MEETING OF THE BOARD OF DIRECTORS IN PUBLIC

Gateshead Health NHS Foundation Trust

Date: Tuesday 27th September 2022
Time: 9:30 am
Venue: Room 3, 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 27 July 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** • Volunteer story (Julie Richardson)	Assurance	Presentation
		ITEMS FOR DECISION		
7.	9:55 am	**Declarations of Interest** To receive the Declaration of Interest of Mrs K Mackenzie, presented by the Deputy Director of Corporate Services & Transformation	Approval	Enclosure 7
8.	10:05 am	**Constitution Amendment** To approve the amendment, presented by the Deputy Director of Corporate Services & Transformation	Approval	Enclosure 8
9.	10:10 am	**Board Committee Terms of Reference** To approve the terms of reference, presented by the Deputy Director of Corporate Services & Transformation	Approval	Enclosure 9
10.	10:15 am	**Winter Plan 2022/23** To approve the plan, presented by the Chief Operating Officer	Approval	Enclosure 10
		ITEMS FOR ASSURANCE		
11.	10:30 am	**Assurance from Board Committees** i. Finance and Performance Committee – 26 July 2022, 30 August 2022 and 26 September 2022 ii. Quality Governance Committee – 24 August 2022 iii. Digital Committee – 8 August 2022 iv. POD Committee – 13 September 2022 v. Audit Committee – 1 September 2022	Assurance	Enclosure 11
12.	10:45 am	**Chief Executive's Update Report** To receive a briefing report from the Chief Executive	Assurance	Presentation
13.	11:00 am	**Governance Reports** i. **Corporate Objective Delivery** ii. **Board Assurance Framework** iii. **Risk Management Maturity & Risk Appetite** iv. **Organisational Risk Register**	Assurance	Enclosure 13

		To receive the reports presented by the Deputy Director of Corporate Services & Transformation and Chief Nurse		
14.	11:15 am	**Finance Update** To receive the report, presented by the Group Director of Finance and Digital	Assurance	Enclosure 14
15.	11:25 am	**Integrated Oversight Report** To receive the report, presented by the Chief Operating Officer, Chief Nurse, Medical Director and Executive Director of People and Organisational Development	Assurance	Enclosure 15
16.	11:40 am	**Ockenden Next Steps & Assurance Visit** To receive the assurance report, presented by the Chief Nurse	Assurance	Enclosure 16
17.	11:50 am	**Nurse Staffing Exception Report** To receive the report, presented by the Chief Nurse	Assurance	Enclosure 17
18.	12:00 pm	**EPRR Core Standards Self-Assessment Report** To receive the report, presented by the Chief Operating Officer	Assurance	Enclosure 18
19.	12:10 pm	**Green Plan 6 Monthly Update** To receive the update report, presented by the QE Facilities Managing Director	Assurance	Enclosure 19
		ITEMS FOR INFORMATION		
20.	12:20 pm	**Register of Official Seal** To note the use of the official seal between 1 September 2021 and 31 August 2022 to be presented by the Deputy Director of Corporate Services & Transformation	Information	Enclosure 20
21.	12:25 pm	**Cycle of Business** To receive the cycle of business outlining forthcoming items for consideration by the Board, presented by the Deputy Director of Corporate Services & Transformation	Information	Enclosure 21
22.	12:30 pm	**Questions from Governors in Attendance** To receive any questions from governors in attendance		Verbal
23.	12:40 pm	**Date and Time of the next Meeting** The next scheduled meeting of the Board of Directors to be held in public will be Wednesday 30th November 2022 at 9:30am		Verbal
24.	12:40 pm	**Chair Declares the Meeting Closed**		Verbal
25.	12:40 pm	**Exclusion of the Press and Public** To resolve to exclude the press and public from the remainder of the meeting, due to the confidential nature of the business to be discussed		Verbal

Gateshead Health NHS Foundation Trust

Trust Board

Minutes of a meeting of the Board of Directors
held at 9.30 am on Wednesday 27th July 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
Mrs J Bilcliff	Group Director of Finance & Digital / Deputy Chief Executive
Dr R Bonnington	Non-Executive Director
Mrs L Crichton-Jones	Executive Director of People & OD
Mrs G Findley	Chief Nurse
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:	
Miss J Boyle	Company Secretary
Mr M Brown	Managing Director, NENC Provider Collaborative (22/95)
Mr N Halford	Deputy Medical Director
Mr G Rowlands	Freedom to Speak Up Guardian (22/103)
Mr K Sohanpal	EDI Manager (22/104)
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 D Costello	Public Governor – Eastern
Mr G Riddell	Public Governor – Western
Apologies:	
Mr A Beeby	Medical Director

Agenda Item	Discussion and Action Points	Action By
22/89	**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. She welcomed Mr Neil Halford, Deputy Medical Director, to the meeting who is attending on behalf of Mr A Beeby, and the Trust's Governors.	

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22/90	**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.	
22/91	**APOLOGIES FOR ABSENCE:** Apologies for absence were received from Mr A Beeby.	
22/92	**MINUTES OF THE PREVIOUS MEETING:** The minutes of the meeting of the Board of Directors held on Wednesday 25th May 2022 were approved as a correct record.	
22/93	**MATTERS ARISING FROM THE MINUTES:** The Board action log was updated accordingly and there were no additional matters arising from the minutes.	
22/94	**YVONNE ORMSTON'S PATIENT JOURNEY** Mrs Y Ormston, Chief Executive, discussed her recent patient journey following her cancer diagnosis which included her experience of new drugs and technologies as well as the care and compassion of the multi-disciplinary teams involved. She drew attention to her Health Service Journal article which highlighted her observations and supporting services going forward. She thanked all those involved in her care and highlighted the good work of the services available within Gateshead. The Board thanked Mrs Ormston for sharing her personal experience and highlighted the excellent services within Gateshead.	
22/95	**PROVIDER COLLABORATIVE OPERATING MODEL** The Board welcomed Mr M Brown, Managing Director of North East and North Cumbria (NENC) Provider Collaborative. Mr Brown explained that the report summarises the proposed formal work structure and governance for the NENC Provider Collaborative, which sets out how the 11 NHS Foundation Trusts will operate, with the creation of a Provider Leadership Board (PLB), set out in the Ambition, Operating Model and Collaboration Agreement. He highlighted that there are separate arrangements for other collaboratives, such as those specifically for specialised mental health, learning disability and autism	

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	services and Trust Boards are being asked to note progress and confirm their agreement to the proposed governance arrangements. Mr Brown further explained that as part of the new system architecture NHS Trusts are required to be part of provider collaboratives which are non-statutory bodies designed to bring providers together to act at scale and in the interest of the wider population. He drew attention to the documents included in the report which describes the establishment of 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 with final authority for any decision remaining 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 Integrated Care Board (ICB) objectives as well as areas where collectively the members feel joint action is required. The Ambitions document summarises the Collaborative's purpose, function and aims primarily for an external audience. Mr Brown discussed some of the corporate programmes including the work already underway around the Pathology regional hub. Mrs Marshall highlighted the new system working and queried how decisions would be fed down to Trusts. Mr Brown explained that monthly Trust Chief Executive meetings have been set up and are well attended to ensure collective progress is made and Mrs Y Ormston, Chief Executive, explained that the forum is in the early stages however it is expected that a cycle of business is established to discuss standard items including the Elective Recovery Programme, Urgent and Emergency Care, Oncology, and Pathology. Mrs L Crichton-Jones, Executive Director for People and Organisational Development, felt that it was important to support the development of a collective culture and behaviours and Mr Brown explained that this was key within the collaboration. Mrs Ormston commented that there was a standard approach to safeguard the future of services. Mrs A Stabler, Non-Executive Director, queried the process should there be any disagreements around decisions and Mrs Ormston felt that it was likely that difficult issues would arise however Board views would be considered in a timely manner. Cllr M Gannon felt that it was important to work collaboratively however statutory responsibility should remain with the Trust and Mrs Ormston commented that evidence could be provided to demonstrate relevant discussion and reasoning. Mr M Robson, Vice Chair, also felt that working collaboratively was important however clear responsibilities and governance should be established.	

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	Mrs M Pavlou, Non-Executive Director, queried purchasing powers and Mrs J Bilcliff, Group Director of Finance & Digital, highlighted that a Directors of Finance consortium has already been set up and is working collaboratively. Mr A Moffat, Non-Executive Director, felt that it was important to have clear Standard Financial Instructions (SFIs) and Mrs Marshall commented that Delegation of Powers would remain with the Trust Chief Executive however standard operational procedures would need to be developed internally and externally. Dr R Bonnington, Non-Executive Director expressed support for collaborative working. Mrs Crichton-Jones felt that there were potential opportunities for the workforce to work flexibly across organisations. After further discussion and consideration, it was: **RESOLVED:** 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. Mr Brown left the meeting.	
22/96	**STANDING FINANCIAL INSTRUCTIONS:** Miss J Boyle, Company Secretary, presented the proposed amendment to the Standard Financial Instructions (SFIs) to reflect changes to the Public Procurement Thresholds. She highlighted that the Public Procurement Thresholds were revised in January 2022 therefore the SFIs have been updated to reflect the new thresholds. She informed the Board that a full review of the SFIs is about to commence, with a view to a further paper being presented to Board outlining other potential changes for consideration. After consideration, it was: **RESOLVED:** to approve the proposed amendment to the SFIs.	
22/97	**BOARD ASSURANCE FRAMEWORK 2022/23:** Miss J Boyle, Company Secretary, presented the report which provides an opening position for the Board Assurance Framework (BAF) 2022/23 based on the corporate objectives approved at the May 2022 Board meeting. She explained that a new format BAF has been designed for 2022/23 in response to feedback from the Board and Internal Audit. The BAF utilises RAG ratings, which are highlighted in the report, when considering progress against action plans to address gaps in controls	

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	and assurances and will be reviewed by the Board on a quarterly basis, with the Board committees reviewing their related extracts at each meeting. She advised the Board that this is dynamic document which will be continually updated during the year and will ensure the triangulation of reports. Mrs J Baxter, Chief Operating Officer, felt that it would be useful for Executives to be provided with further instructions on how the BAF is completed and reported back to the Committees and Miss Boyle will ensure this is made clear within the new format. After discussion, it was: **RESOLVED:** to approve the opening position of the BAF, noting that it will be under continuous review and update at the relevant Board committees.	JBoy
22/98	**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 May meeting at the May 2022 Board of Directors' meeting. He also drew attention to the written assurance report relating to the June meeting with no items for escalation. Mr Robson provided a verbal update on the meeting yesterday (26 July 2022) and reported that an in-depth discussion took place around cancer targets and it was suggested that a full Board discussion would be beneficial at the next Board Strategy Session. Mr Robson also highlighted the following key points: • Integrated Oversight Report – partial assurance and this is on the Board agenda for discussion later in the meeting • Financial Revenue Reports – not assured due to size of deficit and distance from plan. Risks noted relating to future delivery. • Supply Procurement Committee Report - not assured therefore fuller review required. Work is underway in this area. • Corporate Objectives – the Committee agreed relevant actions. Mrs A Stabler, Non-Executive Director queried whether there was feedback available on the impact of delivery and benefits from investment to the new operating model and Mrs J Baxter, Chief Operating Officer, reported that F&P will receive feedback on transformation programmes via the Transformation Board and one of the key objectives specifies a separate report on quarterly basis. Mrs Y Ormston also felt that this needs to be reviewed by the Executive Team however a report to the Board is expected next month.	

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	Quality Governance Committee: Mrs A Stabler, Chair of the Quality Governance Committee (QGC) provided a brief verbal overview to accompany the narrative report and highlighted that there were no items for escalation. She highlighted the following key points: • June 2022 Ockenden visit feedback – positive presentation provided however no formal feedback received as yet. This will come back to the Board once received. • Maternity Serious Incidents reported within the Integrated Oversight Report (IOR) and appropriate actions have been taken in relation to the non-diagnosis of hip dysplasia. Maternity incidents will now be removed from the IOR and reported separately. **Digital Committee** Mr A Moffat, Chair of the Digital Committee, provided a brief verbal overview to accompany the narrative report and highlighted that there were no items for escalation. He highlighted the following key points: • Service Key Performance Indicators (KPIs) – no assurance given at the last meeting however process now in place to focus on key areas. A 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. The Senior Management Team now also have visibility of digital KPI performance and those items escalated to the Digital Committee. **People and Organisational Development (POD) Committee** Dr R Bonnington, Chair of the POD Committee, provided a brief verbal overview to accompany the narrative report and highlighted that there were no items for escalation. She highlighted the following key points: • Freedom to Speak Up Report – to be presented to Board later in the meeting. • Guardian of Safe working - partial assurance provided due to an ongoing issue raised in relation to the lack of progress on the Junior Doctor mess. Mr A Robson, Managing Director of QE Facilities, advised that there were competing pressures on the Capital Plan, however there are plans in place to provide an alternative space whilst the current area is refurbished. Following a query from Mrs A Stabler regarding funding previously provided to the Trust to support this, Mrs J Bilcliff, Group Director of Finance highlighted that this was discussed with the Deputy Medical Director/Medical Education Lead, and fully utilised however it was not a significant amount. Mrs L Crichton-Jones, Executive Director of People & OD, explained that teams are working closely with educational training and health and well-being facilities. **Audit Committee**	

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	Mr A Moffat, Chair of Audit Committee, provided a brief verbal overview to accompany the narrative report and highlighted that there were no items for escalation however the meeting focussed on the recommendation for the Board to formally ratify the Annual Report and Accounts. He highlighted the following key points: • Internal Audit Plan and Counter Fraud Plan yet to be finalised however work is continuing and it is expected to approve these at the next meeting. • Internal Audit Recommendations – the Committee noted an improvement in timeliness however some are still being deferred. A process is being put in place to invite Executive Leads to the Committee to provide update from the next meeting in September. Mrs Marshall thanked the Committee Chairs for their reports. After consideration, it was: **RESOLVED**: to receive the reports for assurance	
22/99	**CHIEF EXECUTIVE'S UPDATE REPORT** Mrs Y Ormston, Chief Executive, gave a verbal update to the Board on the current issues: Mrs Ormston informed the Board that the recent heatwave has impacted on services, with equipment and servers being challenged by the temperatures experienced. She highlighted that a review of the heatwave action plan has been requested to rebase temperature guidance. Pressures remain in relation to ambulance delays and she thanked QE Facilities staff who have been assisting the North East Ambulance Service. Significant issues remain in relation to delayed discharges and the cancellation of electives has been required to manage the pressures. Further details are included within the Integrated Oversight Report. Mrs A Stabler, Non-Executive Director, queried how the increase in 52 week waiters was being addressed and whether there were any plans in place moving forward. Mrs J Baxter, Chief Operating Officer, explained that escalation areas are still open within the hospital however this is also linked to significant staffing gaps. The Regional Chief Operating Officers are working together to manage capacity and there are recruitment plans and business cases in development. Mrs Ormston highlighted that system wide information will feed into future oversight reports. Mrs L Crichton-Jones, Executive Director for People & OD, reported that the national pay award has received mixed reactions and there is a risk of industrial action. She explained that the Royal College of Nursing	

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	and Unison are currently having discussions however will keep the Board updated of any developments. The Board noted the update provided including the significant pressures and after further discussion, it was: **RESOLVED:** to receive the update for assurance.	
22/100	**GOVERNANCE REPORTS** **Organisational Risk Register (ORR)** Mrs G Findley, Chief Nurse, presented the updated ORR to the Board, noting that it had been subject to monthly scrutiny at the Executive Risk Management Group (ERMG). She reminded the Board that a review of strategic risks was undertaken at the Board strategy session in June 2022. As a result of this, 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. This report covers the period 17 May 2022 to 19 July 2022 and Mrs Findley highlighted that a new strategic risk relating to pandemic activity has been added to the ORR and as a result, two covid related risks have been 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. Mrs A Marshall drew attention to discussions which took place at the Finance & Performance Committee in relation to there being no organisational risk in relation to the financial position. Mrs Findley highlighted that this was raised at the last Executive Risk Management Group meeting and has since been added and will be reflected in the next ORR report. After further discussion, it was: **RESOLVED:** to receive the report for assurance.	
22/101	**FINANCE UPDATE:** Mrs J Bilcliff, Group Director of Finance & Digital, provided the Board with a summary of performance as at 30 June 2022 (Month 3) for the Group (inclusive of Trust and QE Facilities, excluding Charitable Funds). Mrs Bilcliff reported that for the period April to June 2022, the Trust has reported an actual deficit of £2.887m after adjustments for donated assets and gains and losses of asset disposal. This is an increase of	

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	£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 and is due to the non-achievement of cost reduction plans (CRP) and assumed positions against the Elective Recovery Fund (ERF). Mrs Bilcliff highlighted that detailed discussions took place at the Finance and Performance Committee in relation to system wide assumptions including inflation and pay award funding and acknowledged the significant risk to delivery of plans. Mrs Bilcliff has contacted the Integrated Care Board Director of Finance to highlight the position and other trusts are also experiencing the same issues. Mrs A Stabler, Non-Executive Director, queried whether Business Unit CRP plans would deliver on a recurrent basis and Mrs Bilcliff explained that the Business Units have been given targets and run rates are also being reviewed, however plans are still being finalised due to current positions being managed. Mrs Stabler felt that it was important for the Board to be sighted on plans and Mrs Bilcliff explained that these are being monitored via the Transformation Board and will also be discussed at the Business Unit Quarterly Oversight meetings. Mr A Moffat, Non-Executive Director, commented on the improved position for June and Mrs Bilcliff explained that this was due to further management of bank and agency spend. Mrs H Parker, Non-Executive Director, felt that some of the system assumptions were unachievable and Mrs Bilcliff highlighted that this is being reported back to the Integrated Care System. After further discussion, it was: **RESOLVED:** to receive the report for assurance and note the risks highlighted.	
22/101	**INTEGRATED OVERSIGHT REPORT:** Mrs J Baxter, Chief Operating Officer, Mrs G Findley, Chief Nurse, Mr N Halford, Deputy Medical Director, and Mrs L Crichton-Jones, Executive Director of People and Organisational Development, introduced the Integrated Oversight Report (IOR) for May and June 2022. The paper has been discussed and received in-depth scrutiny by the various Board Committees. Mr Halford provided an update on some of the key issues relating to front of house and reported that there has been an increase in readmission rates however a deep dive is now in progress to understand the clinical reasons contributing to the increase but it is understood to be primarily due to system pressure. The Trust is within the top 20 trusts in maintaining urgent and emergency care performance however it is reported that 11 patients waited longer than 12 hours despite robust escalation processes being in place. There has been an	

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	improvement in ambulance handover delays and an increase in bed occupancy levels. Mrs Baxter reported that winter bed escalation plans were instigated earlier 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, however this is causing pressures relating to staffing ratios. There is a continued focus on increasing capacity to reduce patient backlogs and waiting times and as previously reported, the Trust has met its 104 week wait target however there has been an increase in 52 week waits, increasing from 52 at the end of April to 71 in May 2022. Ongoing work continues in relation to cancer recovery due to evident capacity pressures and the Trust continues to work closely with Integrated Care System partners. Dr R Bonnington, Non-Executive Director, felt that it would be beneficial to review the cancer 2 week wait conversion rates due to the national drive to increase early referral and Mrs Baxter reported that focus remains on increased speciality groups, particularly breast and lung referrals. Following a query from Mrs A Stabler, Non-Executive Director, in relation to delayed discharges and the recently reported additional provider capacity, Mrs Baxter reported that lots of work around this area continues and an in-depth discussion will take place in the private part of the Board. Mrs Findley provided an update on some of the work being undertaken in relation to the safe indicators and reported that there were five serious incidents reported in June which included themes relating to falls and test results as well as one maternity serious incident. Duty of Candour compliance is causing some concerns due to a gap in process however immediate actions are being looked at. Mrs Marshall queried whether a separate report for maternity incidents should be presented to the Board however further discussion is required on the best way forward and Mrs Findley will pick this up with Mrs Baxter. Mrs Stabler requested further information on the open patient safety alert and Mrs Findley highlighted that this related to ligature points and a way forward has been discussed at the Executive Risk Management Group and the new Head of Risk is working through this. Mrs Crichton-Jones provided an update on the well-led performance and highlighted that challenges continue within workforce however she highlighted that the Trust has recorded its lowest level of sickness absence for the past 12 months and is due in part to a new policy and training being introduced by the interim Head of People Services. Appraisal and core training rates are being addressed within the quarterly Business Unit Oversight meetings.	GF/JMB

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	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.	
22/102	**NURSE STAFFING EXCEPTION REPORT:** Mrs G Findley, Chief Nurse, presented the report for nursing and midwifery staffing in June 2022, and also provided assurance of ongoing work to triangulate quality and safety metrics against staffing and care hours. Mrs Findley reported that June continued with significant staffing challenges due to a continued surge on Covid activity within the organisation which has impacted on staffing resource and the clinical operating model. Significant staffing challenges remain due to vacancies however focused work around the recruitment and retention of staff continues. Out of 138 vacancies, 104 are in progress which include the international trained nurses. Mrs J Baxter, Chief Operating Officer, highlighted that some new student recruits will have also potentially accepted other posts and Mrs Findley reported that they will be contacted to confirm. Mrs A Stabler, Non-Executive Director, queried whether outputs of the Task and Finish Group would be reported back and Mrs Findley explained that feedback is being provided to the Executive Team. Mrs Y Ormston, Chief Executive, expressed concerns in relation to sickness absence in addition to vacancies and queried how this was being managed. Mrs Findley reported that processes are in place including a buddy system for wards. Mrs L Crichton-Jones, Executive Director of People and Organisational Development, highlighted that a new HR Analyst has recently come into post therefore advanced workforce data is moving forward and will be available soon. Mrs Marshall felt that it was important to highlight that the report did not state that no patient harm had taken place due to staffing pressures and Mrs Findley explained that the new Deputy Chief Nurse would be looking into the triangulation of reports and should be able to provide a more in-depth assessment of this by mid October 2022. After consideration, it was: **RESOLVED:** to receive the report for assurance and note the work being undertaken to address the shortfalls in staffing.	

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22/103	**FREEDOM TO SPEAK UP (FTSU) GUARDIAN REPORT:** Mrs L Crichton-Jones, Executive Director of People and Organisational Development, and Mr G Rowlands, FTSU Guardian, provided an update of FTSU activity from 1 January 2022 (Q4 2021-22) to 16 June 2022 (Q1 2022). Mrs Crichton-Jones reported that work has been undertaken to revise the format of the report to highlight trends, patterns and themes in line with national guidance and drew attention to the recommendations within the report. She reminded the Board that training will be provided via a future Board Development Session. Mr Rowlands highlighted some of the activity which has taken place over the past six months and reported that 14 concerns have been raised within the current reporting period. Mrs Crichton-Jones explained that the report is discussed by the People and Organisational Development Committee and assurance can be provided to the Board that this is be monitored and progressed. Mr Rowlands also highlighted that the FTSU Guardian is actively involved in staff induction, medical staff induction and the newly introduced "Managing Well" programme and 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. Mrs Crichton-Jones also thanked Mrs H Parker, Non-Executive Director Lead, who also meets with the team on six-weekly basis. Mrs A Stabler, Non-Executive Director, reported that some of the concerns raised by maternity teams has been addressed and work has been redistributed by the Head of Midwifery. She also highlighted that these were raised during the Ockenden visit and the team were assured that the Board are sighted on concerns. Mrs M Pavlou, Non-Executive Director, queried one of the issues raised in relation to a serious unsubstantiated concern and Mr Rowlands explained that this was raised anonymously and no evidence was found. Mrs Crichton-Jones confirmed that no further contact has been received despite opportunities provided therefore this has been closed. Following further discussion, it was: **RESOLVED:** to receive the report for assurance. Mr Rowlands left the meeting.	JBoy
22/104	**WRES AND WDES 6 MONTHLY REPORT:** Mrs L Crichton-Jones, Executive Director of People and Organisational Director, and Mr K Sohanpal, Equality, Diversity and Inclusion (EDI) and	

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	Engagement Manager, presented the report which provides an update on progress against the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) indicators. The associated actions inform the Trust's Equality Objectives and overarching Equality Diversity & Inclusion Work Plan for 2021 and beyond. Mrs Crichton-Jones highlighted that the Trust was identified as being in the Top 10 within the national WRES report from NHS England for two indicators across England for: • Indicator 2 - likelihood of appointment from shortlisting • Indicator 5 - harassment, bullying or abuse from patients, relatives, or the public in the last 12 months Mr Sohanpal drew attention to EDI work plan, appendix 1 of Agenda Item 17, which is being monitored by the Human Rights Equality Diversity and Inclusion (HREDI) Programme Board and have identified key areas of focus to address the improvement areas. One of the areas includes reverse monitoring and Mrs Crichton-Jones reported that this approach was highlighted as best practice and will be progressed further. Mrs Y Ormston, Chief Executive, felt that there was still work to do in particular around progressing the management profile and suggested a more detailed discussion could take place within one of the Board Strategy Sessions. Mr Sohanpal commented that there was also external work to do around culture and work around culture competencies will begin in September 2022. Further training is also being explored and Mrs Ormston reported that an HR Toolkit was being looked at and will discuss further with Mr Sohanpal outside of the meeting. Mrs G Findley, Chief Nurse, highlighted that there is an opportunity for the Trust to work with NHS England/NHS Improvement in delivering a bespoke programme around Ethnic Minority Band 5 and Band 6 posts. The Board welcomed the opportunity to discuss this in more detail as part of a Board Strategy Session and Mrs Ormston agreed that it was important to highlight Board leadership. Following consideration, it was: **RESOLVED:** i) to receive the report for assurance and note the ongoing EDI Action Plan. ii) to support the prioritisation of the EDI agenda across their work within the Trust. Mr Sohanpal left the meeting.	YO JBoy

Agenda Item	Discussion and Action Points	Action By
22/105	**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 September 2022 and it was: **RESOLVED:** to receive the cycle of business for information.	
22/106	**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. Following Mrs Ormston's patient journey story, Mr J Bedlington felt that it was important for patients to be given more information around wellbeing support. Mrs Ormston highlighted that every patient is provided with third sector information including Macmillan support and patients are also offered buddy support which she found extremely beneficial. Mr Bedlington also felt that there were some concerning issues within the FTSU report and Mrs Crichton-Jones explained that work was progressing to ensure good visibility of the report and Mrs Parker highlighted that discussions are taking place to ensure the report contains meaningful content and comparative data is expected to be included in the future. Mrs Marshall thanked the Governors for their questions and attendance at the meeting.	
22/107	**DATE AND TIME OF THE NEXT MEETING:** The next meeting of the Board of Directors will be held at 9:30am on Tuesday 27th September 2022.	
22/108	**CLOSURE OF THE MEETING:** Mrs Marshall declared the meeting closed and highlighted that this will be Mrs J Bilcliff's last meeting as Group Director of Finance & Digital and Deputy Chief Executive. On behalf of the Board, Mrs Ormston thanked her for her support during her time with the Trust and wished her well in the future.	

Agenda Item	Discussion and Action Points	Action By
22/109	**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	27/09/2022	JBoy	To come back to Board for ratification (September 2022)
22/60	25/05/2022	SIRO/Digital report – to arrange a digital session via Board Strategy Session	27/09/2022	JBoy	Digital Strategy and SIRO report to be featured on November Board agenda
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	Closure report to be deferred to November 2022
22/97	27/07/2022	BAF – to provide further instructions on completion and reporting back to Committees	27/09/2022	JBoy	Training session held with Non-Executive Directors in September, with a further session planned for those unable to attend
22/103	27/07/2022	FTSU – to arrange training within future Board Strategy Session	27/09/2022	JBoy	On agenda for October session
22/104	27/07/2022	WRES/WDES – to discuss HR training toolkit	27/09/2022	YO/KS	
22/104	27/07/2022	WRES/WDES – to arrange EDI discussion to take place within future Board Strategy Session	27/09/2022	JBoy	On agenda for October session

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 7

Report Title:	**Declaration of Interests**			
Name of Meeting:	Board of Directors			
Date of Meeting:	27 September 2022			
Author:	Jennifer Boyle, Company Secretary			
Executive Sponsor:	Yvonne Ormston, Chief Executive Alison Marshall, Chair			
Report presented by:	Kirsty Roberton, Deputy Director of Corporate Services and Transformation			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☒	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☐
	To approve the inclusion of the declaration of interest for Mrs Kris Mackenzie, Group Director of Finance and Digital, into the Board's register of interests.			
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*	In accordance with regulatory requirements and the Trust's own Constitution and Standing Orders, the Trust is required to maintain a register of interests for its Board of Directors. All new Board Members are required to declare their interests on appointment, with the declaration being formally presented to the Board of Directors for approval and incorporation into the register. This is governed locally through the Trust's Conflicts of Interest policy. All new Board Members are also required to make a fit and proper person self-declaration on appointment. This is in accordance with Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Trust's own Fit and Proper Person Test policy. Kris Mackenzie, Group Director of Finance and Digital, joined the Board of Directors on 1 September 2022,			

<table>
<tr><td></td><td colspan="6">having previously held the position of Operational Director of Finance at the Trust.

Assurance can be provided that Kris Mackenzie has completed both the declaration of interests and fit and proper person declaration.

A family connection to Mrs Y Ormston, Chief Executive, has been appropriately declared. Assurance can be provided to the Board that safeguards have been put in place to ensure independence, and safeguards were also implemented throughout the recruitment process.

