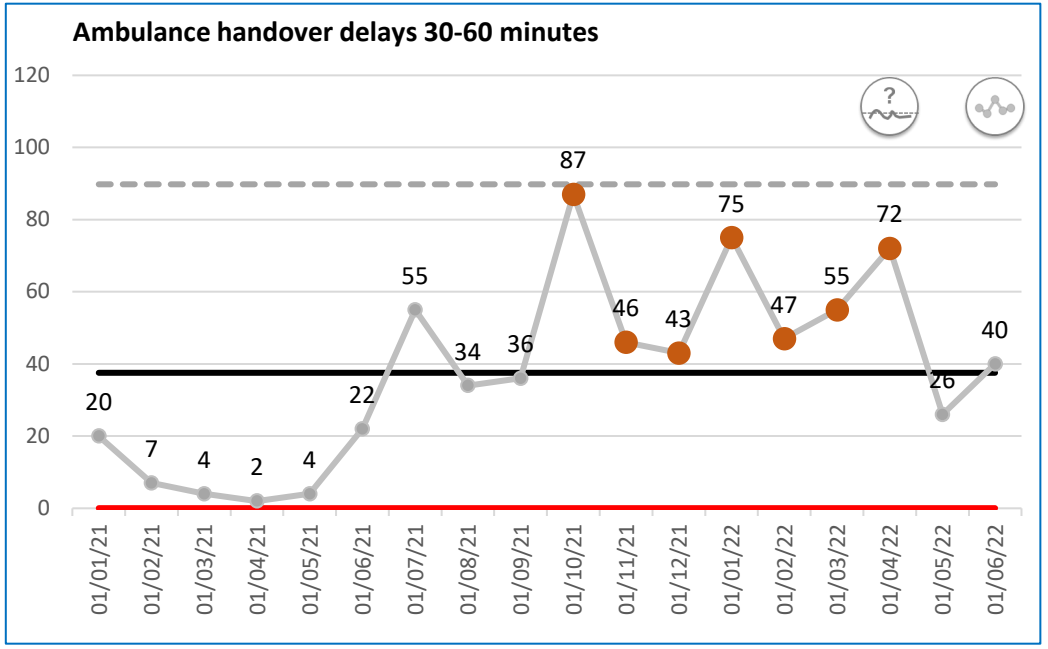
NHS Gateshead Health NHS Foundation Trust

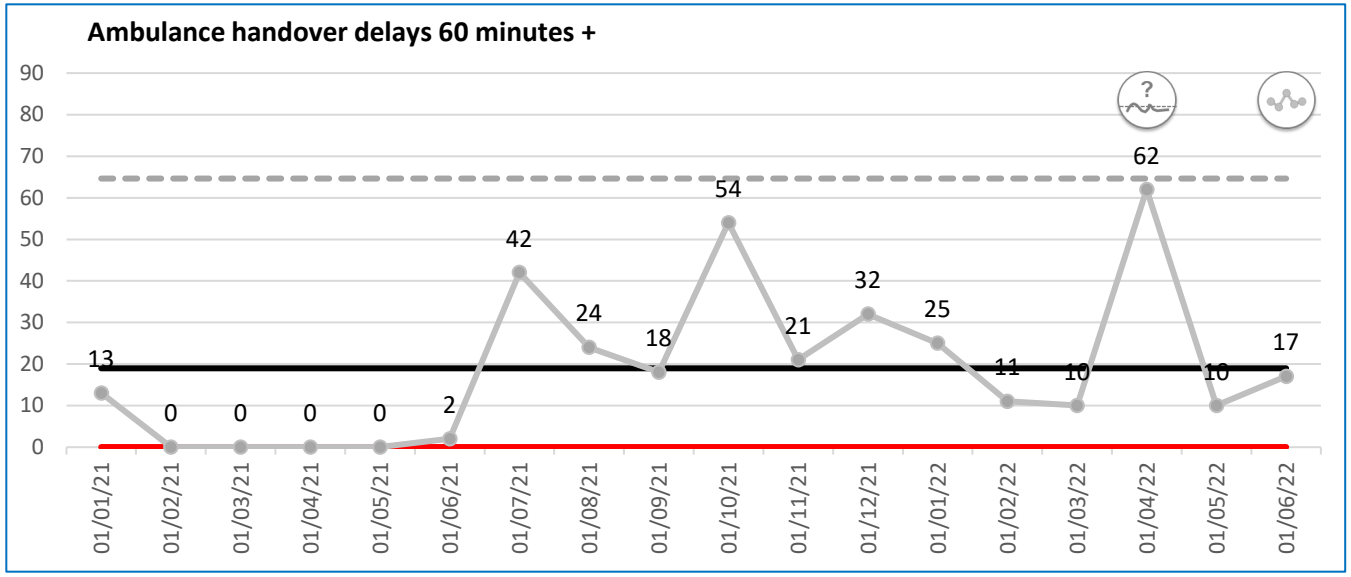
Ambulance Arrivals & Handover Delays	Apr-22	May-22	Jun-22	Q1
% within 15 minute target	52.6%	52.4%	53.9%	53.30%
Ambulance handovers within 30-60 minutes	72	26	40	138
Ambulance handover delays > 60 minutes	62	10	17	89

Background
The NHS Long Term Plan set out a vision to reduce Ambulance delays. Ambulance delays are risky as they delay assessment and treatment for those waiting in an ambulance queue. Delays can compromise safety in the community by reducing the number of ambulances available to respond to emergencies.

There is now greater focus on reducing ambulance delays following AACE publication of clinical review which states that the review should take 15 mins with no patients waiting more than 30 minutes. In 2022/23 an expectation of 65% of handovers should take place within 15 minutes, 95% within 30 minutes and 100% within 60 minutes.

Situation
A noticeable increase in handover delays can be observed from July 2021. Special cause variation is observed for 30-60 minute delays with the number of delays above the mean for seven consecutive months between October 2021 and April 2022. This increased again in June 22, with 40 reported. Over 60 minute delays is displaying common cause variation with 17 delays in June 22.





Community teams

Responsive

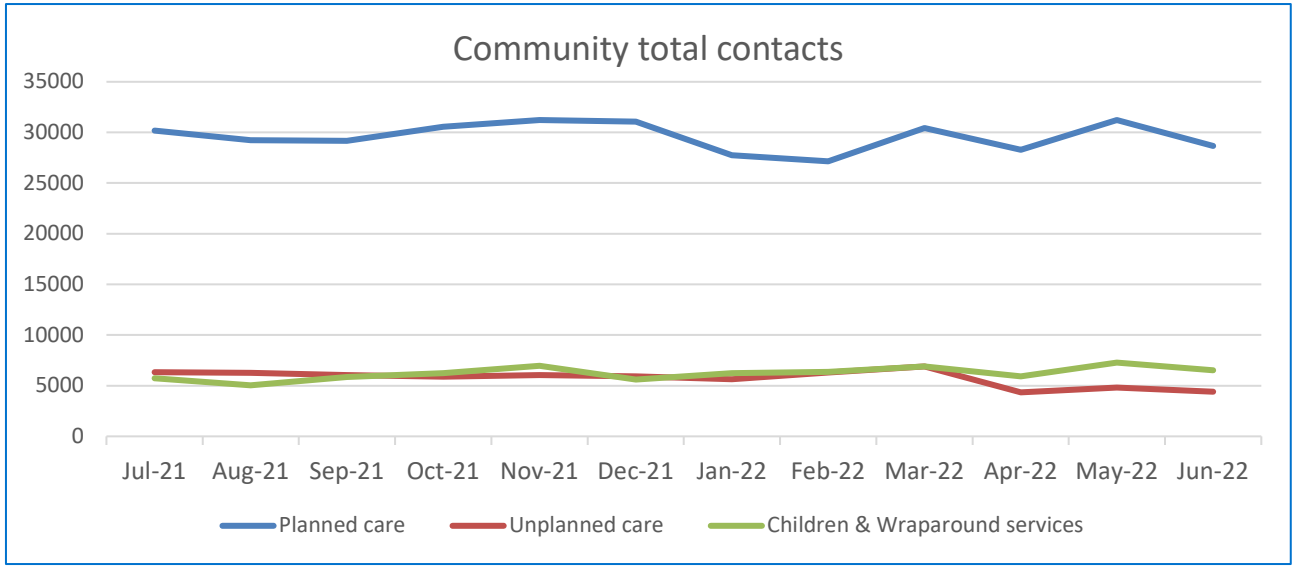
NHS Gateshead Health NHS Foundation Trust

Community teams work with patients from birth to end of life to provide care to patients in their place of residence, clinic or education setting. The aim is to provide care close to home, avoiding admission, support early discharge and support patients to reach their maximum potential and independence in all areas of life. Services are split into 3 areas

Planned Care- Locality Nursing and community COVID vaccination teams

Unplanned Care - Rapid Response, Community Stroke Rehabilitation team and Falls team plus Strength and Balance and Pulmonary Rehabilitation

Children and Wraparound Services
- Children's Community Nursing and Therapy teams (Occupational therapy, Physiotherapy and Speech and Language), Continence team, Podiatry and Adult Speech and Language



Indicator	Team	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Total contacts	Planned care	30183	29247	29181	30548	31232	31055	27739	27134	30418	28288	31218	28674
	Unplanned care	6321	6283	6043	5878	6042	5932	5635	6316	6901	4332	4804	4397
	Children & Wraparound services	5731	5056	5877	6243	6962	5620	6239	6370	6907	5923	7284	6525

Rapid Response
Rapid Response is a 24/7 service providing a nursing and therapy service who require unplanned and rehabilitation assistance in Gateshead. The aim is to supports patients in the community to prevent admission with the 2 hour crisis response service, facilitate early discharge and promote independence in activities of daily life

NHS E/I has implemented the following Community health services Two hour crisis response standard:
Improve outcomes through reaching patients in crisis in under 2 hours where clinically appropriate. Providers will be required to achieve, and ideally exceed in the majority of cases, the minimum threshold of reaching 70% of 2 hour crisis response demand within 2 hours from the end of Q3.

Indicative June data shows the Rapid Response team responded to 106 Two hour crisis response referrals , 68 of which met the 2 hour response time, a compliance rate of 64.15%

Elective Care Activity & Recovery

Gateshead Health NHS Foundation Trust

Trust's should deliver an activity plan to the value of 104% of pre-covid income generated from elective activity.
The Trust submitted 'a stretch' activity plan to deliver 100% over overnight Elective Activity, 104% Daycases with an Outpatient follow-up reduction plan to take full advantage of opportunities to transform the delivery of services. Moving away from non-value outpatient follow up activity and progressing clock stopping activity (predominantly inpatients) to reduce long waiters, Zero 52 week waiters by the end of March 2023.

Elective Activity	Apr-22	May-22	Jun-22	Q1
Trust Total	92.0%	98.0%	96.0%	95.0%
Daycase	90.0%	103.0%	112.0%	102.0%
Elective Overnights	71.0%	71.0%	78.0%	73.0%
Total OP	93.0%	97.0%	95.0%	95.0%
OP New	92.0%	106.0%	99.0%	99.0%
OP Follow Up	93.0%	95.0%	97.0%	94.0%
			Indicative	Indicative

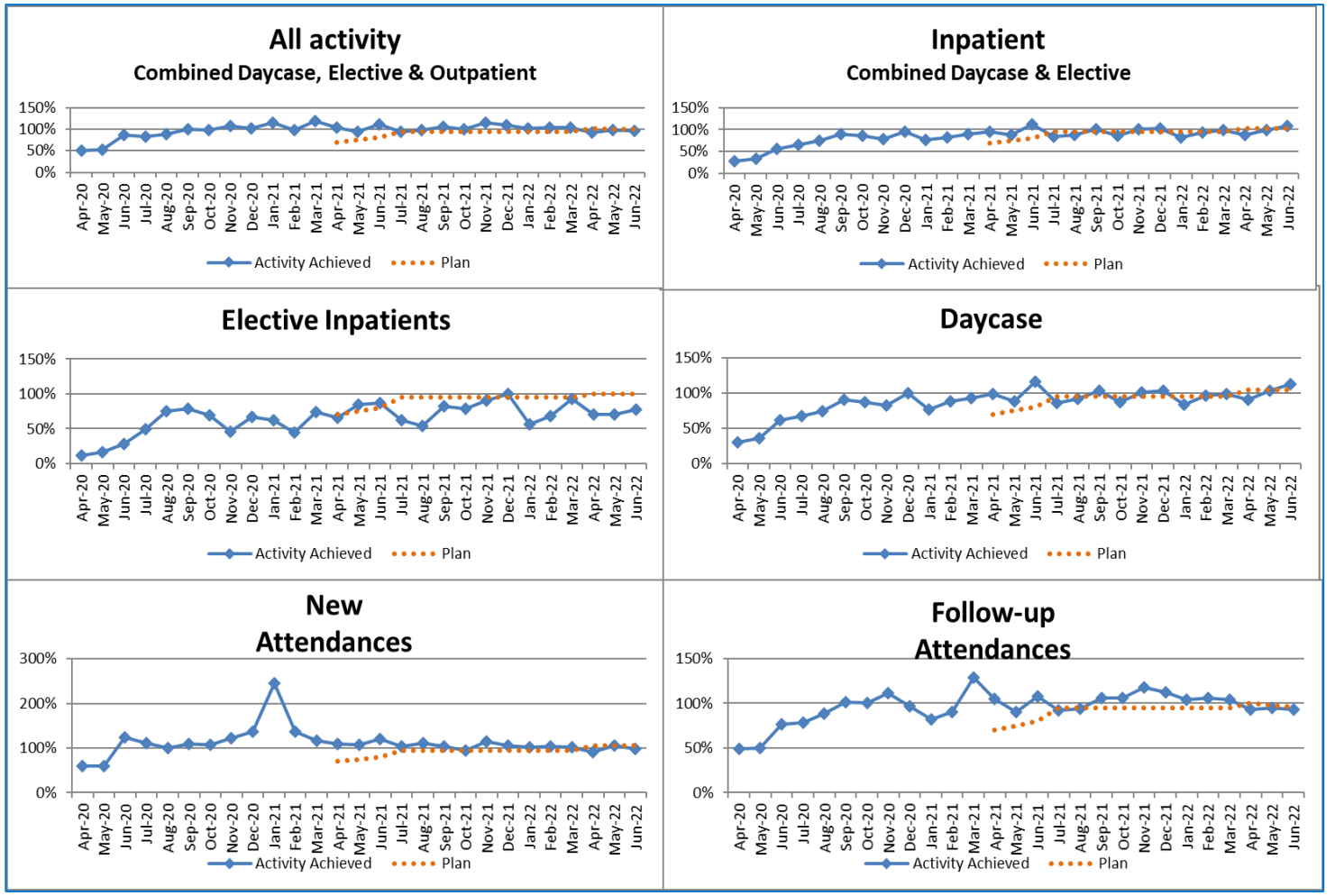
June Activity: (DRAFT) Activity is below planed levels:

- **Combined elective activity 96%**
  - **Day cases 112%**
  - **Elective inpatients 78%**
  - **New Outpatients 99%**
  - **FU Outpatients 93%**

Other key requirements:

The Trust is reporting 25.21% of all outpatient attendances conducted remotely, which is in-line with 25% expectation.

2.02% of all OP recorded as Patient Initiated Follow-Up – which is slightly below planned levels of 2.1% and the expectation.

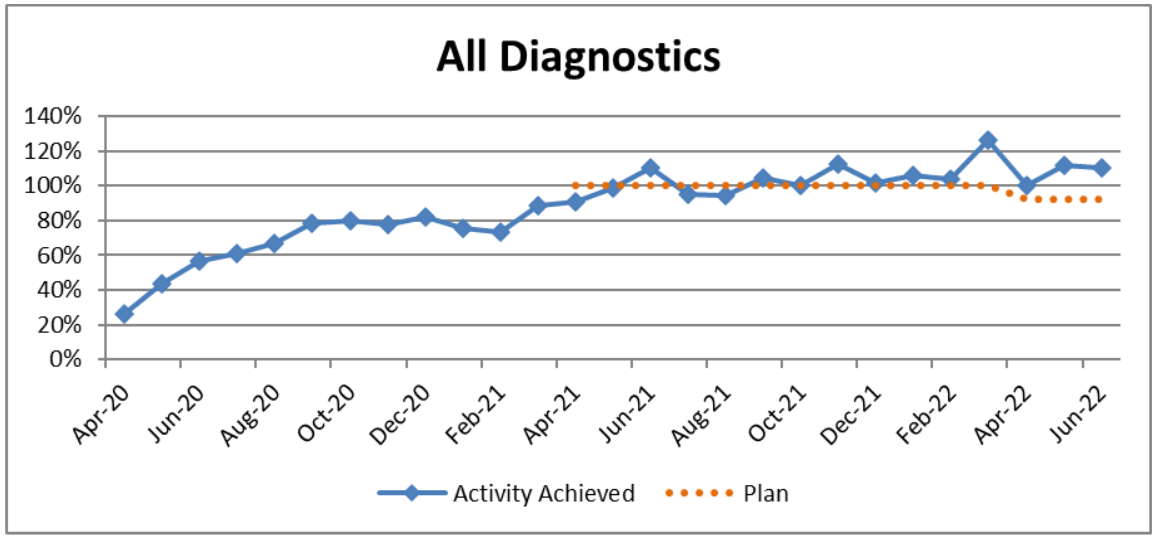


Activity & Recovery

Whilst there are no specific planning thresholds for diagnostic delivery, Trusts are expected to deliver as much as they can to support elective recovery. **All Diagnostics**: 110% of activity in same period 19/20**, Endoscopy:** 129% of activity in same period 19/20**, Echocardiography:** 76% of activity in same period 19/20

Gateshead Health NHS Foundation Trust

Diagnostic Activity Delivered	Apr-22	May-22	Jun-22	Q1
Trust Total	100%	112%	110%	107%
MRI (120%)	91%	101%	100%	98%
CT (120%)	122%	122%	131%	125%
Colonoscopy (100%)	92%	106%	130%	109%
Non Obstetric Ultrasound (100%)	85%	86%	73%	94%
Flexi Sig (100%)	66%	86%	73%	74%
Gastroscopy (100%)	86%	108%	109%	100%
Echocardio (100%)	93%	85%	73%	77%



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

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

- Echocardiography accounts for 74.4% of the diagnostic waiters > 6 weeks with 61.6% of the echocardiography tests waiting longer than 6 weeks.
- Audiology accounts for 21% of the diagnostic waiters over 6 weeks with 42.9% of the audiology patients waiting longer than 6 weeks.