Independent fit and proper person checks against public registers have also been conducted with no issues to highlight.</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="6">The Board is requested to:
Approve the inclusion of Kris Mackenzie’s declaration of interest return in the Board’s register of interests.
Be assured that the self-declaration in respect of fit and proper persons has been completed in accordance with the Trust’s policy.</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">SA1.3, SA3.2</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">None directly</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>

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 8

Report Title:	**Constitution Update: Governors and Volunteers**			
Name of Meeting:	Board of Directors			
Date of Meeting:	27 September 2022			
Author:	Jennifer Boyle, Company Secretary			
Executive Sponsor:	Alison Marshall, Chair			
Report presented by:	Kirsty Roberton, Deputy Director of Corporate Services and Transformation			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☒	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☐
	To vote on a proposed constitutional amendment to reclassify volunteers as public members with respect to Foundation Trust membership.			
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*	Governor Governance and Development Committee – 7 September 2022			
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*	• Volunteers are currently classified as staff members for the purposes of Foundation Trust membership and Governor elections. • This change was made in 2019 and a number of unintended consequences have been identified in respect of this change. • This paper outlines the options available and considers which approach would best protect and promote volunteering and maximise the opportunities for representation at the Council. • It is noted that there would be an impact on existing Governors from both Option 1 and Option 2 and this options appraisal has been undertaken impartially based on an assessment of appropriate governance (as requested by those Governors who may be affected).			
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	It is our recommendation that Option 2 is approved, i.e. to enact a constitutional change to recognise volunteers as public members. The rationale of this is that it supports public Governors to become volunteers whilst also			

<table>
<tr><td></td><td colspan="5">increasing the chances of volunteers being elected as Governors (which we believe is important given the valuable support our volunteers provide to colleagues and patients).

It is noted that the Governor Governance and Development Committee supported the proposal to recommend Option 2 to the Council of Governors.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="4">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td colspan="4">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☐</td><td colspan="4">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☐</td><td colspan="4">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☐</td><td colspan="4">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="5">SA1.2, SA2.1, SA2.2</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">None identified.</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>

Governors and Volunteers

1. Introduction

1.1. Prior to July 2019 the Trust's volunteers were classified for the purposes of membership as being within the public member category.

1.2. In July 2019 a constitutional amendment was made to recategorise volunteers within the staff membership category. This meant that any volunteers who wished to stand for election as Governors would then need to stand as staff Governors, with both staff and volunteers being eligible to vote within staff Governor elections.

1.3. Recently a number of implications of this constitutional amendment have become apparent, and consideration needs to be made as to whether a further amendment is required to reverse the original change. Most notably, the current approach may reduce the chances of current volunteers becoming Governors (as the staff category has become highly contested and staff members significantly outnumber volunteer members within this category), and also prevent public Governors becoming volunteers (as they would need to resign as public Governors).

1.4. It is noted that there are current Governors who will be affected by either retaining the current position and also by any changes to revert back to the previous position for volunteers. The Chair and Company Secretary have discussed the situation with affected Governors, who have requested that the issue be considered impartially and without specific reference to the individuals currently in post.

1.5. This paper aims to provide an impartial assessment of the implications of both options, with a version of this paper being considered at the Governor Governance and Development Committee on 7 September 2022. As the election for January 2023 seats at the Council is fast-approaching, this is a time-critical issue.

1.6. It is noted that constitutional amendments must be approved by both the Board and the Council of Governors, as outlined within the Constitution:

> 18. **Amendment of the Constitution**
>
> 18.1 (1) The Trust may make amendments to this Constitution only if –
>
> (a) more than half of the members of the council of governors of the Trust voting approve the amendments, and
>
> (b) more than half of the members of the Board of Directors of the Trust voting approve the amendments.
>
> (2) Amendments made under this section take effect as soon as the conditions in subsection 18.1 (1) (a) and (b) are satisfied

1.7. The Council of Governors meets the day after the Board of Directors and will receive a verbal overview of the outcome of the vote at Board.

1.8. It is also noted that any amendments would be required to be presented to the next Annual General Meeting / Annual Members' Meeting in 2023 accordance with the following provision of the Constitution:

14.9.4	Where an amendment is made to the constitution in relation to the powers or duties of the Council of Governors - (a) at least one member of the Council of Governors must attend the next annual meeting of members and present the amendment, and

14.9.5	If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise it ceases to have effect and the Trust must take such steps as are necessary as a result.

2. Option 1 – retain current approach with volunteers classified as staff Governors

2.1. Under the current approach volunteers are classified as staff members in respect of Foundation Trust membership. This sends a clear message about the importance of volunteers and the value placed upon them by the Trust. In this sense it embodies the 'one team' approach.

2.2. The current approach doesn't require any amendment to our Constitution and the forthcoming election can proceed as normal.

2.3. A number of risks have been identified with the current approach, which has resulted in the consideration of whether a further constitutional change is required.

2.4. A detailed discussion with the election company has identified that public Governors cannot become volunteers during their tenure without resigning their seats and re-standing as staff Governors during the next round of elections. This relates to a clause within the Constitution, which mirrors the model Constitution for NHS foundation trusts:

5.5.3	A person who is eligible to be a Member of the Staff Constituency (see paragraph 5.4.1 above) may not become or continue as a Member of any Constituency other than the staff Constituency.

2.5. To-date the Trust has been incorrect in its approach here, but as this fact is now clear, there is no option but to apply this rule. This is not consistent with the Trust's desire to encourage volunteering and effectively terminates the term of a public Governor should they wish to become a volunteer.

2.6. Another implication of the current approach is that it may be less likely for volunteers to be elected as Governors within the staff category. In the last election the staff seats were highly contested, and a volunteer who stood as a staff Governor came 6th out of the 7 candidates, who were competing for 3 seats.

2.7. It is reasonable to assume that this would be a likely outcome at future contested staff elections, given that the number of staff who are members of the Foundation Trust will far outweigh the number of the volunteers. It is assumed that staff

candidates would be more likely to be known to their colleagues and therefore would be more likely to attract a higher proportion of votes.

3. Option 2 – reverse the previous amendment and include volunteers within the public membership category

3.1. A change to move volunteers back into public membership would mean that technically they would not be classified as staff members for the purposes of Foundation Trust membership. Whilst in reality this would not result in any notable changes (except for Governor election time), it is appreciated that this may be perceived as being a negative indicator of the value placed on volunteers. This would require some careful messaging to assure volunteer colleagues that this was not the case.

3.2. Should a constitutional change be made, any volunteers in the staff Governor category would be required to resign and stand for election as a public Governor within their relevant constituency in the next round of Governor elections. This is an unavoidable and unfortunate consequence of a change.

3.3. The benefits of Option 2 have already been articulated in respect to the downsides of Option 1. The two key benefits are summarised here.

3.4. This option allows public Governors to become volunteers without resigning from their role as Governors. In this sense it encourages rather than discourages Governors to become volunteers.

3.5. This option also increases the chances of volunteers being elected, as staff seats have become highly contested and the assumption is that staff members are more likely to know and vote for their staff colleagues. Whilst it could be assumed that volunteers are more likely to vote for fellow volunteers, there is a smaller number of volunteers than there are staff. Volunteers who stand for public Governor and refer to their volunteer roles in their nomination statements are likely to attract votes from public members who recognise their commitment and knowledge of the Trust.

3.6. The proposed changes to the wording of the Constitution under Option 2 is included at Appendix 1.

4. Wider context

4.1. Benchmarking information was sought from the election company, Civica, to help understand how the Trust compares to their other clients. It is understood that in most other trusts volunteers are classified as public members. As candidates tend to include information about their volunteering roles in their nomination statements, it is Civica's view that this usually results in good representation from volunteers amongst public Governors.

4.2. The below table outlines the approaches taken by neighbouring trusts:

Trust	How volunteers are reflected in respect of FT membership
Newcastle Hospitals NHS FT	Volunteers are within the staff membership category. This is one protected seat for volunteers, which only volunteers can vote for.

Trust	How volunteers are reflected in respect of FT membership
	This guarantees volunteer representation at the Council, but it is limited to one seat. The standard clause in the Constitution prevents public Governors becoming volunteers and retaining their seat, although this situation has not arisen in recent years at Newcastle.
Northumbria Healthcare NHS FT	Volunteers not specifically referenced and therefore are within the public membership category.
North East Ambulance Service NHS FT	Volunteers not specifically referenced and therefore are within the public membership category.
South Tyneside and Sunderland NHS FT	Volunteers not specifically referenced and therefore are within the public membership category.
Cumbria, Northumberland, Tyne and Wear NHS FT	Volunteers not specifically referenced and therefore are within the public membership category.

5. Recommendations

5.1. It is our recommendation that Option 2 is approved by the Board of Directors, i.e. to propose a constitutional change to recognise volunteers as public members. The rationale of this is that it supports public Governors to become volunteers whilst also increasing the chances of volunteers being elected as Governors (which we believe is important given the valuable support our volunteers provide to colleagues and patients).

5.2. An extraordinary meeting of the Governor Governance and Development Committee was called on 7 September to consider this issue, and a version of this paper was reviewed by the Committee. The Committee discussed and debated the issue at some length, seeking to focus on the wider long-term implications of the options, whilst acknowledging that regretfully both options would have personal implications for some current committed and valued Governors.

5.3. On balance the Committee supported Option 2 – i.e. the recommendation to make a constitutional change to recognise volunteers as public members (and thereby as public Governors). One of the primary reasons for this was that the current approach (i.e. Option 1) prevents public Governors becoming volunteers whilst retaining their Governor positions, and the Committee felt that this could be detrimental to both encouraging volunteering amongst Governors and encouraging volunteers to stand for Governor positions.

5.4. On this basis, the Committee will be recommending Option 2 to the Council, but also recommends that the Trust takes a wider look at the make-up of constituencies and Council composition next year to ensure that it remains fit for purpose and reflective of system-working requirements.

5.5. In summary it is recommended that the Board of Directors approves Option 2 – to enact a constitutional change to recognise volunteers as public members.

APPENDIX 1

Current wording (i.e. Option 1)

The current wording within the Constitution in respect of the classification of volunteers as members of the staff constituency is as follows:

5.5.1 Members of the Trust who are Members of the Staff Constituency are to be individuals:

(a) who are employed under a contract of employment by the Trust or a wholly-owned subsidiary of the Trust; or

(b) who are registered Trust volunteers and

(c) who satisfy the minimum duration requirements set out in paragraph 3(3) of Schedule 1 to the 2003 Act, that is to say:

(i) in the case of individuals described at (a) above:

(aa) who are employed by the Trust under a contract of employment which has no fixed term or a fixed term of at least 12 months, or

(bb) who have been continuously employed by the Trust for at least 12 months;

(ii) in the case of individuals described at (b) above, who have served as a volunteer for a continuous period of 12 months; and

(d) who are not disqualified for Membership under paragraph 6.4 below; and who have been invited by the Trust to become a Member of that Constituency and have not informed the Trust that they do not wish to do so

5.5.2 The minimum number of Members required for the Staff Constituency is 2,000.

5.5.3 A person who is eligible to be a Member of the Staff Constituency (see paragraph 5.4.1 above) may not become or continue as a Member of any Constituency other than the staff Constituency.

There is further mention of volunteers in the following paragraph:

6.2 The Council of Governors of the Trust is to include:

(a) 17 Public Governors

(b) 6 Staff Governors of whom a maximum of 2 may be staff volunteers

(C) 1 Clinical Commissioning Group Governor

(d) 1 Local Authority Governor

(e) 7 Partnership Governors

The number of Public Governors comprise more than half the total Membership of the Council.

Option 2 – proposed changes to wording

The proposed change under Option 2 would be to remove reference to volunteers from the Constitution entirely, as this would return the Trust to the previous position of volunteers being classified as public members (noting that they would be required to register as Foundation Trust members individually, as per previous arrangements).

The proposed change would be to remove the following:

- Paragraph 5.5.1 (b)
- Paragraph 5.5.1 (c) (ii)

Paragraph 6.2 (c) would be reworded to state: *6 staff Governors*

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 9

Report Title:	**Board Committee Terms of Reference**			
Name of Meeting:	Board of Directors			
Date of Meeting:	27 September 2022			
Author:	Jennifer Boyle, Company Secretary			
Executive Sponsor:	Alison Marshall, Chair			
Report presented by:	Kirsty Roberton, Deputy Director of Corporate Services and Transformation			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☒	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☐
	Following the approval of the Trust's new strategy and the corporate objectives for 2022/23, there was a Board action agreed to review the terms of reference of the main Board committees to ensure that core elements of the strategy and objectives are included for assurance purposes. The purpose of this report is to enable the Board to approve minor amendments to the terms of reference.			
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*	People and Organisational Development Committee Please note these minor amendments have not been formally presented to the other Board committees.			
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 Company Secretary has undertaken a review of the terms of reference of the committees which have responsibility for seeking assurance over the delivery of the strategy and objectives, namely: • Digital Committee • Finance and Performance Committee • Quality Governance Committee • People and Organisational Development Committee Minor changes are proposed (highlighted in yellow), which are presented to Board for ratification. It is noted that in all terms of reference there was a pre-existing role already articulated in relation to strategy and corporate objective monitoring. It is not proposed to make the terms			

	of reference too detailed and prescriptive, so only significant new topics (such as health inequalities) are proposed for specific inclusion. Summary of changes: Quality Governance Committee: • Reference to seeking assurance over health inequalities and Gateshead system contribution • Reference to strategies within the remit of the Committee. Finance and Performance Committee: • Reference to strategies within the remit of the Committee. • Transformation role description expanded to include seeking assurance over major schemes likely to impact upon operational and financial performance (e.g. New Operating Model). Digital Committee: • No changes proposed to align to the strategy and objectives. • Minor amendment made to align quoracy to other committees and reference the role of the Governor observers. People and Organisational Development (POD) Committee (note the POD team have undertaken a wider review of the terms of reference, resulting in a number of these amendments): • No specific changes required to align to the strategy. • Attendees revised to include senior managers, including a senior manager from Finance to provide cross-representation. • Reference to the role of Governor observers included. • Quorum amended in line with other committees.
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Board is requested to review and ratify the revised terms of reference for the 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:	All				
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 directly				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐		**No** ☐		**Not applicable** ☒

Committee

Terms of Reference

Gateshead Health NHS Foundation Trust

Quality Governance Committee

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

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

Date Adopted / Reviewed	**Revised February 2022** – approved by the Quality Governance Committee March 2022 – ratified by the Board of Directors
Review Frequency	Annually
Review and approval	Quality Governance Committee
Adoption and ratification	Trust Board

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

	Other Executive Directors and Senior Managers may be invited to attend meetings depending upon the issues under discussion. Two nominated Governors will be in attendance at the Committee as observers.
Meeting frequency and quorum	Meetings shall be held **bi-monthly.** Additional extraordinary meetings of the Committee can be called by the Chair in accordance with business need. To be quorate there should be at **least 1 Non-Executive Director** and 2 **Executive Directors** present. Members and regular attendees are expected to achieve **75% attendance** annually.
Meeting organisation	The Committee shall be supported administratively by the Corporate Management Team secretarial body. In accordance with the Trust's Standing Orders, **papers will be circulated to members and attendees six days before the meeting** wherever possible, and no later than three clear days before the meeting, save in emergency. Minutes of the Committee's meetings are held by the Corporate Management Team secretarial body and are circulated (alongside the agenda for the following meeting), to members and attendees.

Committee duties and responsibilities	
Strategy, planning and risk	To **seek assurance over the delivery of the corporate objectives** mapped to the Committee for monitoring at the commencement of the financial year. This includes seeking assurance over the Trust's contribution to tackling **health inequalities** and the **contribution to Gateshead system** working to improve health and care outcomes to the local population. To approve and seek assurance over the **delivery of national and local-level strategies** relating to the remit of the Committee. This includes: the Allied Health Professional Strategy; Nursing Strategy; Midwifery Strategy; Cancer Strategy; Quality Strategy and Research and Development Strategy. To **review the sections of the Board Assurance Framework (BAF)** mapped to the Committee for oversight and assurance, triangulating the control and assurance assertions on the BAF with the assurances and risks identified during each meeting. To **review the quality / medical–related risks on the Organisational Risk Register**, seeking assurance over the effective management of these risks towards the achievement of their target scores. The Committee will

	triangulate the risk registers against the assurances and risks emerging from the meeting for completeness.
Safety	The **Integrated Oversight Report** will be used to provide an overview of aspects of safety performance (in accordance with the metrics defined in NHS England and Improvement's Single Oversight Report) and enable spotlight reporting on areas of greatest risk. This report includes maternity and neonatal quality and safety indicators and is also reviewed by the Board (resulting in monthly review of maternity metrics). Seek assurance that the Trust has **effective systems for safety**, with particular focus on quality, patient safety, staff safety and wider health & safety requirements. This should also include routine assurance regarding compliance with **safe staffing levels**. Seek assurance over the **robustness of procedures to ensure that adverse incidents and events are detected, openly investigated, with lessons learned being promptly applied** and appropriately disseminated in the best interests of patients, of staff and of the Trust. To seek assurance that the Trust embeds **learning from deaths** and had a robust process in place which complies with mandatory requirements. To seek assurance that the Trust appropriately **responds to requests and requirements from coroners and other regulatory bodies** in respect of patient safety. To gain assurance that the Trust has in place such systems of work and controls that **ensure medicines are effectively managed** and complaint with legislative requirements. To gain assurance that the Trust has in place such systems of work and controls that **ensure medical devices are effectively managed** and complaint with legislative requirements. To gain assurance that the Trust has in place systems of work and controls that ensure **infection prevention and control** is effectively managed and compliant with legislative requirements. To gain assurance that **safeguarding** is compliant with national and local requirements such that patients are safe in the Trust's care. On behalf of the Board the Committee will seek assurance on **maternity services** at least quarterly. This report will include: • Serious Incident key themes • Maternity staffing for all relevant professional groups • Clinical outcomes and compliance • Essential training compliance
Patient experience	The **Integrated Oversight Report** will be used to provide an overview of aspects of patient experience metrics (in accordance with the metrics defined in NHS England and Improvement's Single Oversight Report) and enable spotlight reporting on areas of greatest risk.

	Seek assurance that the Trust has **effective systems for delivering a high quality experience** for all its patients and users, with particular focus on **involvement and engagement** for the purposes of learning and making improvement. To provide assurance to Trust Board that there are robust systems for **learning lessons from complaints**, and action is being taken to minimise the risk of occurrence of adverse events. This should include the **sharing of aspects of good practice identified through compliments** and patient feedback. To seek assurance that the Trust is **delivering high quality care for patients with learning disabilities** in accordance with nationally and locally prescribed standards.
Clinical effectiveness, leadership and training	The **Integrated Oversight Report** will be used to provide an overview of aspects of clinical effectiveness and outcomes (in accordance with the metrics defined in NHS England and Improvement's Single Oversight Report) and enable spotlight reporting on areas of greatest risk. Seek assurance that the Trust has **effective systems for monitoring clinical outcomes and clinical effectiveness,** with particular focus on ensuring patients receive the best possible outcomes of care across the full range of Trust activities. To seek assurance over the **effective engagement of clinical leads** in the development and delivery of quality improvement initiatives. To review the **clinical audit plan and progress reports** to support the assurance process regarding effective clinical practice. Through close working with the HR Committee, seek assurance that **statutory and mandatory training requirements** relating to quality of care and clinical practice are being fulfilled.
Regulatory and governance	To monitor, scrutinise and provide assurance to the Trust Board on the Trust's **compliance with core regulatory standards**, including the Care Quality Commission's Fundamental Standards, quality-related elements of NHS England and Improvement metrics and NICE guidance. On behalf of the Board, take a lead role in **seeking assurance that the Trust's annual Quality Report is compliant with regulatory requirements**, reflective of the main achievements and challenges during the year and has been appropriately consulted upon. To triangulate through assurance the **robustness of quality-assurance processes relating to all research undertaken** in the name of the Trust and / or by its staff, in terms of compliance with standards and ethics, and clinical and patient safety improvement processes.

	To receive an annual assurance report on the compliance with the NHS England and Improvement '**Developing Workforce Safeguards'** requirements. To receive for information and assurance **Internal Audit reports** pertaining to the remit of the Committee. To receive for information and assurance any **reports from external reviews** pertaining to the remit of the Committee. To review **feedback from NHSI** relating to quality and safety. To review any material **emerging regulatory guidance / requirements** in relation to quality and clinical matters on behalf of the Board.

Reporting and monitoring	
Sub-groups	The following sub-groups report into the Committee: • Mental Health Act Compliance Group • Nursing, Midwifery and AHP Professional Forum • Group Health and Safety Committee • Infection, Prevention and Control Committee • Safeguarding Committee • Mortality and Morbidity Steering Group • Safecare, Risk and Patient Safety Council The minutes and summary of assurances and escalations documents are received by the Committee as part of the flow of assurance through the Trust's governance structure. The Committee will receive detailed assurance reports from the Mental Health Act Legislation Committee.
Board reporting	An assurance report from the Committee will be presented by the Chair to the next meeting of the Board of Directors.
Monitoring	Compliance with the terms of reference will be reviewed via an annual self-assessment. This will inform any proposed revisions to the terms of reference and the cycle of business. The outcome of the effectiveness and terms of reference review is presented to the Board of Directors following consideration by the Committee.

Committee

Terms of Reference

Gateshead Health NHS Foundation Trust

Finance and Performance Committee

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

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

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

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

	To be quorate there should be at **least 2 Non-Executive Directors** (one of whom can be the Trust Chair) and **1 Executive Director** present. Members and regular attendees are expected to achieve **75% attendance** annually.
Meeting organisation	The Committee shall be supported administratively by the Corporate Management Team secretarial body. In accordance with the Trust's Standing Orders, **papers will be circulated to members and attendees six days before the meeting** wherever possible, and no later than three clear days before the meeting, save in emergency. Minutes of the Committee's meetings are held by the Corporate Management Team secretarial body and are circulated (alongside the agenda for the following meeting), to members and attendees.

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

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

Transformation	Via the Transformation Board reporting, seek assurance over the **transformation programme, including its plan, delivery and outputs.** This includes delivery of major transformational schemes which have a significant link to operational and / or financial performance.
Regulatory and governance	To receive for information and assurance **Internal Audit reports** pertaining to the remit of the Committee. To review **feedback from NHSI** relating to financial, operational and planning matters. To review any material **emerging regulatory guidance / requirements** in relation to finance and operational matters on behalf of the Board.

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

Committee

Terms of Reference

Gateshead Health NHS Foundation Trust

Digital Committee

Constitution and Purpose – The Digital Committee is a formal committee of the Trust Board with delegated responsibility to develop, implement and review the Trust's Digital Strategy and associated transformation programme initiatives, as approved by the Trust Board with the objective of maximising the contribution of digital solutions and services in the delivery of the Trust's Strategic Plan and objectives. Note the Committee does not have Group-wide responsibilities and is an assurance committee of the Trust only.

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

Date Adopted / Reviewed	December 2021 – Digital Committee January 2022 – Board of Directors
Review Frequency	Annually
Review and approval	Digital Committee
Adoption and ratification	Trust Board

Membership	The Committee shall be appointed by the Trust Board and shall consist of: • 2 Non-Executive Directors • Group Director of Finance and Digital • Medical Director A Non-Executive Director shall be nominated as Deputy Chair for the Committee.
Attendance	The following will be expected to attend the Committee on a routine basis: • Chief Digital Information Officer • Chief Clinical Information Officer • Chief Nursing Information Officer • Head of Digital Transformation and Assurance • Head of Digital Solutions and Technical Services Executive Directors and senior managers should ensure that a deputy attends in their absence.

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

Committee duties and responsibilities	
Strategy and planning	To **seek assurance over the delivery of the strategic objectives** mapped to the Committee for monitoring at the commencement of the financial year. To seek assurance over the **delivery of national and local-level strategies** relating to the remit of the Committee, including the Trust's Digital Strategy and roadmap.
Operational service delivery assurance	To seek assurance over the **responsiveness and effectiveness of the digital services** in respect of user requests and issue resolution. Seek assurance over the **completeness and accuracy of clinical coding**, recognising the importance of coding in respect of both its quality and financial implications.
Regulatory and governance	To seek assurance that the Trust has in place appropriate arrangements for ensuring that **technology is secure** and up-to-date and that IT systems are **protected from cyber threats** in accordance with national requirements. Seek assurance over the **effectiveness of the Trust's Information Asset Owners** and their roles in respect of key systems. This includes assurance over **data quality relating to the Trust's systems and processes**, the completion of Data Protection Impact Analyses where required and assurances regarding the clinical safety of systems.

	To seek assurance over **performance against key information governance standards and requirements**, including Freedom of Information requests, data breaches and information governance training. To provide assurance to the Trust Board that the Trust is compliant with the relevant **Data Security and Protection toolkit standards** and national requirements. To seek assurance over the **appropriate storage and processing of records** across the Trust including compliance with the General Data Protection Regulation requirements, local policy and subject access requests. To receive for information and assurance **Internal Audit reports** pertaining to the remit of the Committee, particularly in respect of audits completed by the Technology Risk and Assurance arm of AuditOne. To receive for information and assurance any **reports from external reviews** pertaining to the remit of the Committee. To review **feedback from NHSI** and the **Information Commissioner** relating to digital technology and information governance. To review any material relating to **emerging regulatory guidance / requirements** with respect to digital and information governance matters on behalf of the Board.
Risk management	To **review the sections of the Board Assurance Framework (BAF)** mapped to the Committee for oversight and assurance, triangulating the control and assurance assertions on the BAF with the assurances and risks identified during each meeting. To **review the digital–related risks on the Organisational Risk Register**, seeking assurance over the effective management of these risks towards the achievement of their target scores. The Committee will triangulate the risk registers against the assurances and risks emerging from the meeting for completeness.

Reporting and monitoring	
Sub-groups	The following sub-groups report into the Committee: • Digital Transformation Group • Digital Assurance Group The minutes and summary of assurances and escalations document are received by the Committee at every meeting as part of the flow of assurance through the Trust's governance structure.

Board reporting	An assurance report from the Committee will be presented by the Chair to the next meeting of the Board of Directors.
Monitoring	Compliance with the terms of reference will be reviewed via an annual self-assessment. This will inform any proposed revisions to the terms of reference and the cycle of business. The outcome of the effectiveness and terms of reference review is presented to the Board of Directors following considered by the Committee.

Committee

Terms of Reference

Gateshead Health NHS Foundation Trust

People and Organisational Development Committee

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

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

Date Adopted / Reviewed	September 2021 – approved by the People and Organisational Development Committee November 2021 – ratified by the Board of Directors September 2022 – Reviewed by People and OD committee
Review Frequency	Annually
Review and approval	People and Organisational Development Committee
Adoption and ratification	Board of Directors

Membership	The Committee shall be appointed by the Trust Board and shall consist of: • 2 Non-Executive Directors, one of whom shall chair the Committee • Executive Director of People and Organisational Development • Chief Nurse • Chief Operating Officer • Medical Director • A Non-Executive Director shall be nominated as Deputy Chair for the Committee.
Attendance	The following will be expected to attend the Committee on a routine basis: • Deputy Director of People and Organisational Development • Lead AHP • People and OD Heads of Service

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

Committee duties and responsibilities	
Strategy, planning and risk	To seek **assurance over the delivery of national and local-level strategies** relating to people and organisational development matters. This should include: • People Plan (national) and local People Strategy • Health and Wellbeing Strategy • Leadership and Organisational Development Strategy • Equality, Diversity and Inclusion Strategy • Freedom to Speak Up Strategy To **seek assurance over the delivery of the corporate objectives** mapped to the Committee for monitoring at the commencement of the financial year. To undertake **detailed scrutiny** of the adequacy of the Trust's **workforce and recruitment forecasts and planning assumptions** (in line with the latest regulatory planning requirements), making a recommendation to

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

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

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

	The outcome of the effectiveness and terms of reference review is presented to the Board of Directors following considered by the Committee.

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 10

Report Title:	**Draft Strategic Winter Plan 2022/23 Assurance Report**			
Name of Meeting:	Trust Board			
Date of Meeting:	27th September 2022			
Author:	Tom Knox, Head of EPRR			
Executive Sponsor:	Joanne Baxter, Chief Operating Officer			
Report presented by:	Joanne Baxter, Chief Operating Officer			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☐
	This report seeks the endorsement of the Trust Board for the Draft Strategic Winter Plan 2022-23 prior to submission to NHSE			
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 Senior Management Team Strategic EPRR Committee			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	• The planning requirements for meeting the challenges of winter are a dynamic and on-going process and the Operational Trust Winter Plan will need to continue to evolve to meet winter pressures • The winter of 2022/23 is expected to bring an increase in demand for services as the trust continues to meet the challenges of managing Covid alongside other winter viruses, the on-going costs and challenges of attaining greater winter capacity and a parallel need to recover activity significantly affected by the pandemic • The Trust are collectively focused on using winter planning to reduce impacts and provide mitigation to ensure our patients continue to receive safe, effective care and positive patient outcomes • Staffing shortages, in particular nurse staffing vacancies, continue to provide a challenging environment for winter planning			

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

- The focus of our winter planning continues to be on avoiding admissions, reducing length of stay and ensuring timely discharges

- The Trust has worked collaboratively on winter planning with EPRR and Integrated Care System partners, the Regional Chief Operating Officer Group and the Urgent & Emergency Care Network

The Draft Strategic Winter Plan 2022-23 is attached as appendix 1 to this report.
</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 Trust Board are asked to review the Strategic Winter Plan and to consider if it provides reasonable assurance to support the work of the Trust during the Winter period 2022-23</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="4">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td colspan="4">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td colspan="4">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☒</td><td colspan="4">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☒</td><td colspan="4">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="5">List corporate objective reference and headline – e.g. 1.4 Maximise the use of Nervecentre to improve patient care</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">There are a number of key operational risks in delivering this plan and the current mitigations are referenced within the draft Operational Winter Plan.