Referral to Treatment

Responsive

NHS Gateshead Health NHS Foundation Trust

NHSI SOF Operational Performance & National Operational Standard

1. Number of patients waiting on an incomplete RTT pathway at month end
2. Number of patients on an incomplete pathway waiting 18 weeks or more
3. Percentage of patients waiting < 18 weeks on an incomplete pathway (target> 92%)
4. No of patients waiting longer than 18 week

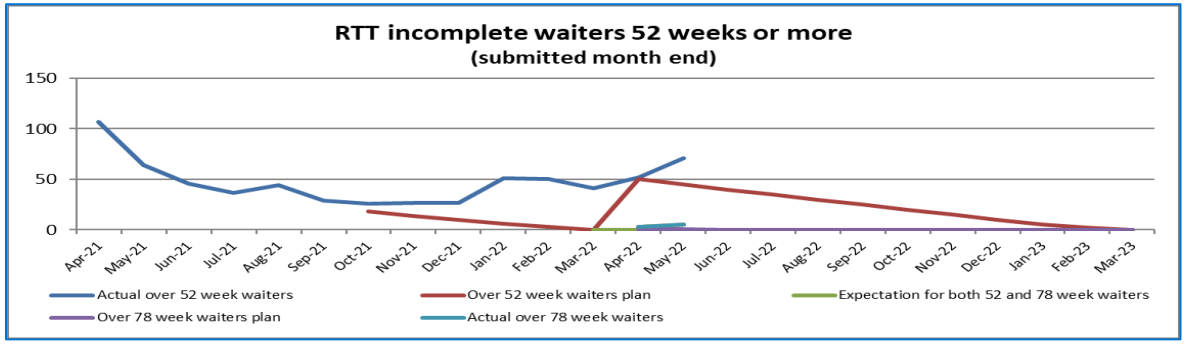
RTT % Within in 18 weeks (92%)	Apr-22	May-22	Jun-22	Q1
Trust Total	74.2%	75.9%	74.0%	74.7%
General Surgery	79.5%	80.4%	77.2%	79.0%
Gynaecology	72.8%	77.3%	78.5%	76.0%
Orthopaedics	64.2%	66.7%	66.0%	66.0%
Urology	77.7%	78.2%	73.7%	77.0%
Paediatrics	76.3%	74.6%	72.2%	74.0%
Cardiology	76.5%	78.7%	74.9%	77.0%
Gastroenterology	72.7%	78.1%	78.3%	77.0%
General Medicine	64.0%	78.1%	81.8%	71.0%
Geriatric Medicine	87.3%	91.2%	95.3%	91.0%
Respiratory Medicine	68.9%	69.1%	64.8%	68.0%
Rheumatology	83.5%	84.3%	76.1%	81.0%
Other	75.3%	73.3%	71.2%	73.0%
National Average	61.70%	Not published		

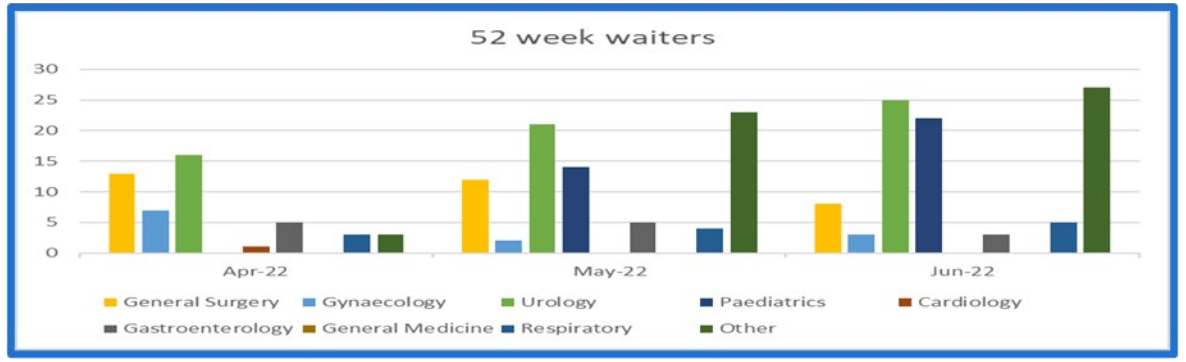
	Apr-22	May-22	Jun-22
Total Waiters	11336	11542	11563
52 Week Plan	50	45	40
>52 weeks Actual	52	71	73
General Surgery	13	12	8
Gynaecology	7	2	3
T&O	16	21	25
Urology	4	4	2
Paediatrics	0	14	22
78 Week Plan	1	1	1
>78 weeks		4	2
T&O			1
Urology			1

Trust's RTT performance is stable (74.1% Quarter 1 – indicative)
Performance is above national average in M1 74.2% against Nat. ve. of 61.7%
Total waiting list increased in quarter from 11,336 to 11,563 (indicative)

Main Risks
Outpatient capacity to review the backlog
Theatre capacity / Theatre workforce
Covid staff absences

Risks: Increases in > 52 weeks over planned levels
- T&O 25, Paediatrics 22, general surgery 8, gynaecology 3, urology 2
- 2 patients waiting over 78 week are T&O and urology





Maximum 6-week wait for diagnostic procedures

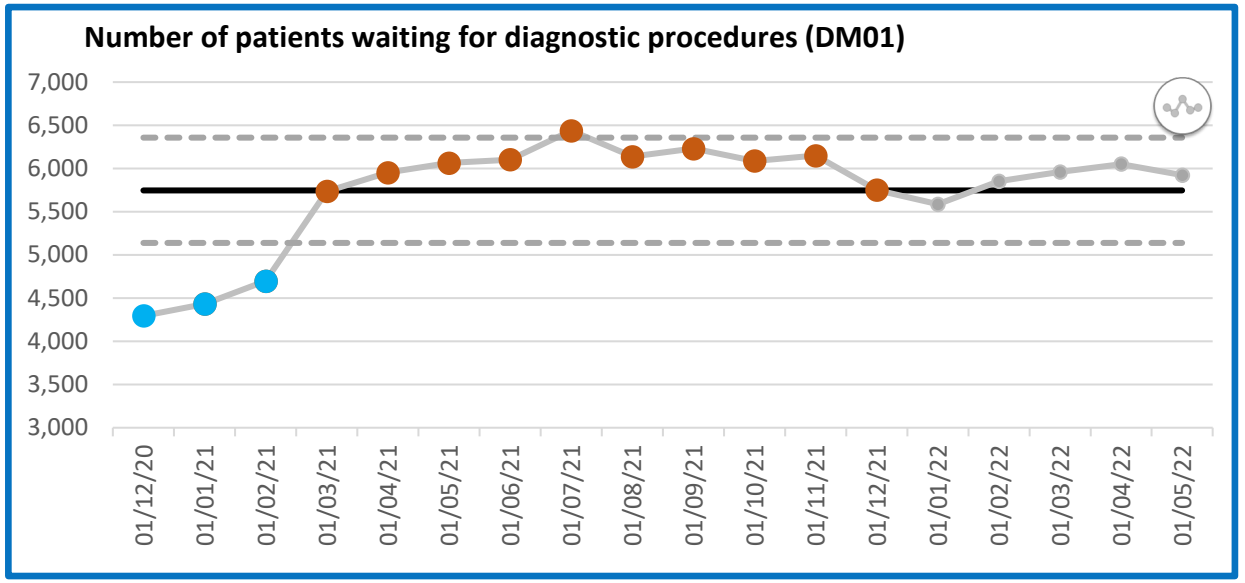
Responsive

NHS Gateshead Health NHS Foundation Trust

NHSI SOF Operational Performance & National Operational Standard

1. Number of patients waiting on a diagnostic WL at month end.
2. Number of patients waiting on a diagnostic WL at month end waiting greater than 6 weeks
3. % patients waiting 6 weeks or more for a diagnostic test at month end (target ,1%)
4. Number of diagnostic tests/procedures carried out in month

Diagnostics waiters < 6weeks (99%)	Apr-22	May-22	Jun-22	Q1
Trust Total	75.1%	78.7%	73.4%	75.7%
Barium Enema	98.3%	100.0%	98.4%	98.9%
CT	99.4%	99.5%	99.0%	99.3%
MRI	96.7%	97.6%	98.9%	97.8%
Non Obs Ultrasound	89.9%	99.6%	98.2%	95.6%
Audiology	56.7%	57.1%	52.1%	55.2%
Urodynamics	86.7%	90.0%	82.4%	85.7%
Colonoscopy	95.6%	97.7%	93.6%	95.8%
Flexi-Sig	94.3%	93.5%	90.9%	93.1%
Gastroscopy	95.0%	96.8%	94.7%	95.5%
DEXA	97.2%	97.9%	97.4%	97.5%
Echo	32.6%	38.4%	30.0%	33.6%
Cystoscopy	83.5%	85.7%	59.3%	75.0%
National Average	71.6%			
			Indicative	Indicative



Trust's Diagnostic performance is Deteriorating across the quarter:

- 75.1% to 73.4% (June indicative)
- Performance is above national average in M1 75.1% against Nat. ave. of 71.6%
- Total waiting list decreased in quarter from 6,050 to 5,986 (indicative)
- Volumes of patients waiting > 6 weeks increased from 1508 (24.9% to 1588 (26.5%)
- Echocardiology and Audiology are the risk

Cancer Standards 62 Day Waits

Responsive

NHS Gateshead Health NHS Foundation Trust

62 Day Cancer Treatments (85%)	Apr-22	May-22	Jun-22	Q1
Trust Total	67.2%	34.5%	51.7%	51.6%
Breast	93.3%	91.7%	78.9%	86.6%
Gynae	44.4%	4.2%	6.3%	17.2%
Lower GI	0.0%	0.0%	47.1%	36.4%
Urology	13.6%	20.0%	25.0%	20.2%
Skin				
Head & Neck				
Haematology	80.0%	66.7%	66.7%	73.7%
Lung	54.5%	30.0%	28.6%	3.0%
Sarcoma	100.0%		100.0%	100.0%
Upper GI	200.0%		200.0%	100.0%
Other	100.0%			100.0%
			Unconfirmed	

NHSI SOF Operational Performance & National Operational Standard

1. No. of patients receiving 1st definitive treatment for cancer following an urgent referral for suspected cancer/NHS Screening/Consultant upgrade
2. No of patients receiving 1st definitive treatment for cancer 62 days or more following an urgent GP referral for suspected cancer/NHS Screening/Consultant upgrade
3. % of patients receiving 1st definitive treatment for cancer within 62 days following an urgent GP referral for suspected cancer (target 85%)
4. No. of patients receiving 1st definitive treatment 104 days or more

Trust's Cancer performance is not in process control

- (51.1% Quarter 1 – indicative)* not finalised
- Total waiting list decreased in quarter from 829 to 782 (indicative)
- Total patients waiting > 62 days decreased from 82 to 66 (19.5%) Within planned trajectory
- Patients waiting between 63-104 days decreased from 65 to 55
- Patients waiting over 104 days decreased from 14 to 11

Tumour Update:

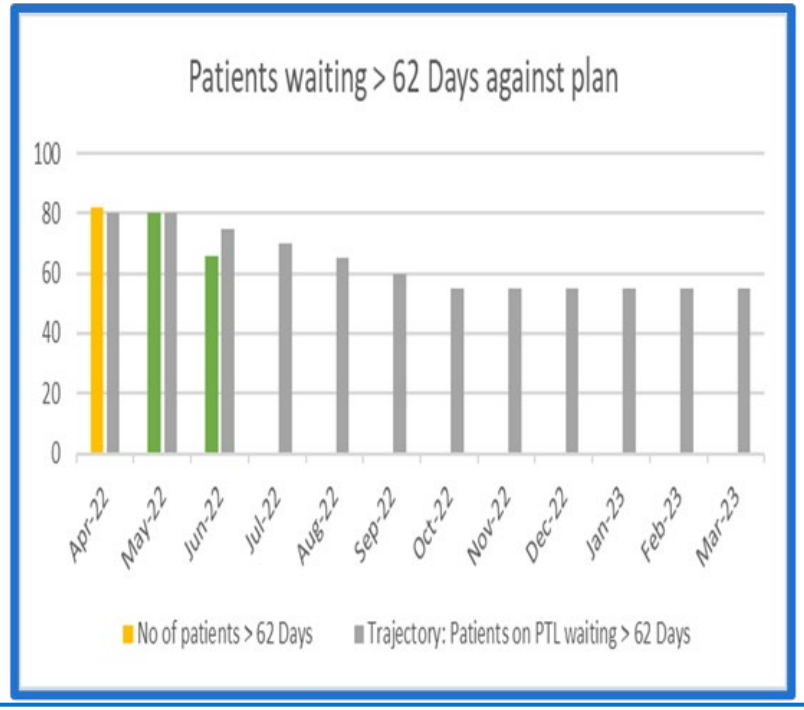
- Performance Risks across all specialties to achieve 85% with the exception of Breast. Challenged specialties include Gynae, Lower GI and Urology, haematology & lung.

Waiting List:

- Trust is within trajectory at the end of Q1 reporting 66
- Good reduction of waiters across the quarter

Risks

- Capacity / summer holidays and shared pathways (urology/lung)
- Theatre capacity
- Gynaecology



Waits Between 63 - 104 days	Apr-22	May-22	Jun-22
Breast	4	7	2
Gynaecological	25	16	13
Lower Gastrointestinal	8	5	6
Lung	4	7	2
Other	0	1	0
Upper Gastrointestinal	8	10	9
Urological	16	16	23
	65	**62**	**55**

Waits over 104 days	Apr-22	May-22	Jun-22
Breast	1	1	0
Gynaecological	9	6	2
Lower Gastrointestinal	1	1	1
Lung	2	1	1
Upper Gastrointestinal	0	3	2
Urological	4	6	5
	17	**18**	**11**

Cancer Standards 2 week Waits

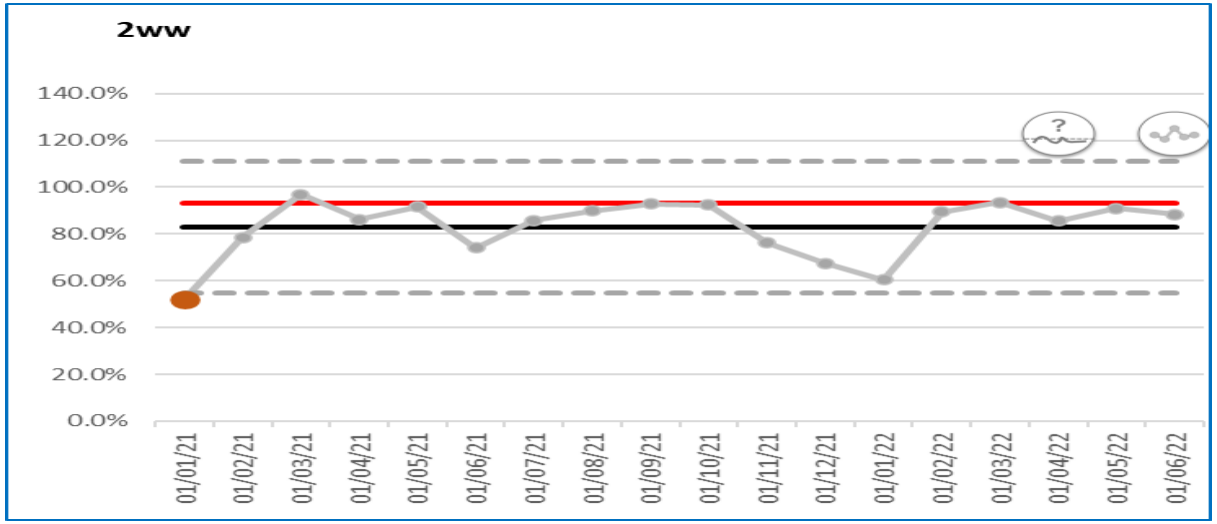
Responsive

NHS Gateshead Health NHS Foundation Trust

NHSI SOF Operational Performance & National Operational Standard

1. No. of urgent GP referrals for suspected cancer
2. Number of patients seen after more than 2 weeks
3. % patients seen within 2 weeks

2 week waits (93%)	Apr-22	May-22	Jun-22	Q1
Trust Total	84.8%	89.4%	88.4%	87.7%
Breast	92.4%	97.4%	94.9%	95.0%
Gynae	78.3%	95.5%	89.8%	88.0%
Lower GI	87.4%	80.0%	80.0%	82.3%
Testicular	70.0%	85.7%	100.0%	80.0%
Urology	84.2%	79.0%	65.3%	77.0%
Haematology	100.0%	100.0%	88.9%	96.0%
Lung	21.7%	43.1%	61.3%	40.0%
Upper GI	83.5%	82.1%	79.4%	
Other				



Trust's 2 week wait Cancer performance
Stable performance averaging 87.7% over the quarter (below 93% requirement)

Tumour Update:
Breast & haematology continue to achieve this target – pressures with capacity across all other pathways

Referrals continue to increase:
- Breast and lung referrals

Risks
- Capacity / summer holidays and shared pathways (urology/lung)
- Outpatient capacity
- Workforce pressures across tumour groups (lung)

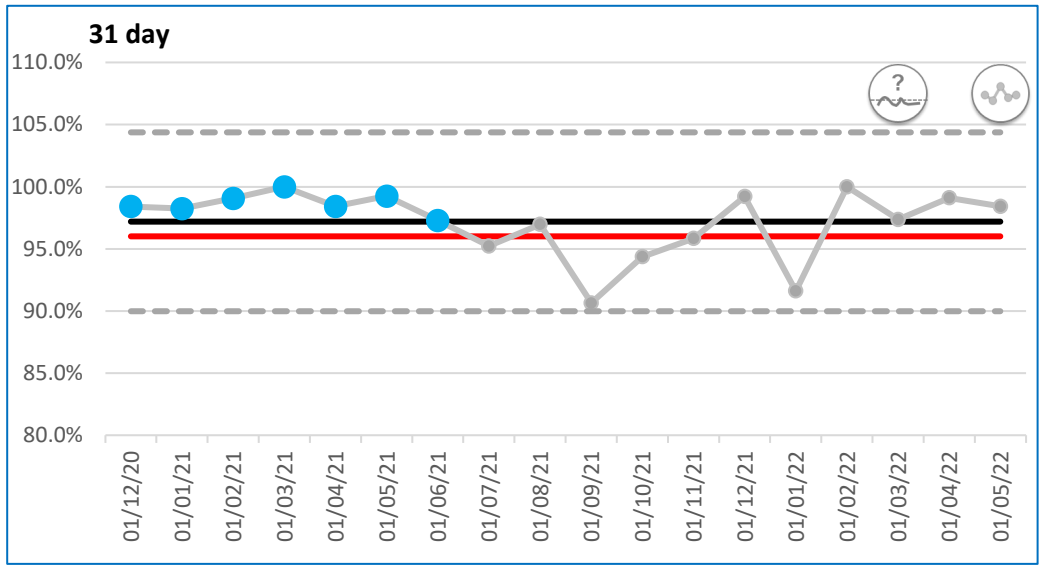
Cancer Standards 31 Days

Responsive

NHS Gateshead Health NHS Foundation Trust

NHSI SOF Operational Performance & National Operational Standard

1. No. of patients receiving 1st definitive treatment following a cancer diagnosis
2. No, of patients receiving fist definitive treatment more than 1 month pf a decision to treat following a cancer diagnosis
3. % of patients receiving 1st definitive treatment within 1 month of a DTT following a cancer diagnosis > 96%
4. Patients receiving surgery (94%) or drug treatment for cancer within 31 days (98%)



31 Day Diagnosis to Treatments (96%)	Apr-22	May-22	Jun-22	Q1
Trust Total	98.2%	96.0%	91.3%	95.1%
Breast	97.6%	100.0%	98.1%	98.6%
Gynae	100.0%	88.9%	59.1%	81.5%
Lower GI	90.0%	85.7%	100.0%	91.9%
Urology	100.0%	100.0%	100.0%	100.0%
Haematology	100.0%	100.0%	50.0%	92.9%
Lung	100.0%	100.0%	100.0%	100.0%
Sarcoma	100.0%		100.0%	100.0%
Upper GI	100.0%	100.0%	100.0%	100.0%
Other	100.0%	100.0%	100.0%	100.0%

Subsequent Treatments	Apr-22	May-22	Jun-22	Q1
Surgery	100.0%	100.0%	91.3%	96.9%
Drug	100.0%	100.0%	100.0%	100.0%

Trust's Cancer performance for May is 96% against the 31 Day standard and both subsequent treatment standards have been achieved I the month of May.

(June is indicative data* and is subject to change following sharing of information between Trusts)

Tumour Update:
- 31 Day All specialties achieved this standard except gynae and Lower GI.
- All tumour sites achieved subsequent treatment regimes

Risks
- Capacity / summer holidays and shared pathways (gynaecology)
- Theatre capacity
- Gynaecology – supporting ICS wide cancer treatments

Cancer Faster Diagnostics

Responsive

NHS Gateshead Health NHS Foundation Trust

NHSI SOF Operational Performance & National Operational Standard

1. No. of patients receiving diagnosis of cancer or ruling out cancer
2. No of patients receiving communication more than 28 days after referral
3. % of patients receiving communication within 28 days of referral (target 75%)

28 Day FDS (75%)	Apr-22	May-22	Jun-22	Q1
Trust Total	73.4%	69.3%	75.5%	72.6%
Breast	96.8%	96.6%	97.1%	96.8%
Gynae	49.1%	46.3%	61.0%	51.9%
Lower GI	46.0%	36.4%	42.0%	41.6%
Urology	28.1%	27.0%	29.9%	28.3%
Testicular	100.0%	100.0%	66.7%	94.1%
Haematology	81.8%	100%	80.0%	87.0%
Lung	39.1%	37.2%	77.8%	48.2%
Upper GI	53.1%	51.2%	51.9%	52.0%

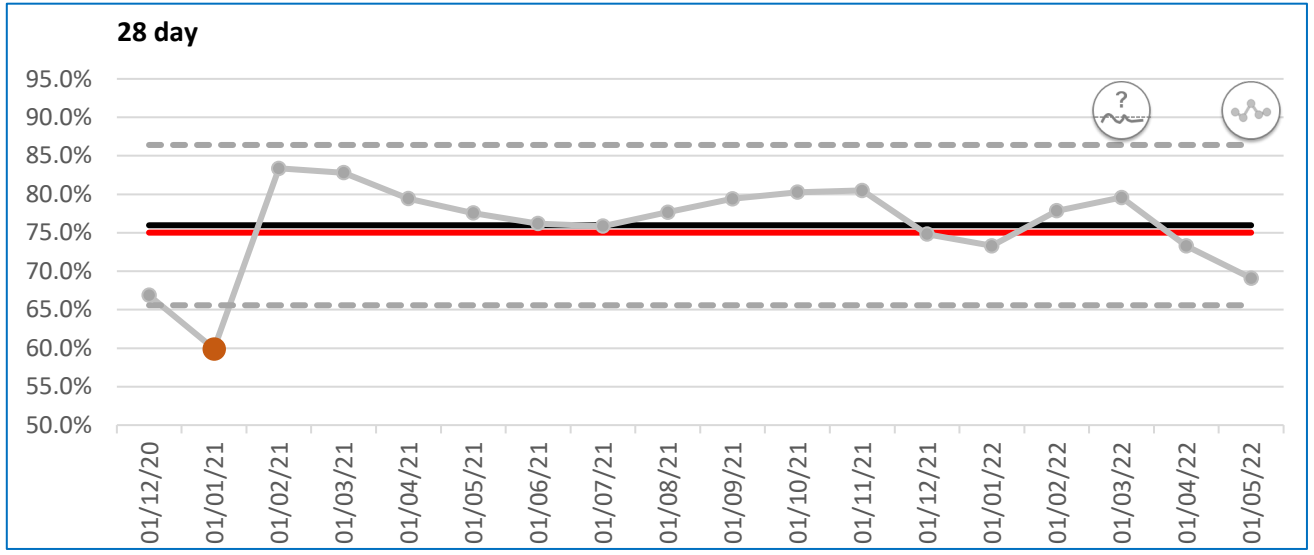
Trust's Faster Diagnostic performance is at 69.3% in May
(June data is indicative) below the 75% standard.

Tumour Update:

- Historically Trust was achieving this target – performance deterioration from March 2022.
- Performance Risks across all specialties - Particular challenged specialties include Lung, Gynae, Lower GI and Urology
- Implementation of Best Practice Timed Pathways is underway

Risks

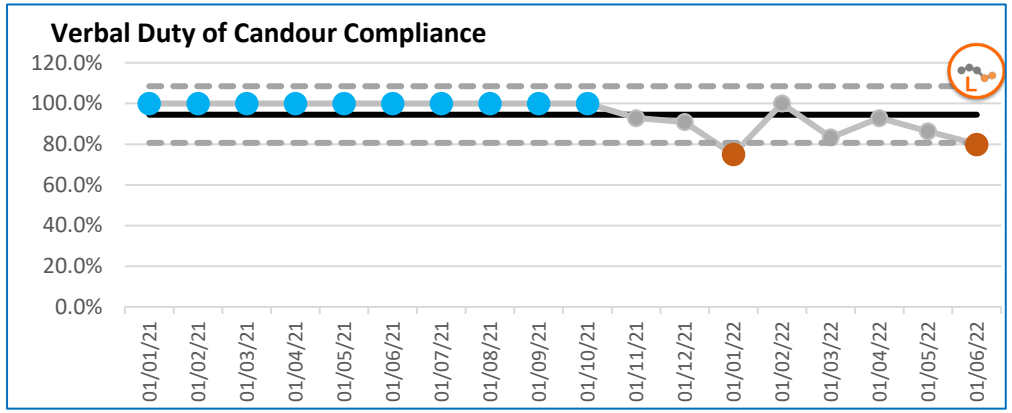
- Capacity / summer holidays
- Endoscopy capacity
- Shared pathways
- TP biopsy capacity (urology)

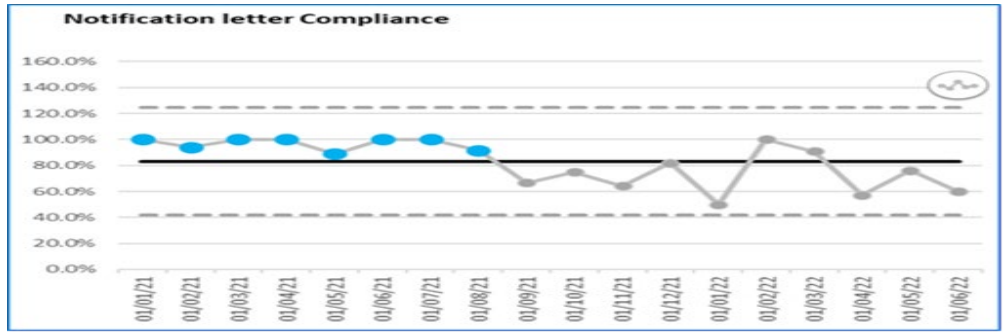


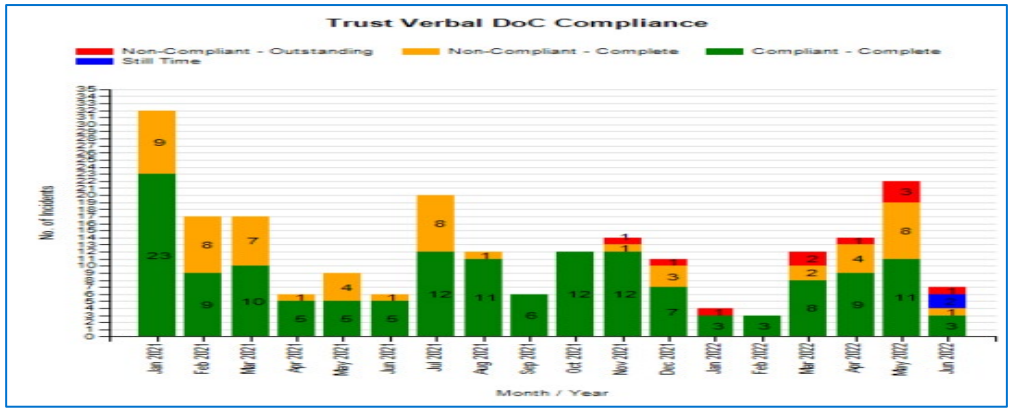
Report by exception: Duty of Candour Verbal Compliance

Responsive

NHS Gateshead Health NHS Foundation Trust







Situation
Verbal Duty of Candour compliance is displaying special cause variation for concern in June 2022

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 and underpinning statute, stipulates that an individual (or other appropriate person) must be notified "as soon as reasonably practicable" after a notifiable patient safety incident has occurred. Notifiable is further defined as requiring three criteria to be met in the reasonable opinion of a health care professional. Once determined as notifiable the enactment should occur verbally within 10 working days. Current Trust processes for Duty of Candour require review to ensure consistent compliance with defining notifiable patient safety incidents, as within the current process there is potential for enacting Duty of Candour on non notifiable incidents which should be managed under 'Being Open'

Assessment
Duty of Candour compliance in June is sitting just below 80%, triggering a cause for concern, this figure is after a number of initiatives to ensure that DOC has been undertaken for all cases meeting the notifiable Safety incident criteria. The reason for the remaining low compliance is due to the small numbers involved June only 5 incidents met the criteria 4 have been completed (80%)- the 5th is an IT incident spanning multiple patients and as yet the harm level for the SI is unknown and has therefore been set at moderate until any harm is identified. The SPC tool we are currently using for all metrics does not consider volumes in its calculations.

Actions

All Business units must ensure they record DOC enactment in DATIX it is the responsibility of the staff undertaking DOC to do this.

Work is ongoing to align the system recording DOC enactment in line with determination that this incident is notifiable and legal duty of Candour applies, and to simplify and stream line the recording within DATIX

Duty of Candour Written	Apr-22	May-22	Jun-22	Q1
Written Compliance 10 working days	8	13	2	23
Total	14	22	7	43
Live Datix Report	57%	59%	29%	53%
Best case (still within timeframe)		64%	57%	60%

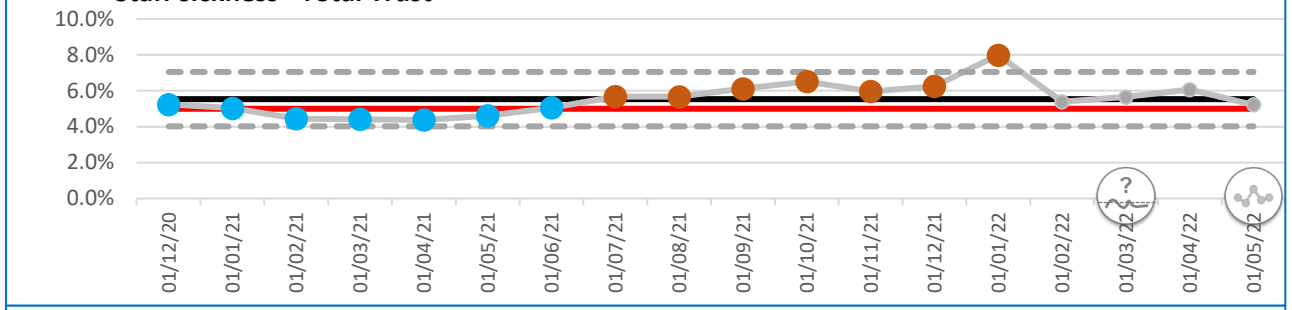
Duty of Candour Verbal	Apr-22	May-22	Jun-22	Q1
Verbal Compliance	9	11	3	23
Total	14	22	7	43
Live Datix Report	64%	50%	43%	53%
Best case (still within timeframe)			71%	58%

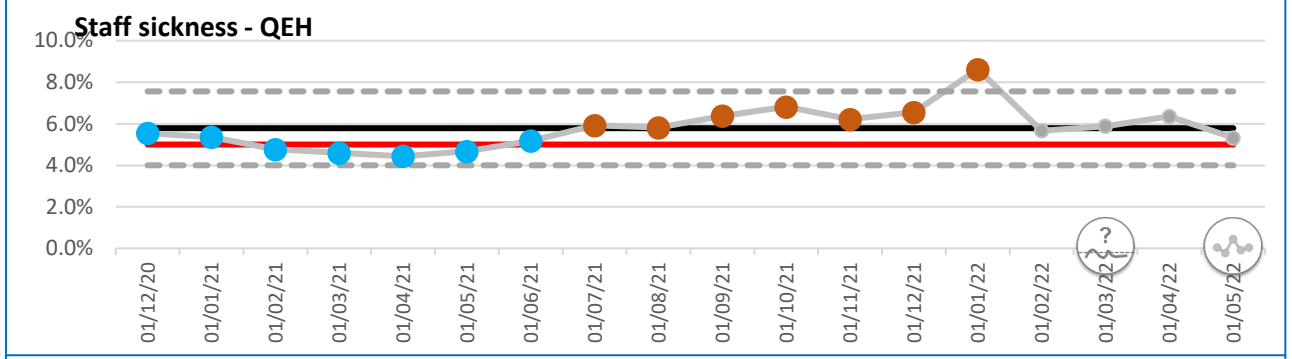
Report by exception: Well led – Sickness Absence

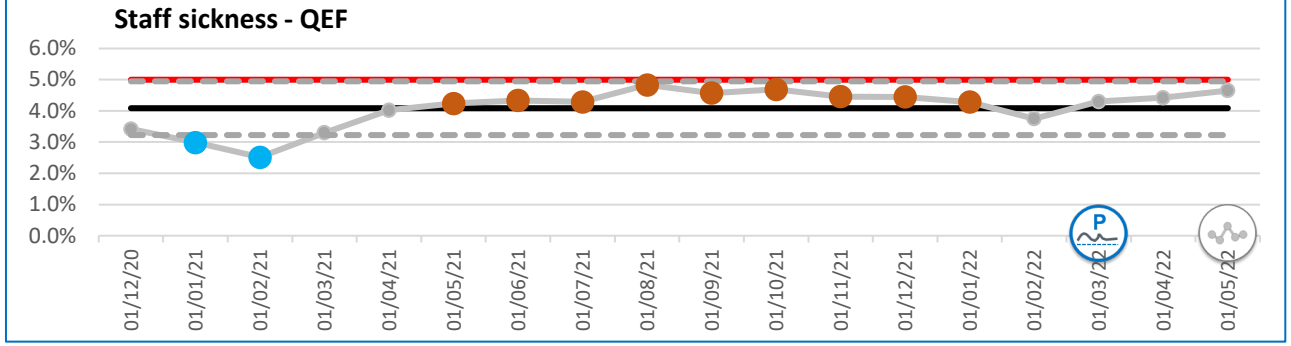
Detail on this measure is included because the target will either be achieved or failed based on variation within the performance.