In addition, there are several external risks, acknowledged in existing Trust risk registers, that may impact the trust concurrently if collectively realised</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☐</td><td>Not applicable
☒</td></tr>
</table>

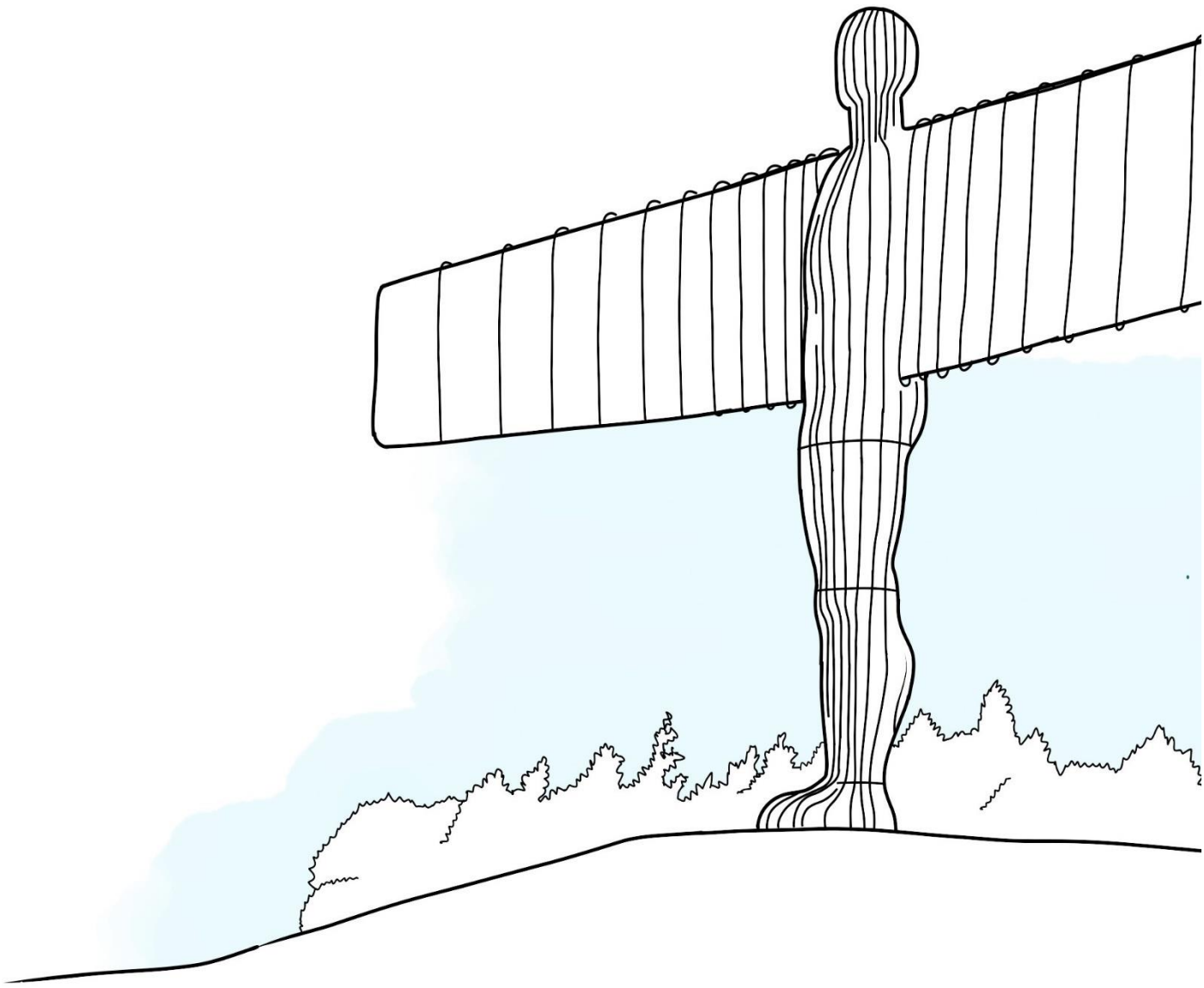
Gateshead Health
NHS Foundation Trust

DRAFT

Winter Plan 2022-23

A strategic overview

September 2022



Contents

1. Aim and Objectives

The **aim** of this plan is to provide a strategic overview and assurance for winter planning arrangements at Gateshead Health NHS Foundation Trust.

The following **objectives** have been identified to deliver our overall aim:

- To identify and embed organisational learning from previous winter and covid-19 experiences
- To set trust roles and responsibilities during the winter period
- To establish a framework for winter surge and demand management
- To identify and manage risks to enhance safety and patient experience
- To provide appropriate staffing and resources during the winter period
- To provide a costed budget to deliver our Winter Plan 2022-23

Winter 2022-23 covers the period from 28 November 2022 to 26 March 2023.

2. Introduction & Overview

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

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

During the Covid-19 pandemic there was a notable reduction in other respiratory viral infections such as influenza and RSV. As a result, the population, including our most vulnerable, have not been recently exposed to these common circulating viruses.

As life begins to return to normal the co-circulation of Covid-19 variants and other respiratory viruses is expected to further impact the UK this winter.

Despite the success of the Covid-19 vaccine rollouts, Winter 2022-23 is expected to once again be particularly challenging as the NHS manages Covid-19 alongside other winter viruses. This increase in demand for services will provide further pressure on a system that has never fully recovered from the wider impacts of the pandemic.

These factors will impact the Trust's ability to deliver a high-quality service over the winter months. Robust planning, mitigation and forecasting are therefore required in order to reduce these impacts and to ensure our patients continue to have a positive patient experience and receive safe, compassionate and effective care.

- Winter 2022-23 will be made more complex by a continuing need to respond to and recover from Covid-19 waves alongside the added requirement of managing a likely challenging flu season.
- The Trust provides a diverse range of services from Acute Medical and Surgical specialities, Urgent and Emergency Care (UEC) provision, Diagnostic and Screening services, to Older Persons Mental Health services consisting of inpatient beds, community and day care services

and a wide range of Community Services. It is important our winter planning facilitates resilience in all services to ensure that winter pressures are managed appropriately.

The Trust has continued to evolve with the challenges of Covid-19 and has taken a number of steps over recent years to improve overall resilience. The Trust has:

- Made significant investment in workforce and estate to deliver a new operating model that streamlines patient pathways and ensures patients are seen in the right place, at the right time, by the right team. This includes urgent and emergency care services within the Emergency Care Centre (ECC) which now includes an extended Same Day Emergency Care (SDEC) department co-located to the emergency department.
- Committed to an extensive transformation programme two strands of which support delivery of the new operating model namely Unscheduled Care and Elective and Planned Care. The unscheduled care programme in particular which focuses on reducing avoidable emergency admissions; reducing length of stay; and improved discharge are key to winter planning.
- Aligned the roles of senior medical, nursing and service managers in triumvirate teams to ensure ownership of operational pressures including winter escalation in line with leading practice
- Reviewed and updated all related policies and procedures relating to operational site management, incident response and the on-call framework to deliver the NHS England (NHSE) Emergency Preparedness, Resilience and Response (EPRR) core standards
- Introduced Same Day Emergency Care (SDEC) in September 2021 and reviewed and revised policies and procedures relating to admission, criteria to reside, length of stay, medically optimised patients and discharge in order to support capacity in the hospital in and out of hours and at weekends
- Introduced real-time performance dashboards to support operational decision making, ensuring forecasting and planning assumptions are informed by available data and information
- Improved surge and demand management and regional Operational Pressures Escalation Levels (OPEL) response via on-going dialogue with NEAS and other local health partnerships to ensure focused collaborative working
- Trained and exercised on-call managers on the Trust Incident Response Plan, Operational Site and On-call requirements at Operational, Tactical and Strategic levels
- Revised the Trust OPEL escalation procedures and multi-agency response arrangements

The Trust has co-operated and collaborated with winter planning for system partners via the Regional Chief Operating Officer Group (COO Group) and Urgent and Emergency Care (UEC) Network the Integrated Care System (ICS), Local A&E Delivery Boards (LAEDB), Gateshead Care System Board, Integrated Care Partnership (ICP) and more recently the Integrated Care Board (ICB) in their transition to becoming a Civil Contingencies Act (CCA) Category One response organisation.

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

This partnership working emphasises the importance of:

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

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

- Transforming Urgent and Emergency Care Services, Safer, Faster, Better (v28 2015)
- Good Practice Guide, focus on patient flow (2017)
- Safer Patient Flow Bundle Emergency Care Improvement Programme (ECIP) (2019)
- Hospital Discharge Service Requirements (NHS England 2020)
- Heath and Social Care Act (2022)
- Health and Social Care Act Regulations (2014)
- NHS Long Term Plan (2019)

It also relates to other associated **internal** documents such as:

- Covid-19 Outbreak Policy (v3 May 2022)
- OPEL escalation Plan (January 2021)
- Operational Site Management Procedures (September 2022)
- Incident Response Plan (May 2022)
- Influenza patient placement guidelines 2021-22 with COVID guidance incorporated
- Covid-19 Excess Deaths Management Framework - NLRF (v4 March 2021)
- Adverse Weather Plan
- Discharge Policy
- Opening a ward procedure
- Individual Business Continuity plans

3. Covid-19-Organisational Learning

Points of learning from Covid-19 have included:

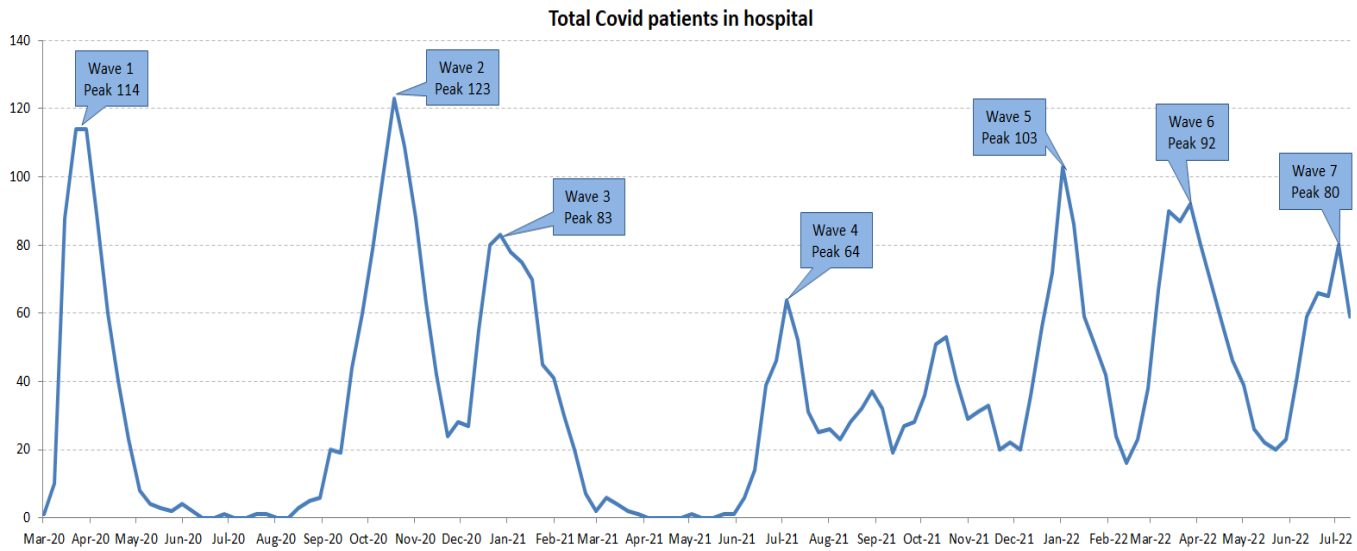
- On-going assessment on management and allocation of dedicated or hybrid wards to support Covid, query Covid and non-Covid patients in particularly in relation to provision of front of house services
- Increased infection control measures ranging from wearing Personal Protective Equipment (PPE), donning and doffing requirements, to social distancing requirements throughout the Trust
- Enhanced cleaning regimes and therefore turnaround times of clinical estate
- Having a flexible and robust Covid outbreak policy that can be instituted quickly to minimise spread of potential Covid cases
- Linking our winter, Covid escalation and recovery work with triggers and thresholds determining operational delivery
- Ongoing risk assessment of our staff and in particular our Black, Asian and Minority Ethnic (BAME) staff to reduce the risk of their exposure to Covid
- Supporting staff shielding/previously self-isolating which impacts on staffing numbers
- Adopt patient testing requirements on admission and discharge or for symptomatic patients as appropriate
- Following national guidance to ensure appropriate testing and tracing of staff potentially exposed to Covid in line with national guidance.
- Assessing the need for use of 2 metres between beds which has reduced bed capacity, during outbreaks
- Widespread disruption to social care, therefore a need to innovate in order to support social care especially care homes
- Promoting Independence Centres have not reinstated intermediate care bed provision

- Discharge to assess model
- Continuing health care funding has completely changed
- The implementation of shielding requirements for patients
- An on-going focus on managing care which was delayed by Covid-19 and has had an impact on waiting times and referrals to treatment

Further shared learning can be identified via this link:
https://www.nhsemployers.org/case-studies/covid-19-shared-learning-nhs-trusts

Covid-19 cases and staffing availability
The number of peak cases in Hospital is demonstrated in the table and represented graphically below:

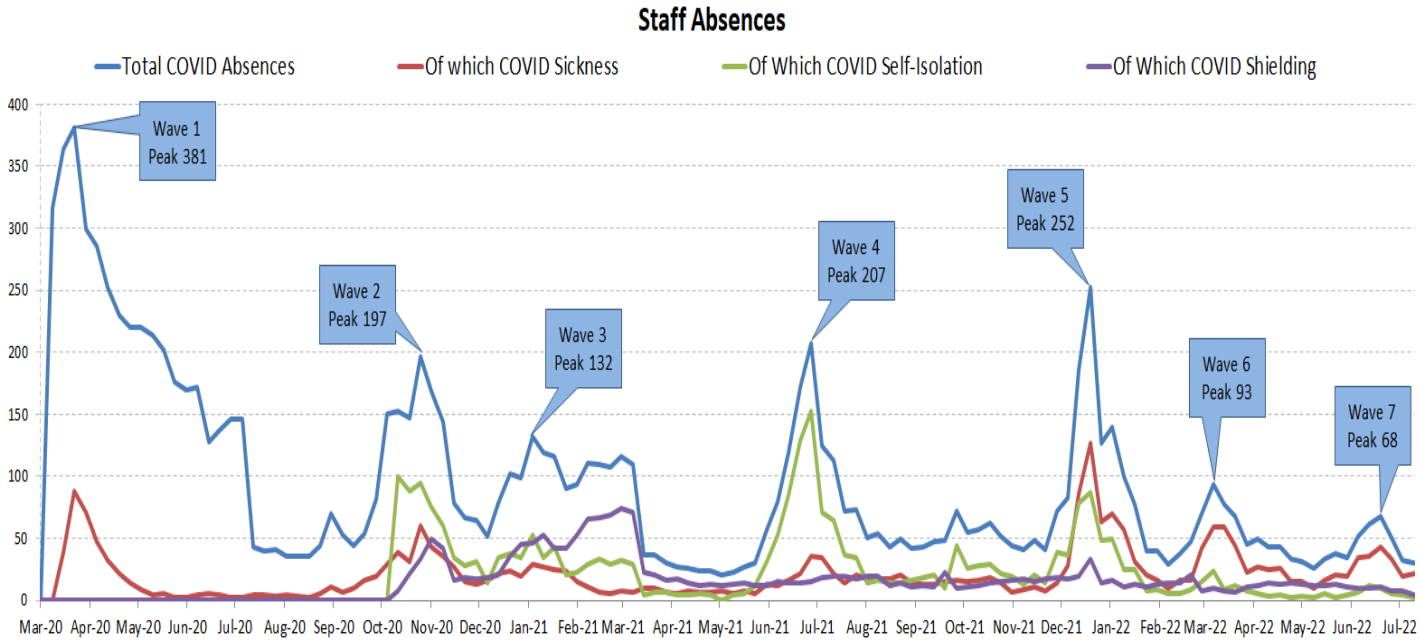
Covid Wave	No:	Date
Wave 1	Peak: 114	(11/04/2020)
Wave 2	Peak: 123	(07/11/2020)
Wave 3	Peak: 83	(16/01/2021)
Wave 4	Peak: 64	(24/07/2021)
Wave 5	Peak: 103	(23/01/2022)
Wave 6	Peak: 92	(17/04/2022)
Wave 7	Peak: 80	(24/07/2022)



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

The number of staff COVID absences is demonstrated in the table and charts below (sourced from Covid SITREP):

Covid Wave	No:	Date
Wave 1	Peak: 381	(12/04/2020)
Wave 2	Peak: 197	(15/11/2020)
Wave 3	Peak: 132	(24/01/2021)
Wave 4	Peak: 207	(18/07/2021)
Wave 5	Peak: 252	(09/01/2022)
Wave 6	Peak: 93	(27/03/2022)
Wave 7	Peak: 68	(10/07/2022)



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

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

- Increased critical care capacity to 24 beds and redeployed staff
- Suspended elective surgery
- Created Covid and non-Covid areas

- Suspended routine Community Services
- Carried out estates work to increase capacity for oxygen supply and therapy
- Implemented revised discharge arrangements
- Revised the whole estate to ensure services were safe, this involved moving a number of services within the Trust acute and community sites

The Trust support cells instigated internally and externally were.

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

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

The Trust have embedded the learning from earlier phases and have well established Covid-19 systems and processes. The trust is advocating following the national guidance that would be to screen any symptomatic patient for Covid and Influenza – a document is to follow regarding patient screening in light of the latest NHSE letter suggesting that the trust 'pause' all asymptomatic Covid testing on all patients except the immunocompromised and hospice admissions whilst Covid prevalence rates are low.

For Winter 2022-23, the Trust has identified pathways for Covid-19 positive and Query Covid patients as part of our evolved approach to bed management. Thresholds and trigger points to support escalation and de-escalation for Covid are now part of our core business escalation plans.

The Winter Plan 2022-23 is developed on planning assumptions from previous Covid-19 waves and acknowledges the need for flexibility with predicted numbers and that the demand placed on our Trust by extra elective requirements and the anticipated increased impacts from influenza above those in Winter 2021-22 are key risk factors.

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

- Infection and admission rates are maintained at predicted levels
- The social care sector being able to maintain residents at home and accept discharges
- The potential impact on bed capacity if there are high levels of patients who do not meet the criteria to reside
- No major changes in Infection, Prevention and Control (IPC) which would reduce our bed base or staff availability
- No major staffing difficulties as a result of staff required to self-isolate

4. Review of Winter 2021-22

Winter 2021/22 was one of the most challenging ever faced by the NHS and this winter is anticipated to be equally challenging if not more severe.

The key features continued to be:

- Management of Covid-19 variants and associated respiratory infections
- Ongoing staffing pressures linked to Covid-19 absences
- Staffing and budget pressures caused by the need to open beds over and above the winter plan.
- The Trust opened additional beds for a longer period than planned, with our winter wards continually remaining open into the Summer of 2022 to meet the extra and unpredictable demand.
- Levels of performance below the nationally mandated targets and the exceptional situation of a several breaches of 12 hour waiting times
- Poor patient experience
- Sustained stress on staff
- Requests to other Trusts for mutual help on more occasions
- Increased scrutiny by regulators and reporting to Trust Board

For the Trust this meant:

Average/Peak G&A Occupancy

- Wave 1: 71.7% (Peak 89.53% - 18/06/20)
- Wave 2: 85.9% (Peak 98.8% - 05/10/20
- Wave 3: 85.79% (Peak 95.0% - 15/03/21)
- Wave 4: 90.1% (Peak 97.6% - 25/07/21)
- Wave 5: 92.6% (Peak 98.9% - 20/02/22)

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

Our Winter 2021/22 highlighted:

a) The need to work on a day-to-day basis at a senior level with ICP and ICS partners to plan for winter and in the management of operational pressures

   - The establishment of a regional Chief Operating Officer Network supported by the regional Urgent and Emergency Care Network reporting directly to the ICS

b) The need to strengthen our operational management of winter aligned with business continuity planning and emergency response and resilience (EPRR)

   - Focus of the Chief Operating Officer (Accountable Emergency Officer) and Head of EPRR to align the winter response through robust on-call, escalation and resilience planning

c) The need to review our structures and investment in operational capacity

- Leadership to be provided by the Operational Directors and Divisional Managers within the Medicine and Surgery Business Units

d) The severe staffing pressures in the nursing and medical workforce to be addressed:

- Recruitment to nursing posts early in the planning stages to ensure best use of medical teams and ensuring processes are lean.
- Need for a revised on-call rota and robust management systems. A revised Incident Management Plan, to strengthen our senior decision maker presence overnight and at weekends

e) The requirement for our new operating model to take into account the most recent bed-modelling and staffing availability. The enhanced Site Resilience Team to proactively manage planning by:

- Modelling from previous scenarios taken from actual activity and progressed through different Phases of the Pandemic to ensure our staffing and bed capacity can flex to meet that demand as best possible

f) A required focus on admissions, provision of extra beds, safely and effectively through improved bed occupancy, reduced length of stay and better discharge processes

- Best practice relating to the above is being incorporated into our transformation programme and winter planning requirements

5. National Guidance & Good Practice

Leading practice has been identified from sources including:

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

The leading practice the Trust will implement is:

- Working collaboratively with wider partners in Social Care, Ambulance Services, Primary Care, the Voluntary Sector and Community Services to reduce avoidable presentations to A&E, admissions and re-admissions. Taking into account the 6 key system priorities; -
    - 111/999 Clinical advisory service
    - Fit to sit Standing Operating Procedures (SOP) and clinical supervision in waiting areas
    - Primary care presence in Urgent Treatment Centre (UTC)
    - Managing internal hospital flow
    - Mental health provision in acute settings
    - Discharge and social care
- The Trust will continue to broaden the scope on our Same Day Emergency Care requirements to safely avoid admissions for those with ambulatory conditions

- Further development/expansion of ‘Talk before you Walk’ to manage urgent activity more effectively
- Challenge culture to reducing length of stay by setting an expected date of discharge on the day of admission, utilising model hospital benchmarked length of stay (LOS) data and one that the whole of the multi-disciplinary team (MDT) work together to realise
- Ensuring robust discharge transport arrangements are in place
- Closely and proactively monitoring and reviewing stranded, super stranded and patients who no longer meet the criteria to reside
- Implement Red and Green Days approach
- Implement SAFER Care Bundle
- As part of discharge and caring for people at home, have Rapid Response health and care services available
- Embed new discharge requirements published August 2020 (updated April 2022) https://www.gov.uk/government/collections/hospital-discharge-service-guidance

Through the Trust’s Transformation Portfolio, the Trust are also working towards good practice with an emphasis on:

- Embracing the available technology to ensure real time bed management is in place and utilising a ‘command’ centre approach making informed decisions via the live dashboards
- Proactively managing capacity through forecasting, modelling and improved preparation and planning through live dashboards
- Ensuring real time workforce information is available

6. Approach to Winter 2022-23

At the beginning of 2020 the Trust commenced a comprehensive piece of work to determine the future operating model and clinically led estates strategy. This determined that medicine needed 404 beds in the peak of winter, 104 for surgery. This work was presented to the Trust Board in June and July 2021 when significant capital and revenue investment was made to ensure Gateshead Health is not only resilient but sustainable for the future. However, over the past two years all staff and services have been expected to work in very different ways to meet the challenges of Covid and this has delayed some of the proposed changes.

The revised operating model included changing urgent and emergency care pathways front of house. In the new model that went live on 20th September 2021, same day emergency care was co-located with the emergency department within the emergency care centre (ECC) to ensure patients were seen in the right place at the right time with an emphasis on admission avoidance.

The emergency admissions unit increased from 24 to 48 beds within ECC with the aim of shortening pathways of care and where possible avoiding longer stay admissions. Where patients are admitted to a back of house ward, transformation programmes are looking at ward ways of working to reduce length of stay and improved discharge processes.

In relation to back of house, the new operating model aimed to ensure medicine and surgery had the right number of beds in the right locations in normal times and winter.

The Trust has an escalation plan in relation to beds with the aim of achieving 367 of the required 404 medicine bed capacity in the peak of winter (historically January) whilst also protecting surgical beds for trauma and the surgical elective programme.

The table below illustrates the escalation plan:

			Winter escalation plan				
	Core beds (normal times)	Winter beds required (peak)	Nov-22	Dec-22	Jan-23 (peak)	Feb-23	Mar-23
Medicine	336	**404**	368	367	367	361	361
Surgery	94*	104	85**	85	89	100	100
Total	430	508	453	452	452	461	461
Surplus (deficit)			-	-	(56)	-	-

* Surgery currently running with a deficit of 10 beds due to displaced CEV patients
**reduction in beds due to building works associated with the new operating model

The Trust is limited in its estate to fully realise and deliver the number of beds required for winter. All modelling assumes 92% bed occupancy.

Note that the shortfall in winter escalation beds detailed in the table above will be mitigated in part by realising benefits of the Unscheduled Care Transformation Programme that focuses on reducing avoidable emergency admissions; reducing length of stay and improving discharges before 12noon and 5pm along with NHSE funded schemes as follows:

Front of house team to prevent admission avoidance (5 beds) - addition of Occupational Therapists and Prescribing Pharmacists to work with the existing team to work towards preventing patients from being admitted by resolving underlying needs that do not require hospitalisation.

Weekend discharge support (8 beds) – additional Occupational Therapists, Physiotherapists, Pharmacists, junior doctors and porters to extend Monday to Friday services into the weekend. Lack of weekend intervention and support can extend the length of stay for patients and this scheme provides the opportunity to understand the impact of having normal weekday provision at the weekend.

PTS vehicle – via QEF this is linked to the above two schemes in that once patients are identified for discharge, they can be transported earlier in the day than may have otherwise have been the case.

Spot purchase of care home beds (11 beds) - This scheme will enable Gateshead patients to be discharged more promptly and receive ongoing temporary nursing care out of hospital either while waiting for a social care placement or receiving intermediate care support.

Virtual Wards^ – for Respiratory (7 beds) and Acute Frailty (15) beds.
^ funded for two years

The schemes listed above are funded as part of national planning for winter, when NHSE asked all trusts in the region to bid against a funding allocation of around £12m to develop schemes which would result in a reduced demand for winter beds for a six-month period. Funding was subsequently pared back and provides cover for the five months from November 2022 to March 2023. NB virtual ward funding is for two years to end March 2024. The schemes are designed to facilitate admission avoidance and/or early discharge thereby notionally creating bed capacity.

NHSE have asked the Trust to develop a suite of metrics which will be monitored from November to March to help determine the success of the schemes and therefore the potential for long term adoption and funding.

Current position and Winter staffing recruitment
It is worth noting that at the time of writing this plan (September 2022) the Trust is in full escalation with 337 core medical beds open, 94 core surgical beds plus an additional 24 medical beds and 4 surgical beds open. **The Trust is at maximum capacity.** The average cost of these additional beds for the period April to August is £1.33m. Is it likely these beds will remain open on top of the winter beds described above. The number of patients no longer meeting the criteria to reside is playing a significant part in the position and we are working closely with colleagues in social care to remedy the situation. The total average number of patients who do not meet the criteria to reside on a monthly basis is 44, therefore utilising 28 escalation beds and 16 core beds. Applying the winter ward cost the monthly cost of a bed totals £9,176 which results in the Trust spending a total of £2m for the period April to August caring for patients who no longer meet the criteria to reside.

With regard to recruitment, operational teams are working hard to appoint to the workforce elements of all of the escalation plans for winter. Whilst the majority of recruitment is for the winter ward within medicine, additional posts in clinical support and screening and community services are included in the plan. National shortage of professions and in particular nurses will make securing appropriate levels of staffing challenging which in turn may impact on our ability to deliver the winter plan in its entirety. This is likely to be the case for all Trust and is not exclusive to Gateshead Health. The Trust will skill mix where possible and utilise non-ward based nurses as necessary in its plan.

7. Purpose of the Internal Operational Winter Plan 2022-23

Taking into consideration the learning from previous winters and the COVID pandemic, the internal operational Winter Plan for 2022-23 sets out the framework within which the operational processes will be implemented, and any surge in activity effectively managed.

It does not however contain the detailed daily operational site management and contingency plans or the related procedures that will be implemented over the winter period to deal with regular business as usual escalation. These existing plans will support and complement winter planning.

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

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

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

Operating model for Covid and Influenza

From an IPC perspective the trust is advocating following the national guidance that would be to screen any symptomatic patient for Covid and Influenza – a document is to follow regarding patient screening in light of the latest NHSE letter suggesting that the trust 'pause' all asymptomatic Covid testing on all patients except the immunocompromised and hospice admissions whilst Covid prevalence rates are low

The national guidance with regards isolation/cohorting suggests anyone with Influenza A/Influenza B or Covid would need to be either isolated in single room en suite accommodation or cohorted by organism type. Based on previous trust approaches, this will be in speciality bases rather than in respiratory isolation wards.

Operational arrangements

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

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

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

8. Risk Management

There are a number of **key operational risks** to delivering this plan and the current mitigations are set out in **appendix 1**. In addition, there are several **external risks** that are factors to the successful delivery of the winter plan that may impact the trust concurrently. This includes:

- Industrial action across various sectors including nursing
- Negative impacts on population health of seasonal illness and cold weather
- Disruption to Adult Social Care
- Ambulance service pressure
- Outbreaks of infectious disease
- Agency caps with staffing frameworks
- Increases in the cost of living

The detail of the likelihood and consequence of any impacts will be a dynamic process and will be captured on the organisation risk register and will be continually monitored throughout the winter period.

At this time of writing (September 2022), there is a notice of ballot for potential Industrial Action across a number of sectors including the nursing profession. A specific trust-wide task and finish group has been implemented to enable planning and mitigate any risks and impacts in conjunction with this winter plan.

9. Flu planning

This year the Trust are looking to revert back to the very successful campaigns that delivered Flu vaccinations to 80% of Trust staff prior to the COVID19 Pandemic

- The Flu campaign commences 10th October 2022 (this is due to Vaccine delivery dates)
- The Vaccine Committee including a wide range of representatives from across the Trust and currently meeting on a monthly basis to consider the plans for both Flu Vaccine and Autumn COVID 19 booster doses recommended for Health Care Workers

- The plan is to look to give the flu vaccine and Covid booster dose both at the same time

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This includes:

- Use of a booking system where staff will attend pre-booked appointments
- Plans to use the Occupational Health Department and PCAS unit as the base to deliver the vaccinations on a daily basis
- Planning is reliant on a consistent supply of relevant vaccines to meet planned demand
- Trust staff, including some senior nurses, may be required to coordinate the clinics, supported by the booking team, Pharmacy, Communications, IT, HCAs and admin, dependant on which COVID 19 vaccine the Trust receive
- Staff can continue to inform the Trust they've received the Flu or booster vaccine at a pharmacy/GP surgery/ supermarket
- Bank staff employed to visit wards and departments to offer the vaccines to staff in their workplace
- Peer vaccinators to be used in the Community
- A full communications plan has been developed and will be implemented by the Communications Team, commencing 2 weeks preceding the campaign/delivery
- Staff incentives will again be considered for teams achieving over 80%
- Level of uptake will be shared with all staff via QE Weekly/Screensavers/Flu page
- Business Units/Service Lines will be informed of their current level of uptake, and senior teams asked to engage/encourage/communicate key messages

10. Roles and Responsibilities

To enable the winter plan to work effectively staff must be clear about their roles and responsibilities in delivery of the plan.

Outlined below are the identified roles and responsibilities of key stakeholder's instrumental in supporting delivery of the winter plan.

Where a key stakeholder is unavailable (e.g. Leave) they are required to ensure clear arrangements are in place to ensure continuity of their responsibilities/tasks by nominating an appropriate deputy.

The following section outlines the known responsibilities for key stakeholders. As circumstances evolve additional responsibilities may be added to reflect Trust and plan requirements.

Trust Board

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

Chief Executive

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

Chief Operating Officer

The Chief Operating Officer (COO) has delegated responsibility from the Chief Executive for the development, implementation and monitoring of effectiveness of the plan, alongside being the Accountable Emergency Officer (AEO). In addition, the Chief Operating Officer has the responsibility of

bringing to the attention of the Chief Executive and other Executive Directors aspects of the plan that require input from support service directorates.

The Chief Operating Officer has shared responsibility, along with the Medical Director and the Chief Nurse, through the Executive triumvirate to ensure that the quality of care and patient safety is maintained during times of increased patient activity and acuity throughout the winter period.

The Chief Operating Officer is also responsible for the development of appropriate communication mechanisms in collaboration with ICS partners and the local COO network specifically relating to winter management and escalation and will liaise with the Trust Communication lead as appropriate

Medical Director

The Medical Director has shared responsibility with the Chief Nurse and Chief Operating Officer of ensuring the quality of care and patient safety and clinical outcomes is maintained during times of increased patient activity and acuity during the winter period.

The Medical Director will ensure that when quality and safety risks occur, they are quantified and escalated appropriately, and that mitigating actions are identified, implemented and monitored. The medical director is responsible for ensuring clinical outcomes are maintained.

The Medical Director will continue to provide visible, professional, leadership to medical colleagues, most specifically at times of increased pressure. The Medical Director will play a major role in liaising with the ICB, Social Services and GPs and will provide leadership and support during any staff vaccination programmes.

Chief Nurse

The Chief Nurse has shared responsibility with the Medical Director and Chief Operating Officer to ensure the quality of care and patient safety is maintained at times of increased patient activity and acuity during the winter period. The Chief Nurse must ensure that quality and safety risks are quantified and escalated appropriately and ensure that mitigating actions are identified, implemented and monitored. The chief nurse will be responsible for the monitoring of safe staffing in line with the safer nursing tool kit recommendations and escalate to CEO and AEO when issues arise

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

Managing Director QEF

The Managing Director for QEF will ensure that arrangements are in place to monitor the temperature of clinical areas and take action to ensure safe temperatures are maintained; timely repairs are made and contingency plans put in place to address winter issues; access to the hospital is clear and safe in the event of snow and ice and the site is adequately gritted and that QEF support the actions to manage winter pressures and surges in activity and ensure adequate provision of transport, portering and domestic resources to support the delivery of operational services whilst also embedding a robust health and safety culture.

Directors of Operations

The Directors of Operations are responsible for ensuring the development and operational management and delivery of the winter plan and its related arrangements, including ensuring there are robust processes in place for SITREP reporting. The Director of Operations will; , and will ensure teams are fully aware of their roles and responsibilities in relation to winter; ensure that staff are identified and

trained to fulfil appropriate on-call roles in relation to winter and surge management; provide Tactical level support to ensure the site is managed appropriately and take a key role in Tactical on call rota

The Directors of Operations will ensure that, wherever possible patient flow occurs in a way to benefit patients who are on an acute pathway and also support the teams who are delivering the pathways of care across the health and social care economy so they are joined up to ensure that there is a seamless transition of care into and out of hospital to and from different care settings; ensure services are managed appropriately and performance standards are met and maintained; and escalate any concerns which cannot be resolved by them to the Chief Operating Officer

Heads of Clinical Service

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

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

Divisional Managers

Divisional Managers will be responsible for ensuring their areas are staffed appropriately and escalate to the Ops Director when they have exhausted all possibilities within their remit or when forecasted staffing difficulties can be foreseen and remain unmitigated. They will proactively manage staff in relation to demand and acuity. The Divisional Managers will work at tactical level to ensure patients are seen in the right place, at the right time by the right team in a triumvirate with the Clinical Head of Service and Chief Matron.

Consultants

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

Clinical Leads

Clinical Leads will work closely with the Service Line Managers (SLMs) and Matrons and their clinical teams as the operational triumvirate to ensure that patients are reviewed and discharged in a timely manner. This should ensure that patient flow in their respective areas does not adversely impact on patient safety. Where appropriate, they will instigate additional ward rounds to ensure patients move quickly and safely through their pathways of care.

In addition, they will ensure, as far as practicable, that there is sufficient medical cover to meet the increased demand and complexity of patients. They will ensure that internal professional standards remain in place over the winter period.

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

The Clinical Lead will ensure that patients and staff within the Community Business Unit remain safe and will support any mitigation of unforeseen clinical risk throughout the winter period. The Clinical Lead

as part of Community Services will support partners across Gateshead's wider system to ensure patients with complex needs remain at home. Support in the prevention of unnecessary hospital admissions and a safe discharge where possible to an agreed place of residence. The Clinical Lead will also ensure that the COVID and Flu vaccination programme is delivered to the housebound and those residing in Older Persons Nursing Care Homes in Gateshead.

Deputy Director of Nursing, Quality & Safety

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

Head of Nursing

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

Chief Matrons

Chief Matrons will provide support to the Matrons to proactively and effectively manage resources to deliver the winter plan. The Chief Matrons will ensure the quality and safety of patient care provision of robust support to Matrons and oversee the management of clinical areas and prevention of excess lengths of stay.

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

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

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

Head of EPRR

The Head of EPRR will ensure sit-rep reporting is communicated externally on behalf of the Chief Operating Officer; act as a point of contact for NHSE winter command room and communications including surge; oversee the monitoring of the winter plans reporting to the Chief Operating Officer; and be responsible for ensuring robust resilience is managed daily in relation to surges in activity along with daily management of the Site Resilience Team.

In addition, the Head of EPRR will receive the cold weather alerts on behalf of the Trust and circulate as appropriate; manage the on-call rota ensuring appropriate cover is available at all levels and any gaps in the rota are filled; ensure Trust Business Continuity (BC) is maintained; and put in place escalation arrangements to respond to BC, Critical and Major Incidents

Service Line Managers (SLMs) / Clinical Business Managers (CBMs)

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

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

Site Resilience Team Manager and Site Resilience Team

The Site Resilience Team is the single point of contact for decisions regarding the allocation of beds in collaboration with Ward Managers and Matrons for all acute and elective admissions to promote patient flow and an optimum patient journey. The Team is responsible for maintaining a current bed state ensuring the use of available electronic /systems and the functionality of the daily Site resilience huddles.

They are also responsible for liaising with the ECC to ascertain their activity throughout the day, and to plan the bed base for anticipated admissions. They will arrange the transfer of patients (in accordance with the Transfer Policy) between wards in liaison with front of house managers and manage transfer requests from external organisations.

Matrons/ Clinical Operational Managers (COMs, Community)

Matrons/Clinical Operational Managers will work with the Clinical Site Resilience Team to ensure sufficient staff are available and appropriately deployed using Safe Care Live to meet the fluctuations of patient acuity and dependency. They will prioritise appropriate available resource to monitor the flow of patients. Where demand exceeds available staff, a dynamic risk assessment will be undertaken to prioritise workload appropriately.

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

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

Ward Managers/Team Leaders (Community)

Ward Managers/Teams Leaders (Community) will be responsible for ensuring their areas are staffed appropriately each day but also forecast ahead to key holidays, ensuring sickness and annual leave is managed appropriately and where necessary escalate to the Matron/COM whey they have exhausted all possibilities within their remit or when forecasted staffing difficulties can be foreseen and remain unmitigated. Proactively managing staff in relation to demand and acuity, they will be responsible for ensuring all patients receive the best care possible. Ward managers need to ensure all patients have an Estimated Discharge Date (EDD) and ensure the MDT work towards that date at each daily board round

They will also ensure the new discharge requirements are adhered to. They will ensure that real-time bed management information is actioned in Careflow and that nerve-centre information is in real- time.

IPC and Microbiology

The IPC Team and Microbiology will provide expert advice and support to wards and departments in line with national guidance.

The COVID-19 pandemic continues to dominate the IPC agenda. The IPC team and Microbiologists are involved in the interpretation and dissemination of the guidance issued from national bodies, including UK Health Security Agency (UKHSA) and NHS England. This supports operational effectiveness within this organisation and the wider healthcare community.

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

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

Gateshead Health as part of the Gateshead system response to outbreak control and management that has been established during Covid, works collaboratively to understand the prevalence, share information, support PHE guidance working closely with microbiology consultants, DIPC and the ICB.

Out of hours on-call arrangements

Out of hours on-call arrangements have been reviewed in line with the EPRR Core standards and the Trust On-Call, and Command, Control and Coordination (C3) structures put in place. This will ensure the continued use of a robust escalation model deployed and in response to Trust impacts to bring Operational, Tactical and Strategic on call managers and directors together to manage surge and provide clear Trust direction.

To assist on-call teams, all policies, protocols, key contacts and procedures are stored on a Microsoft teams channel for easy access when required.

The Operational Site Resilience Huddles, held a number of times daily, will ensure hands-on operational day to day site management incorporating escalation plans and OPEL levels and appropriate actions cards specific to role.

11. Communications

Internal Communications

The Trust Winter Plan will be cascaded through the internal communications channel as well as online resources and updated on the intranet. Any ‘all staff’ urgent internal communications about winter and surge will be determined by the Operational Site Resilience Huddles or the Trust Impact Management Meeting (TIMM) and disseminated via appropriate channels.

External Communications

The trust is part of the regional communications network, which leads the #DoYourBit campaign. This encourages people to take responsibility to protect themselves, each other and their communities and focusing on messages around our recovery, flu vaccinations, surge plans and staying well over winter.

The campaign includes shared content which can be used across multiple channels, region-wide media and advertising buy which enables us to amplify messages but also localise options where the Trust need to.

12. Workforce Plan

The following actions focus on preparedness, decision making and escalation processes to support safer nursing and midwifery staffing as the winter period approaches. They build on NHSE guidance issued in relation to COVID-19 workforce models and the fundamental principles for the nursing and midwifery workforce as set out in the National Quality Board (NQB) Safe Sustainable and Productive staffing guidance.

Planning

- The chief nurse will review all forecast staffing plans on a weekly basis or more frequently as required by the operating context and changing circumstances. This will be supported by the Deputy Chief Nurse and /or Head of Nursing and be responsive to support matrons managing dynamic risk assessments.
- Any changes in staffing configuration should be subject to a Equality/Quality Impact Assessment (EQIA) with final sign-off by the Chief nurse (Executive director of nursing) and countersigned by the medical director as joint quality lead. (NHSi2021).
- The matrons will be collectively responsible for workforce planning, providing practice safeguards, to ensure there is a Trust-wide effort to ensure staff with the right skills and experience are redeployed throughout the winter period in order to care for patients.
- Collaborative working with matrons and People and Organisational Development (POD) (ie – health roster clinical lead) will identify what temporary workforce anticipated requirements are required during activity peaks and consider steps such as block booking for hard to fill areas.
- Identification of available winter resource will be supported by clinical leaders and service managers.
- Redeployment of any nursing staff should be voluntary where possible and individual risk assessments will be undertaken with staff prior to any immediate, short or long term redeployment.

Decision Making and Escalation

With reference to: NQB Safe Sustainable and Productive staffing guidance and Developing Workforce Safeguards guidance.

- When implementing escalation plans, decisions regarding skill mix and nurse ratios will be taken in conjunction with an assessment of patient acuity and dependency, professional judgement and the environment of care.
- In preparation for periods of increased demand, matrons will ensure that staffing plans are reviewed and signed off by the Chief nurse.
- Matrons will be responsible for staffing risk assessments on a shift by shift basis and concerns and issues escalated in a timely manner via clearly established routes. Unresolved issues will be escalated in line with local governance processes. A system wide discussion in and out of hours should be taken to reach solutions wherever appropriate.
- Staff should be supported to discuss and raise concerns regarding staffing and their ability to safely care for patients. Where concerns are raised, the matrons will support staff and mitigate where possible.

Staff training and well being

- Professional nurse/midwife Advocates (PNA/PMAs) who are trained to provide confidential restorative clinical supervision and support nurses in clinical practice will be available throughout the winter period.
- Only in OPEL 4 will staff training be considered for stand down. Access to Professional leadership and development days will continue throughout the winter period.

Governance

The governance and delivery of the nursing winter staffing plan will be led with support from the Deputy Chief Nurse and Operational Directors. The plan will be mobilised, implemented and monitored by the Chief Matron/Matrons in the acute setting and the Clinical Lead for community services.

The following are already in place as part of Covid -19 recovery and winter planning

- Nurse recruitment - realigned to the new operating model, including induction and practice development of internationally trained nurses and a system of review of domestic processes for registered and Health Care Support Workers (HCSW).
- A continuation of the Trainee Nurse Associates programme and deployment of newly registered Nursing associates.
- Real time staff monitoring through electronic systems, capturing acuity, staffing resource and deployment
- A review of flexible working initiatives
- Frontline support for clinical practice from Specialist nurses, Practice Education and Practice Development were deemed appropriate through risk assessment.

This is particularly relevant as specific / clinical skills training will be scoped to support where necessary deployment of specialist/non-ward-based nursing staff in the event of industrial action.

Specialist and Non- frontline (NWBN) clinical nurses - supporting winter pressures 2022-23

Historically, over the winter period Registered and un- registered Health Care support staff (HCSW/HCA) from across the organisation are redeployed into nominated ward areas aligned to their speciality to support the release of substantive ward-based staff to create an establishment for the winter ward.

From mid-September 2022 until end of March 2023, specialist nurses will be required to spend time in their areas to ensure familiarity within the clinical environment, supported by the practice development team to refresh their clinical skills and undergo any necessary training to upskill knowledge and use of systems. Thereafter they will be deployed into clinical practice, predominantly supporting their nominated ward areas.

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

Learning from winter 2021 and noting our organisational learning from covid, planning has been strategically led with collaboration from all business units to ensure the Trust make informed decisions on risk. This is to support safe and effective deployment of staff across the trust and in particular support areas in the business units that are subject to winter escalation and surge. This will continue to require a collective trust-wide effort to ensure capacity and demand are managed.

The fundamental areas of practice that specialist and non - ward based clinical staff can also contribute to are;

Registered Nursing staff	Tasks undertaken as part of the registrant's daily practice	RNs who work regular bank shift and /or who have been deemed competent and or supported by Practice Development
Personal care Nutritional assistance. Undertaking observations. 2nd checker for medications. Record keeping. Escorting patients. Communication skills.	Phlebotomy, Cannulation, Point of care testing Catheterisation Use of e- systems Medical devices	Undertake the role of the nurse in charge of a team of patients

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

The business unit lead will collate RN availability and share this with the matron/ POD clinical lead. The RN availability will be added to existing rosters to support safe and effective nurse staffing.

The matron responsible for Winter 2022 will report to the Chief Matron in Medicine and work closely with other matrons and service line managers to support nursing resource to be deployed.

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

Nurse staffing

The winter nurse staffing plan is challenging due to a number of factors including the availability of appropriately trained registered staff to support surge requirements and the safe deployment of staff. The winter ward requires active assessment of acuity, registered staff availability and skills and knowledge of the staff deployed. It is essential to have the correct mix of experienced staff, bank and agency and healthcare support staff to keep patients safe.

Leadership

An existing matron will be deployed to support the management of the winter ward and support safe discharge.

Registered nursing

NHSE has mandated that staffing plans must be signed off by a senior nurse to ensure that safe staffing levels are maintained. In Gateshead Health NHS Foundation Trust this will be the Chief Nurse or deputy. The safe staffing levels will be determined in line with the staffing policy and any deficits will be escalated in accordance with this policy. Registered staff may be required to move to support other

areas during periods of surge. Each individual's skills and knowledge will be taken into account and no professional will be asked to act outside their code of practice.

Any agency staff employed must be provided with an induction that covers trust wide systems and local induction to the area they are supporting

Non-registered

20 Health Care Assistants have been recruited to support the winter plan. They are allocated to nominated ward areas to allow experienced non registered nursing staff who have completed their care certificate to be redeployed the winter ward to support the continuity and delivery of fundamentals of nursing care. The nurse staffing establishment requirements are tabled in internal operational winter plan. Where possible the deployment of staff will be flexible to ensure that staff are not disadvantaged by moving to another area but will be based on the needs of the patient.

Administrative staff

A housekeeper and ward clerk will be deployed to support the important administrative function of the winter ward.

Non frontline, specialist and Non-Ward Based Nursing (NWBN)

This group of staff will be offered top up training in the use of systems and technology to allow them to be safely deployed to front line areas during periods of surge. The deployment of the nurse specialist and NWBN will be coordinated by the winter matron and the practice development team and will take account of the individual nurse's skills and experience. The deployment will also take into account the impact on the service that the nurse is currently working within.

Equality/ Quality Impact Assessment (EQIA)

An Equality and Quality Impact Assessment must be undertaken where there are changes in estate, ward function, or staff roles including base line staffing levels, this must be reviewed by the matron and signed off throughout the winter period (phase 1-4) by the Chief Nurse.

In September 2022, the matrons will work together with their ward managers/nursing teams to coordinate the release of appropriately trained staff to support the winter ward and nurse staffing plan. It is important that staff with the right skills and experience are deployed appropriately to the right place. Workforce safeguards such as not redeploying staff who are still within their preceptorship period must be maintained. Staff who are likely to be deployed to the wards for the winter period will be offered bespoke support from teams such as Practice Development / Education, Health Roster and Vocera systems management. Training will be coordinated by the Practice Development Team and the winter matron. Each registered nurse is responsible for identifying their areas of need.

Assurance and Oversight

Daily operational pressure and staffing shortfalls are managed by the matrons in line with the staffing policy at the operational site huddles. Out of hours the site resilience team support staff redeployment.

There is a weekly meeting between the Chief Matrons, the Head of Nursing and the Chief Nurse and Deputy to identify and areas of concerns. Reporting of concerns is actively encouraged and managed via the incident management structures, minimising any potential exposure of patients to harm and to aid understanding the current staffing levels and its impact on patient care. A daily and weekly forecast position is risk assessed and mitigated via operational discussions. Activation of staffing deployment plans are clearly documented in the incident logs and assurance is gained that this is successful, and that safe care is sustained

The monthly staffing report gives assurance to the Trust Board and Quality Governance committee, showing where wards fall below 75% compliance with fill rates. Actions and risks are identified within the

report. The Trust Board considers the impact of any significant and sustained staffing challenges on their ability to deliver on strategic objectives and these risks are clearly documented in the board assurance framework.

Health Roster and management of bank and Agency

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

Community Staffing

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

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

This needs to be done in parallel with the acute staffing rota's and in conjunction with local partners eg Local Authority (LA) and Primary Care. There will need to be investment to deliver the expectations of primary care in terms of both flu vaccination and the COVID additional vaccinations which are required for cohorts identified below. It has been confirmed that due to the schedules for vaccine release, it is unlikely these will be able to be delivered concurrently.

In order to fully implement the discharge to assess model work has been undertaken to look at further assessments being undertaken in the Community by Therapies staff and the introduction of discharge coordinators to support this. The Discharge Liaison Nurse (DLN) team will continue to work 8am until 6.30 p.m. Monday to Saturday to continue to early supported discharge model implemented during COVID. They will be supported on Sunday by the Trusted Assessor function within the Rapid Response team.

13. Medical cover

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

14. Surgery

During the new operating model works, beds will need to flex within Surgery to be able to accommodate the required demand during the winter period.

Maintaining Elective Recovery

The suspension of elective surgery during the pandemic has resulted in the Trust accumulating a significant backlog of elective cases with associated risk to patient safety due to lengthening delay to surgery. The North ICP recovery and accelerator programme has mandated that activity is maintained consistently over a 12-month period in order to reduce the waiting times for the Trusts elective patients.

All trusts must achieve their planned activity levels on a month-by-month basis otherwise the whole region will fail to achieve the target required to secure the financial incentive arrangements.

In previous years the Trust surgical winter plan has been based around a scheduled reduction in elective in-patient activity to free up bed capacity to support an increase in unscheduled activity. For Winter 2022-23 in order to maintain our elective recovery trajectory it is essential that there is a plan in place to mitigate against the need to board medical patients into surgical beds and in doing so protect planned elective activity for as long as possible during the winter months.

Surgery escalation plan

In previous years the surgical services winter escalation plan would reconfigure the footprint and condense the bed base. When escalation necessitates the previous plan would reduce the footprint to 94 beds. This year surgery will only have 89 beds and will start the winter period below this number, meaning any further reduction in the winter planning would put the elective programme, and potentially emergency/cancer work at risk. The Trust will work towards mitigating this shortfall in numbers by implementing initiatives ensuring full focus is given to reduction in length of stay.

Use of the Independent Sector

The Trust has been working in collaboration with other ICS partners throughout the pandemic to optimise the use of independent sector capacity. The national contract remains in place facilitate access to independent sector facilities, however the terms of the contract with individual providers are not as favourable compared with winter 2020-21. This does constrain access primarily due to requirement of practicing rights for individual consultants. The Trust has access to Nuffield Hospital in Newcastle for a limited amount of elective orthopaedic work within Trauma and Orthopaedics (T&O). However, this is focused on low acuity patients and at this point in time is suitable for only a small number of patients on the elective waiting list. It is anticipated that this resource will enable the Trust to continue with both day-case and inpatient elective work during periods of significant escalation.

Critical Care

The Trust's Critical Care Department (CCD) is commissioned to provide up to 12 flexible beds to accommodate a mix of level 2 (HDU) and Level 3 (ITU) patients. Due to the onset of Covid 19, the unit prepared for an extreme surge of up to 26 ventilated patients in April 2020, in response to modelling provided by the North East, North Cumbria (NENC) Critical Care network and Newcastle University. An escalation plan was implemented to increase physical capacity providing 16 spaces in the main department to accommodate covid patients (identified as red CCD) A non-covid 'yellow' critical care patents was established on ward 21 which had been upgraded with enhanced oxygen supply and had space to accommodate up to 10 patients.

The unit retracted back to the main department in August 2021. The main CCD department has now been reconfigured to facilitate physical separation into two areas for purposes of infection control. The level 3 side of the unit can accommodate up to 7 patients; the level 2 side of the unit can accommodate up to 6 patients. There is a central area which can house 3 patients which can be flexed to either the level 2 or level 3 side of the unit to match demand depending upon the nature of the surge (i.e covid, flu etc) .

15. Clinical Support Services

Diagnostic

All 7 diagnostic modalities prioritise inpatients throughout the winter period to minimise the length of hospital stays and to ensure effective use of bed capacity. Ultrasound (US), CT and MRI do this by allocating increased capacity throughout the day to inpatient scans which would be allocated to

outpatients at other times of the year. The modalities also reflect the position and needs of A&E and Emergency Assessment Unit (EAU) to support patient flow.

Service hours

- CT and X-Ray 24hrs 7 days a week
- MRI 8-8 7 days a week
- US 8-8 Monday to Friday and 8-4 on weekends
- Interventional Radiology and Venous Access Team 9-5 Monday to Friday
- Medical Physics 9-5 Monday to Friday

General Operating Model

- Prioritise services based on staffing resources available and reflecting competing demands in the Department as defined in the Business Continuity Plan.
- Implement rapid prioritisation of outpatient work across all modalities to ensure sufficient capacity for urgent, A&E and inpatient demand
- If necessary assess risk and cease non urgent scans and procedures
- Cross cover staffing between modalities to ensure priority scans and procedures are maintained including; inpatient and A&E, cancer and other urgent scans, theatres, biopsies, drainages and chemo lists
- Review the use of off-site facilities at eg Blaydon and Tranwell for CT, MRI, US and X-ray, which are routinely used for outpatients, to prioritise scans for vulnerable patients off site to reduce cross infection and free up capacity on site for inpatients
- Maintain reporting turnaround times by increasing reporting capacity with outsourcing companies
- Ensure a full staffing compliment going into winter period
- Consultant duty and on-call rotas will focus on urgent needs
- Maintain agreed patient flow throughout the department for covid/non covid patients
- Actively encourage all staff to have flu and booster covid jab when required

Nursing and Vascular access and interventional Radiology Services

The services will prioritise VAT and IR inpatient procedures to facilitate timely discharges, creating additional capacity for biopsies/drainages as required; nursing capacity to deliver prep and recovery for diagnostic procedures in CT such as VAT connections and contrast injections; forward plan to stand down routine work to release staff to support in ward areas/critical care; increase venous access support where appropriate to support ART teams, wards and patient discharge with CT, MRI and X-ray to ensure cover provided and support available; and maintain current patient flow for COVID/non COVID and continue with Trust approved swabbing process for all procedures

Phlebotomy

The Phlebotomy Department will aim to deliver full services across wards and outpatient settings. The Department will complement the phlebotomy done by ward staff where urgent bloods are needed; maintain good staffing levels through agreed annual leave cover and use of bank staff and; prioritise staffing to support to pressure points in the Trust to and to assist in the delivery of escalation areas.

Endoscopy Capacity

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

Therapy Cover

The current Physiotherapy and Occupational Therapy workforce will continue to deliver service as usual managing referrals from across the Trust. Due to funded staffing establishments weekend cover is limited and provides cover for urgent assessments and interventions only. Therapy services continue to work across the Business Units to deliver transformational change, which may provide additional opportunities to support new workforce models and patient pathways to reduce length of stay. Any increased requirement for therapy staff to support enhanced respiratory or critical care provision over the Winter period will significantly reduce patient services that currently support timely discharges. Therapy services continue to explore opportunities to over recruit newly registered staff as newly qualified therapists graduate in August/ September.

In addition to existing provision Occupational Therapy Staff will be supporting new models of service including escalation area, frailty and weekend working model. Over recruitment of 5 Occupational Therapists plus Therapy Assistant staff has been actioned which will support winter demand and provide opportunity to backfill roles to support the different operational models.

Pharmacy Cover

The Pharmacy department currently has a well-established 7-day service, offering comprehensive operational, clinical, medicine supply and pharmacy on call services.

Many of the successful pilot schemes the Trust have trialled over the last 4 winters have now been developed into ‘business as usual’ services. This year there it is hoped to bolster the Pharmacy staffing resource to the admissions areas, and to the dispensary.

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

The Trust has an established agile and home working capability to allow staff required to isolated due to COVID, to provide remote patient care from home, using a range of hardware and software enablers.

Management of Outpatient Department

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

- Proactive management of available clinic capacity to ensure best use of available resource
- During staff shortages/inclement weather, liaise with clinical service leads regarding flexibility for consolidating clinics to the main site to flex staff usage
- Assess staffing levels across the 9 locations during periods of site escalation, to determine staffing requirements and alternative options for cover
- Assess and prioritise availability of offsite clinic provision at Blaydon Primary Care Centre for vulnerable patients/additional capacity/flexibility
- In the event of clinics have to be cancelled at short notice due to outpatient nursing staff shortages or site unavailability, liaise with specialty admin teams and clinical leads to ensure they are able to contact patients quickly to re-book appointments and prioritise patients depending upon clinical need

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

- Allocate appropriately risk assessed nursing staff to support wards to mitigate staffing shortages and site pressures.
- Work with clinical service leads to support additional clinics/ re- provision of clinics due to site pressures.

- Within resource capabilities, flexibly support evening and weekend/ad hoc clinics to maintain priority clinics such as 2 week wait clinics and waiting list demands/cancellations due to site pressures.