Well Led

Gateshead Health NHS Foundation Trust







Situation
Common cause variation displayed for the Trust overall and both QEH and QEF for the latest month

Current performance of 5.2% represents a fail of the Trust target.

Background
Absence levels continue to contribute to overall pressures in relation to supply and the focused management of sickness absence remains a strategic priority

Assessment
May sees a further decrease in absence levels to the lowest point in 12 months, so although over the target, a sustained improvement.

Actions
The Promoting and Supporting Attendance policy was launched on 1st June and a training programme for managers has commenced. Sickness presentations were given at each of the Ops boards as well as Trust Board, JCC and POD committee. The POD advisory teams are running clinics for managers and working closely with teams to manage absence

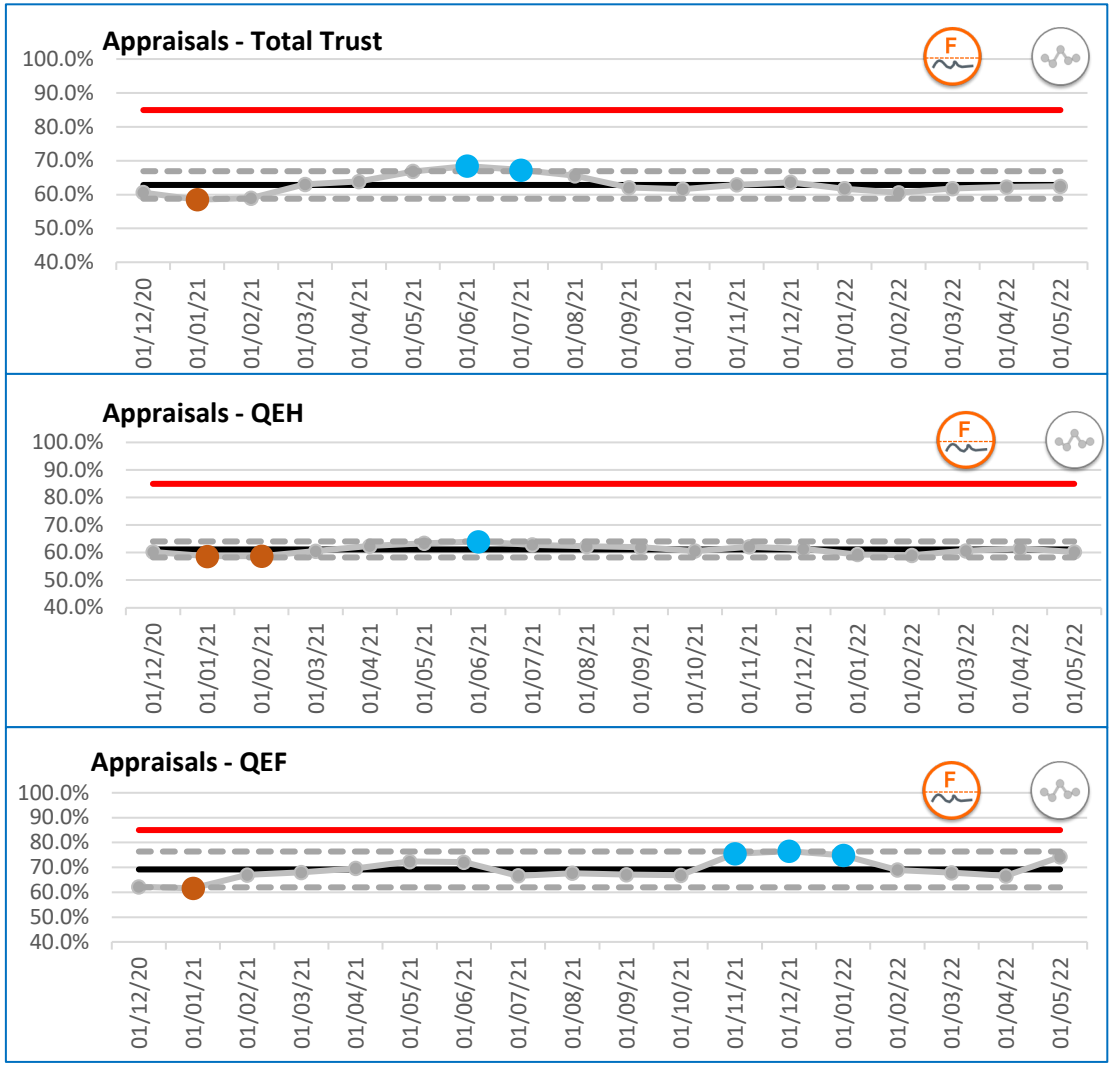
Recommendation
Continue support and roll out of the new approach as per the policy.
Continue to monitor sickness levels at POD committee and SMT

Report by exception: Well led – Appraisals

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

Well Led

NHS Gateshead Health NHS Foundation Trust



Situation
Appraisal compliance consistently fails the 85% target, with this target not being achieved during the past 18 months.

Background
Rates of Appraisal in operational business units remain at a lower compliance than corporate services, with Ward based services such as Medicine and Surgery having the lowest rates of appraisal compliance.

Assessment
Compliance rates are monitored via ESR and reported to business units as part of the suite of workforce metrics that are produced. Current compliance is 61.8% against an 85% target. Services remain under significant pressures from staffing, however work to improve compliance continues, with support from the POD teams.

Actions
POD continue reporting monthly to line managers, with the aim of reducing the volume of information, and include additional data about appraisals due in the next 90 days. The aim is to encourage managers to make realistic plans for the coming months. Work continues to provide support by updating ESR on behalf of managers and the new Education, Learning & Development Group, which has now been established, will oversee a wider review of the process, with an aim to launch a new document and process by the end of July 2022. Targeted training of appraisers by L&D has stared in the BUs with the support of the POD leads to increase the understanding of the process and requirement of the action to be input onto ESR.

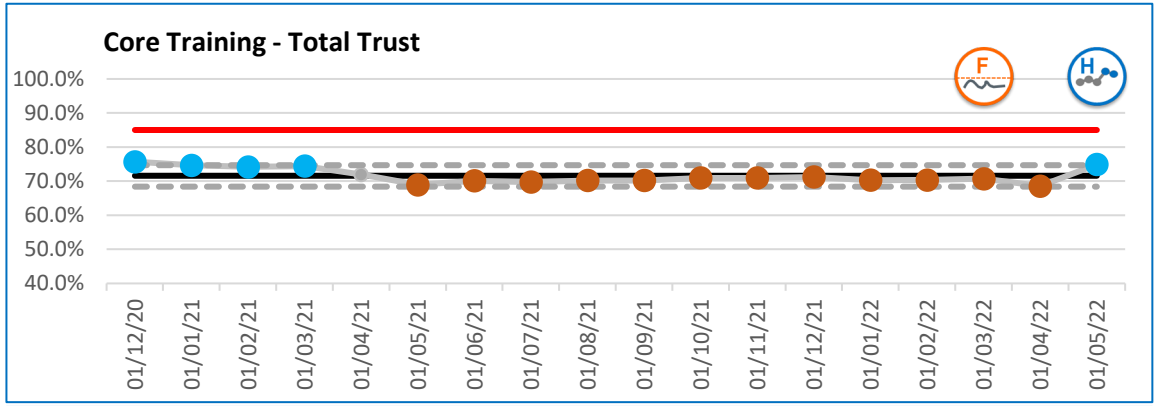
Recommendation
Review, management and oversight at Senior Leadership Team and continued management by operational teams.

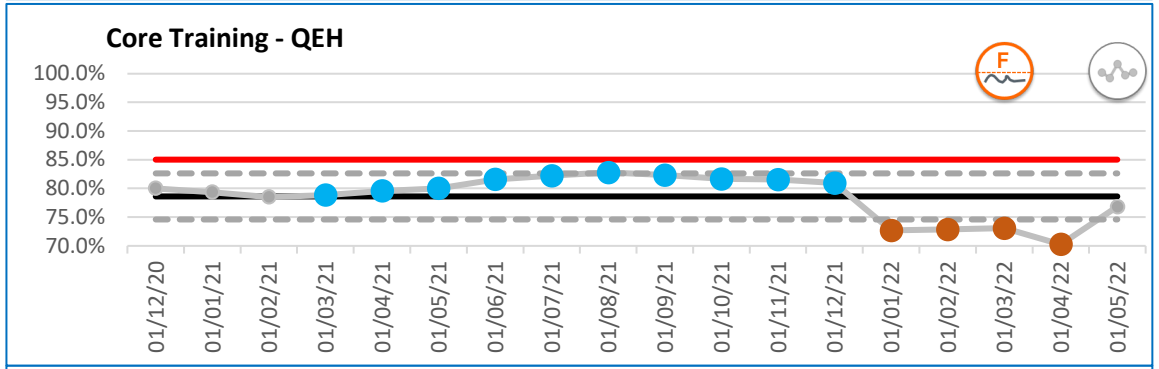
Report by exception: Well led – Core training

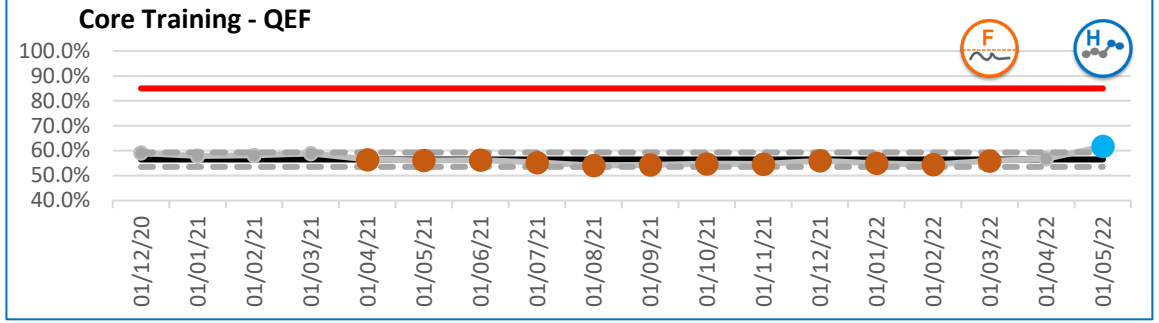
Detail on this measure is included because the target is no longer being met and special cause variation indicates a shift in performance.

Well Led

Gateshead Health NHS Foundation Trust







Situation

A shift in core skills compliance is observed between May 2021 and April 2022 with special cause variation (deterioration) triggering. The latest month is triggering special cause variation (improvement)
QEH figure displaying common cause variation for May 2022
QEF figures displaying special cause variation (improvement) for May 2022.
The indicator is flagging to consistently fail the target based on current performance and monthly variation.

Background

Core training covers those programmes which are recognised as core or essential training for all employees. However the need to respond to the significant demands on staff and services as a result of the pandemic and recovery, has meant this was not as high a priority in some services. In addition it was necessary to cancel attendance at a number of taught core skills courses; capacity on taught courses is still reduced as a result of social distancing measures; and difficulties to source other suitable accommodation. This inevitably affects capacity to improve certain core skills performance.

Assessment

Current compliance is at 68.5% against an 85% target

Actions

A core skills review is complete and with SMT for approval, which will ensure that the training aligned to staff is appropriate.
New recovery plans have been requested for business units to ensure there is plan to improve compliance. This project will be overseen by the newly formed Education, Learning & Development Group and will include BU recovery planning in partnership with POD Leads. As social distancing measures have been reviewed within the trust, face to face teaching can increase where required and this will support an increase in compliance. Numbers for face to face have now been increase in line with covid protocols and allow for additional training capacity. This will aid in speeding up the compliance figures.
New portlets added to ESR homepage to support staff in accessing training and to act as reminders

Recommendation

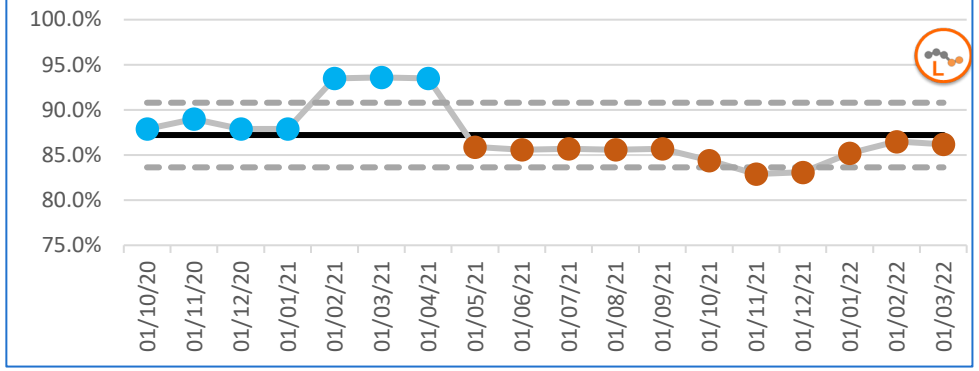
Review, management and oversight at Senior Leadership Team and continued management by operational teams.

Report by exception: Well led – Data Quality Maturity Index (Mental Health Services Dataset)

Well Led

Gateshead Health NHS Foundation Trust

Detail on this measure is included because special cause variation indicates a shift in performance.



Data Set	Recoded Data Item	Data Item score (%)	National Data Item Average (%)
MHSDS	PRIMARY DIAGNOSIS DATE	*	71.9
MHSDS	SECONDARY DIAGNOSIS DATE	*	67.0
MHSDS	ACTIVITY LOCATION TYPE CODE	100	60.5
MHSDS	CARE PLAN TYPE	100	74.4
MHSDS	CARE PROFESSIONAL SERVICE OR TEAM TYPE ASSOCIATION (MENTAL HEALTH)	100	69.7
MHSDS	CONSULTATION MEDIUM USED	100	82.9
MHSDS	ETHNIC CATEGORY	100	78.7
MHSDS	GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	100	88.8
MHSDS	MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE	100	76.5
MHSDS	NHS NUMBER	100	82.5
MHSDS	PERSON BIRTH DATE	100	93.6
MHSDS	PERSON STATED GENDER CODE	100	83.6
MHSDS	REFERRAL CLOSURE REASON	100	72.7
MHSDS	SERVICE DISCHARGE TIME (HOUR)	100	81.0
MHSDS	SERVICE OR TEAM TYPE REFERRED TO (MENTAL HEALTH)	100	88.2
MHSDS	SOURCE OF REFERRAL	100	69.6
MHSDS	EX-BRITISH ARMED FORCES INDICATOR	44	39.6
MHSDS	PRIMARY REASON FOR REFERRAL (MENTAL HEALTH) (REFERRAL RECEIVED ON OR AFTER 1ST JAN 2016)	49	42.8
MHSDS	INDIRECT ACTIVITY TIME (HOUR)	88	73.0
MHSDS	ATTENDED OR DID NOT ATTEND	91	85.7
MHSDS	DISCHARGE PLAN CREATION TIME (HOUR)	93	38.2
MHSDS	CARE CONTACT TIME (HOUR)	94	82.3
MHSDS	ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)	99	80.8
MHSDS	POSTCODE OF USUAL ADDRESS	99	91.4
MHSDS	REFERRAL REQUEST RECEIVED TIME (HOUR)	99	73.2

Situation
A shift in the data quality maturity index for Mental Health Services Data Set observed from May 2021 with special cause variation (deterioration) triggering with the latest nine months below the 18 month mean.

Background
The Data Quality Maturity Index (DQMI) for the Mental Health Services Dataset is a monthly publication intended to highlight the importance of data quality in the NHS. It provides the Trust with timely and transparent information about their data quality.

Assessment
The current DQMI score is 86.2% for the most recent available data (March 2022).
Comparing to the national average the Trust is exceeding the national average for the majority of data items.

Following a shift in performance the remedial actions below have been introduced, however the score remains broadly the same as recent months

- Investigation identified that for a number if records the 'Primary Referral Reason' field was missing at the time of the original submission. This data is now populated and is being submitted retrospectively to improve the Trust's score.
- There may be potential to improve the 'Activity Type Location Code' within the dataset. This again could improve the Trusts score if any missing data can be sourced. Resubmissions can be made for any records dated October 2021 to March-22

Actions
- Resubmission of records where the data is now available
- Investigate further opportunities to improve the Trusts score and resubmit where possible.
- As part of a review of the Single Point of Access review, to clarify the process with the admin team to ensure that the primary referral reason is captured.

Recommendation
To continue to monitor and benchmark.