Pathology demand from increasing winter illness

Pathology planning for winter pressures include:

- The laboratory has procured a stock of Covid/Flu multiplex assays to provide rapid Covid/flu testing for patients presenting with respiratory symptoms over the winter season. The turnaround time on this test is 60 minutes and will be available 24/7. This is in addition to the standard Covid test for all admissions
- Point of care services are available in acute locations to provide blood gas analysis including in A&E and EAU, there is a laboratory back up service in place
- A point of care device for Full Blood Count is also available in A&E
- The main laboratory equipment has sufficient capacity to service the additional demand from increasing winter illness

Excess Death Management

Gateshead Health manage mortuary services in Gateshead, South Tyneside and Sunderland Hospitals; agreements between the coroners, provides resilience. In instances where a site reaches capacity, the deceased can be transported and stored across the three mortuary facilities.

In instances where excess deaths are anticipated, the Trust can escalate temporary facilities which can be located adjacent to the main mortuary facilities

16. Community

The following are the initiatives and service changes that will be in place to support system pressures during Winter 2022-23.

- The use of mobile devices and access to live clinical records in the patient home enhances patient safety and team efficiency and responsiveness
- Community services are in the third year of delivering the Hospice at Home service. The team support timely discharge and /or step-up support for palliative patients. The impact over winter should be specifically the support this service can provide in timely discharge for patients at the end of life which has been problematic in past winters. The team generally has 30 patients cared for at home, half of work are hospital discharge and half admission avoidance.
- Rapid Response service has implemented the 2hr crisis response service from April as per government guidance and has been working closely with NEAS regarding pathways and with SDEC. The team will continue to build pathway developments expanding out of hospital care and treatment to avoid more efficiently hospital attendances and admissions
- Frailty Nurses will work Front of House (FoH) and be part of any new FoH frailty model as well as with new/developing SDEC pathways particularly related to falls
- 7 day-a-week therapy-cover in community to continue into winter
- Falls car to continue into winter months ongoing discussions with ICB regarding funding and model
- Community service staff input, and support increased to cover across all Promoting Independence Centres (PICs) to support LA staff
- Discharge team offer support working hours, 8am-8pm, 7 days.

- Community services manage wound care clinics over 7 days for ambulatory patients, previously seen by primary care available over 3 sites. This will ensure no patents unnecessarily attend ED for routine dressing changes
- Immunisation programme of house bound and care home patients against Influenza and any COVID 19 to be carried as per plan in negotiation with ICB and primary care once the vaccine is available.
- Health care support is across all elderly care homes in Gateshead. The Certified Nurse Practitioners (CNPs) have been key to supporting the care homes and providing daily contact to help problem solve as well as clinically supporting residents care plans and the GP link on ward rounds
- Locality MDTs working in the main virtually have been implemented across all 5 locality areas. These MDTs include health and care staff from the trust and LA as well as primary care colleagues. The aim is to reduce admissions and LoS with better coordinated support within the community
- Adult Speech and Language Team (SLT) will prioritise patients due to their clinical need with the potential of flexing the team to support prompt discharge where appropriate in line with SLT clinical standards

Working in collaboration with Gateshead Council, there will be an increase in capacity in the PRIME service to increase discharges on Pathway 1 supporting medically optimised patients to return home in a timely manner and reduce ongoing care needs in a care market with limited capacity. This will be a minimum of 14.5 FTE roles utilising Better Care Fund funding and will be in place for the Winter 2022-23 period

17. Discharge

The Trust has been working towards a home first principle in line with national guidance. There are ongoing challenges in sourcing packages of home-based social care within Gateshead at present. Therefore, patients are being offered an alternative out of hospital placement for Gateshead residents.

In line with established principles:

- Working with patients and their families discharge planning will start on admission
- Discharges will continue to be categorised 0-3 with (0 being non-complex ward based co-ordinated discharges (estimated 50%) pathways 1-3 need to be referred to the Discharge Liaison Nurse (DLN) team (estimated 45% will be pathway 1, <4% pathway 2 ,<3% pathway residential or nursing care)
- The acute service should not be deciding which pathway the patient will follow they need referral to the Discharge team as part of the integrated system support if the patient has any ongoing needs/support or intervention- this service will be available 8am-8pm 7 days a week throughout winter
- A DLN team member will attend board rounds to support and identify any patients with complex needs post discharge
- EOL care patients suitable for home (requiring care up to 12 weeks) will be referred to the Hospice at Home service via the Discharge team
- The principle of discharge to assess model is embedded in the Hospital Discharge and Community Support and Guidance (updated July 2022) and will operate to ensure no delays to those patients requiring on going health requirements via the trusted assessor model
- Community services will work with partners to embed the new continuing health care guidance

- There is a need to continue the follow up phone calls to all discharged patients as has been established and continued throughout Covid- this will have a resource implication, Age UK currently supporting until 31.03.2023.
- Re-enablement and rehabilitation will be provided by community services but will need resourcing appropriately with the right time right pace right skills principles
- A protocol will be developed to manage patients who do not accept the care offered to them to enable discharge as previous “Choice” principles are no longer relevant

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

Working in collaboration with Gateshead Council, there will be a review of the discharge pathway to incorporate Health and Social Care pressures with a re-baseline of activity data utilising the Bolton outcomes model. The purpose of the review is to assess capacity and demand and ensure flow through the system with a focus on home first and prevention / reablement. The review will take start in Autumn 2022 and conclude during the Winter 2022-23 period.

18. Collaborative Operational Planning

There will continue to be multi-agency Regional Surge Meetings which will increase in frequency as pressures increase over the winter period. These will be chaired by the North of England Commissioning Support (NECS) Surge Team and will include Trust UEC representation and the Site Resilience Team Manager, to ensure the Trust are sighted and integral to any system wide response to challenges that arise in admission/ discharges or transfers of care.

19. QEF Facilities Team

Facilities team plans for winter will be responsive to the increased level of activity and the additional risks during this period. Queen Elizabeth Facilities (QEF) will look to provide additional front-line staffing specifically within the response team for winter period within Domestic services. However, at very severe pressure it may be necessary for the Trust to support the deployment of staff with domestic skills and knowledge e.g., housekeepers to support domestic response teams.

In addition, domestics will redeploy staff from lower risk areas to high-risk areas to maintain quality, standards and support patient flow decisions. Requests to escalate will be made via existing escalation routes. Communication of the impact of redeploying resources will be actioned by the Trust Communication Team. It is essential that clear routes of communication are followed, and domestic resources are used effectively.

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

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

Medical engineering and medical devices will need to be guided with clear details on expected patient numbers and requirements to ascertain additional demand for medical devices. Medical Engineering will be available 24/7 with an On Call engineer available out of hours, contactable via the switchboard.

Medical Engineering will attend bed management meetings when requested to support patient flow decisions and manage the deployment and retraction of assets (medical devices and beds) across the estate.

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

20. Transformation Portfolio

The trust has been implementing a New Operating Model as a key part of the trust transformation portfolio. The new operating model has included the reconfiguration of services in line with activity modelling carried out on current and forecasted activity but also based on current practice such as the current length of stay, patient pathways and discharge processes. The model therefore has defined the bed base required in both medicine and surgery along with the safe staffing plan in which to staff those areas. It also included the support required from clinical support and community services in order to fully realise the benefits of the new model.

The changes to the proposed model are considered essential to address longstanding issues and risks relating to the current configuration of our services but also to allow the Trust to proactively and robustly respond to the challenges presented by the post-covid recovery and to assure long term sustainability and resilience of the Trust.

The overall aims of the new operating model project are to:

- Enhance urgent and emergency care pathway front of house to deliver alternatives to inpatient admissions using 'Home First' principles and meet national requirements to increase the number of patients through same day emergency care (SDEC). This will reduce our bed base requirements over time and prevent avoidable admissions for patients and reduce the risks to patients that being in hospital can bring e.g. deconditioning, delirium, HCAI etc.
- Fulfil the requirement of 336 beds for medicine in 'normal' times rising to 404 in winter and 104 beds for surgery to prevent the need to board patients and maintain our elective recovery
- Consistently maintain a bed occupancy level of below 92% to maintain flow through the hospital
- Support consistent delivery of the elective recovery / acceleratory programme and in doing so assure the long-term sustainability of elective surgical services within the Trust.
- Ensure the correct numbers of staff with the right skills are in the right place at the right time and improve recruitment and retention, improve patient safety, reduce falls, pressure damage and patient experience
- Allow for the delivery of our transformation programme, to reduce our length of stay, avoidable admissions and bring the areas where the Trust are outliers from our peers back in line or better still excel and support our route map to outstanding

Supporting the new operating model are the Unscheduled and Elective Care Programmes. The Unscheduled care programme is focusing on the delivery of three key objectives:

1. Reducing avoidable emergency admissions
2. Reducing length of stay
3. Improving discharges (including before 12 noon and before 5pm)

A Discharge Rapid Process Improvement Workshop (RPIW) in partnership with the Local Authority was completed in July 2022 and the outcomes of an audit of work on discharges before 12 noon and before 5pm will be produced.

The Elective care programme is focusing on outpatients, theatres and diagnostics aiming to improve efficiency and productivity. The main aim of this work is to ensure the continued ability to provide sustained elective activity by ensuring the appropriate staffing levels are in place.

Enabling work is being undertaken to ensure the digital requirements to enable the key changes to ways of working are aligned and embedded as part of the transformation programmes with some examples of the roll out of nerve centre and continuous improvement of data capture and live dashboard to support patient flow.

A workforce programme is established which is supporting recruitment and the development of new roles to develop a sustainable workforce

21. Financial Plan

The Trust is expecting to spend **£2.256m** on its response to winter pressures over the period November to March. This includes a dedicated winter ward to be staffed by a mix of substantive staff, bank and agency locums as a consequence of national and regional supply issues. The Trust initially planned to spend **£2.046m** which has been uplifted to **£2.256m** due to the increase in costs relating to the pay award and NIC contributions. The detailed supporting information is included as Appendix 2 to this report.

For comparison, the Trust spent £2.101m on winter in the financial year 2021/22.

This plan assumes the opening of additional beds both on a dedicated winter ward and in escalation areas as detailed in the below table.

	Core	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Medicine	336	368	367	367	361	361
Surgery	94	85*	85	85	100	100
Total	430	453	452	452	461	461

*85 Beds due to building work associated with the new operating model

The bed number modelling informing the financial forecast reflects necessary adjustments in relation to other NHSE winter capacity monies in 2022/23 as detailed below:

Additional Winter Capacity Schemes:	**Value of Scheme (£)**
Front of house team to support admission prevention	114,730
Spot purchase of care home beds	388,800
Additional PTS vehicle for discharge via QEF	46,200
Weekend discharge support teams	186,340
Total	**736,070**

22. Conclusion

In conclusion, the Trust has identified that Winter 2022-23 is expected to be particularly challenging and anticipate the need to respond to unprecedented demand for services. However, our winter planning has allowed the Trust to forecast pressures, to provide mitigation and to assure our patients that they will continue to receive safe and effective care.

Appendix 1 – Risk Management

Risk Assessment

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

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

Appendix 2 - Financial Plan

Scheme	Band	WTE	Period	22-23 PYE	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Total
				£	£	£	£	£	£	£
Paediatric Winter Beds	Band 5/6	1.12	Jan to Mar 23	13,420			4,473	4,473	4,473	13,420
Sub-Total Surgical Business Unit		**1.12**		**13,420**	**0**	**0**	**4,473**	**4,473**	**4,473**	**13,420**
Physiotherapist	Band 6	1.00	Nov to Mar 23	18,706	3,741	3,741	3,741	3,741	3,741	18,706
Occupational Therapy	Band 6	1.00	Nov to Mar 23	18,706	3,741	3,741	3,741	3,741	3,741	18,706
Pharmacist Prescriber COE Complex Discharge Support	Band 8a	1.00	Nov to Mar 23	25,727	5,145	5,145	5,145	5,145	5,145	25,727
Clinical Pharmacy Technician	Band 5	2.00	Nov to Mar 23	30,483	6,097	6,097	6,097	6,097	6,097	30,483
Phlebotemy	Band 2	2.00	Nov to Mar 23	20,443	4,089	4,089	4,089	4,089	4,089	20,443
X-ray 24/7 front of house	Band 5	1.00	Nov to Mar 23	17,795	3,559	3,559	3,559	3,559	3,559	17,795
Sub-Total Clinical Support & Screening Business Unit		**8.00**		**131,860**	**26,372**	**26,372**	**26,372**	**26,372**	**26,372**	**131,860**
Winter Ward - Winter Matron	Band 8A	1.00	Nov to Mar 23	25,743	5,149	5,149	5,149	5,149	5,149	25,743
Winter Ward - Ward Manager	Band 7	1.00	Nov to Mar 23	22,022	4,404	4,404	4,404	4,404	4,404	22,022
Winter Ward - Senior Sister	Band 6	2.00	Nov to Mar 23	41,633	8,327	8,327	8,327	8,327	8,327	41,633
Winter Ward - Staff Nurse	Band 5	12.11	Nov to Mar 23	226,910	45,382	45,382	45,382	45,382	45,382	226,910
Winter Ward - Staff Nurse	Agency	12.11	Nov to Mar 23	440,738	88,148	88,148	88,148	88,148	88,148	440,738
Winter Ward - Healthcare Assistant	Band 2	22.50	Nov to Mar 23	335,821	67,164	67,164	67,164	67,164	67,164	335,821
Winer Ward - Housekeeper	Band 2	1.80	Nov to Mar 23	19,795	3,959	3,959	3,959	3,959	3,959	19,795
Winter Ward - Admin (Clerk)	Band 2	1.00	Nov to Mar 23	10,997	2,199	2,199	2,199	2,199	2,199	10,997
Winter Ward - CT1s Junior Medical	Agency	3.00	Dec to Mar 23	89,126		22,282	22,282	22,282	22,282	89,126
Ward 3 - CT1s Junior Medical	Agency	2.00	Nov 22	14,854	14,854					14,854
Ward 21 - CT1s Junior Medical	Agency	2.00	Nov 22	14,854	14,854					14,854
Winter Ward - Registrar	Agency	2.00	Nov to Mar 23	101,297	20,259	20,259	20,259	20,259	20,259	101,297
Winter Ward - Consultants	Agency	1.00	Nov to Mar 23	136,053	27,211	27,211	27,211	27,211	27,211	136,053
Winter Ward - Non Pay			Nov to Mar 23	69,077	13,815	13,815	13,815	13,815	13,815	69,077
Winter Ward - Incentive Payment			Nov to Mar 23	30,453	6,091	6,091	6,091	6,091	6,091	30,453
Escalation Beds - Ward 22	Band 5	3.95	Nov to Mar 23	74,013	14,803	14,803	14,803	14,803	14,803	74,013
Escalation Beds - Ward 22	Band 2	2.42	Nov to Mar 23	36,119	7,224	7,224	7,224	7,224	7,224	36,119
Escalation Beds - Ward 24	Band 5	3.95	Nov to Mar 23	74,013	14,803	14,803	14,803	14,803	14,803	74,013
Escalation Beds - Ward 24	Band 2	2.42	Nov to Mar 23	36,119	7,224	7,224	7,224	7,224	7,224	36,119
Escalation Beds - Ward 25	Band 5	3.95	Nov to Mar 23	74,013	14,803	14,803	14,803	14,803	14,803	74,013
Escalation Beds - Ward 25	Band 2	2.42	Nov to Mar 23	36,119	7,224	7,224	7,224	7,224	7,224	36,119
Discharge Lounge - Staff Nurse	Band 5	3.55	Nov to Mar 23	54,166	10,833	10,833	10,833	10,833	10,833	54,166
Discharge Lounge - Healthcare Assistant	Band 2	1.77	Nov to Mar 23	19,465	3,893	3,893	3,893	3,893	3,893	19,465
Sub-Total Medicine Business Unit		**87.95**		**1,983,402**	**402,622**	**395,195**	**395,195**	**395,195**	**395,195**	**1,983,402**
COVID vaccine delivery - 3 months only	Band 5	2.86	Nov to Jan 23	26,155	8,718	8,718	8,718			26,155
COVID vaccine delivery - 3 months only	Band 3	1.00	Nov to Jan 23	6,747	2,249	2,249	2,249			6,747
Income from PCNs for COVID Vaccinations - ESTIMATE			Nov to Jan 23	-26,035	-8,678	-8,678	-8,678			-26,035
Occupational Therapist	Band 7	0.20	Nov to Mar 23	4,634	927	927	927	927	927	4,634
Continuation of Care Home Support	Band 7	4.00	Nov to Mar 23	0	0	0	0	0	0	0
Discharge Liasion Nurses in Hub 6 months secondment	Band 6	2.00	Dec to Mar 23	37,412		9,353	9,353	9,353	9,353	37,412
Therapy Assistants to Suport RR Rehabilitation	Band 3	2.00	Dec to Mar 23	19,181		4,795	4,795	4,795	4,795	19,181
Sub-Total Community Business Unit		**12.06**		**68,094**	**3,216**	**17,364**	**17,364**	**15,075**	**15,075**	**68,094**
Additional Porters	QF0A	4.00	Nov to Mar 23	0	0	0	0	0	0	0
PTS Staff Day Shift	QF0A	2.00	Nov to Mar 23	0	0	0	0	0	0	0
Pay Award			Nov to Mar 23	3,605	721	721	721	721	721	3,605
QEF Margain			Nov to Mar 23	4,123	825	825	825	825	825	4,123
4 x 4 vehicle x 2 for 181 days £90 per day			Jan to Mar 23	16,290			5,430	5,430	5,430	16,290
PTS vehicle for 6 months			Nov to Mar 23	0	0	0	0	0	0	0
Sub Total QEF		**6.00**		**24,018**	**1,546**	**1,546**	**6,976**	**6,976**	**6,976**	**24,018**
Excess Deaths Portakabin - Hire			22 weeks	36,164	7,233	7,233	7,233	7,233	7,233	36,164
Excess Deaths Portakabin - Installation										
Total Cost		**115.13**		**2,256,958**	**440,988**	**447,709**	**457,613**	**455,324**	**455,324**	**2,256,958**
Funding held in reserve				-2,045,720	-409,144	-409,144	-409,144	-409,144	-409,144	-2,045,720
Increased for pay award & NIC incease				-2,256,958	-451,392	-451,392	-451,392	-451,392	-451,392	-2,256,958
Financial Shortfall				**0**	**-10,403**	**-3,682**	**6,221**	**3,932**	**3,932**	**0**

Notes
Pay scales effective from April 2022. NI and Superannuation all at 2022-23 rates. For the winter ward - 50% of posts costed at mid-point of scale / point of employee if known, assuming member of staff pays superannuation. 50% of posts costed at agency rates.

Gateshead Health NHS Foundation Trust

Assurance Report

Agenda Item: 11i

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	Finance and Performance Committee – 26 July 2022			
Name of Meeting:	Trust Board			
Date of Meeting:	27 September 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>Cancer 62 Day Recovery Plan</u> The Committee received an update from Mrs D Renwick, Associate Director of Planning and Performance and Mrs H Routh, Director of Operations, Surgery on the above and noted the Cancer 62 day recovery plan, the performance for the 62 day standard and also key parts of the pathway (2ww, 28 day and 31 day). The Committee agreed partial assurance. <u>Integrated Oversight Report</u> The Committee received a report which covers the reporting period for May and June 2022. The Committee noted the key areas of pressures within the report and received partial assurance as there are still some outstanding issues. <u>Financial Revenue Report</u> The Committee received a report and noted that for the period April to June the Trust has reported an actual deficit of £2.887m after adjustments for donated assets and gain & losses of asset disposal. The Committee were not assured on this report. <u>Supply Procurement Minutes</u> The Committee received a verbal update as there were no minutes available as there had been no recent meetings of			

<table>
<tr><td></td><td colspan="6">the Supply Procurement Committee. The Committee noted that there would be an internal investigation and were therefore not assured.

<u>Corporate Objectives – F&P</u>

The Committee received a report and noted that 3 corporate objectives have been mapped to the Finance & Performance Committee. These are strategic objectives and will not be monitored monthly. The Committee agreed partial assurance due to the gaps and noted that this will develop going forward. The Committee agreed the corporate objectives.

<u>Board Assurance Framework</u>

The Committee received a report and noted the new format of the Board Assurance Framework. The Committee noted the key issues and that there are still gaps in control and assurance.</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
☐</td><td colspan="5">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☐</td><td colspan="5">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td colspan="5">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☐</td><td colspan="5">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☒</td><td colspan="5">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Financial Implications:</td><td colspan="6">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>
</table>

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

Gateshead Health NHS Foundation Trust

F&P Assurance Report Agenda Item: 11i

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	Finance and Performance Committee – 30 August 2022			
Name of Meeting:	Trust Board			
Date of Meeting:	27 September 2022			
Author:	Miss J Boyle			
Executive Lead:	Mrs K Mackenzie and Mrs J Baxter			
Report presented by:	Mr M Robson, Chair of Committee			
Matters to be escalated to the Board:	No items identified for escalation			
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	<u>Echo Recovery Plan Update</u> The Committee received an update from Ms E Scott, Service Line Manager, Medicine on the above and noted the current Echo performance, challenges and action plan to support with recovery and making the department sustainable. The Committee agreed partial assurance. <u>Integrated Oversight Report</u> The Committee received a report which covers the reporting period for June and July 2022. The Committee noted the key areas of pressures within the report and were not assured on this item. <u>Financial Revenue Report</u> The Committee received a report and noted that for the period April to July the Trust has reported an actual deficit of £3.322m after adjustments for donated assets and gain & losses of asset disposal. The Committee were not assured on this report. <u>Supply Procurement Committee Update</u> The Committee received a verbal update as there were no minutes available from the Supply Procurement Committee to share with members. The Committee noted that an investigation should be being undertaken by Internal Audit and that work is continuing on this issue.			

	Capital Plan Update The Committee received a report and noted the Trust has an approved CDEL of £8.419m, which has been increased to £8.846m due to the carry forward of decarbonisation grant of £0.427m. The revised capital programme totals £9.824m an over commitment of £0.978m. To date the Trust has underspent so far due to the delay on the New Operating Model, and there may be a risk of some slippage on this. The Committee received full assurance. Update on New Operating Model The Committee received a detailed report which updates members on the progression of delivery of the various components of the New Operating Model, namely Estates, Workforce and Transformation Plans. Members noted that there has been an increase in the overall costs from the initial Business case. The Committee received partial assurance. Sustainability Report The Committee received a verbal update and noted the main issues and that good progress is being made. The Committee received partial assurance. QE Facilities Financial Update The Committee received a report which provides a summary of trading performance, profit and loss and statement of financial position. The Committee received full assurance. Board Assurance Framework The Committee received a report and noted that this may be discussed at the next Board meeting and that there are some gaps that have been identified and more information will be provided for the next meeting.	
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 include: • 3093 – 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. Resulting oin the failure to deliver sustainable services and deliver objectives.				
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: 11ii

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☒
Committee Reporting Assurance:	Quality Governance Committee August 2022			
Name of Meeting:	Trust Board			
Date of Meeting:	August 2022			
Author:	Mrs A Stabler, Non-Executive Director			
Executive Lead:	Dr G Findley, Chief Nurse			
Report presented by:	Mrs A Stabler, Non-Executive Director			
Matters to be escalated to the Board:	Looked After Children Annual Report – The CCG completed a review of our service and have not as yet shared the outcome / report with the Trust. The Committee want to request further escalation by the Board to the Integrated Care Board (ICB) noting the increased activity and the capacity of the service to continue to deliver the required outcomes for looked after children.			
Executive Summary:	**Items received for assurance:** **Assurances from Strategic, SafeCare Risk and Safety Council** The Committee acknowledged two issues to escalate to QSG: • CAS alert notices specifically the discrepancy in those noted as open on the IOR and number noted as open on our internal system. • The respiratory team presented an audit which highlighted gaps due to pressure on the team. It was noted that the current levels of respiratory illness within the Trust are at the peak winter point and agreed to escalate these two issues to the Committee. **Integrated Oversight Report** The Committee acknowledged that a number of patient safety alerts were not closed on our internal system but are closed in the national system which has been raised via the SafeCare Council because there is now a discrepancy between the IOR and the internal system. A plan is in place to have this resolved the discrepancy by the next Safe Care Council meeting. Based on the above, the Committee agreed that a partial level of assurance had been provided from this report.			

	Objective Delivery Report The Committee acknowledged the four corporate objectives mapped to the Committee for assurance purposes. The Committee agreed that a partial level of assurance had been provided from this report noting that there is a plan in place but are yet to see delivery. **Maternity Assurance Report** The Committee acknowledged that the maternity service has performed a full gap analysis on the final report from Donna Ockenden and the six monthly midwifery staffing review has been completed. The maternity IOR is being developed and will be presented at either QSG or Board. One maternity SI was reported, and a full review has been completed identifying a diagnostic referral pathway was not followed. The review concluded no risks identified and agreed to downgrade from a SI. The Committee agreed that a full level of assurance had been provided from this report noting that we know where the gaps are and plans are in place. **Patient Experience Annual Report** The Committee acknowledged that 280 complaints were received and acknowledged within three working days in line with the NHS Complaints Regulations with 279 complaints closed and 78% were classed as upheld. It was noted that we are working through the backlog of complaints learning from compliance and has been shared within the report. Further assurance was requested on the 40 complaints that had been reopened. The Committee agreed that a partial level of assurance had been provided from this report noting the gaps in complaints and associated backlogs. **Mental Health Update** The Committee acknowledged the demand in older person's mental health has remained stable and obtaining data on waiting times remains challenging. Bed occupancy has increased and vacancies has reduced. The Committee agreed that a partial level of assurance had been provided from this update noting that the practice needs modernising. **Serious Incident Report** The Committee acknowledged a total of 19 serious incidents were reported during Q1 2022/23, 9 of which were related to inpatient falls and 7 related to delays in diagnosis. It was noted that there are a backlog of incidents from the pandemic and some investigations remain outstanding due

	to vacancies in the team, but posts have been recruited with new members joining shortly. The Committee agreed that a partial level of assurance had been provided from this report noting that we do not have the learning and to make sure this is being implemented. **Safe Staffing Report** The Committee acknowledged that there are no reports of wards having less than 75% fill rates for Health Care Assistants. It was noted that there are new students starting in September and internationally trained nurses due to undertake the OSCE examination in September. The Committee agreed that a partial level of assurance had been provided from this report noting the recruitment system in place but acknowledging the numbers recruited cannot be guaranteed until staff commence in post. It was also acknowledged that the duration of the preceptorship arrangements will impact. **Health and Safety Quarterly Report** The Committee acknowledged there are ongoing recurrent group issues of breaches in statutory reporting requirements of 15 days post employee accident resulting in ongoing issues of late RIDDOR. It was noted that COSSH training was brought to the Executive Risk Management Group in August for further discussions. It was noted there is a shortfall in the number of staff training in areas including First Aid, COSSH and Fire Wardens. The Committee agreed that a partial level of assurance had been provided from this report. **Safeguarding Progress Report** The Committee acknowledged the key performance indicators and that the quarterly dashboard is circulated to the ICB then monitored against those performance indicators. The Committee agreed that a partial level of assurance had been provided from this report. **ECIST Feedback** The Committee acknowledged that recommendations have fed into the work of the Unscheduled Care Programme Board who meet monthly with an action plan and there has been a specific focus on discharge and standardisation of board rounds to facilitate home today, home tomorrow. The Committee agreed that a partial level of assurance had been provided from this report.

	New CQC Framework The Committee acknowledged that it was agreed by SMT to be put forward for the new CQC inspection framework and will find out the outcome in September. It was noted that the new framework is being classed as a single assessment framework and CQC will gather evidence from six domains. **Looked After Children Annual Report** The Committee acknowledged that 483 children were in the looked after system at the beginning of the year which is an increase of 45 children and the CCG have completed a review of the service but have not received a copy of the review. It was noted that end of the end of March 2022, there were 237 children placed outside the borough of Gateshead compared to 203 for the previous year. The Committee agreed that a full level of assurance had been provided from this report noting the content and pressures on the team. **Nursing Strategy** The Committee received the above report of the draft nursing strategy for 2022-2027 for consideration which has been developed in consultation with staff and on the pathways to excellent principles six development areas. **Audit Final Reports** The Committee acknowledged the audit reports for Performance Targets – Data Quality, Quality Governance Framework, Controlled Drug Security and Pharmacy Medicines Assurance Report. The Committee agreed that a full level of assurance had been provided from the Pharmacy Medicines Assurance Report. **Items received by the Committee for information:** • Mental Health Act Compliance Minutes – May and June 2022	
Recommended actions for Board	Board are asked to note the work of the Committee and the assurances received and note the areas of risk identified but note the actions in place to resolve.	
Trust Strategic Aims that the report relates to: (Including reference to any specific risk)	**Aim 1** ☒	We will continuously improve the quality and safety of our services for our patients
	Aim 2 ☐	We will be a great organisation with a highly engaged workforce
	Aim 3 ☐	We will enhance our productivity and efficiency to make the best use of resources
	Aim 4 ☐	We will be an effective partner and be ambitious in our commitment to improving health outcomes

	Aim 5 ☒	We will develop and expand our services within and beyond Gateshead			
Financial Implications:	None to Note				
Links to Risks (identify significant risks and DATIX reference)	ORR Risks, 2879 – Maternity, 2779 CQC Compliance/ Improvement, 2868 – Further wave of Covid, 2880				
People and OD Implications:	Gaps in workforce in nursing, midwifery and mental health.				
Links to CQC KLOE	Caring ☒	Responsive ☒	Well-led ☒	Effective ☒	Safe ☒
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: 11iii

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	Digital Committee Assurance Report from Meeting held on 8 August 2022			
Name of Meeting:	Board of Directors			
Date of Meeting:	27 September 2022			
Author:	Mr A Moffat, Chair of the Digital Committee			
Executive Lead:	Mrs K Mackenzie, 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)***	**Organisational Strategic Objectives** The report showed how the existing digital objectives mapped to the updated and new (22/23 and beyond) Trust strategic objectives. For the existing objectives the progress against each was clearly indicated and as such this element was rated as fully assured in respect of the 21/22 objectives. With regards to the new objectives it was noted that further development was needed to ensure they were SMART and therefore this was rated as partially assured. **Digital Strategy Roadmap** It was noted that Digital Transformation Group (DTG) was reviewing the prioritised digital roadmap and a change control process to ensure the finite resource capacity is focussed on the appropriate deliverables. The Digital Roadmap was judged to be fully assured as the list is complete, although refinements are required around providing an indication if resourcing is available. **EPR Systems Strategy – Outline Business Case** The committee reviewed the Electronic Patient Record (EPR) Systems Outline Business Case (OBC). It was noted that recommendation was for option 2- a 'single integrated care record'. This OBC has been shared with Senior Management Team and Clinical Policy Group; and will now follow the business case process. It was recognised there is a significant funding gap with the OBC that would require external funding sources – in order to deliver the benefits identified; but also that there are additional funding requirements needed to exploit the			

	existing systems currently in operation in the Trust. A rating of full assurance was awarded to the OBC but the Committee is not fully assured in terms of funding availability. **Service Key Performance Indicators** An updated KPI report was presented to provide digital performance assurance. It was noted this had previously been reviewed at Digital Assurance Group and any operational escalations reported for action at SMT - prior to submission to the Digital Committee. A rating of partially assured was awarded as there is still an item outstanding and clarity was required in terms of setting targets. It was noted that significant progress has been made to date and that the work undertaken is of good quality. **Data Security and Protection Toolkit** The DSPT was submitted with a score of 97% across the 33 areas of compliance, it was noted this has been verified by internal audit. An action plan was submitted to close the area on which the trust was non-compliant – namely having an appropriately trained information security specialist within the organisation. A rating of partial assurance was given as this action is due to be completed in February 2023. **Internal Audit Reports** There are a number of open audit actions, none of which are overdue against previously prolonged delivery dates; however due to fairly extensive delays in anticipated completion, a rating of partial assurance was awarded. The Docstore audit was rated partially assured due to the risk identified around the provision of support and ongoing development required by Newcastle Hospitals. The actions arising from the Dionach review were considered but it was noted these are due for formal re-assessment by the company. Until the work is completed the report was considered partially assured. **Sub-Group Reporting** Assurance reports were received from the Digital Transformation Group and the Digital Assurance Group. As no gaps in assurance were identified, full assurance was awarded.
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

Gateshead Health NHS Foundation Trust

Assurance Report

Agenda Item: 11iv

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	People and OD Committee – September 2022			
Name of Meeting:	Trust Board			
Date of Meeting:	27 September 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: **Items referred from F&P Committee – Staffing Position in Theatres** Partial assurance was received as further interventions and engagement required. **Growing the workforce – *Absence & Supply*** The committee were partially assured reflecting the amount of work underway but had hoped to see a reduction in Nursing vacancies but the gap has grown. Further modelling to include forward look and benchmarking. **Update report from POD Portfolio Board** The Committee were partially assured due to lack of progress on the Junior Doctors mess. **Strategic Objectives** Understanding the work ongoing across the People and OD portfolio the committee were partially assured noting actions to be reviewed. **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. **EDI** The Annual report was shared alongside the latest WRES/WDES submission. The committee were partially assure as actions identified.			

<table>
<tr><td></td><td colspan="6">GMC Survey
The group were partially assured due to lack of progress on the Junior Doctor mess and hot food provision out of hours.

Guardian of Safeworking Annual & Q1
The Guardian of Safeworking presented the Annual and Q1 report. The committee were partially assured due to lack of progress on the Junior Doctor mess.

Board Assurance Framework
Partial assurance was received, BAF to be updated.

People and OD Organisational Risk Register
The group were partially assured understanding the workforce risk is to be reviewed, both score and narrative.</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
☐</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>
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☐</td><td colspan="5">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☐</td><td colspan="5">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Financial Implications:</td><td colspan="6">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="2">Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)</td><td>Obj.1
☒</td><td colspan="5">The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance between working life and personal commitments</td></tr>
<tr><td>Obj. 2
☐</td><td colspan="5">All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers</td></tr>
</table>

	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: 11v

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	Audit Committee Assurance Report from Meeting held on 1 September 2022			
Name of Meeting:	Audit Committee			
Date of Meeting:	1 September 2022			
Author:	Miss J Boyle, Company Secretary			
Executive Lead:	Mrs K Mackenzie, 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 escalated the lack of implementation of overdue Internal Audit recommendations, noting that several due dates had already been extended a number of times.			
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	<u>Executive Risk Management Group – Update</u> The Committee received the update report and was fully assured regarding the work of the Group. In particular it was noted that the Group had reviewed the strategic risks for 2022/23, as well as the output of the Board's risk appetite and maturity discussions. <u>Board Assurance Framework (BAF)</u> An overview was provided of the process and controls in place for the development of the 2022/23 BAF and its review at the Board and its committees. Recognising that the new format of the document continues to embed, a rating of partial assurance was provided pending the delivery of training on the BAF to Members. <u>Internal Audit Work Plan 2022/23</u> The Committee approved the Internal Audit work plan subject to some final amendments to reflect some discrepancies in Director leads and deadline dates for the presentation of final reports to the Audit Committee. <u>Internal Audit Progress Report</u> The report provided a summary of the 8 internal audits recently completed across the Group. The Committee			

	were satisfied with the outcomes of these audits and the resulting recommendations. The report also detailed the audit actions currently classified as overdue, including those where due dates had been amended through discussion with action owners. The Committee expressed concern over the number of overdue actions, particularly in relation to long-standing actions, and it was agreed to undertake a piece of work to review and assure Committee members over progress, as well as to escalate this issue to the Board. As such a rating of partial assurance was awarded. <u>External Audit Annual Report</u> The report provided assurance that the audit for 2021/22 was fully completed. This included an unqualified opinion on the financial statements, confirmation that consolidation schedules were consistent with the financial statements, as well as confirmation that no significant weaknesses had been identified in relation to value for money. The audit certificate had been issued. As such, a rating of full assurance was awarded. <u>Counter Fraud Progress Report</u> It was noted that there were two outstanding tasks from the workplan, with assurance provided that they would be completed in time for the December 2022 Audit Committee. The Annual Report would also be presented at this time. The Counter Fraud Workplan 2022/23 was approved by the Committee and assurance was provided that an investigation had been completed and closed during the period. A rating of partial assurance was awarded, noting the delays in the completion of the final workplan tasks whilst also recognising the positive progress made in respect of enhancing the format and style of the Counter Fraud reports. <u>Schedule of Losses and Special Payments</u> The Committee approved the losses and special payments register for the period 1 April 2022 to 30 June 2022 and was 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. The Board is requested to review the escalated item relating to overdue internal audit actions.	
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 ☒

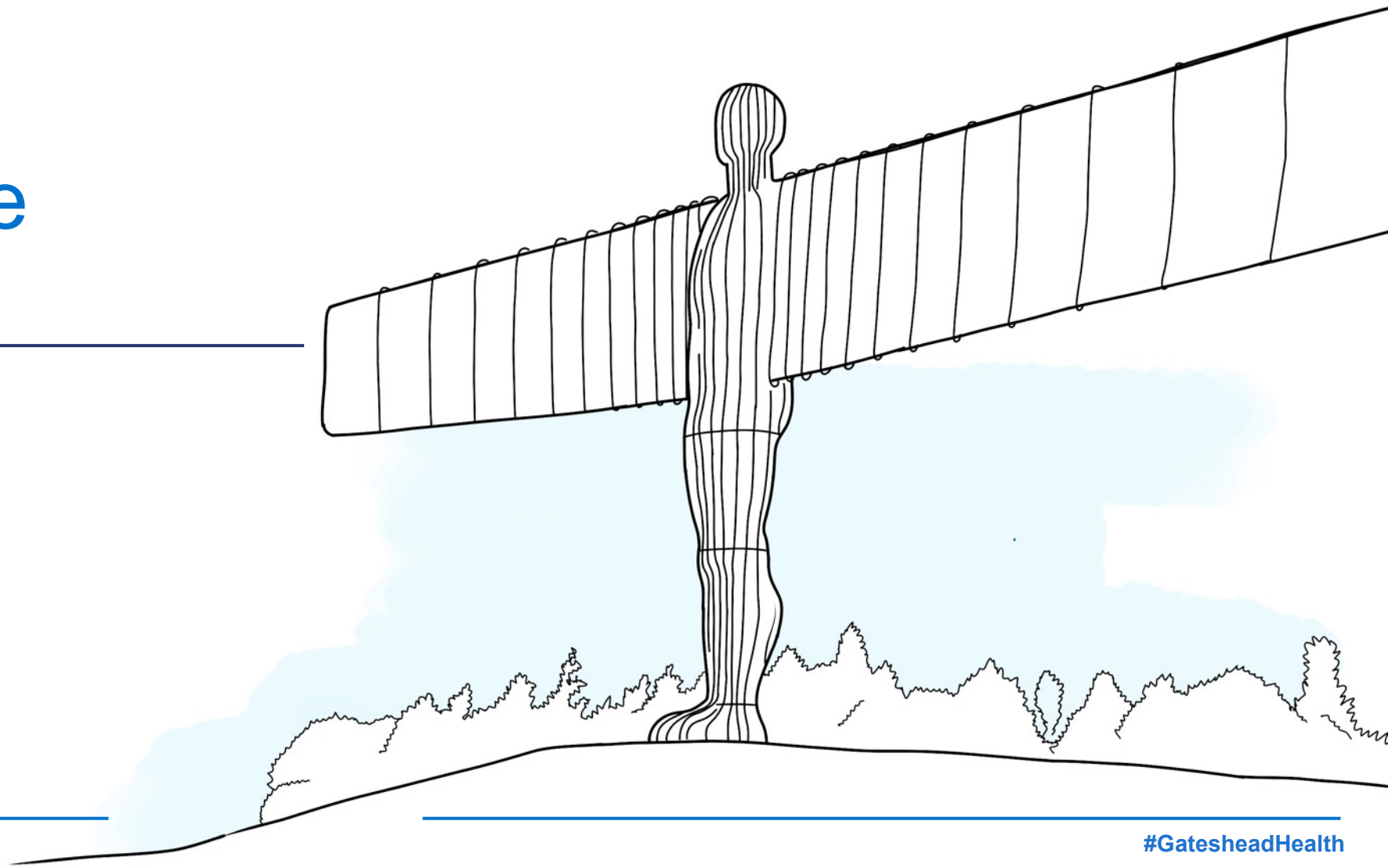
Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)	**Obj.1** ☐	The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance between 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

September 2022



Operational performance

Operational performance

Gateshead Health NHS Foundation Trust

Urgent and emergency care

- Footfall and patient numbers decreased in August from July however daily attendances are more than last year
- 4-hour performance is at 74.5% (77.5% last month)
- Bed occupancy increased from 95.1% in July to 96% in August
- Ambulance delays have decreased since last month
- Delayed discharges still a significant issue

A&E Indicators	Apr-22	May-22	Jun-22	Jul-22	Aug-22
Attendances: Type 1	5431	6098	6090	6051	5686
Attendances: Type 3	3323	3618	3569	3356	3319
Total Attendances	8754	9716	9659	9407	9005
Total Breaches	2164	2148	2212	2116	2292
Trust Total - % seen in 4 hours	75.3%	77.9%	77.1%	77.5%	74.5%
National Rank (Accute trusts - Lower is better)	23	20	19	16	29
12 hour trolley waits (DTA breaches)	71	4	11	18	32
Volumne in department > 12hours	252	108	193	213	318
A&E >12hour waits (target <2%)	2.88%	1.11%	2.00%	2.26%	3.53%

Ambulance Arrivals and handover delays	Apr-22	May-22	Jun-22	Jul-22	Aug-22
No. Patients arriving by Ambulance	1619	1803	1733	1748	1760
% of handovers <15 Minutes	44.1%	46.7%	45.1%	42.5%	45.8%
Number of >30 Minute Breaches	72	26	40	63	45
Number of >60 Minute Breaches	62	10	17	37	36

Performance benchmarking

Gateshead Health NHS Foundation Trust

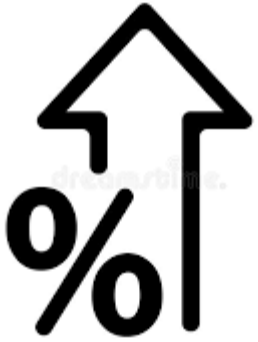
	GHFT Benchmarking Figure					GHFT Benchmarking Position						
	May IOR	June IOR	July IOR	Aug IOR	Sep IOR	Rank out of:	Rank is better if:	May IOR	June IOR	July IOR	Aug IOR	Sep IOR
A&E 4 hour waiting time target	75.3%	77.9%	77.1%	77.5%	74.5%	139 - All Type 1 NHS Providers	Lower	23	20	19	16	29
Latest weekly PTL: patients waiting > 104 weeks	0	0	0	0	0	8 Providers in ICS	Lower	1	1	1	1	1
Latest weekly PTL: patients waiting > 52 weeks	50	60	73	75	58	8 Providers in ICS	Lower	2	2	3	3	2
Latest weekly PTL: patients waiting > 62 days for cancer treatment	63	65	57	68	64	8 Providers in ICS	Lower	1	1	1	1	1
62 day backlog as % of waiting list	8.7%	9.1%	9.3%	10.2%	8.3%	139 - top 20 under NHSE/I scrutiny	Higher	73	75	69	59	83

Latest update:

- The Trust remains in a relatively strong position against available benchmarking data. While in 3 of the 5 metrics, we are staying static and achieving the best rank for 2 indicators

Our People

Slight improvement on Appraisal rates



Core skills increased to 78.1%

Reciprocal mentoring uptake

2 Cohorts of International Nurses

Absence levels sit at 6 %

Recruitment remains a top priority

September, October and November courses full

General updates

Provider Collaborative / ICS / ICB

- ICB
  - New Governance arrangements at place currently being discussed and proposals being submitted to ICB by 1st October 2022
  - ICB event took place to discuss improvement in System Resilience and preparation for winter – our winter plan is on the agenda
- Provider Collaborative
  - A Strategic Session on the development of the NENC Provider Collaborative Estates Strategy took place focusing on population health and the estate requirements to deliver the future NHS services in the region

Other key updates

- Following the death of Her Majesty the Queen, we held a day of mourning and had the bank holiday whilst continuing to deliver clinical services in line with our internal EPRR Plan.
- Hosted a visit from NHSE/I to learn best practice as we have been identified as one of the best performers in some of the metrics in Urgent and Emergency care –specifically ambulance handovers
- The CQC will conduct a medicines management inspection in the Trust on 27th and 28th September. This visit is part of a pilot which focuses on this one specific area only.

General Update

- Visits:
  - Strategy Roadshow at the QE
  - Official opening of the new maternity theatre
- Meetings
  - Business Unit Quarterly Oversight Meetings
  - New recruits induction meeting
  - Meeting with Unison representative
  - Director of Finance and Digital interview panel
  - F1 doctors induction
  - International recruits induction
  - Meeting with the Chief Executive of Gateshead Council
  - EDI meeting with Sam Allen and Tracie Joliff
  - Gateshead leaders planning meeting
  - Pathology Network meeting
  - Provider Collaborative Board
  - Fortnightly ICS Chief Executive calls
  - Objective-setting with Executive Directors
  - North & NC ICP Meeting
  - Testing plans event
- Planning and Development
  - SMT Development Session

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 13i

Report Title:	**Corporate Objectives Delivery Update**			
Name of Meeting:	Board of Directors			
Date of Meeting:	27 September 2022			
Author:	Executive Directors			
Executive Sponsor:	Executive Directors			
Report presented by:	Kirsty Roberton, Deputy Director of Corporate Services and Transformation			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	To provide assurance over the plans to support the achievement of the corporate objectives for 2022/23			
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*	Board committees have considered the objectives which have been mapped to them.			
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 Board of Directors approved the corporate objectives in May 2022. • Corporate objective delivery action plans have been developed by the Executive Director owners of each of the objectives since this time. • They have been reviewed by the relevant Board committee. • This report presents an overview of the progress in the form of the updated action plans demonstrating the delivery of each of the 11 corporate objectives in place for 2022/23.			
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Board is requested to review the accompanying action plans and the summary contained within this report, being assured that progress is being made towards the delivery of the corporate objectives, whilst noting an element of risk in relation to some sub-actions.			

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:	All				
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 which may pose a threat to the delivery of the corporate objectives are recognised via the Board Assurance Framework (Item 13ii).				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐		**No** ☐		**Not applicable** ☒

Corporate Objective Delivery Update

1. Introduction

1.1. The Board of Directors approved the Trust's corporate objectives for 2022/23 at the May 2022 meeting.

1.2. It was agreed that Executive Leads would populate corporate objective action plans which would be presented to Board committees to provide frequent assurance over the progress made in delivering the identified actions which support the overall delivery of each of the 11 corporate objectives.

1.3. This report brings the corporate objective action plans together to provide an overall snapshot of progress in delivering the corporate objectives.

2. Summary of progress

2.1. The following table summarises the progress made towards the delivery of the actions which in turn support the delivery of the corporate objectives. Note that actions can be both identified as 'some risk' and 'work in progress', and therefore the total number of status updates can exceed the number of actions.

Objective	Total no of sub-actions	Overdue	Some risk	Work in progress	Action complete
SA1.1 Continue to improve our maternity services in line with the wider learning from the Ockenden review	4	0	1	2	2
SA1.2 Continuous Quality improvement plan	3	0	3	3	0
SA1.3 Digital where it makes a difference	6	0	1	4	1
SA2.1 Protect and understand the health and well-being of our staff by looking after our workforce	9	0	5	3	1
SA2.2 Growing and developing our workforce	8	0	3	3	1
SA2.3 Development and Implementation of a Culture Programme (2-3 year Programme)	9	0	1	7	1
SA3.1 Improve the productivity and efficiency of our operational services through the delivery of the New	3	0	3	3	0

Objective	Total no of sub-actions	Overdue	Some risk	Work in progress	Action complete
Operating Model and associated transformation plans					
SA3.2 Achieving financial sustainability	4	0	4	4	0
SA4.1 Tackle our health inequalities	5	0	0	5	0
SA4.2 Work collaboratively as part of Gateshead Cares system to improve health and care outcomes to the Gateshead population	5	0	0	2	3
SA5.1 We will look to utilise our skills and expertise beyond Gateshead	1	0	0	1	0

2.2. In summary there are currently no overdue sub-actions, although a number are considered at risk. There are 9 sub-actions which have been completed, demonstrating that progress is being made towards corporate objective achievement.

2.3. Board committees will continue to monitor the delivery of the action plans, with the next update due to be presented at Board in January 2023.

3. Recommendations

3.1. The Board is requested to review the accompanying action plans and the summary contained within this report, being assured that progress is being made towards the delivery of the corporate objectives, whilst noting an element of risk in relation to some sub-actions.

Strategic Aim	**1. We will continuously improve the quality and safety of our services for our patients**
Committee	**Digital**
List Objectives	**SA1.3 Digital where it makes a difference**

				Quantity		0	1	4	1			
Objective	**Summary of Actions**	**How**	**Action Owner**	**Start Date**	**End Date**	**Overdue**	**Some Risk**	**Work in Progress**	**Action Complete**	**Completion Date**	**Expected Outcomes/ measures**	**Comments/progress**
SA1.3 Digital where it makes a difference	Increasing digitisation of our services where it adds value, increases safety and improves the patient experience	Agree digital priorities that support the Trusts transformation programme	AA	Apr-22	Sep-22				4	01/09/2022	Achievement of the Digital Strategy	Agreed at Digital Tranformation Group, to be shared at Senior Management Team in Sept
	Increasing digitisation of our services where it adds value, increases safety and improves the patient experience	Develop a digital workplan detailing the prioritised milestones	AA	Apr-22	Oct-22		2					Following agreement of priorites, focus now on resourcing allocation. Concerns demand will be higher than capacity
	Investing in the skills our people and patients need to use these tools	Develop a digital service workforce development plan	AA	Dec-22	Mar-22			3				Not started
	Investing in the skills our people and patients need to use these tools	Develop a digital skills and inclusion plan for staff and patients	AA	Dec-22	Mar-22			3				Not started
	Make the best use of the systems and data to continuously improve the clinical care provided	Develop a data quality plan and indicators that provide assurance on clinical systems use	DT	Apr-22	Mar-22			3				Some digital indicators developed and built into DAG reporting
	Make the best use of the systems and data to continuously improve the clinical care provided	Develop a systems exploitation plan for the core systems	DT	Nov-22	Mar-22			3				Not started

Strategic Aim	**3. We will enhance our productivity and efficiency to make the best use of our resources & 5 We will develop and expand our services within and beyond Gateshead**
Committee	**Finance and Performance**
List Objectives	**SA3.1 Improve the productivity and efficiency of our operational services through the delivery of the New Operating Model and associated transformation plans; SA3.2 Achieving financial sustainability; SA5.1 We will look to utilise our skills and expertise beyond Gateshead**

				Quantity		0	7	8	0			
Objective	**Summary of Actions**	**How**	**Action Owner**	**Start Date**	**End Date**	**Overdue**	**Some Risk**	**Work in Progress**	**Action Complete**	**Completion Date**	**Expected Outcomes/measures**	**Comments/progress**
SA3.1 Improve the productivity and efficiency of our operational services through the delivery of the New Operating Model and associated transformation plans	The associated New operating Model transformation programmes will be delivered demonstrating an impact on key performance indicators	moniitored through the New Operating Model (NOM) programme board and Trust Transformation Board. KPI's to be monitored through the IOR	JMB	Apr-22	Mar-23		2	3			Improvement in the Responsive indicators in the Integrated Oversight Report	The programme is a 2-3 year programme however timescales for delivery of each element available Update paper to be presented to the Board in September 2022
	Ensure estates changes relating to the new operating model are realised	working collaboratively with QEF and Business units to realise plans	JMB	Apr-22	Mar-23		2	3				Update paper to be presented to the Board in September 2022
	Realising the recruitment to the new operating model	working collaboratively with POD and Business units to realise plans	JMB	Apr-22	Mar-23		2	3				Workforce challenges have been referred to People and OD Committee by F&P and being discussed at Sept Committee
SA3.2 Achieving financial sustainability	Development of a 3 year financial strategy for Gateshead	Through internal and external discussion and assessment of the environment. To be drafted and then consulted on by the senior finance team.	KM	Aug-22	Dec-22		2	3			Achievement of the annual financial plans	
	Full assessment of the underlying recurrent position to inform the financial strategy	Review of current spending patterns and recurrent / non recurrent forecast	JF	Aug-22	Oct-22		2	3			The development of the longer term strategy to manage recurrent position	
	In year actions to achieve / meet the financial plan for 2022/23 in both revenue and capital	Financial accountability framework, robust budgetary monitoring and reporting to F&P. Robust assessment of capital priorities (financially) and in CRP	KM	Apr-22	Mar-22		2	3				

Strategic Aim	**2. We will be a great organisation with a highly engaged workforce**
Committee	**People and OD**
List Objectives	**SA2.1 Protect and understand the health and well-being of our staff by looking after our workforce; SA2.2 Growing and developing our workforce; SA2.3 Development and Implementation of a Culture Programme (2-3 year Programme)**

				Quantity		0	9	13	3			
Objective	**Summary of Actions**	**How**	**Action Owner**	**Start Date**	**End Date**	**Overdue**	**Some Risk**	**Work in Progress**	**Action Complete**	**Completion Date**	**Expected Outcomes/measures**	**Comments/progress**
SA2.1 Protect and understand the health and well-being of our staff by looking after our workforce	Delivery of the HWB strategy	Review and assess the HWB responses in the staff survey: My organisation takes positive action on health and well-being from 60.2% to 65% My immediate manager takes a positive interest in my health and well-being from 67% to 71% My organisation is committed to helping me balance work and home life from 44.7% to 50%	DJ	Aug-22	Jan-24		2				Delivery of the Health and Wellbeing Strategy and Future Priorities	Target figures have been selected to be ambitious, achievable and ultimately take Gateshead from above the national average in scoring to a leading organisation. The new health and wellbeing strategy creates action and commitment towards positive action. Managing Well provides an in-road into standardising manager approach, while new policy on promoting attendance is in place to support work/life balance.
		Support and promote seven campaigns annually: #BeatTheBlues (January), International Women's Day (March), Stress Awareness Month (April), Mental Health Awareness Week (May), Walking Month (May), World Menopause Day (October), International Men's Day (November)	DJ	Jan-22	Jan-23			3				At the start of each year the health and wellbeing team confirms key campaigns for the year ahead, before meeting monthly to agree on support/coverage of other relevant events. Further campaigns may also be added reactive to arising needs or in order to help obtain other objectives - such as the Better Health at Work Award.
		Relaunch HWB conversations and monitor uptake via appraisal returns and increase returns from 49% in staff survey to 85%	DJ	Aug-22	Aug-23		2					Updated Appraisal Form includes a question within the final checklist asking appraisees to confirm that a HWB Conversation has taken place. This will be captured within ESR, which will allow central monitoring although this is unlikely to be rolled out in time to see a direct
		Launch and promote listening space, monitor usage and seek feedback from users on their experience reports from ID system on usage for baseline	KG	Jul-22	Dec-22			3				Listening Space launched August 2022, with an events calendar currently in development.
		Provide access to hot food 24/7	TP						4	01/06/2022		Steam vendors now in situ, with issues surrounding stock levels rectified.
		Ensure KPIs for waiting times for occupational health services are met and strive to exceed these: Counselling (Contact made within 5 days) MSK clinics (10 working days) Physiotherapy (10 working days)	CH	Oct-22	Oct-23		2					MSK clinics in place and meeting 10 day KPI, currently carried out by Clinical Ergonomics team. Newly appointed Physio will start mid-September due to notice period. The clinics will then need set up. Counselling KPI currently being met with the use of Talk Works, plan to employ an additional part-time in-house counsellor. Recruitment process started in July 2022
		Deliver a successful campaign and ensure 85% of staff are vaccinated	CH	Oct-22	Jan-23		2					Vaccine Committee established, with both flu and covid programmes being delivered through this channel. Confirmation on delivery dates for both flu and covid vaccines received and planning currently underway re: delivery of the programme.
		Grow and support the network of HWB ambassadors audit action	DJ	Jul-22	Jan-23			3				Work underway to review and continue to develop this support offer.
		Reduction in sickness absence new suite of metrics for managers differentiate between covid and non covid absence review new policy in 6 months time Roll out training for managers	CS	Apr-22	Dec-22		2					

SA2.2 Growing and developing our workforce	Improvements in the WRES/WDES for delivering improved staff experience	To be inserted from WRES/DRES action plan									Development of a People strategy; Reduced workforce gaps; Improved responses to staff survey	
	A reduction in vacancy rates and staff turnover	Improve understanding of why people leave	LH	Jul-22	Oct-22			3				People Analyst in post . Dashboard in development
		Develop retention plans	FC	Oct-22	Mar-23			3				Retire and Return Process under review Nurse Rotation Programme being scoped
		Develop a comprehensive strategic workforce plan	FC	Apr-22	Mar-23		2					Data shared with WSP Next steps mapped and dates in diary to review data and do a Deep Dive into ECC Roll out across the trust to be scoped
		Roll out of E-Rostering for Medical Workforce	PM	Apr-22	Mar-23		2					Programme dates and Membership revisited T&O testing complete - Go live date deferred until all of Medicine is Live 3 Focus areas - Medicine - Job Planning - Leave
	Increase in annual staff survey % of staff experiencing opportunities for career and skills development.	Deliver 10 Managing well cohorts	L&D	Apr-22	Mar-23				4	01/08/2022		10 cohorts have been delivered, with 106 participants up to w/c 16/8/22
		Achieve 85% compliance for Appraisal and core skills	SMT	Apr-22	Sep-22		2					
		Maximise Apprenticeship levy. and reduce expiring funds	SN	Apr-22	Mar-23			3				Significant reduction in expiring funds. Apprenticeship strategy will be incorporated into People Strategy
SA2.3 Development and Implementation of a Culture Programme (2-3 year Programme)	Programme Plan to be developed and ratified at Transformation Board	Align with the NHSE Culture & Leadership Programme Plan, complete Stage 1 (Scoping) and Stage 2 (Diagnostic) by 31 March 2023.	LF	Jun-22	Jun-23			3			Programme Plan to be developed and ratified at Transformation Board Launch and embedding of strategy, values and behaviours within the people infrastructure i.e. appraisals, policies, development plans, recruitment Improvement in annual/pulse survey results – particularly in the area of psychological safety measures	Scoping currently underway, which includes an internal mapping exercise to ensure all existing work is captured within the programme. Engagement activities have also begun.
		Provide assurance to the Transformation Board via monthly Highlight Reports outlining the work of the Culture Team.	LF	Jun-22	Jun-23			3				Underway and being incorporated into the wider plan.
	Launch and embedding of strategy, values and behaviours within the people infrastructure i.e. appraisals, policies, development plans	Launch the new Trust Vision, Values, Behaviours and underpinning Strategy.	HF	Jan-22	May-22				4			Complete
		Embed the values and new behavioural framework within the revised Appraisal process, ensuring they also feature within development and talent conversations.	LF/SN	Jun-22	Jun-23			3				Underway and being incorporated into the wider plan.
		Introduce value-based recruitment across all roles within the organisation.	FC	May-22	Jun-23			3				Pilot currently underway and being incorporated into the wider plan.
	Improvement in annual/pulse survey results – particularly in the area of physiological safety measures	Launch the Leading Well development programme and deliver to a new cohort each month	SG	Sep-22	Jun-23			3				Launch planned for 12 September 2022, with a monthly delivery plan in place.
		Pilot the TED Engagement Tool, with 30 teams across the Trust, bringing focus to improving team engagement.	SC	Aug-22	Aug-23			3				Launch planned for September 2022
		Engagement score within the Annual Staff Survey to be within the top 20% of our benchmark group.	LF	Apr-22	Apr-23		2					Work underway to begin scoping our approach to colleagues engagement. This is currently in its infancy and a plan is yet to be developed.
		Increase the 2022 Annual Staff Survey response rate by at least 8 percentage points, which would equate to a 55% response rate and align with the 2021 increase in engagement.	LF	Sep-22	Nov-22			3				Recognised within the comms and engagement plan and shared with SMT for awareness and ongoing support throughout the survey window.