Progress with Ockenden compliance – assurance visit from regional team 16 June 2022

Maternity

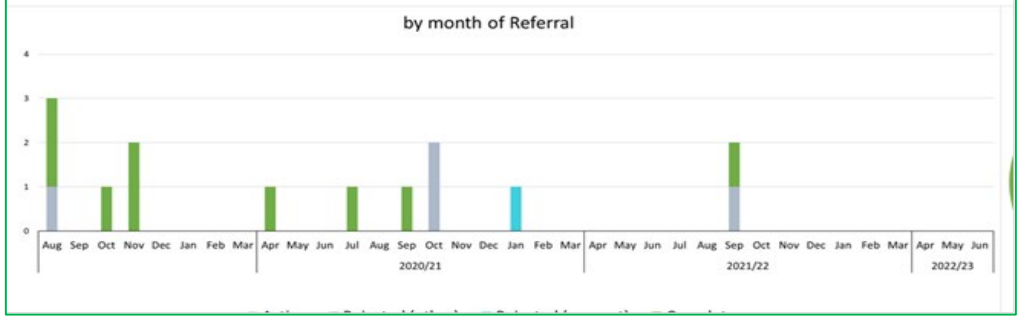
Gateshead Health NHS Foundation Trust

Key Headlines

- *Exceptionally friendly, open and honest MDT. Good working relationships evident.*
- *Leadership team have been transparent, open and responsive to all support offered.*
- *All grades of staff engaged with team and were happy to talk.*
- *The organisation views each person as an individual with their own needs. Including women, families and staff.*
- *Aware of need to 'close the loop' with audits.*
- *Good communication and feedback with all staff groups, especially around 'closing the loop' with complaints and escalations. Good relationship between ward to board.*
- *The NEDs safety champion is visible and known by all staff. Also, evidence of communication of the role of the safety champions in all areas.*
- *Examples of improving and learning from feedback from incidents and action relating to patient complaints.*
- *Examples of learning and quality improvements shared.*
- *Positive learning culture evident.*
- *MVP coproduction evident.*

HSIB update – no active cases, last reported case September 2021

Trend analysis – all referrals



Recommendations / Points for Consideration

- Continue audit to demonstrate embedding and sustainability of interventions and support QI methodology.
- Consider investment in audit/guidelines midwife to support above and support ongoing assurance.
- Consider how you can involve service user voice in triumvirate and maternity safety champions meetings.
- Work on embedding MVP co-production and involvement in governance, guidelines, complaints and information materials.
- Consider gaps to the RCM leadership manifesto in relation to what is currently in place within the organisation.
- Ensure all new staff are aware how to escalate issues with safety (i.e safety champions).

Serious Incident update (June 2022)

Maternity

Gateshead Health NHS Foundation Trust

- The service reported 1 SI this month – Datix 99129/StEIS 2022/14073
- Missed developmental dysplasia of hip diagnosis (DDH)

Summary

- Baby referred via GP at 11 months of age with parental concerns about restricting movement on left hip

Immediate Actions

- Urgent review at QE, referral to paediatric orthopaedics, x-ray – DDH confirmed – correct care pathway now in place
- Rapid review & reported to regional screening QA team, duty of candour & offer of FLO

Learning

- Risk factors correctly identified at newborn NIPE examination (Breech at 36 weeks) – referred for USS at 6 weeks
- Abnormal findings on USS – recommendation for rescan – scan report never seen/actioned as no named Consultant on initial request form
- New pathway from orthopaedic team – no rescan required – automatic referral to team following single abnormal scan

Actions following Trust review

- Complete SIAF (serious incident assessment framework) for regional QA team & await their assessment
- Immediate communication to all NIPE practitioners to inform that all neonatal tests/requests must be put under named Consultant
- Paediatric team to disseminate orthopaedic pathway with immediate effect
- Longer term – radiology to look at pathway for direct referral
- Look-back audit completed for 12 months for assurance that no other missed cases

Maternity Incentive Scheme update

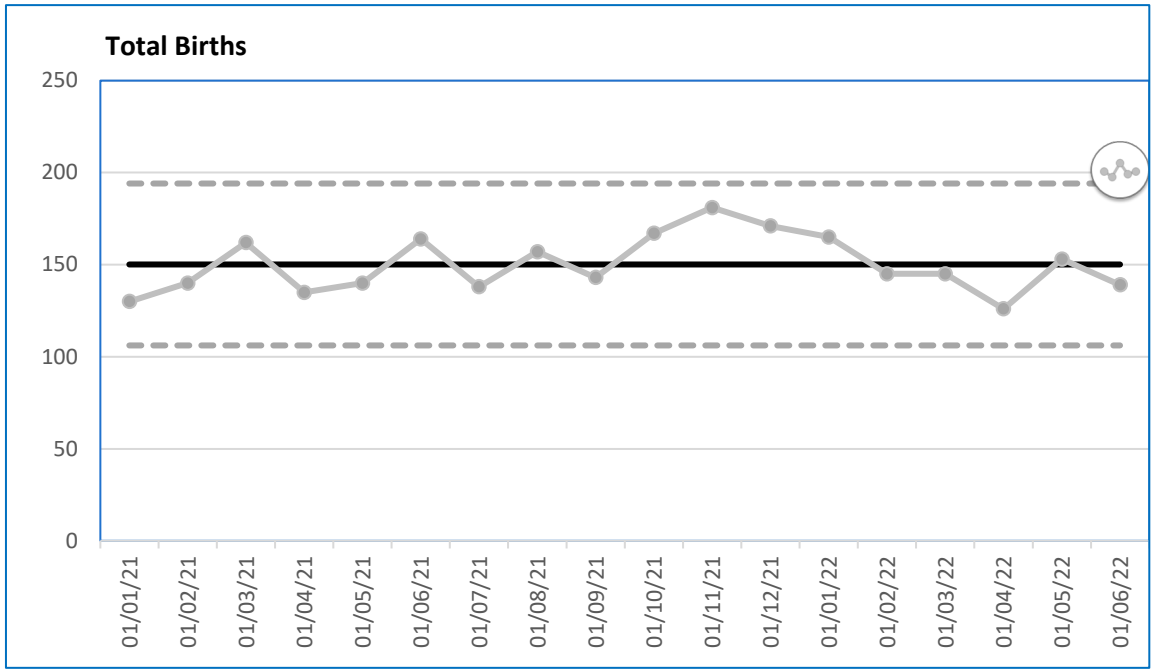
- Relaunch of year 4 scheme with extended submission date to 4 January 2023 & amended standards
- Fully complaint with safety actions 1, 2, 7, 9, 10
- Working towards full compliance with safety actions 3, 4, 8
- At risk of non-compliance with safety action 6 – due to altered standard to include pregnant people declining CO monitoring in the fail data – working with national group to challenge this wording as it does not replicate the Saving Babies Lives care bundle requirements and does not support the principle of informed choice. Our decline levels are typically higher in our Jewish population – to work with the local population leads to educate & understand service user voices.

Report by exception: Maternity – Total births

Maternity

Gateshead Health NHS Foundation Trust

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



Situation Common cause variation displayed
139 births in June represents birth rates within expected range.

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

Assessment

The variation in total number of births shows common cause variation and does not indicate a sustained increase in births, however the comparison with the 20/21 number of births which was 1757 and the 21/22 total births which was 1848 shows a 5% increase. The increase in acuity continues to have a significant impact on the input required from the Obstetric, midwifery and Anaesthetic teams, due to increased levels of intervention.

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

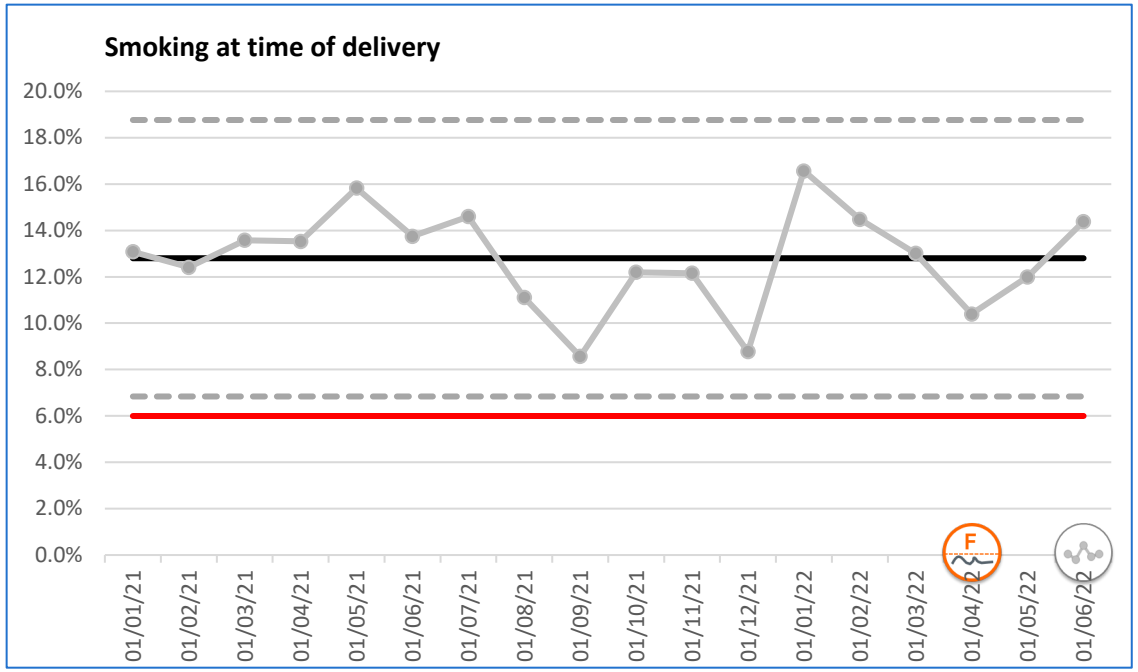
Recommendation
Continue to monitor intervention rates and discuss whether additional medical/theatre staffing is required. There are added pressures due to covid sickness absence as with all staffing.

Report by exception: Maternity – Smoking at time of delivery

Maternity

Gateshead Health NHS Foundation Trust

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



Situation
Common cause variation is displayed. The target has not been achieved in the last 18 months Current performance of 14.4% is above the Trust target.

Background
Strategic/LTP aim to achieve 5% or less women tobacco dependant at time of birth by 2025.

Embed enhanced stop smoking support and NRT as per ambitions of the NHS LTP through maternity provision. Support and enhance the ICS Tobacco Dependency in Pregnancy pathway to maximise support to those with highest health inequalities.

QUIT team in post to target mothers who smoke and their partners in high risk clinics in WHC.

Improvement seen in CO monitoring at booking and 36 weeks following pathway launch

Assessment
Working towards compliance with Saving Babies Lives Care bundle and compliance with MIS year 4 which includes access to smoking referral pathways and improved training and dedicated smoking cessation leads. Public health action plan agreed with NENC/ICS leads. 20/21 overall performance 13.52% and 21/22 overall performance at the end of the financial year 12.99%.

Monthly reporting of CO monitoring shows month on improvement.

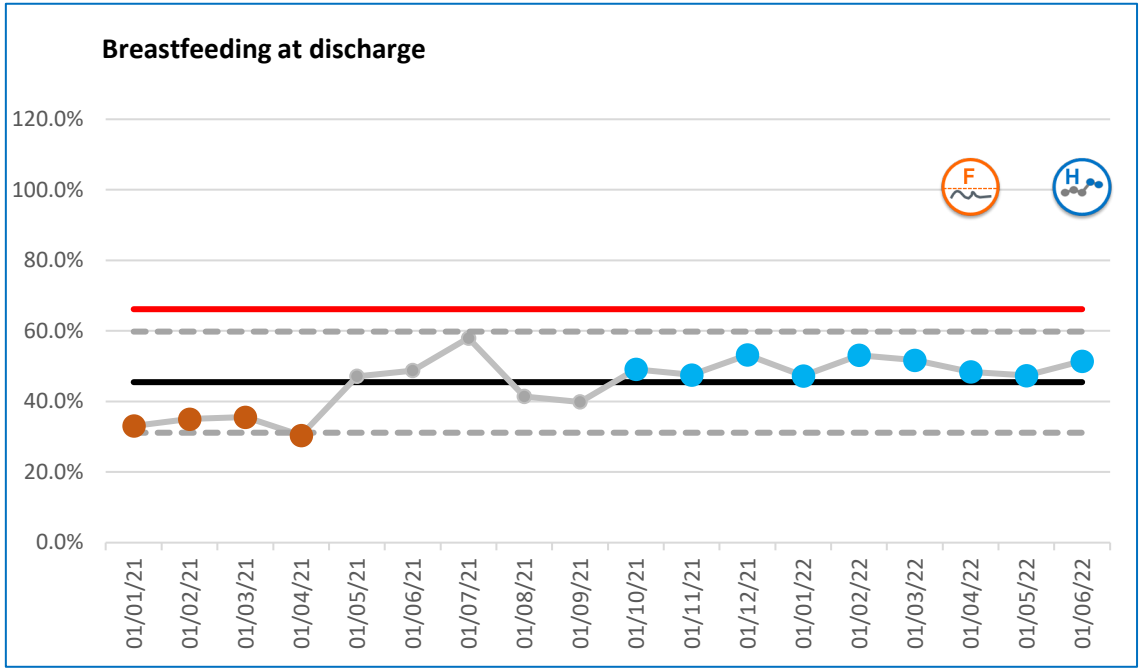
Recommendation
PH plans in place to address KPI's

Report by exception: Maternity – Breastfeeding at discharge

Maternity

NHS Gateshead Health NHS Foundation Trust

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



Situation
Better Births (2016), the Maternity Transformation Programme and the NHS Long Term Plan (2019) highlight the importance and benefits of breastfeeding. There is a regional breastfeeding target to achieve of 72% by 2025, currently the department initiation rate 51.0% in June 2022.

Background
As part of the NHS's ongoing vision to improve postnatal care, the Long Term Plan includes a commitment to support maternity services to deliver an accredited, evidence-based infant feeding programme (such as the UNICEF UK Baby Friendly Initiative.)
The targets are set as:
100% of units at UNICEF level 2 by 2020
100% of units at UNICEF level 3 by 2025

Assessment
Gateshead Health NHS Foundation Trust is accredited at Level 1 and is eligible for Level 2 support: accreditation assessment costs and additional support. UNICEF Breastfeeding & Relationship Building Course facilitated - March, meetings in progress to discuss commencing the relevant UNICEF audits.

The maternity infant feeding guidelines were assessed as part UNICEF stage 1 accreditation in September 2019 and will be due to be reviewed again in the summer. SCBU planning for level 1 accreditation will start with review of infant feeding guidelines to review.

Actions
Monthly face to face UNICEF staff training and Practical Skills Review's re-commenced from October 2021.
Planning meeting held with Unicef 28 June 2022
Working towards stage 2 accreditation July 22.
Part of regional maternal breast milk in preterm infants QI group

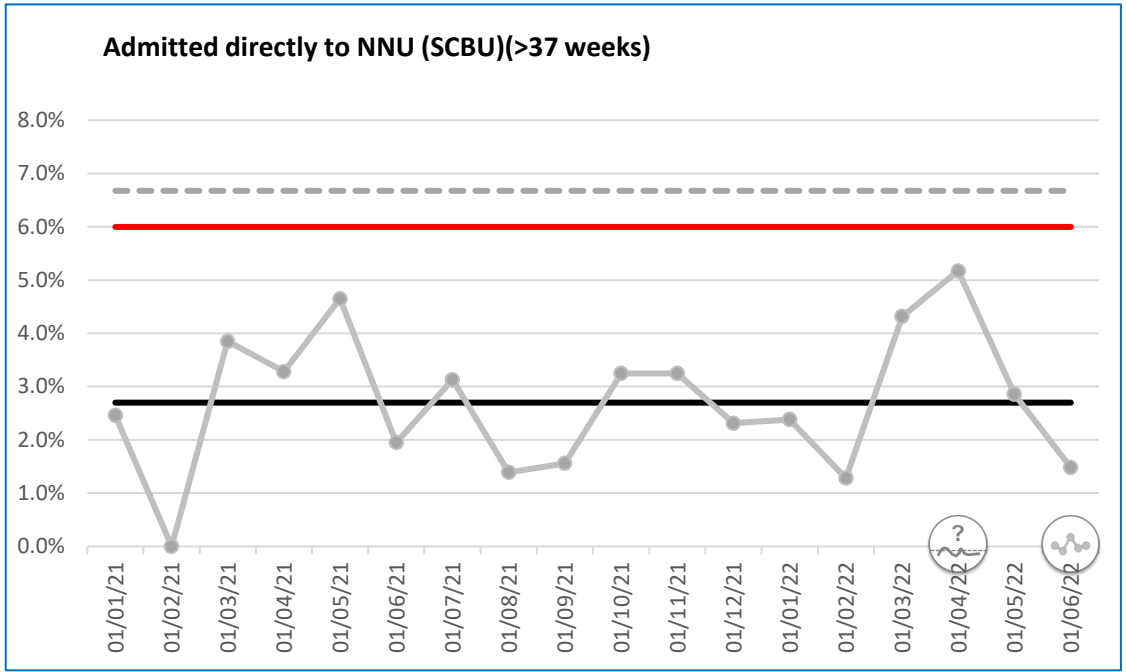
Recommendation
There will always be some mothers who do not continue to fully breast feed for various reasons. A full review of target indicators will be part of Maternity Sub group reporting and benchmarked regionally with the NENC Infant feeding leads.

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

Maternity

NHS Gateshead Health NHS Foundation Trust

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



Situation Common cause variation displayed. The target has been achieved for every month in the last 18 months. Current performance of 1.5% represents an achievement of the Trust target. On target to achieve Year 4 MIS safety action.

Background
Our transitional care model enables babies who would have once been admitted to SCBU to remain with their mothers and be supported on the postnatal ward with input from the Neonatal nurse practitioners and maternity support workers. This reduces SCBU admissions and enables mother and baby bonding.