Strategic Aim	**1. We will continuously improve the quality and safety of our services for our patients & 4 We will be an effective partner and be ambitious in our commitment to improving health outcomes**
Committee	**Quality Governance Committee**
List Objectives	**SA1.1 Continue to improve our maternity services in line with the wider learning from the Ockenden review; SA1.2 Continuous Quality improvement plan; 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**

				Quantity		0	4	12	5			
Objective	**Summary of Actions**	**How**	**Action Owner**	**Start Date**	**End Date**	**Overdue**	**Some Risk**	**Work in Progress**	**Action Complete**	**Completion Date**	**Expected Outcomes/measures**	**Comments/progress**
SA1.1 Continue to improve our maternity services in line with the wider learning from the Ockenden review	understand where we have gaps against the immediate and essential actions in the second Ockenden report	baseline gap analysis of Immediate and essential actions to be completed	LH	Apr-22	Jul-22				4		Delivery of the 19 safety priorities and improvement in the maternity metrics outlined and reported in the IOP	Gap analysis completed and assurance provided to the Quality Governance Committee in August 2022
	Monitor the midwifery and support staffing levels within the service	Use Birth Rate plus to establish the number of midwives required to provide safe services	LH	Apr-22	Mar-23		2	3				
	Implement second maternity theatre	Ensure that maternity theatre is appropriately commissioned and opened	KH/AR	Apr-22	Dec-22				4			Second maternity theatre opened in mid-August
	Implement the IEAs in the second Ockenden report	monitor implementation of IEAs at the SafeCare, Risk and Patient Safety Council	GF	Apr-22	Mar-23			3				
SA1.2 Continuous Quality improvement plan	Implement the Quality Account Priorities	Develop a Quality Account implementation action plan	GF	Apr-22	Mar-23		2	3			Quality Account Priorities achieved	
		Monitor the implementation plan for the Quality Account Priorities at SafeCare, risk and Patient Safety Council	GF	Apr-22	Mar-23		2	3				
	Governors are involved in the assessment of the Quality Account for 2022/23	Invite the governors to comment about progress towards the delivery of the quality account priorities	GF	Mar-23	Mar-23		2	3				Meeting held with one of the public Governors to obtain feedback on the current process and discuss suggestions for 22/23
SA4.1 Tackle our health inequalities	Restoring NHS services inclusively: where performance reports will be broken down by patient ethnicity and index of multiple disadvantage quintile, focussing on unwarranted variation in referral rates, waiting lists for assessment, diagnostic and treatment pathways, immunisation, screening and late cancer presentations.	Scoping exercise to look at available data through current collection on careflow and nerve centre.	AB	Apr-22	Mar-23			3			The delivery of an agreed health inequalities action plan	Initial scoping reported to the Health Inequalities Board. Health Inequalities workshop planned for 11 October 2022
	Mitigating against 'digital exclusion' ensuring providers offer face to face care to patients who cannot use remote services and ensure more complete data collection to identify who is accessing face to face /telephone/video consultations is broken down by patient age, ethnicity, disability status	Included in the data scoping will be to review DNA and link with the learning disability team and also the MECC community teams.	AB	Apr-22	Mar-23			3				
	Ensuring data sets are complete and timely - to continue to improve data collection on ethnicity and other protected characteristics, across primary care/ outpatients, A&E, mental health, community services, waiting list minimum dataset (WLMDS)	Ensure data collection for ethnicity and protected characteristics are recorded	AB	Apr-22	Mar-23			3				
	Accelerating preventative programmes, covering flu and covid 19 vaccinations, annual health checks for people with severe mental illness and learning disabilities. Supporting the continuity of maternity carers and targeting long term health condition diagnosis and management. Focus on Acute tobacco Service, Alcohol navigation posts, healthy weight including foodbanks	Introduction of the acute tobacco service for acute and maternity patients. Working with the community and acute learning disability teams to introduce the diamond pathway.	AB	Apr-22	Mar-23			3				
	Strengthening leadership and accountability - Supporting our workforce to access training and wider support offer including MECC, health inequalities framework,	MECC training for staff including, mental health, smoking cessation, alcohol, healthy weight, cancer and 5 ways to wellbeing.	AB	Apr-22	Mar-23			3				
SA4.2 Work collaboratively as part of Gateshead Cares system to improve health and care outcomes to the Gateshead population	Ensure we play a key role in the development and delivery of the system priorities	Ensure we have Senior leadership roles as members of the GH system	JMB	Apr-22	Apr-22				4	30/04/2022	Delivery of Gateshead Cares priorities and action plans	Senior leaders confirmed as representatives
	Plan Joint sessions with all GH system partners to identify priorities	session planned an took place April 2022	JMB	Apr-22	Apr-22				4	30/04/2022		Session took place in April 2022
	Ensure the trust strategy aligns to that of the wider system	Hatching ideas involved in GH partners in the development of our strategy - presentation of same being presented to GH system and H&WB board in September 2022	JMB	Apr-22	Sep-22				4	09/09/2022		Presentation delivered to HWB on 9 September
	Ensure there are trust representatives on each workstream	Ensure workstreams are presented widely to SMT and Trust Board	JMB	Sep-22	Dec-22			3				workstreams receved to be included on next SMT for wider discusson
	Establish governance and reporting on the delivery of system priorities to the Trusts Management team and Board	work with Trust secretary to agree governance and reporting of system priority delivery to Board	JMB/JB	Sep-22	Mar-23			3				Wider governance of the ICB and system working at place is being discussed and a proposal will be available before submission to the Sept Board for agreement

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 13ii

Report Title:	**Board Assurance Framework 2021/22**			
Name of Meeting:	Board of Directors			
Date of Meeting:	27 September 2022			
Author:	Jennifer Boyle, Company Secretary Executive Directors			
Executive Sponsor:	Gillian Findley, Chief Nurse			
Report presented by:	Kirsty Roberton, Deputy Director of Corporate Services and Transformation			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	This report provides the Board with the current Board Assurance Framework 2021/22 for review and assurance, following scrutiny by each of the mapped Board committees.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Executive Directors Board Committees			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	• A new format BAF has been designed for 22-23 in response to feedback from the Board and Internal Audit. • The BAF was formally approved by the Board in July 2022. • BAF extracts relating to the corporate objectives within each committee's remit have been presented to committee meetings for review and triangulation against the controls and assurances considered as part of the business of the committee. • The current contents of the BAF should be triangulated against the assurance, risks and issues discussed during the Board meeting to determine whether its content remain accurate. • The BAF key is as follows:			

Key	Description
	Not yet started
	Started and on track no risks to delivery
	Plan in place with some risks to delivery
	Off track, risks to delivery and or no plan/timescales and or objective not achievable
	Complete

- It is noted that so far there has been no movement in the overall BAF risk scores for each summary risk, although it is recognised that the new BAF has only been reviewed at 1 to 2 meetings of each committee.
- It is acknowledged that the new BAF is still embedding, and this was reflected in discussions on the BAF control environment at the Audit Committee in September 2022. This was reflected in the partial assurance rating the Committee assigned to the BAF.
- A training session has now been held with Non-Executive Director colleagues, with a further session to be scheduled for October. A narrative guide is also in development.

Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Board is requested to review the BAF, noting that it is 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:	August 2022 QGC meeting (with further changes proposed by the Chair of QGC in September 2022 – shown in red)						
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 2868 - New Operating Model - Risk to the delivery of the new operating model resulting in adverse impact on performance & recovery plans (16) CEOL2 3029 - Covid - Risk of further waves/continued endemic Covid, which could impact operational delivery across the whole Trust. (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. Aug – decision made not to progress with 3rd team at present time. **Gap and action suggested for removal from BAF**	**No longer relevant action**
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. Note - Process amended so that an independent IOR for maternity will be presented on a monthly basis at either QGC on behalf of the board or trust board						
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:	August 2022 QGC meeting (with further changes proposed by the Chair of QGC in September 2022 – shown in red)						
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:	MEDIC 2982 - Risk of delayed transfers of care and increased hospital lengths of stay (16) POD 2764 - Workforce - Risk of not having the right people in right place at the right time with the right skills. (16) CEOL2 3029 - Covid - Risk of further waves/continued endemic Covid, which could impact operational delivery across the whole Trust. (16) IMT 3090 - Digital Quality - risk of inconsistent use of systems resulting in poor quality care and impact on quality (8)						

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	As per the Enabling Strategy paper to Board this is due at QGC for approval in October.	**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		A need to verify that SafeCare meetings are in place for each operational business unit – a review of business unit governance is ongoing	J Boyle	October 2022	Review is underway, with draft findings to be collected in September 22.	On track
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:	August 2022 QGC meeting (with further changes proposed by the Chair of QGC in September 2022 – shown in red)						
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	COO is regular member of the Gateshead Cares System Board	**Complete**
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		On track
		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)		To amend QGC cycle of business to incorporate health inequalities reporting	Deputy Director of Corporate Services & Transformation / Company Secretary	October 2022		On track
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)						
Feedback from ICB and Place Based Partners on Health Inequalities work and outcomes						

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:	August 2022 QGC meeting (with further changes proposed by the Chair of QGC in September 2022 – shown in red)						
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) MEDIC 2982 - Risk of delayed transfers of care and increased hospital lengths of stay (16) CEOL2 3029 - Covid - 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**
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 Presentation to HWB on 9th September to show case our strategy and links to HWB	**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**
		To identify reports to include health outcomes to go to committee and Board	COO	October 2022		**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:	July 2022						
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 & Covid Vaccination Campaign	CH	Jan 23	Vaccination Committee established and plans for both programmes developed.	**On Track**
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	Dec 22	Check incorporated within newly designed Appraisal Form, which will allow ESR reporting on completion. Launch planned for Nov 2022.	**Started with some risks to delivery**

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:	July 2022						
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 (16)						

Controls	**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Task and finish group well established and phase 1 of work complete. Phase 2 establishing to coordinate recruitment and retention activity, inc reporting and agency controls	People Strategy Retention Strategy Apprenticeship Strategy	AV FC SN	Dec 22 Mar 23 Dec 22	People Strategy timeline in place and discussions underway within POD, using Hatching Ideas data	**On track**
International recruitment – first international recruits arrived, programme established	Further development of metrics Comprehensive Workforce Plans Agency controls working group	FC FC AV / JF	Dec 22 Mar 23 Dec 22	HR analyst in post, first suite of new metrics produced for PODC (sept), next iteration in plan Fortnightly meeting in place, DOPOD meeting with Business Units in Oct re vacancies and agency reduction plans	**On track with some risk**
Recruitment process streamlined (RPIW)	E-Rostering for Medical Workforce	PM	Mar 23	Ongoing	**On track with some risk**
Managing Well and Leading Well programmes fully operational	Embedding new absence management policy, policy training and robust absence management practice	DB	Dec 22	Training underway, policy agreed, guidance for managers agreed, refreshed case review approach in place.	**On track**

Assurance (Level 1: Operational Oversight)		Gaps in assurance and corrective action	Owner	Timescale	Update	Action status
Staffing Task and Finish Group		BU Dashboard	LH	OCT 22	In draft currently	On track
Nursing Workforce Group (People Portfolio Board approach)		Medical Staffing Dashboard	LH	OCT 22	In draft currently	On track
POD Management Meeting and SMT		Nurse/HCSW Dashboard	LH	OCT 22	In draft currently	On track
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
POD Metrics to POD Commitee		Metrics being further developed	LH	Nov 22		
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:	July 2022						
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:	POD 2759 - Workforce health & Wellbeing - Risk of adverse impact to staff health and wellbeing due to internal and external pressures (12)						

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	Dec 2022	To be confirmed following conversation with sponsor	**On track with some risk**
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	Dec 2022	Plan underway based on Hatching Idea's recommendations. Full project plan awaiting steer from sponsor.	**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:	September 2022 (note this doesn't reflect any updates agreed at the September meeting)						
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. (12) POD 2764 - Workforce - Risk of not having the right people in right place at the right time with the right skills. (16) COO 2868 - New Operating Model -Risk to the delivery of the new operating model resulting in adverse impact on performance & recovery plans (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	Review ongoing with draft findings due in September 2022	**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:	September 2022 (note this version does not reflect any updates agreed at the meeting)						
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	Revised timescale of December 2022 to deliver this update – approval sought to amend timescale accordingly	**Off 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						
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. Discussions remain underway to finalise CRP reporting lines	**Some risk**
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:	September 2022 (note this version does not reflect any updates agreed at the meeting)						
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. (12)						

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	Workshop held with SMT in early September	**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:	August 2022						
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 strategy in place	Digital strategy to reflect the new Trust strategy - in development	Chief Digital Information Officer	December 2022	Digital strategy refresh underway aligned to corporate objectives	**On track**
Digital re-prioritisation and engagement exercise to ensure digital work plan is realistic based on current resource	Digital workforce capacity tracker to inform planned delivery of digital initiatives – in development	Chief Digital Information Officer	October 2022	Current digital delivery work plan continues to be monitored and will be updated as new priorities are agreed. This will be reviewed against the digital capacity available to deliver.	**On track**
Digital Transformation and Digital Assurance Groups in place	None	Chief Digital Information Officer	April 2022	DTG meets monthly to review work plan progress DAG meets bi-monthly to provide assurance on Digital Services	**Complete**

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	February 2023	Comms and Engagement Strategy was developed to support GDEFF programme, this will be revisited and socialised to ensure stakeholders are able to inform future developments	**Not Started**
Engagement of Channel 3 Consulting to lead options appraisal and the outline business case development for further development of the electronic patient record (EPR).		None – OBC developed	Chief Digital Information Officer/Nominated Exec Lead (Clinical)	July 2022	OBC completed and submitted into business case process – meeting 23rd Aug	**Complete**
Clinical Safety resource in place to oversee and manage best practice process		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 submitted into business case process – meeting 23rd Aug. Safehands commissioned to support review of best practice process.	**Behind – risks to delivery**
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 and Senior Management Team to ensure full clinical ownership and technical assurance.		CPG and SMT supportive of OBC, needs approval through business case process	Chief Digital Information Officer	August 2022	Complete – OBC shared with CPG and SMT	Complete
Approval to proceed with Clinical Systems OBC		Source of funding for OBC	Chief Digital Information Officer	October 2022	Awaiting outcome from business case process	On track
Assurance (Level 2: Reports / metrics seen by Board / committee etc)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Digital roadmap reviewed by Digital Committee at each meeting		None	Chief Digital Information Officer	Every meeting	Pressures on workforce capacity	On track
Digital & Data Strategic objectives update report reviewed by Digital Committee		None	Chief Digital Information Officer	Every meeting	Being updated to reflect the Trust strategy	On track

Digital & Data KPIs reported to Digital Committee	None	Chief Digital Information Officer	Every meeting	KPIs routinely reported through DAG and Committee	On track
SIRO report presented to Board	None	Chief Digital Information Officer	June 2023	Submitted in June 2022. Reviewing the need to do this separately from the DAG report	On track
AuditOne outstanding actions – progress report presented to Digital Committee	None	Chief Digital Information Officer	Every meeting	Report monitored monthly with progress tracked and slippage justified	On track
Assurance (Level 3 – external)	**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
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).	None – all external digital reports presented to Digital Committee	Chief Digital Information Officer	Every meeting	Reports reviewed and actions monitored at each meeting	On track
Global Digital Exemplar Fast Follower accreditation	None	Chief Digital Information Officer	March 2022	Complete – Trust awarded HIMSS 5 and Fast Follower status.	**Complete**

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 13iii

Report Title:	**Risk Management Maturity & Risk Appetite**			
Name of Meeting:	Board of Directors			
Date of Meeting:	27 September 2022			
Author:	Kendra Marley, Corporate Risk Manager Shelley Dyson, Head of Risk and Patient Safety			
Executive Sponsor:	Gill Findley, Chief Nurse and Professional Lead for Midwifery and AHPs			
Report presented by:	Gill Findley, Chief Nurse and Professional Lead for Midwifery and AHPs			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☐	**Information:** ☐
	To present and gain formal agreement from the Board of Directors on the levels agreed for risk management maturity and risk appetite.			
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*	Board Strategy session workshop 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* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	An assessment of risk management maturity and review of risk appetite was undertaken by the board of directors at a board strategy session in June 2022. The risk management maturity assessment results are presented in this paper for formal board agreement. They acknowledge that improvements have been made and demonstrate stronger performance in some areas than others, as well as scope for improvement across all areas. These will be considered in developing the Risk Management Strategy and action planning for the coming year. Risk Appetite was reviewed with 4 of 5 areas remaining the same, however the appetite for risks that may affect quality has been increased to 'seek' reflecting the challenging decisions that may be required to deliver strategic objectives.			

<table>
<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:

▪ Approve the risk management maturity levels agreed.
▪ Approve the risk appetite statements and levels.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="4">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td colspan="4">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td colspan="4">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☒</td><td colspan="4">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☒</td><td colspan="4">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="5">All</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">N/A</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>

Risk Management Maturity & Risk Appetite

1. Executive Summary

An assessment of risk management maturity and review of risk appetite was undertaken by the board of directors at a board strategy session in June 2022. This builds upon the work undertaken in April 2021.

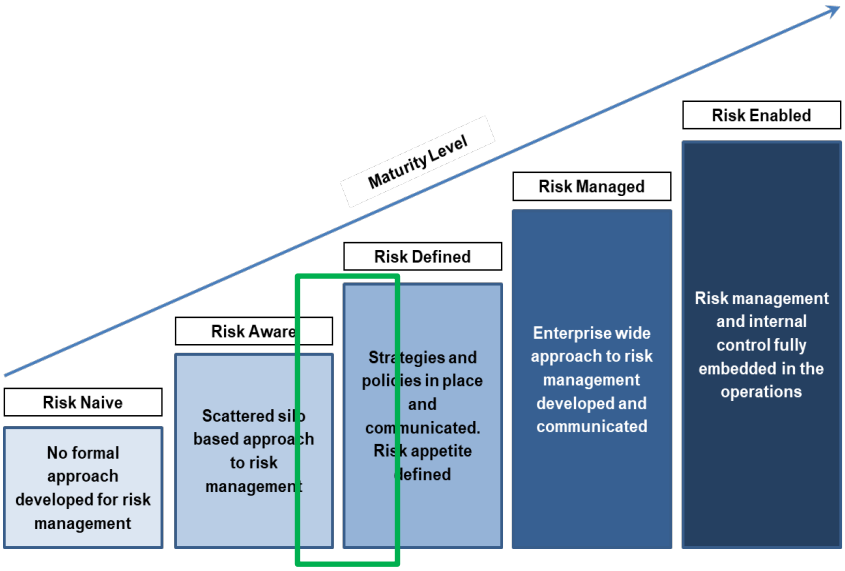
The risk management maturity assessment results demonstrate stronger performance in some areas then others, as well as scope for improvement across all. While these do indicate an improvement against the previous year, as the assessment tool this year is more detailed, they are not directly comparable. Potential areas for improvement will be considered in the developing Risk Management Strategy and action planning.

Risk Appetite was reviewed with 4 of 5 areas remaining the same, however the appetite for risks that may affect quality has been increased to 'seek' reflecting the challenging decisions that may be required to deliver strategic objectives.

2. Risk Management Maturity

2.1. Background

A board workshop was held in April 2021, considering the risk appetite and risk management maturity of the organisation. This was a starting point for the Board to consider risk management maturity and utilised a simple visual sliding scale and overarching statements, with risk management maturity agreed to sit between level 2 (risk aware/ happening) and level 3 (risk defined/working).



While discussion and agreement of risk maturity level was beneficial, being based on such a simple visual did not aid the organisation in identifying our strengths or where we may be best placing our resources to improve our overall risk management maturity. While we successfully undertook some work this was based on a well led self-assessment, internal audit, and peer review.

Our aim at the time was stated to be to reach Risk Enabled within three years and the risk management strategy and plan would be developed to enable us to deliver this. The strategy development was delayed due to further pandemic activity, however

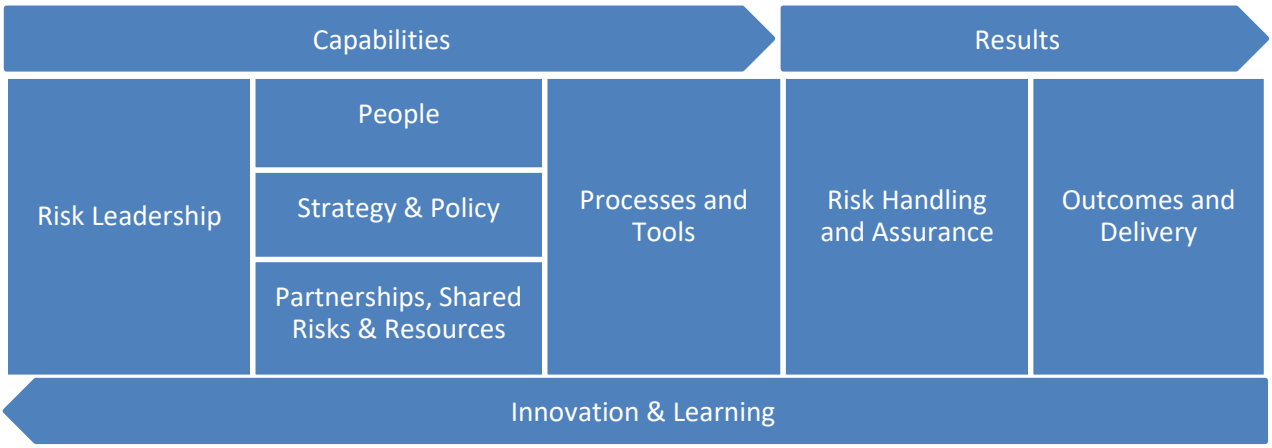
improvements were made as a result of feedback from the well led self-assessment, internal audit and peer reviews.

2.2. Risk Management Maturity Assessment Tools

Consideration of a more detailed maturity assessment to help to identify areas for improvement was undertaken and while there is no risk management maturity specifically for the NHS or even healthcare in general, various models are available. These range from simple scale overviews as above, statements and suggestions for different areas (eg leadership, processes etc.) to in depth questionnaires and evidence review, each is subjective and is better informed if undertaken by a wider group. However, while each model may differ, the overall levels do provide some consistency and having considered assessment levels on a few different models these do begin to provide a consistent overall theme.

2.3. Risk Management Maturity Assessment

This year's assessment has been undertaken based on the ALARM national performance model for risk management. The model breaks down risk management activity into seven areas, five considered 'enablers' and two 'results', with innovation and learning running throughout.



A maturity matrix with overarching statements for each area, at each of the maturity levels, was used to aid assessment, as well as an outline of the elements to consider within each area and suggested evidence, supported by identified evidence from a desktop self-assessment and potential areas for development.

Assessed at one of 5 levels	
Level 1	Risk Management is **engaging (risk naive)** with the organisation
Level 2	Risk Management is **happening (risk aware)** within the organisation
Level 3	Risk Management is **working (risk defined)** for the organisation
Level 4	Risk Management is **embedded (risk managed)** and integrated within the organisation
Level 5	Risk Management is **driving (risk enabled)** the organisation

In advance of a workshop, the directors had an opportunity to consider the detail of each area, including coverage of the area, the type of evidence that would support this, as well as information provided from a self-assessment, providing suggested evidence in place and potential areas for improvement. Within the workshop, members voted on each area, with discussion, questioning and challenge, reaching agreement on an overall maturity level for each area.

The results of the assessment are shown in the following table with the overall descriptor of that level.

Enablers	Level 1	Level 2	Level 3	Level 4	Level 5	Selected level descriptor
Leadership and Management	Engaging	Happening	Working	Embedded & Working	Driving	Risk Management is championed by the CE. The Board and senior managers challenge the risks to the organisation and understand their risk appetite. Management leads on risk management by example.
Policy and Strategy	Engaging	Happening	Working	Embedded & Working	Driving	Risk management principles are reflected in the organisation's strategies and policies. Risk framework is reviewed, developed, refined and communicated
People	Engaging	Happening	Working	Embedded & Working	Driving	People are encouraged and supported to take managed risks through innovation. Regular Training and clear communication of risk is in place.
Partnerships and Shared Resources	Engaging	Happening	Working	Embedded & Working	Driving	Approaches for addressing risk with partners are being developed and implemented. Appropriate tools are developed and resources for risk identified.
Processes	Engaging	Happening	Working	Embedded & Working	Driving	A framework of risk management processes in place and used to support service delivery. Robust business continuity management system in place.
Results						
Risk Handling and Assurance	Engaging	Happening	Working	Embedded & Working	Driving	Evidence that risk management is being effective and useful for the organisation and producing clear benefits. Evidence of innovative risk-taking.

Outcomes and Delivery	Engaging	Happening	Working	Embedded & Working	Driving	Very clear evidence of very significantly improved delivery of all relevant outcomes and showing positive and sustained improvement.

Once approved this information will be reflected in the risk management strategy and policy and updated on the intranet, as well as being communicated to managers across the group. As it does not directly affect the escalation of risk, there are no changes to governance processes.

3. Risk Appetite

3.1. Background

Risk Appetite was initially set for the first time in April 2021, against the 5 categories outlined in the Good Governance Institutes (GGI) matrix. Subsequently the datix system has been updated to enable the category of risk to be reflected and reports grouping risks by category.

3.2. Risk Appetite Review 2022

The appetite levels set in 2021 were considered within a board workshop, with all but 1 level remaining the same.

The 4 categories with no changes are;

Category Sub-categories	Risk Appetite Level	Risk Appetite Statement	Risk Appetite, Tolerance, and Escalation
Financial/ Efficiency Financial Efficiency Business Continuity	Open (Moderate)	We have a Moderate risk appetite for financial/VfM risk. This means we are prepared to take risks which may have a financial impact, enabling our eagerness to innovate and grow whilst ensuring we minimise the possibility of financial loss, however would not take risks that impact on the future financial stability of the organisation. However within commercial arms of the organisation we may have a higher appetite for financial/ VfM risk which brings with it opportunity and beneficial outcomes, such risks would be assessed on a case by case basis.	Appetite - 10 Tolerance 8-12 Escalation 15+
Regulatory/ Compliance Compliance - CQC,SFI IG, Fraud, Legal	Open (Moderate)	We have a Moderate risk appetite for Compliance/Regulatory risk. This means we are prepared to take risks which may result in the possibility of some regulatory challenge, providing that by doing so we are doing what is best for our patients and/or staff and are reasonably confident we could challenge this successfully. The regulator and the potential sanction that could be imposed would be key within our risk assessments.	Appetite - 10 Tolerance 8-12 Escalation 15+
Reputation Public Partners	Seek (High)	We have a High risk appetite for reputational risks. This means we are prepared to take actions and decisions in the best interests of our patients and staff to ensure quality and sustainability which may have an adverse effect on the reputation of the organisation to some stakeholders.	Appetite - 15 Tolerance 12-20 Escalation 15+

People and Resources Resources Wellbeing, Safety	Open (Moderate)	We have a Moderate risk appetite for people and resource risks. This means we are prepared to take limited risks with regards to our workforce. At the current time we are focussing on the basics, helping our staff to recover and recuperate, and increase overall wellbeing. While innovation in this area will be important going forward this will only be explored where any impact on our staff was minimal. Within our Commercial Arms, there may be a higher risk appetite and this would be explored on a case by case basis.	Appetite - 10 Tolerance 8-12 Escalation 15+

With 1 category, Quality Outcomes, the board discussion reflected an agreement to increase the appetite level from ‘open’ to ‘seek’ reflecting the challenging decisions that may be required to deliver strategic objectives.

The appetite and tolerance ‘risk scores’ have been set lower than the Reputation category.

	Category Sub-categories	Risk Appetite Level	Risk Appetite Statement	Risk Appetite, Tolerance, and Escalation
Previous Level	Quality Outcomes Safety Effectiveness Experience	Open (Moderate)	We have a Moderate risk appetite for Quality Outcome risks. This means we are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support risks relating to innovation to deliver improved services and outcomes for our patients and staff.	Appetite - 10 Tolerance 8-12 Escalation 15+
New Level	Quality Outcomes Safety Effectiveness Experience	Seek (High)	We have a High risk appetite for risks which may have an impact on quality, being eager to innovate and choose options offering potentially increased benefits. This means we are prepared to take actions and decisions in the best interests of our patients and staff to ensure longer term quality and sustainability.	Appetite -12 Tolerance 8-15 Escalation 15+

4. Recommendations

The Board are asked to:

- Approve the risk management maturity levels agreed.
- Approve the risk appetite statements and levels.