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

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

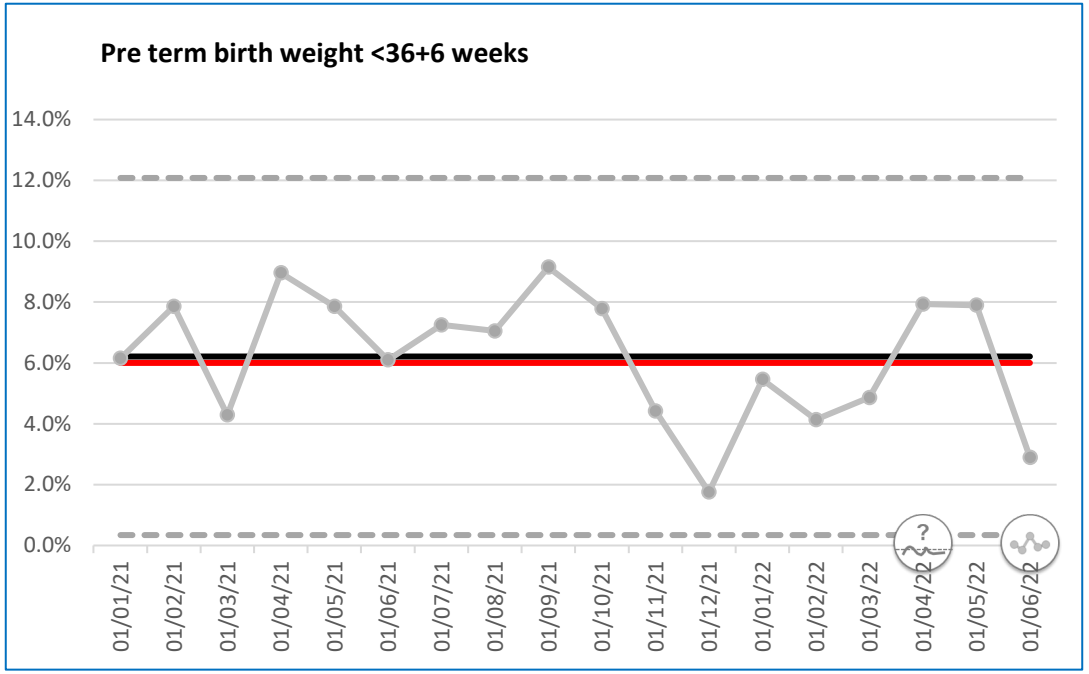
Recommendation
Review of transitional care staffing and succession planning for development of the ANNP role as without this the model will not function. Quarterly audit of term admissions to be reported on IOR as exception.

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

Maternity

NHS Gateshead Health NHS Foundation Trust

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



Situation
Common cause variation displayed. The target has been achieved in seven of the last eighteen months.

Current performance of 2.9% represents achievement of the Trust target in June 2022.

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

Assessment
Data capture of any pre-term births (definition; delivery prior to **37 weeks gestation) is monitored and reported. This has been added to the clinical dashboard.**

Actions
Engagement with regional preterm birth network including allocated funding to provide specialist pre-term birth clinic – metrics to be reported to NENC LMNS
Engagement with MatNeoSIP national pre-term birth optimisation pathway
Implementation of Saving Babies Lives v2 care bundle (element 5 relates to preterm birth)
Trust preterm birth quarterly meetings commenced, lead midwife & HCA in post & additional fetal fibronectin machine to be purchased utilising LMNS funding

Recommendation
Continue to engage & monitor outcomes following full implementation of these work streams. Reported to the Neonatal Network.

Need to identify funding for sonographer to support preterm birth pathway

Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 15

Report Title:	**Nursing Staffing Exception Report**			
Name of Meeting:	Board of Directors			
Date of Meeting:	27th July 2022			
Author:	Karen Roberts, Deputy Chief Nurse Laura Edgar, People Data and Information Lead			
Executive Sponsor:	Gillian Findley, Chief Nurse and Professional Lead for Midwifery and AHPs			
Report presented by:	Gillian Findley, Chief Nurse and Professional Lead for Midwifery and AHPs			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☒
	This report is to provide assurance to the Board that staffing establishments are being monitored on a shift-to-shift basis.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☒ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*				
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	This report provides information relating to ward staffing levels (funded against actual) and details of the actions taken to address any shortfalls. June continued with significant staffing challenges as we experienced a continued surge on COVID-19 activity within the organisation. This has impacted on staffing resource and the clinical operating model. Significant staffing challenges remain due to vacancies and we continue focused work around the recruitment and retention of staff. Wards where staffing fell below 75% of the funded establishment are shown within the paper. Detailed context and actions taken to mitigate risk are documented. A staffing escalation protocol is now in operation across all areas within the organisation and assurance of this operating as expected, is provided by the number of staffing incident reports raised through the Datix system.			

	Ongoing concentrated work continues within the safe staffing Task and Finish Group to review staffing establishments, recruitment, managing sickness absence, recording and escalation of staffing challenges. Regular updates are shared with the executive team from this work.				
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Board are asked to: • receive the report for assurance • note the work being undertaken to address the shortfalls in staffing				
Trust Strategic Aims that the report relates to:	**Aim 1** ☒	We will continuously improve the quality and safety of our services for our patients			
	Aim 2 ☒	We will be a great organisation with a highly engaged workforce			
	Aim 3 ☒	We will enhance our productivity and efficiency to make the best use of resources			
	Aim 4 ☐	We will be an effective partner and be ambitious in our commitment to improving health outcomes			
	Aim 5 ☐	We will develop and expand our services within and beyond Gateshead			
Trust corporate objectives that the report relates to:					
Links to CQC KLOE	Caring ☒	Responsive ☒	Well-led ☐	Effective ☒	Safe ☒
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks and DATIX reference)	There were staffing shortfalls raised via datix in the month of June, of which there was no moderate or above harm incident identified.				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

Gateshead Health NHS Foundation trust
Nursing and Midwifery Staffing Exception Report
June 2022

1. Introduction

This report details the staffing levels for Gateshead Health NHS Foundation Trust during the month of June 2022. The staffing establishments are set by use of the Safer Nursing Care staffing tool (SNCT). This is a recognised, nationally used tool that matches the acuity of patients with the staffing requirements for acute medical and surgical wards. It also includes the emergency assessment unit. Separate staffing tools are available for the emergency department, and mental health units. The senior nursing team are currently being trained to use these tools and as soon as the assessment has been completed the Board will be presented with the results for these areas. Maternity use the Birth Rate Plus tool and this has been reported to Quality Governance Committee and the Trust Board separately.

2. Staffing

The level of staff available for shifts within the ward areas is monitored and reported in real time within the Safecare Live system. Matrons and Ward Managers have access to this system, and they adjust staffing accordingly with the use of professional judgement. Table 1 shows the overall actual ward staffing against the budgeted establishments from June for the wards. Appendix 1 shows the fill rate figures broken down for every ward area. In addition to the fill rate calculation, the Trust submit monthly "care hours per patient day" (CHPPD) as a national requirement to NHS Digital (see section3The actual ward staffing against the budgeted establishments from June are presented in Table 1.

Table 1: Whole Trust wards staffing June 2022

Day	Day	Night	Night
Average fill rate - registered nurses/midwives (%)	**Average fill rate - care staff (%)**	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**
78.3%	118.4%	89.8%	107.2%

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

2.1 Exceptions

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

A Safer Nursing Care Tool (SNCT) data collection is being undertake in July 2022. Data will be triangulated with key performance indicators and professional judgement templates in line with the National Staffing review from the National Quality Board. The outcome and recommendations from this review will be presented at Trust Board.

2.2 **Contextual information and actions taken**

Critical care department have shown low fill rates as they currently have 8.7 registered WTE gaps, which have now been recruited to, and are due to start in September. Sickness absence for the department throughout June was 7.9%.

JASRU have 4.87 WTE registered staff vacancies. JASRU continue to support ward 12 medicine with one registered nurse. They have higher sickness absence rates throughout June at 27.3% for registered staff. They are receiving support from the POD team for long-term sickness absence management.

Ward 8 demonstrates ongoing reduced Registered fill rates as they support ward 12 with a registered staff member and also have 4.38 wte registered nurse vacancies. They experienced sickness absence rates of 16.4% for Registered staff throughout June.
Ward 9 currently have 6.45 wte Registered nurse vacancies. They have also experienced a Registered Nurse sickness absence rate of 10.1%. The NIV nurse has supported with ward-based care during staffing shortfalls.
Ward 11 experienced 10.7% sickness absence for registered staff and they currently have 3.55% Registered vacancies.
Ward 12 demonstrates a reduced fill rate as they currently have 8.63 wte Registered vacancies. They have an additional 3.65 wte Health Care Support Workers to support acuity and dependency of patients. Throughout June, there was a sickness absence rate of 16.7% for Registered staff on ward 12. They are receiving registered nursing support from other areas across the Trust.
Ward 21 elective orthopaedics have operated with a reduced bed capacity, averaging six open beds per day, therefore have supported other areas across the Trust.
Ward 22 currently have 5.61 wte Registered vacancies. Ward 22 are still working within a covid hybrid model.
Ward 25 have 3.32 wte Registered vacancies with a registered sickness absence of 8.5%.

The exceptions to report for June are as below:

June 2022	
Qualified Nurse Days	**%**
Critical Care	74.2%
JASRU	50.9%
Ward 08	58.8%
Ward 09	57.0%
Ward 11	73.7%
Ward 12	70.3%
Ward 21 ortho	65.6%
Ward 22	73.5%
Ward 25	67.4%
Qualified Nurse Nights	**%**
Ward 10	71.2%
Healthcare Assistant Days	**%**
N/A	
Healthcare Assistant Nights	**%**
Ward 21 Elective Ortho	40.5%

In June the Trust worked to the agreed clinical operational model which meant at times some wards listed above had lower patient occupancy and staff were redeployed appropriately to areas with the greatest clinical need. Throughout June, areas of deficit were escalated as per staffing policy and mitigations were put in place by the Matron teams using professional judgement as to the acuity and demand in each area, which included:

- Redeployments of Registered Nurses and HealthCare assistants on a daily and at times hourly basis between wards according to patient acuity and demand.
- Concentrated support from the Matrons and the People and Organisational Development team to address the sickness absence levels within the divisions and to recruit to vacant posts.

3. Care Hours Per Patient Day (CHPPD)

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

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

Ward level CHPPD is outlined in Appendix 1. For the month of June, the Trust total CHPPD was 8.1. This compares well when benchmarked with other peer reviewed hospitals.

4. Monitoring Nurse Staffing via Datix

The Trust has an escalation process in place for addressing staffing shortages with identified actions to be taken. Further discussion is to take place to scope the potential for identifying whether triggers as to when a staffing related DATIX should be submitted could be added to this process to provide reporting consistency. In addition to this the ongoing work to triangulate fill rates and care hours against reported staffing and patient safety incidents, has highlighted that the subcategories available to the reporter within DATIX requires review to streamline and enable an increased understanding of the causes of the shortages, e.g., short notice sickness, staff moves or inability to fill the rota.

A task and finish group streamline data capture and explore these potential emerging themes is being set up, alongside reviewing the potential to triangulate this data against a number of potential care quality measures to truly explore any impacts of staffing challenges on patient care, and to enable targeted support for staff.

A report of staffing concern related incidents is generated monthly and discussed at the Nursing and Midwifery Professional Forum. The report helps identify areas where nurse staffing may have fallen below planned levels and what actions were taken to manage the situation and the ongoing work of the task and finish, will enhance this understanding.

The numbers of staffing incidents are an effect of the Global COVID19 pandemic and subsequent government guidelines around self-isolation when staff have tested positive or had significant contact throughout the 4th wave of COVID 19. The number of Registered Nurse vacancies also contribute to this.

5. Recruitment, retention and attendance of Nursing workforce

The below table displays the percentage of sickness absence per staff group for June. This includes Covid-19 Sickness absence. Total Sickness absence percentage includes all workforce groups, such as Admin and Clerical and domestic services where applicable.

Area/Dept	Registered Nurse/Midwife	HCSW	Total
EAU	4.9	10.9	6.9
St Bedes	6.8	11.1	8.2
JASRU	27.3	14.4	17.8
Critical Care Dept	8.3	2.3	7.9
Ward 8	16.4	3.4	9.3
Ward 9	10.1	7.2	8.0
Ward 10	3.8	10.8	7.1
Ward 11	10.7	17.2	12.8
Ward 12	16.7	5.6	8.3
Ward 14	0.5	13.8	8.4
Ward 14a	23.0	15.2	19.7
Ward 21	11.2	7.4	8.7
Ward 22	5.3	10	7.2
Ward 23	3.4	4.9	5.9
Ward 24	0.9	15.6	7.9
Ward 25	8.5	16.1	12.6
Ward 26	6.0	7.8	6.5
Ward 27	9.5	6.2	7.6
Cragside	20.9	10.9	15.0
Sunniside	1.3	11.9	10.8
Maternity	8.7	4.1	7.3
Paediatric Services	0	4.5	5.5
SCBU	7.7	20.5	9.2

6. Governance

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

7. Conclusion

This paper provides an exception report for nursing and midwifery staffing in May 2022, and also provides assurance of ongoing work to triangulate quality and safety metrics against staffing and care hours.

8. Recommendations

The Board is asked to receive this report for assurance.

Gill Findley

Chief Nurse and Professional Lead for Midwifery and Allied Health professionals

19.07.22

Appendix 1- Table 3: Ward by Ward staffing June 2022

	Day		Night		Care Hours Per Patient Per Day (CHPPD)			
Ward	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative patient count over the month	Registered midwives / nurses	Care Staff	Overall
Emergency Care Centre - EAU	78.3%	109.8%	76.7%	103.5%	1314	5.6	3.9	9.5
Ward 8	58.8%	128.2%	100.2%	101.7%	616	2.9	3.6	6.5
Ward 9	57.0%	125.4%	79.2%	120.0%	800	2.6	3.1	5.6
Ward 10	95.5%	135.0%	71.9%	109.0%	614	2.9	3.6	6.5
Ward 11	73.7%	108.1%	108.2%	118.4%	777	2.3	2.9	5.2
Ward 12	70.3%	138.9%	108.3%	123.4%	742	2.3	3.6	6.0
Ward 14 Medicine	79.3%	122.7%	110.0%	129.2%	718	2.6	3.3	5.9
Ward 14A	76.9%	132.2%	102.3%	93.1%	702	2.6	3.8	6.4
Ward 21 Elective Ortho	0.0%	0.0%	0.0%	0.0%	152	0.0	0.0	0.0
Ward 21 Medicine	73.5%	120.9%	103.9%	80.4%	852	2.2	3.4	5.6
Ward 22	85.0%	145.9%	101.4%	122.9%	692	2.5	4.5	7.0
Ward 23	86.9%	110.2%	111.2%	96.9%	856	2.5	3.3	5.8
Ward 24	79.3%	122.7%	110.0%	129.2%	718	2.6	3.3	5.9

	Day		Night		Care Hours Per Patient Per Day (CHPPD)			
Ward	**Average fill rate - nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Cumulative patient count over the month**	**Registered midwives / nurses**	**Care Staff**	**Overall**
Ward 25	67.4%	124.5%	121.6%	86.7%	904	2.1	3.3	5.3
Ward 26	88.9%	118.1%	106.2%	117.2%	815	2.7	3.3	6.0
Ward 27	88.1%	96.7%	100.5%	118.2%	835	2.6	2.8	5.4
Cragside Court	91.4%	184.5%	101.4%	301.8%	350	5.4	12.1	17.4
Critical Care	74.2%	143.3%	90.2%	82.4%	251	26.6	6.4	33.0
JASRU	50.9%	109.2%	103.2%	97.0%	551	2.5	5.0	7.5
Maternity	117.8%	170.6%	91.2%	96.7%	445	15.4	7.2	22.6
Paediatrics	111.3%	135.7%	102.5%		37	58.6	20.1	78.8
SCBU	88.6%	125.7%	97.0%	83.5%	163	9.9	3.8	13.7
St Bedes	92.4%	119.3%	97.1%	108.6%	246	5.8	5.4	11.3
Sunniside	122.9%	127.3%	118.2%	145.4%	303	6.9	4.7	11.6
QUEEN ELIZABETH HOSPITAL - RR7EN	**78.3%**	**118.4%**	**89.8%**	**107.2%**	**13794**	**4.1**	**4.0**	**8.1**

NHS
Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 16

Report Title:	**Freedom to Speak Up Guardian Update**			
Name of Meeting:	Trust Board			
Date of Meeting:	27th July 2022			
Author:	Gareth Rowlands, Freedom to Speak Up Guardian (FTSUG)			
Executive Sponsor:	Lisa Crichton-Jones, Director of People and OD			
Report presented by:	Gareth Rowlands, Freedom to Speak Up Guardian (FTSUG)			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** X	**Information:** ☐
	To provide an update of FTSU activity from January 2022 (Q4) and current Q1 report			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** X *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	N/A			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	This report will continue to be developed and feedback is welcomed. For this period. - Most concerns could be regarded as “cultural” - Concerns regarding Worker Safety in Community Maternity due to caseload, vacancies and sickness and inconsistent use of Lone worker Devices. This may be a patient safety risk. - Concerns regarding culture in Surgery and development proposals. - New FTSU Training for Board members. - New National FTSU to be launched. Where concerns have arisen these are being managed in a variety of ways with those of greater significance / risk notified to the executive team. Future reports will include an overview as to what actions are being taken.			

<table>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="6">1.1. The Committee is asked to receive this report by way of assurance on FTSU concerns and broader activity.
1.2. The Committee is asked to note the concerns in relation to the community maternity team and seek assurance that this has oversight within the executive and senior operational teams.
1.3. The Committee is asked to note the concern regarding the service development culture within Surgery and seek assurance that this has oversight within the executive and senior operational team
1.4. The Committee are asked to note the ongoing pressures for staff arising from cost of living pressures and the work within the ICS to develop a standard approach to any financial wellbeing initiatives.
1.5. The Committee is asked to note the publication of the new Training module for FTSU and the work underway via the Board Secretary to review the best way to cascade / deliver this to board members.
1.6. The Committee is asked to note that the new National FTSU Policy and additional guidance was received at the end of June, and the updating of trust policy and documentation is in hand.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="5">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td colspan="5">We will be a great organisation with a highly engaged workforce</td></tr>
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☐</td><td colspan="5">We will develop and expand our services within and beyond Gateshead</td></tr>
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<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 colspan="7">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td colspan="6">Risk to lone workers in community midwifery</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☒</td><td colspan="2">Not applicable
☐</td></tr>
</table>

Freedom to Speak Up Guardian Report

1. Executive Summary

1.1. 14 concerns raised in the current reporting period (*Jan 1- June 16, 2022*). In 2021-22, 34 concerns were raised. In Q1 of 2022-23, 9 concerns have been raised.
1.2. Serious concerns in relation to Community Maternity Team (Surgical BU). Worker safety with possible consequences for Patient Safety.
1.3. Serious concern with regards to a service development and culture within the Surgical BU.
1.4. Fuel Poverty may become an increasing issue for staff (together with the Cost of Living Crisis)
1.5. New FTSU training for Board / VSM now available
1.6. New National FTSU Policy and guidance launched and Trust paperwork to being updated.

2. Introduction

2.1. The Board has a key role in shaping the culture of the Trust. Freedom to Speak Up (FTSU) is an important component in respect of developing an open, transparent and learning culture.

2.2. The National Guardian's Office (NGO) expects Boards to lead in this area, ensuring that the Board actively promotes learnings, encourages staff to speak up and sends a clear message that the victimisation of workers who speak up will not be tolerated. It is also the responsibility of the Board to ensure that there is a well-resourced Guardian with named Board lead and to ensure that there is investment in leadership and development.

2.3. The FTSUG reports to the Board twice per annum and also presents a paper to the People and OD Committee.

2.4. This Report provides the Board of Directors with a summary of FTSU activity from January 1st 2022 (Q4 : 2021-22) to June 16th 2022 (Q1: 2022)

3. Cases

14 concerns raised in the current reporting period (Jan 1- June 16 2022). In 2021-22, 34 concerns were raised. In Q1 of 2022-23, 9 concerns have been raised.

GREEN– Case Closed / Resolved

AMBER Open / Ongoing

RED Serious / High Risk

3.1. Q 4 2021-22

No	Role	Area	Concern Patient Safety, Worker Safety, B&H	Detri ment	Resolution	Learning	Speak Up Again
1	N/k	Trust wide	Culture, Facilities,		Ongoing External investigation		N/K
2	Medical Secretaries	Surgery	Bullying, poor communication, inconsistent management		Watching brief. Do not wish to escalate at present		YES
3	Midwife	Maternity	Unsupported - unequal case load – stress - concerned about Patient Safety/ Quality		Watching brief		YES
4	N/K	Finance and Digital	Culture – high attrition rate for some staff in the department		External investigation concluded. Watching brief	Ongoing OD	N/K
5	Junior Doctor	Surgery	I have some issues with working hours in which I don't feel safe to exception report despite working more hours than contracted regularly.		Ref to Guardian of Safe Working		YES

3.2. Q1 2022-23

No	Role	Area	Concern Patient Safety, Worker Safety, B&H	Resolution	Learning	Speak Up Again
1	Midwife	Surgery	Bullying – grievance Management culture	Taking out Grievance	Cultural / management of the service	YES
2	Potential Ex-employee	Not known	Serious unsubstantiated concern	No further contact received and no potential areas to investigate internally	N/A	No
3	Junior Doctor	Medicine	Attitude / communication of Senior Colleague– Junior Doctors afraid to make referrals/ ask advice.	Escalated to Clinical Lead Consultant to be spoken with. Alternative arrangements for contacting speciality put in place	Cultural and behavioural work to be undertaken	YES
4	Radiographer	CSS	Concern regarding reporting of NAI in a child. Safeguarding	Interim Head of Safeguarding Reviewed by Safeguarding Paediatrician	Case reviewed and assurance received.	YES
5	HCA	Community and NH	Fuel poverty / cost of living	Escalated to CEO - ICS looking at it.	ONGOING	YES
6	Consultant	Surgery	B&H culture Service development concerns	Already escalated to CEO MD	ONGOING	n/k
7	Midwife	Surgery	Lone worker devices - not being routinely issued, used or monitored. Not all staff. High risk to staff and Trust	Escalated to Chief Nurse, Head of Midwifery LWD Lead and operational director	Devices allocated to the appropriate staff and training given. LWD Lead reviewing	N/k
8	Midwife	Community Midwifes	Case load Chaotic management Staff shortages	Awaiting further info		N/K
9	Midwife	Community Midwifes	Work stress Pt safety	Awaiting further info		N/K

4. Guardian Activity

4.1 During this Reporting Period, the FTSUG has received 14 concerns, had 154 individual meetings/ contacts and delivered face to face training to 250 members of staff as well as providing additional training via video presentations.

4.2 The FTSUG continues to maintain a comprehensive log of all activity and submits data on a quarterly basis to the National Guardian's Office

4.3 The FTSUG is actively involved in staff induction, medical staff induction and the newly introduced "Managing Well" programme.

4.4 The FTSU meets with the POD Leads and Head of People Services on a monthly basis to ensure a close working relationship and joined up approach to people issues

4.5 The FTSUG has attended all the monthly Northeast and Cumbria Regional FTSUG meetings. The FTSUG stood down as chair of this group in June 2022 after nearly 2 years in office. As Chair, he also regularly attended National Chair and Trainers meetings

4.6 The FTSUG has had initial conversations with an external provider with regards to a Freedom to Speak Up App, which is being piloted in other Trusts.

4.7 FTSU will be part of the core skills programme in the Trust. FTSUG is currently in discussion with L&D Team with regards to the launch and implementation

5. National Guardian Office

5.1 Training

Third level of FTSU Training *(Follow Up*) for Board Level/ VSM is now available. (To be used in conjunction with *Speak Up* and *Listen Up* modules)

https://youtu.be/xyj98GrcyFM

and accessed via: Freedom to Speak Up - eLearning for healthcare (e-lfh.org.uk)

the Board Secretary will review the most appropriate way to cascade and deliver the training to board members.

5.2 National Policy Update
It is expected to be launched before the end of June 2022 and will be enable the Trust to update our Trust Policy (currently overdue).

6. Recommendations

6.1. The Committee is asked to receive this report by way of assurance on FTSU concerns and broader activity.
6.2. The Committee is asked to note the concerns in relation to the community maternity team and assurance that this has oversight within the executive and senior operational teams.

6.3. The Committee is asked to note the concern regarding the service development culture within Surgery and seek assurance that this has oversight within the executive and senior operational team

6.4. The Committee are asked to note the ongoing pressures for staff arising from cost of living pressures and the work within the ICS to develop a standard approach to any financial wellbeing initiatives.

6.5. The Committee is asked to note the publication of the new Training module for FTSU and the work underway via the Board Secretary to review the best way to cascade / deliver this to board members.

6.6. The Committee is asked to note that a new National FTSU Policy is expected soon, and the updating of trust policy will duly follow.

Gateshead Health NHS Foundation Trust

Report Cover Sheet

Agenda Item: 17

Report Title:	**WRES and WDES 6 Monthly Report**			
Name of Meeting:	Board of Directors			
Date of Meeting:	Wednesday 27 July 2022			
Author:	Kuldip Sohanpal, EDI and Engagement Manager			
Executive Sponsor:	Yvonne Ormston, Chief Executive			
Report presented by:	Lisa Crichton-Jones, Director of People and OD			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	This paper presents a 6-monthly position update in respect of the current Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES), which have been incorporated into the trust's overarching equality, diversity and inclusion action plan (appendix 1). The WRES and WDES, first mandated in July 2015 and July 2018 respectively are covered by the Equality Act. The WRES sets out what Trusts need to do to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair and equal treatment in the workplace. The WDES builds on the WRES indicators but focuses on disability, seeking to promote the concept of disability as an asset as research identifies that disabled people have poorer experience of working in the NHS in England than their non-disabled colleagues.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Versions have been submitted to the monthly Human Rights Equality Diversity Inclusion Programme Board, the People and OD Portfolio Board.			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.*	In the national WRES report from NHS England published in April 2022, Gateshead Health NHS Foundation Trust was highlighted in the benchmarking as being in the top 10 for two indicators across England. These were for:			

<table>
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- *Finance*
- *Patient outcomes / experience*
- *Quality and safety*
- *People and organisational development*
- *Governance and legal*
- *Equality, diversity and inclusion*

</td><td colspan="2">

- **Indicator 2: likelihood of appointment from shortlisting**
- **Indicator 5: harassment, bullying or abuse from patients, relatives, or the public in the last 12 months**

The national report also highlighted areas for improvement, which included:

- **Indicator 2: likelihood of appointment from shortlisting** [this is benchmarked within the top 10 as identified above however it is still an area for improvement].
- **Indicator 6: harassment, bullying or abuse from staff in last 12 months against BME staff**
- **Indicator 8: discrimination from a manager/team leader or other colleagues in last 12 months against BME staff**

The Human Rights Equality Diversity and Inclusion (HREDI) Programme Board, have identified the following key areas of focus to address the improvement areas:

- Attracting staff – specifically focused on ensuring recruitment and selection has equity from start to finish
- Developing staff – specifically focused on reverse mentoring
- Supporting staff – specifically focused on introducing a zero-tolerance policy, by having ambassadors trained to aid in any Grievance and Harassment procedures
- Monitoring the EDI dashboard

Additionally, an action plan (see appendix 1) has been developed with the current actions being undertaken across the organisation.

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Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper

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The Board is asked to note the content of this report for assurance and agree the ongoing EDI Action Plan.

To request the board's support and engagement to support the prioritization of the EDI agenda across their work within the trust.

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Trust Strategic Aims that the report relates to:

</td><td>**Aim 1** ☒</td><td>We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>**Aim 2** ☒</td><td>We will be a great organisation with a highly engaged workforce</td></tr>
</table>

	Aim 3 ☐	We will enhance our productivity and efficiency to make the best use of resources			
	Aim 4 ☒	We will be an effective partner and be ambitious in our commitment to improving health outcomes			
	Aim 5 ☐	We will develop and expand our services within and beyond Gateshead			
Trust corporate objectives that the report relates to:	Growing and developing our workforce				
Links to CQC KLOE	Caring ☒	Responsive ☒	Well-led ☒	Effective ☐	Safe ☐
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks and DATIX reference)	N/A				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐		**No** ☐	**Not applicable** ☒	

Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES)

1. Executive summary

1.1. The Government introduced the Equality Act on the 1st October 2010 replacing previous anti-discrimination laws (gender, race and disability) with a single act, simplifying the law, removing inconsistencies and making it easier for people to understand and comply with.

1.2. The Public Sector Equality Duty introduced specific duties and regulations (5th April 2010) applying to all public sector bodies, authorities extending the protection from discrimination on the basis of nine protected characteristics – Age, Disability, Race, Gender, Religion or Belief, Sexual Orientation, Gender Reassignment, Marriage and Civil Partnership, and Pregnancy and Maternity.

1.3. The McPherson Report (arising from the Stephen Lawrence Enquiry) gave substance to issue pertaining to race equality, introducing the term 'institutional discrimination' to describe the way in which organisational systems, structures, processes and procedures can operate against equality of opportunity. This paved the way for addressing inequalities across all protected characteristics as reflected in the Equality Act 2010.

1.4. The WRES and WDES, first mandated in July 2015 and July 2018 respectively are covered by the Equality Act. The WRES sets out what Trusts need to do to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair and equal treatment in the workplace.

A national WRES report produced for the Trust placed us in the top ten best performing Trusts for two indicators:

Indicator 2: likelihood of appointment from shortlisting

Indicator 5: harassment, bullying or abuse from patients, relatives, or the public in the last 12 months

However, three priority areas have been identified for improvement.

Indicator 2: likelihood of appointment from shortlisting - further work required

Indicator 6: harassment, bullying or abuse from staff in last 12 months against BME staff

Indicator 8: discrimination from a manager/team leader or other colleagues in last 12 months against BME staff

The WDES builds on the WRES indicators but focuses on disability, seeking to promote the concept of disability as an asset as research identifies that disabled people have poorer experience of working in the NHS in England than their non-disabled colleagues.

1.5 The National WDES team will produce a similar report and will identify any strengths and areas that need addressing.

1.6 We have developed a Human Rights Equality Diversity Inclusion action plan (Appendix 1) that sets out our direction of travel for Trust. This cross-references both the WRES and WDES actions, our work priorities and nominated leads.

2. Introduction and Background

2.1. This paper provides an update on progress against the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) indicators. Our associated actions inform the Trust's Equality Objectives and overarching Equality Diversity & Inclusion Work Plan for 2021 and beyond.

3. WRES / WDES

3.1. Addressing inequalities and reflecting Equality and Diversity in all we do is not only a legal duty, but integral to promote equality on moral and democratic grounds. For the NHS addressing health inequalities by using the associated WRES / WDES KPI's are but two of the national indicators used to assess year-on-year improvement.

3.2. The WRES and WDES standards are also cross referenced to the Equality Delivery System 2 (EDS2), which sets out how Trusts should support performance reviews, set equality objectives and deliver on the Public Sector Equality Duty (PSED).

3.3. To put the WRES and WDES into context the NHS People Plan states that…
'… to embed the important interventions that improve the experience of our people, we will develop a new offer with our people setting out explicitly the support they can expect from the NHS as a modern employer…' This will be framed around the broad themes of:
'… creating a healthy, inclusive and compassionate culture, enabling great development and fulfilling careers, and ensuring everyone feels they have voice, control and influence…'

4. WRES Metrics

4.1. Nationally, NHS England's report (April 2022) based upon **5 years WRES data** collected against several indicators shows that although progress has been made, more work is still required in the following areas:

- 6.8% of very senior managers in NHS Trusts 2020 are from a BME[1] background (5.4% in 2016)
- 10% of all trust board members are from a BME background (7% in 2017)

[1] BME refers to those members of the NHS who are not White. The definitions used in the WRES have followed the national reporting requirements of ethnic categories in the NHS data model, that is BME. The Trust has used the acronym BAME – incapsulating BME, but including Asian

- The relative likelihood of BME staff entering the disciplinary process is at the lowest level since data collection began
- **However, the relative likelihood of BME staff accessing non – mandatory training is at the lowest since this data collection began**.

4.2. Locally, the National WRES team have generated a WRES report specifically for each Trust. As part of this, Gateshead Health Foundation Trust was highlighted in the top ten best performing trusts for two indicators.

- **Indicator 2: likelihood of appointment from shortlisting**
- **Indicator 5: harassment, bullying or abuse from patients, relatives, or the public in the last 12 months**

4.3. The report also highlighted three high priority areas for improvement for the Trust. These are the areas with the worst percentile rankings against other Trusts. These indicators are:

- **Indicator 2: likelihood of appointment from shortlisting**
  At March 2021 the likelihood ratio was 0.70 lower than "1.0" or equity to a small degree. Specifically, 435 out of 1617 white candidates were appointed from shortlisting (26.9% of white candidates) compared to 44 out of 114 BME candidates (38.6% of BME candidates).

- **Indicator 6: harassment, bullying or abuse from staff in last 12 months against BME staff:**
  Figures for 2019 / 2020 show that there was a 1% increase of harassment against White staff (from 20% to 21%), compared to a decrease of 3% against BME staff (from 36% to 33%).

- **Indicator 8: discrimination from a manager/team leader or other colleagues in last 12 months against BME staff**
  Figures for 2019 / 2020 show that there has been no change in the level of discrimination experienced by White staff (remains at 4%), while BME staff experienced an increase (from 12% to 17%).

4.4. The Human Rights Equality Diversity and Inclusion Programme Board (HREDIG) continues to monitor the EDI action plan. Any revisions / additions to the detailed WRES action plan will pay due regard to our BAME Network's input and national debate to future proof the action plan. Specific actions identified include:

- Assessing how local communities served are able to access NHS jobs
- Promotion via job fairs in community venues
- Ensure reasonable adjustments can be made for the recruitment journey
- Cultural ambassadors trained to aid in any grievance and harassment procedures
- Working towards a zero-tolerance policy
- Cultural competency training

- Equality, diversity and inclusion is one of the golden threads within the managing well programme

5. WDES Metrics

5.1 The WDES aims to inform year on year improvements in reducing those barriers that impact most on the career opportunities and workplace experiences of Disabled staff - driving changes in attitudes, increasing employment and career opportunities, and implementing long-lasting change for Disabled staff.

5.2 The Human Rights Equality Diversity and Inclusion Programme Board (HREDIG) continues to monitor the EDI action plan. Any revisions / additions to the detailed WDES action plan will pay due regard to our Disabled Network's input and national debate to future proof the action plan.

6. Recommendation

The Board is asked to note the content of this report and the ongoing monitoring and delivery of the EDI Action Plan via the HREDI Programme Board.

To request the board's support and engagement to prioritise the EDI agenda across their work within the trust.

Appendix: Human Rights Equality Diversity and Inclusion Objectives and Action Plan 2020-2024

Acronyms used	RAG ratings used	
WRES - Workforce Race Equality Standard		
WDES - Workforce Disability Equality Standard	Red	Work Not yet started / underdeveloped
GPG - Gender Pay Gap	Amber	Developing
PSED - Public Sector Equality Duty	Green	Achieving
EDS - Equality Delivery System	Purple	Excelling

EDI Objectives	Outline of supporting actions	Summary of progress	Current Position as at 31st May 2022	Cross Reference	RAG Rating	Time Frame / Completed by	Lead Person
	Ensure Human Rights Equality, Diversity and Inclusion (HREDI) are integrated within the provision of care and employment practices	• Draft HREDI strategy developed and reviewed at the HREDI governance group. • Strategy to be presented to SMT and then to Exec. Team for sign off	• *Strategy sent to all 3 Network Chairs for members views and incorporated into the Strategy.* • *A number of face-to-face focus groups to be held for final update, prior to being submitted for ratification*	*WRES / WDES indicators 1 and 2*		End of July 2022	K Sohanpal EDI Manager

Ensure EDI Strategy, principles and practice are embedded into Trust Governance and assurance arrangements at every level in the Trust.	Ensure Equality Diversity and Inclusive practices are mainstreamed	• HREDI group established. • Terms of reference for this group have been agreed • Regular meetings scheduled	• *Agenda items circulated prior to meeting.* • *WRES / WDES / GPG are the drivers for actual work delivery.* • *Key colleagues identified for implementation cross reference to WRES / WDES action plan* • *Monthly updates take place with the Director of People and OD*	*WRES / WDES indicators 1 and 2*		Ongoing on a monthly basis	K Roberton Dep. Director Corporate Services and Transformation
	Ensure schedule of reporting for all national EDI initiatives is on track (WRES/ WDES/GPG	• WRES/ WDES data reporting being collated. • Schedule timeframes being checked and will be passed on to the appropriate individuals for actioning.	• *During the Pandemic the time frames for reporting were changed. This has now been resurrected to previous years* • *EDI piece of work being picked up by nominated colleagues.* • *National EDI literature and recommendations are tabled at the HREDIG*	*WRES / WDES / GPG across all indicators*		Progress report to HREDIG on a monthly basis	K Sohanpal EDI Manager F Clements Head of People Planning, Performance and Quality

			meetings as and when they arise.				
	Reverse and Reciprocal Mentoring	• Bespoke packages and offers being assessed	• *Planning meetings have taken place during April and May.* • *Reciprocal mentoring paper agreed and submitted to Board* • *Agreement for 30 places for both White and BME participants. Roll out in July* • *Agreement with Surgical services for a pilot scheme.*	*WRES Indicator 1*		Update to be provided by POD colleagues to HREDIG monthly. Starting July 2022	L Farrington Head of Leadership, OD and Staff Experience

Continued improvement of service provision and patient care	**Equality Delivery system 2 (EDS) Qualitative and Quantitative measurements around EDI and direction of travel**	• Agree how EDS2 in new format should be rolled out. HREDI Governance group to monitor progress. • All information for EDS to be cross referenced to the WRES /WDES / • R and S actions.	• *EDS 2 is being replaced by a revised version. New roll out date – Feb 2023. EDS actions will be crossed referenced to the WDES/ WRES action plans.*	*WRES / WDES indicators 1 and 2 and EDS indicator 3*		Update to HREDIG July 2022	K Sohanpal EDI Manager
	Faith Considerations Meet the spiritual needs of patients and staff	• Provision of faith / religious sacraments across all groups provided by the Chaplaincy service. • Provision of prayer materials for faith groups have been purchased via charity funds.	• *Religious artefacts for the Muslim and Christian faith available in the Chapel and the Muslim prayer room.* • *Ongoing work around ensuring existing religious literature is available on wards.*	*EDS indicator 2 (Potential change in this indicator)*		Update to HREDIG July 2022	G Rowlands Head of Chaplaincy
		• Reassess the current space being utilised for both Existing Chapel and Muslim Prayer room	• *Muslim Prayer room refurbished.* • *Scoping exercise to be undertaken re relocation of both Chapel and Prayer room*	*EDS indicator 2*		Update to HREDIG July 2022	G Rowlands Head of Chaplaincy

		• Reassess the current provision for all faith groups and existing peer groups	• *Assess the current makeup of volunteers offering support to our patients* • *Engage with communities of interest to volunteer at QE*	*EDS indicator 2*		Update to HREDIG July 2022	J Conroy Head of Quality and Patient Experience
		• Further work being scoped around engaging faith leaders from the community groups served by the Trust to offer Cultural awareness sessions • Developmental programme being scoped around Cultural competency	• *Initial discussions undertaken with Connected Voice to deliver Cultural competency training on a monthly basis.* • *Local faith groups have been approached to deliver 'cultural awareness sessions' September/ October* • *Cultural and Spiritual booklet covering all faith groups has been produced - to be tabled at Ward Managers / Matrons Forums once to being ratified.*	*EDS indicator 2*		Update to HREDIG August 2022	G Rowlands Head of Chaplaincy

	Clinical Service Continuous improvement in clinical services and identification of how EDI will be addressed in services	• To be progressed, however detailed action plan in place for rolling out EDS Goal 3 meeting the E and D agenda. • To be addressed in the HRBP meetings, specifically linked to service specific issues. • To table findings from national research in light of the pandemic	• *EDS Goal 3 outcome is linked to ' A representative and supported workforce'- this is an action plan in its own right indicated within the WRES WDES action plan*	*WRES / WDES indicators 1 and 2 and EDS indicator 3*		Update to HREDIG on a monthly basis.	Clinical services Lead
	Utilise local population information on equality characteristics to identify service usage and develop plans with partners and external stakeholders, including service users from the communities served.	• Initial stakeholders' meetings yet to start due to lack of face-to-face meetings. • Detailed information pertaining to Health and Inequalities will be discussed at the newly established Health Inequalities Board	• *Health In equalities paper tabled at the Health Inequalities Board - actions still to be agreed*	*NA*		Update to HREDIG August 2022	K Roberton Dep. Director Corporate Services and Transformation

	Estates strategy Assess current provision of facilities, equipment that aid and support the 9 protected characteristics (e.g., Access, loop induction, prayer facilities and equipment)	• An audit of our estates will be scoped to assess compliance with the Disability Discrimination Act and address how EDI is integrated within the Estate strategy. • Assess how Estate's strategy insures equity of provision in the availability of all facilities and environment, equipment and services	• *Reassess the current Estates Strategy* • *Agreed actions to be tabled at the HREDIG meetings.*	*WDES indicator 8 and EDS objective 3*		Update to HREDIG August 2022	K Sohanpal EDI Manager
	Equality Analysis Assessment management and review process Quality and Equality Analysis Process to enable more effective assessment including, (stakeholders views where appropriate).	• An integrated Quality Impact assessment tool being used to capture any Business / Service Change. • Equality Impact Assessments pro-forma aimed at assessing Policies and Procedures and Service Changes has been produced and is being used.	• *To fully understand how assessments should be undertaken a training package has been produced and will be rolled out.*	*PSED / WRES / WDES*		Update to HREDIG August 2022	K Roberton Dep. Director Corporate Services and Transformation

	Information collected to be used by services as part of any service changes						

Improved Equality and Diversity data collection and information	**Accessible Information Standard (AIS) Ensure** the implementation of AIS across services.	• Assess how the 5 Key principles of the AIS are being implemented. • Assess current provision of training offered in respect of the AIS • Assess how AIS info is captured across service provision.	• *Assess the implementation of the AIS*	*WDES*		Update to HREDIG July 2022	J Conroy Head of Quality and Patient Experience
	Reasonable Adjustments Develop managers understanding of reasonable adjustments and the AIS and develop a process by which we can collate the information and have an overview of RAs across the Trust	• As above including reasonable adjustments within the Recruitment and selection process • Ensure all reasonable adjustments are met	• *Cross reference to WDES - Reasonable adjustments are in place from start to finish.* • *The Trusts meets the Disability Compliant L2 status and is one of the Pilot sites working towards achieving DCL3. Ongoing engagement with the Shaw Trust who are facilitating this process.*	*WDES*		Information for L3 being complied - for submission end of March 2022 Update to HREDI Group July 2022	F Clements Head of People Planning, Performance and Quality
	Equality Data Improve Equality Data for service users,	• Collection of equality data from service users completing patient	• *Information has been collected from PALS / Complaints team*	*WRES / WDES*		Update to HREDI Group July 2022	J Conroy Head of Quality and Patient Experience

	addressing data gaps.	experience surveys and complaints and support services to inform key areas of improvement.					K Sohanpal EDI Manager
		• Assess how Patient Experience and Complaint incorporate E&D data captured from patients / families / carers completing patient experience surveys, complaints and compliments	• *Assessment being undertaken at how to triangulate Patient Experience data such as PALS, formal complaints and the FFT, with patient safety data such as incidents and staffing data for wards and departments.* • *The Patient Experience team are working collaboratively with both the Community Business Unit and Maternity and are looking to implement a digital FFT option in 2022/23.*	*WRES / WDES*		Update to HREDI Group July 2022	J Conroy Head of Quality and Patient Experience

		• Develop EDI KPI Data set	• *Initial proforma developed* • *First set of KPI indicators populated* • *Data to be refreshed on a quarterly basis*	*PSED/ WRES/ WDES*		Ongoing data set to be populated and presented to the HREDIG every three months.	D Elders Policy Project Facilitator
	Sexual orientation monitoring and transgender monitoring Equity for service users as well as incorporating data collection in Systems used by the Trust	• Scoping yet to begin – Check which Information systems capture protected characteristic e.g., PARIS and other electronic systems used and assess viability of capturing • Sexual Orientation. Meetings with Stonewall have taken place. HR Policies to be assessed for inclusive language	• *Training around LGBTQ have been scoped and an external provider approached. Dates for training being discussed.* • *Bespoke service specific training of gender reassignment and sexual orientation being developed*	*PSED and EDS indicator 1 and 2*		Update to HREDIG Aug 2022	K Sohanpal EDI Manager
	Recruitment and Selection Equality across all groups incorporating the principles of EDI	• Assess how local communities served are able to access NHS jobs.	• *HR to provide Information from TRAC to the next EDIG meeting information*	*WRES / WDES*		Update to HREDIG Aug 2022	F Clements Head of People Planning, Performance and Quality

	across the full process	• Promote via Job Fairs in community venues.	• *Due to the Pandemic - face to face engagement has not been possible - to be resurrected once conditions are acceptable. HR to provide update*	*WRES / WDES*		Update to HREDIG Aug 2022	F Clements Head of People Planning, Performance and Quality
		• Ensure that reasonable adjustments are in place for the whole of the recruitment journey for disabled applicants and candidates	• *Cross reference to WDES - Reasonable Adjustments are put into place from start to finish.* • *The Trusts meets the Disability Compliant L2 and is working towards achieving DCL3.*	*WDES*		Information for L3 being complied - for submission end of March 2022 Update to HREDIG Aug 2022	F Clements Head of People Planning, Performance and Quality
	Increased use of social media to engage directly with patients / families / carers	• Assess best ways to provide information taking into consideration the breadth of diversity in languages spoken	• *To be agreed*	*PSED*		Update to HREDIG Aug 2022	H Fox Head of Communications

Ensure the Trust meets statutory compliance and promotes workforce and E&D matters	**Workforce Race Equality Standard (WRES) Workforce Disability Equality Standard (WDES) Gender Pay Gap**	• Detailed action plans for these standards developed monitored by HREDIG group • Gender Pay Gap report has been written	• *Details pertaining to all activities for WRES / WDES being picked up by POD and HR* • *Detailed WRES / WDES action plan has been written and is monitored.*	*WRES / WDES / GPG*		Ongoing updates to HREDIG	K Sohanpal EDI Manager F Clements Head of People Planning, Performance and Quality
	Local Champions Embed equality and diversity by identifying local champions and ensuring that services have a local reference point as well as a corporate service.	• Specific actions indicated within the detailed WRES action plan around Bullying and Harassment • 9 Cultural ambassadors trained to aid in any Grievance and Harassment procedures	• *Data to be provided for the number of Bullying and Harassment cases and no of trained ambassadors utilised.* • *Scoping has begun to train more Cultural Ambassadors*	*WRES / PSED*			K Sohanpal EDI Manager
	Staff Networks Help readdress any detrimental impact as well as progressing the EDI agenda	• 4 Networks established and currently functional. Networks workplan to be brought to the EDI steering group for continuous updates	• *Network workplans yet to be established*	*WRES / WDES / PSED*			K Sohanpal EDI Manager

CORE and Essential Training:	Continued provision and monitoring of core/essential EDI training	• EDI currently briefly mentioned in Induction and E-Learning. • EDI one of the golden threads within the Managing well programme. • Cultural Competency training	• *Induction Slides updated.* • *A review of the current provision is being scoped for face to face and a new E – learning Package.* • *Every session of the Managing Well programme covers EDI* • *Cultural competency training and delivery dates being agreed*	*WRES / WDES / PSED*		Rollout April 2022 Update to HREDIG Aug 2022	J Kennedy learning and Development Manager
	Training and Awareness Develop and promote employee guidance for equality issues and make available localised equality data packs for services.	• Cross reference to EDS Goal 3, WRES / WDES actions.	• *To be reassessed*	*WRES / WDES / PSED*		Update to HREDIG July 2022	F Clements Head of People Planning, Performance and Quality

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

	Lead	Type of item	Public/Private	Jul-22	Sep-22	Nov-22	Jan-23	Mar-23
Standing Items			Part 1 & Part 2					
Apologies	Chair	Standing Item	Part 1 & Part 2	√	√	√	√	√
Declaration of interests	Chair	Standing Item	Part 1 & Part 2	√	√	√	√	√
Minutes	Chair	Standing Item	Part 1 & Part 2	√	√	√	√	√
Action log	Chair	Standing Item	Part 1 & Part 2	√	√	√	√	√
Matters arising	Chair	Standing Item	Part 1 & Part 2	√	√	√	√	√
Chief Executive's Update Report	Chief Executive	Standing Item	Part 1 & Part 2	√	√	√	√	√
Cycle of Business	Company Secretary	Standing Item	Part 1 & Part 2	√	√	√	√	√
Patient & Staff Story	Company Secretary	Standing Item	Part 1	√	√	√	√	√
Questions from Governors	Chair	Standing Item	Part 1	√	√	√	√	√
Items for Decision			Part 1 & Part 2					
Annual Declarations of Interest	Company Secretary	Item for Decision	Part 1					√
Trust Strategic Aims & Objectives	Chief Executive	Item for Decision	Part 1					√
Board Assurance Framework - approval of closing and opening position	Company Secretary	Item for Decision	Part 1	√				√
Standing Financial Instructions & Delegation of Powers ***(deferred - to be rescheduled)***	Company Secretary / Group Director of Finance	Item for Decision	Part 1		√			
Calendar of Board Meetings	Company Secretary	Item for Decision	Part 1					
Winter Plan	Chief Operating Officer	Item for Decision	Part 1		√			
Constitution and Standing Orders - annual review ***(deferred - to be rescheduled)***	Company Secretary	Item for Decision	Part 1		√			
Board Committee Terms of Reference - Ratification	Company Secretary	Item for Decision	Part 1		√			
Board Committee Annual Reviews of Effectiveness and Terms of Reference Update	Company Secretary	Item for Decision	Part 1			√		
Items for Assurance			Part 1 & Part 2					
Board Committee Assurance Reports	Committee Chairs	Item for Assurance	Part 1	√	√	√	√	√
Corporate Objective Delivery	Company Secretary	Item for Assurance	Part 1		√		√	√
Board Assurance Framework	Company Secretary	Item for Assurance	Part 1		√		√	
Organisational Risk Register	Chief Nurse	Item for Assurance	Part 1	√	√	√	√	√
Annual Staff Survey Results	Exec Director of People & OD	Item for Assurance	Part 1					√
Finance Report	Group Director of Finance	Item for Assurance	Part 1 & Part 2	√	√	√	√	√
Integrated Oversight Report	Chief Operating Officer	Item for Assurance	Part 1	√	√	√	√	√
Nurse Staffing Exception Report	Chief Nurse	Item for Assurance	Part 1	√	√	√	√	√
Nurse Staffing Annual Capacity & Capability Report	Chief Nurse	Item for Assurance	Part 1				√	
Learning from Deaths (6 monthly report)	Medical Director	Item for Assurance	Part 1			√		
SIRO Report & Digital Update	Group Director of Finance	Item for Assurance	Part 1		√			√
EPRR Core Standards Self-Assessment Report	Chief Operating Officer	Item for Assurance	Part 1		√			
CNST Maternity Compliance Report / Ockenden Update	Medical Director	Item for Assurance	Part 1					
Green Plan (formally Sustainable Development Management Plan)	QEF Managing Director	Item for Assurance	Part 1		√			√
QEF 6 monthly update report	QEF Managing Director	Item for Assurance	Part 1			√		
Freedom to Speak Up Guardian Report	Exec Director of People & OD	Item for Assurance	Part 1	√			√	
Improving People Practices Update (now via POD Committee)	Exec Director of People & OD	Item for Assurance	Part 1					
WRES and WDES Report (6 monthly report)	Exec Director of People & OD	Item for Assurance	Part 1	√				√
Quality Accounts Priorities 6 monthly update	Chief Nurse	Item for Assurance	Part 1			√		
People's Plan Briefing (dependent upon national publication)	Exec Director of People & OD	Item for Assurance	Part 1					
Items for Information			Part 1 & Part 2					
Ad Hoc Items (i.e. items emerging during the year)			Part 1 & Part 2					
Trust Green Plan 2022-2025 annual updates	QEF Managing Director	Item for Assurance	Part 1					√