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 13iv

Report Title:	Organisational Risk Register (ORR)			
Name of Meeting:	Board of Directors			
Date of Meeting:	27th September 2022			
Author:	Marie Malone, Corporate and Clinical Risk Lead.			
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*	One Chief Operating Officer (COO) Risk- 2868 *Risk to the delivery of the new operating model resulting in adverse impact on performance & recovery plans* has increased in score from 16 to 20.			

<table>
<tr><td>

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

</td><td colspan="5">One Surgical Business Unit (SBU) Risk 2869, relating to reduced service provision due to Covid-19 has been removed from the ORR.

One Chief Executive Officer (CEO) risk- 3029 has been reduced from 16 to 12 due to the decreasing levels of covid -19 waves.

Risk and action review compliance shows improvement, 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>
<tr><td>Aim 2
☒</td><td colspan="4">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td colspan="4">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☒</td><td colspan="4">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☒</td><td colspan="4">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="5">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 15th July 2022 to 1st September 2022 (extraction date for this report).

Organisational Risk Register – Movements

New risks added to the ORR in the period;

- Risk (CEO) 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.* (CRR 12)

- Risk (NMQ) 3089- *Risk of quality failures in patient care due to external causes such as delayed discharges and external pressures (CRR 12)*

- Risk (Digital) 3090- *Digital Quality - risk of inconsistent use of systems resulting in poor quality care and impact on quality (CRR 08)*

Risk 3029 above is a strategic risk relating to Covid, and as a result 2 existing risks related to Covid have been removed from the ORR. These are:

- Risk (COO) 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.* (CRR 16)
- Risk (POD) 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.* (CRR 9)

One risk has been reduced in the period:

- Risk (CEO) 3029 - *Risk of further waves of Covid-19.*
  This risk has now been reduced from 16 to 12 due to stabilisation of covid waves, with smaller waves of less pathogenic disease.

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

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

Following ERMG meeting in August 2022, one further risk has been closed;

- Risk (Finance) 2964- *Risk that there is insufficient and formal oversight on the 4 GP practices currently hosted by the trust*. Tender not awarded. No longer an issue.

A further 2 risks have been removed in period:

- Risk (POD) 2765 - *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.
- Risk (NMQ) 2779- *The trust fails to meet The CQC's Fundamental standards.*
  Recent Improvements have been observed in Clinical environmental audit data.

One risk has been escalated in score;

- Risk (COO) 2868 - *Risk to the delivery of the new operating model and associated transformation plans due to the increase in activity and reduced workforce capacity (potentially due to covid waves), resulting in adverse impact on key performance and recovery plans.*

Subsequent linked risks to the above are as follows*:*

  - 3029 Covid - *Risk of further waves/continued endemic Covid, which could impact operational delivery across the whole Trust*
  - 2764 *Risk of not having the right people in right place at the right time with the right skills.*

Risk and action review compliance is currently at 64% and 71% consecutively, 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: 15-Jul-2022 to 01-Sep-2022

Comparison Date: 14-Jul-2022

Gateshead Health NHS Foundation Trust

Risk Profile (Current/Managed)

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 - Workforce health & Wellbeing - Risk of adverse impact to staff health and wellbeing due to internal and external pressures (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 - 3

CEOL2 3029 - Covid - Risk of further waves/continued endemic Covid, which could impact operational delivery across the whole Trust. (12)

NMQ 3089 - Quality - Risk of quality failures in patient care due to external causes such as delayed discharges and external pressures. (12)

IMT 3090 - Digital Quality - risk of inconsistent use of systems resulting in poor quality care and impact on quality (8)

Delivery of Objectives - 3

COO 2868 - New Operating Model -Risk to the delivery of the new operating model resulting in adverse impact on performance & recovery plans (20)

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

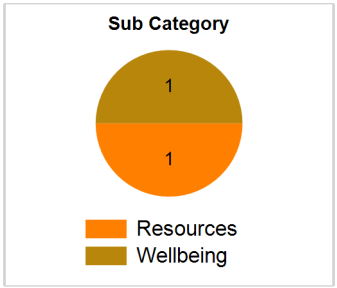
Organisational Risk Register Report

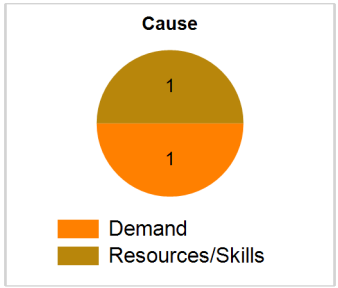
Reporting Period: 15-Jul-2022 to 01-Sep-2022

Comparison Date: 14-Jul-2022

Gateshead Health NHS Foundation Trust

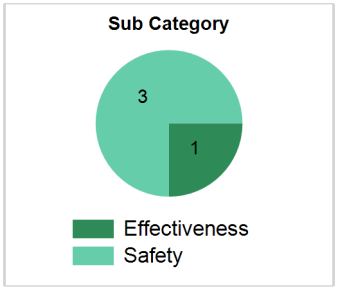
People & Resources

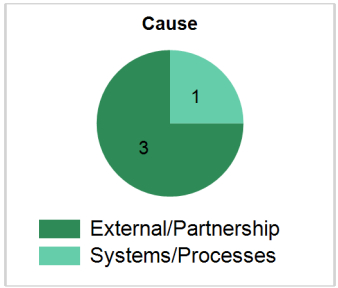




Risk Sub Cat	Risk Cause	No. Risks
Resources	Resources/Skills	1
Wellbeing	Demand	1

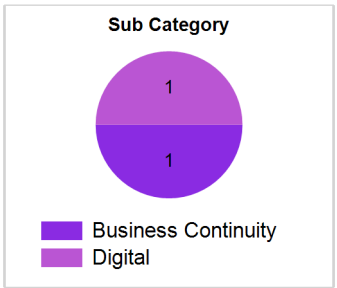
Quality Outcomes

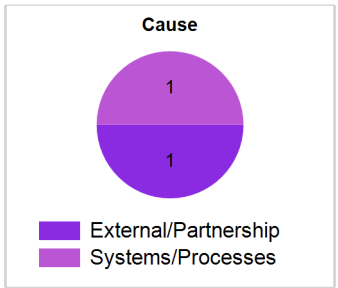




Risk Sub Cat	Risk Cause	No. Risks
Effectiveness	External/Partnership	1
Safety	External/Partnership	2
	Systems/Processes	1

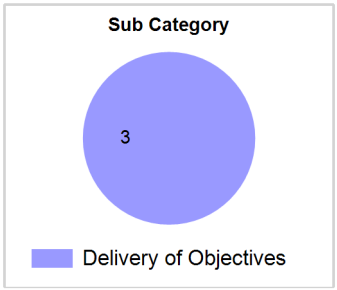
Finance & Efficiency

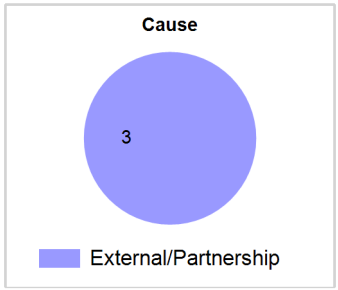




Risk Sub Cat	Risk Cause	No. Risks
Business Continuity	External/Partnership	1
Digital	Systems/Processes	1

Regulation & Compliance, Reputation





Risk Sub Cat	Risk Cause	No. Risks
Delivery of Objectives	External/Partnership	3

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

Organisational Risk Register Report

Reporting Period: 15-Jul-2022 to 01-Sep-2022

Comparison Date: 14-Jul-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	Linked Risk ID / Description	CRR
2868 27/04/2021 Joanne Baxter Chief Operating Officer 03/10/2022 BAF COO EPRR FPC ORG QGC SA3.1 Improve the productivity and efficiency of our operational services through the delivery of the New Operating Model and associated transformation plans	New Operating Model - Risk to the delivery of the new operating model and associated transformation plans due to the increase in activity and reduced workforce capacity (potentially due to covid waves), resulting in adverse impact 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	20	triangulations of incidents and low staffing	Shelley Dyson 31/07/2022	6	2764 - Workforce Capacity & Capability - 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 along with regional and national supply pressures, resulting in failure to deliver current and future services that are fit for purpose	16
					active recruitment to vacanices	Lisa Crichton-Jones 30/09/2022			
					international recruitment programme	Lisa Crichton-Jones 30/09/2022			
					WLI rate for theatre staffing to be determined	Helen Routh 30/09/2022		3029 - Covid - 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 difficulty maintaining flow of patients presenting acutely and deflection from 'business as usual' activities and development / improvement work.	12
					De-escalation	Nicola Bruce (Completed 28/06/2022)			
					Review of temporary staffing solutions	Joanne Baxter (Completed 02/09/2022)			

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

Organisational Risk Register Report

Reporting Period: 15-Jul-2022 to 01-Sep-2022

Comparison Date: 14-Jul-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	Linked Risk ID / Description	CRR
2764 17/11/2020 Ferne Clements People and OD Human Resources 30/09/2022 BAF ORG HRC SA2.2 Growing and developing our workforce	Workforce Capacity & Capability - 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 along with regional and national supply pressures, 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/ways of working identified.	Ferne Clements 31/12/2022	8	2761 - Risk of a lack of strategic direction and collective ownership on the people agenda within the organisation due to the Trust's People Strategy being out of date. Capacity and delivery impacted due to covid. Resulting in the ability to set clear and appropriate priorities and the potential to not deliver on the national NHS People Plan, and the People Strategy not being at heart of the trust and delays in progressing immediate actions .	9
								2765 - Leaders in the organisation may not lead with an expected level of competence due to lack of leadership and OD strategy.	9
								2768 - Reduction in staff competence, non compliance with legislation and guidance, learning and staff not supported with experience at work, career development and retention.	9
								2868 - New Operating Model - Risk to the delivery of the new operating model and associated transformation plans due to the increase in activity and reduced workforce capacity (potentially due to covid waves), resulting in adverse impact on key performance and recovery plans.	20

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

Organisational Risk Register Report

Reporting Period: 15-Jul-2022 to 01-Sep-2022

Comparison Date: 14-Jul-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	Linked Risk ID / Description	CRR
2982 06/12/2021 Amy Muldoon Medical Services Medical Services - Divisional Management 02/09/2022 BU_DIR COO ORG	Risk of delay in transfer to community due to lack of social care provision and intermediate care beds, 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 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: 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	System leadership post for discharge created and to be recruited to RPIW to unblock obstacles to same day discharge	Joanna Clark 31/10/2022 Joanna Clark (Completed 02/08/2022)	9		

Organisational Risk Register Report

Reporting Period: 15-Jul-2022 to 01-Sep-2022

Comparison Date: 14-Jul-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	Linked Risk ID / Description	CRR
2759 16/11/2020 Amanda Venner People and OD Human Resources 30/09/2022 BAF ORG HRC SA2.1 Protect and understand the health and well-being of our staff by looking after our workforce	Workforce Health & Wellbeing - Risk of adverse impact to staff health and wellbeing due to internal working conditions and pressures as well as external factors (demand, patient acuity, staffing levels, covid, civil unrest) resulting in increasing physiological and psychological harm.	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	Relaunch Health and wellbeing check ins	Amanda Venner 31/08/2022	8		
					Increase the number of Mental Health first aiders	Amanda Venner 30/09/2022			
					Engagement on HWB Strategy to be undertaken during May 2022, with strategy finalised and agreed in June 2022	Amanda Venner (Completed 31/08/2022)			
					Listening Space	Amanda Venner (Completed 31/08/2022)			

Organisational Risk Register Report

Reporting Period: 15-Jul-2022 to 01-Sep-2022

Comparison Date: 14-Jul-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	Linked Risk ID / Description	CRR
2945 14/09/2021 Debbie Renwick Chief Operating Officer Planning & Performance 08/08/2022 BU_DIR ORG	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	• 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	4		
					• 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			
					• Assess what is currently available and set up in yellow fin under relevant business units	Michael Smith (Completed 15/07/2022)			
3029 04/04/2022 Mr Andrew Beeby Chief Executive Office Medical Directorate 16/11/2022 BAF BU_DIR ORG QGC SA1.2 Continuous Quality improvement plan	Covid - 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 difficulty maintaining flow of patients presenting acutely and deflection from '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	12			8	2868 - New Operating Model - Risk to the delivery of the new operating model and associated transformation plans due to the increase in activity and reduced workforce capacity (potentially due to covid waves), resulting in adverse impact on key performance and recovery plans.	20

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

Organisational Risk Register Report

Reporting Period: 15-Jul-2022 to 01-Sep-2022

Comparison Date: 14-Jul-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	Linked Risk ID / Description	CRR
3089 25/07/2022 Gillian Findley Nursing, Midwifery & Quality Quality Governance 14/09/2022 BAF BU_DIR ORG QGC SA1.2 Continuous Quality improvement plan	Quality - There is a risk of quality failures in patient care (patient safety, patient experience and effectiveness) due to external causes such as delayed discharges and pressures from other Trusts resulting in patient harm, regulatory action, and reputational impact	15	Daily report provided detailing all delayed discharges within the Trust. regular meetings now established with social care. Discharge liaison staff available to support wards and facilitate earlier discharge.	12			6	2779 - The Trust fails to meet the CQC Fundamental Standards resulting in potential regulatory action, harm to patients, decline in ratings, and resulting reputational damage.	12
								2982 - Risk of delay in transfer to community due to lack of social care provision and intermediate care beds, 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 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: 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.	16

Key: **CRR** - Current Risk Rating **PRR** - Previous Risk Rating
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Organisational Risk Register Report

Reporting Period: 15-Jul-2022 to 01-Sep-2022

Comparison Date: 14-Jul-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	Linked Risk ID / Description	CRR
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	Manage replacement of End of life Network Hardware Complete Cyber Essential Plus Accreditation	Jon Potts 30/07/2022 Jon Potts 31/03/2023	5		

Organisational Risk Register Report

Reporting Period: 15-Jul-2022 to 01-Sep-2022

Comparison Date: 14-Jul-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	Linked Risk ID / Description	CRR
2880 30/04/2021 Mr Andrew Beeby Chief Executive Office Medical Directorate 16/11/2022 BAF ORG QGC	Health Outcomes - Risk that Place/ICS/ICP strategy and plans do not fully align with our objectives and aspirations to tackle health inequalities due to different approaches resulting in 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		
3090 25/07/2022 David Thompson Digital Systems 11/10/2022 BAF BU_DIR DIGC ORG QGC SA1.3 Digital where it makes a difference	Digital Quality - If our digital systems are not implemented fully and staff are not appropriately trained, there is a risk that the inconsistent use of systems could result in poor quality care and impact on quality.	12	- Systems team in place - experts in clinical system functionality - Delivery methods in place to support digital change - Clinical change team involved in business change processes (limited capacity) - Ability to deliver online training via captivate means staff can choose to be trained at a time that suits them	8	Review of clinical change requirements	Andrea Adams 30/09/2022	4	2929 - There is a risk of disrupted or delayed implementation of the Trusts digital strategic objectives - due to lack of digital resource, clinical resource, reprioritisation of workload (e.g. pandemic), supplier failure, financial constraints - resulting in failure to achieve the desired outcomes.	8
3093 25/07/2022 Kris MacKenzie Finance Finance 25/08/2022 BAF BU_DIR FPC ORG SA3.2 Achieving financial sustainability	Finance – 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. Resulting in the failure to deliver sustainable services and deliver objectives								
									11

Changes in CRR - Current/Managed Risks

Organisational Risk Register Report

Reporting Period: 15-Jul-2022 to 01-Sep-2022

Comparison Date: 14-Jul-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	PRR
2868 27/04/2021 Joanne Baxter Chief Operating Officer 03/10/2022 BAF COO EPRR FPC ORG QGC SA3.1 Improve the productivity and efficiency of our operational services through the delivery of the New Operating Model and associated transformation plans	New Operating Model -Risk to the delivery of the new operating model resulting in adverse impact on performance & 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	20	triangulations of incidents and low staffing	Shelley Dyson 31/07/2022	6	risk reviewed and actions updated	16
					active recruitment to vacanices	Lisa Crichton-Jones 30/09/2022			
					international recruitment programme	Lisa Crichton-Jones 30/09/2022			
					WLI rate for theatre staffing to be determined	Helen Routh 30/09/2022			
					De-escalation	Nicola Bruce (Completed 28/06/2022)			
					Review of temporary staffing solutions	Joanne Baxter (Completed 02/09/2022)			

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Organisational Risk Register Report

Reporting Period: 15-Jul-2022 to 01-Sep-2022

Comparison Date: 14-Jul-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	PRR
3029 04/04/2022 Mr Andrew Beeby Chief Executive Office Medical Directorate 16/11/2022 BAF BU_DIR ORG QGC SA1.2 Continuous Quality improvement plan	Covid - Risk of further waves/continued endemic Covid, which could impact operational delivery across the whole Trust.	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	12			8	Risk downgraded to 12	16
									2

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

Organisational Risk Register Report

Reporting Period: 15-Jul-2022 to 01-Sep-2022

Comparison Date: 14-Jul-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 / (Open Actions)	TRR	Closure Details	PRR
2964 28/10/2021 Jacqueline Bilcliff Chief Executive Office Chief Executive Office 16/06/2022 BU_DIR ORG	There is a risk that there is insufficient and formal oversight on the 4 GP practices currently hosted by the trust	16	Some informal oversight by Medical Director / Chief Nurse and COO.	1			6	tender not awarded - no longer an issue	16
									1

Risks Added 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 Added to ORR
3094 25/07/2022 Nick Black Digital Informatics Project 25/08/2022 BAF BU_DIR DIGC ORG SA3.1 Improve the productivity and efficiency of our operational services through the delivery of the New Operating Model and associated transformation plans	Digital Transformation - There is a risk that we fail to deliver digital transformation and cyber resilience due to a lack of investment resulting in the failure of long-term strategies and delivery of sustainable services.	20	- Outline business case developed for digital strategic direction - Achievement of HIMSS EMRAM level 5 in Jan 22 - digital maturity level - Reprioritisation of current digital portfolio plan to ensure current staffing are managing 80% BAU and 20% transformation - Workforce capacity plan in place to inform requests for change and new work requests - Review of in flight projects underway to inform way forward for lower priority work - stop/contain/delay - Cyber Information Security Group in place to review more granular plans around cyber resillience	16	DELETED DELETED	Nick Black (Completed 11/08/2022) Dianne Ridsdale (Completed 11/08/2022)	8	Duplicate of risk 2929 25-07-2022

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

Organisational Risk Register Report

Reporting Period: 15-Jul-2022 to 01-Sep-2022

Comparison Date: 14-Jul-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	Latest Progress Note / Date Added to ORR
3089 25/07/2022 Gillian Findley Nursing, Midwifery & Quality Quality Governance 14/09/2022 BAF BU_DIR ORG QGC SA1.2 Continuous Quality improvement plan	Quality - There is a risk of quality failures in patient care (patient safety, patient experience and effectiveness) due to external causes such as delayed discharges and pressures from other Trusts resulting in patient harm, regulatory action, and reputational impact	15	Daily report provided detailing all delayed discharges within the Trust. regular meetings now established with social care. Discharge liaison staff available to support wards and facilitate earlier discharge.	12			6	changed to current risk following discussion with GF. Review date updated in line with policy. 25-07-2022
3092 25/07/2022 Rob Anderson QE Facilities Estates 25/08/2022 BAF BU_DIR FPC ORG SA3.1 Improve the productivity and efficiency of our operational services through the delivery of the New Operating Model and associated transformation plans	Estate infrastructure – There is a risk that we are unable to invest in our estate infrastructure due to the costs of sustainable investment not being met by the centre (national CDEL (capital departmental expenditure limit), capital being a scarce resource in the current climate and larger centrally funded schemes a rarity) and having only limited internally generated resources resulting in being unable to deliver sustainable services in a fit for purpose environment.	16	Capped annual Capital Budget Long term clinical lead estates strategy	9			6	Unfortunately this is a recurrent risks due to the current financial restraint's. A options have been explored however it comes down to the capital budget is the budget which is closely managed though the capital steering group and the capital approvals process 25-07-2022
3090 25/07/2022 David Thompson Digital Systems 11/10/2022 BAF BU_DIR DIGC ORG QGC SA1.3 Digital where it makes a difference	Digital Quality - If our digital systems are not implemented fully and staff are not appropriately trained, there is a risk that the inconsistent use of systems could result in poor quality care and impact on quality.	12	- Systems team in place - experts in clinical system functionality - Delivery methods in place to support digital change - Clinical change team involved in business change processes (limited capacity) - Ability to deliver online training via captivate means staff can choose to be trained at a time that suits them	8	Review of clinical change requirements	Andrea Adams 30/09/2022	4	Strategic risk review - new strategic risk added. Formally agreed in ERMG 25/7/2022 25-07-2022

Organisational Risk Register Report

Reporting Period: 15-Jul-2022 to 01-Sep-2022

Comparison Date: 14-Jul-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 Added to ORR
3091 25/07/2022 Rob Anderson QE Facilities Facilities 25/08/2022 BAF BU_DIR COO FPC ORG SA5.1 We will look to utilise our skills and expertise beyond Gateshead	Business Development - Risk that we lose business or miss out on business opportunities to support growth due to averse risk taking or lack of resources to invest in developing plans or business cases, resulting in services becoming unsustainable.							This is a risk that is all ready being tracked Teated and managed thorugh the QEF Corporate risk register RR 6 risk number QEFCR 010 All new business/tender submissions are required to be signed off by either the Managing Director or Director of Finance prior to submission. No new bids negotiated in Isolation. No authorisations to be approved out side of the scheme of reservations and delegations. Finance element of all new tenders submitted are signed off by QEF finance. Successful award monitored as part of the monthly finance meeting with the departmental lead 25-07-2022
3093 25/07/2022 Kris MacKenzie Finance Finance 25/08/2022 BAF BU_DIR FPC ORG SA3.2 Achieving financial sustainability	Finance – 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. Resulting in the failure to deliver sustainable services and deliver objectives							New strategic risks agreed as part of strategic risk review. Formal agreement at ERMG 25/07/2022 25-07-2022

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Key: **CRR** - Current Risk Rating **PRR** - Previous Risk Rating
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Organisational Risk Register Report

Reporting Period: 15-Jul-2022 to 01-Sep-2022

Comparison Date: 14-Jul-2022

Gateshead Health NHS Foundation Trust

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
2765 17/11/2020 Laura Farrington People and OD Workforce Development 30/11/2022 BU_DIR 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 Pilot of Leading Well 3 day programme Leadership & OD Strategy	Laura Farrington 30/09/2022 Laura Farrington 31/10/2022 Laura Farrington 31/12/2022	8	Following review of strategic rsiks, risk removed from ORR/BAF and linked to 2764 26-07-2022
2779 01/07/2020 Jane Conroy Nursing, Midwifery & Quality Quality Governance 28/09/2022 BU_DIR 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 Develop a route map to Outstanding	Jane Conroy 28/09/2022 Jane Conroy 28/09/2022	6	Reviewed 25/08/22 - Monthly paper presented to August's Safecare Council and paper for information to August's QGC about new CQC monitoring approach. Improvements seen in environmental audit data. Plan in place for "Your time to shine" visits in September. 25-07-2022
								2

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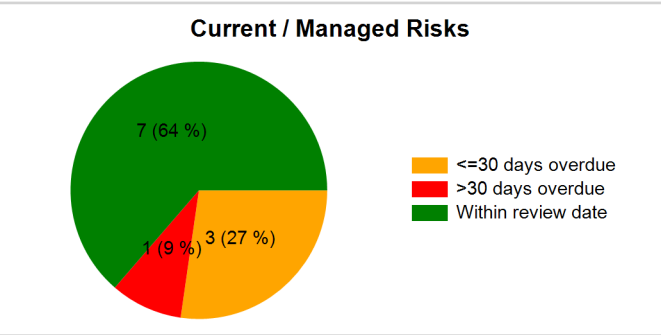
Organisational Risk Register Report

Reporting Period: 15-Jul-2022 to 01-Sep-2022

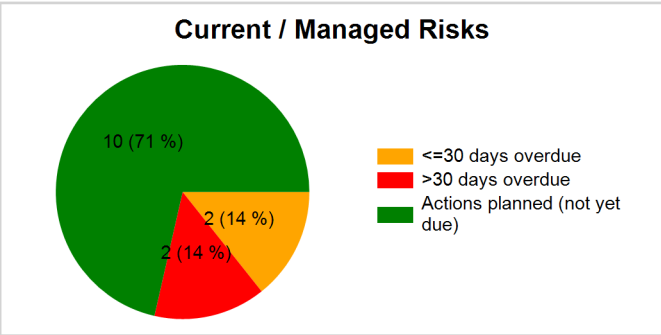
Comparison Date: 14-Jul-2022

Gateshead Health NHS Foundation Trust

Risk Review Compliance



Risk Action Compliance



Movements in CRR

				CRR		
BU	Service Line	ID	Risk Description	Jul-2022	Aug-2022	Today
Chief Executive Office	Medical Directorate	2880	Health Outcomes - Risk that Place/ICS/ICP strategy/plans do not align with our objectives to tackle health inequalities	9	9	9
		3029	Covid - Risk of further waves/continued endemic Covid, which could impact operational delivery across the whole Trust.	16	12	12
Chief Operating Officer		2868	New Operating Model -Risk to the delivery of the new operating model resulting in adverse impact on performance & recovery plans	16	16	20
	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
	Systems	3090	Digital Quality - risk of inconsistent use of systems resulting in poor quality care and impact on quality	8	8	8
Finance	Finance	3093	Finance – There is a risk that the Trust does not achieve its financial and capital plans.			

Organisational Risk Register Report

Reporting Period: 15-Jul-2022 to 01-Sep-2022

Comparison Date: 14-Jul-2022

Gateshead Health NHS Foundation Trust

				CRR		
BU	Service Line	ID	Risk Description	Jul-2022	Aug-2022	Today
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	3089	Quality - Risk of quality failures in patient care due to external causes such as delayed discharges and external pressures.		12	12
People and OD	Human Resources	2759	Workforce health & Wellbeing - Risk of adverse impact to staff health and wellbeing due to internal and external pressures	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

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

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Report Cover Sheet Agenda Item: 14

Report Title:	**Consolidated Finance Report – Part One**			
Name of Meeting:	Trust Board			
Date of Meeting:	27th September 2022			
Author:	Mrs Jane Fay, Acting Operational Director of Finance			
Executive Sponsor:	Mrs Kris Mackenzie, Group Director of Finance & Digital			
Report presented by:	Mrs Kris Mackenzie, Group Director of Finance & Digital			
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 – to be completed by paper sponsor:	**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*	Not 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*	For the period April to August 22 the Trust has reported an actual deficit of £1.545m after adjustments for donated assets and gain & losses of asset disposal. This is an improvement of £2.833m from the deficit reported at the end of July mainly due to the inclusion of £2.594m elective recovery fund income (ERF) for the period April to August 22. The reported deficit is an adverse variance of £2.864m from the Trust's planned surplus totalling £1.320m. For the period April to Aug 22 the Trust has spent £2.047m (22%) 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 31st August 2022 (Month 5) 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:	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)	3093				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐		**No** ☐		**Not applicable** ☒

1. Introduction

1.1 The purpose of this report is to provide a summary of financial performance as at 31st August 2022 (month 5) 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 released 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 with the vaccination programme being funded on a staff member vaccinated basis
- An Integrated Care System requirement to achieve a breakeven position

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

2.3 Reporting for August is against the Trusts 2022-2023 financial plan submission.

3 Income and Expenditure

3.1 The Trust has reported an unadjusted deficit of £1.260m for the period April to August 2022 and an adjusted deficit of £1.545m following the adjustments for donated assets and profit/loss on disposal of assets.

3.2 This is a year-to-date adverse variance of £2.865m against the Trusts financial plan as detailed on the Trust Statement of Comprehensive Income (SOCI) as presented in Table 1.

3.3 For the month of August 2022 the Trust has reported actual income of £32.091m, and an in-month favourable movement of £2.600m against the Trusts plan mainly due to the recognition of ERF income for the first time totalling £2.594m for the period April to August. The recognition of ERF is in response to ICB confirmation that despite not achieving ERF income targets funding will not be retracted for the first two quarters of 2022-23.

3.4 Total year to date income is £149.795m and a favourable variance of £2.344m from the year-to-date plan. The year-to-date variance is mainly due to more income than planned for pass through drugs £0.500m, income for specific developments not included in the plan £0.702m, education & training income £0.500m and a one-off grant to fund the Trust de-carbonisation scheme £0.428m.

3.5 For the month of August 2022 the Trust has reported actual operating expenditure of £29.975m and in-month adverse variance of £1.167m against the Trusts plan mainly due to the non-achievement of the CRP target across pay and non-pay totalling £0.688m and an over-spend against drugs of £0.333m and premises expenses of £0.157m.

3.6 Total year to date operating expenditure is £149.383m and an adverse variance of £5.345m from the year-to-date plan. The year-to-date variance is mainly due to the non-achievement of the CRP target across pay and non-pay totalling £4.713m and an over-spend against drugs of £1.041m and premises expenses of £0.895m. These over-spends are offset by an underspend against depreciation and a non-recurring benefit relating to the release of provision for bad debts.

August 22-23

	NHSE APRIL - MARCH 23 FINAL 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)	(26,741)	(29,238)	(133,705)	(134,994)	(1,289)	1,208
Income From Local Authority Care Contracts	(90)	(7)	(15)	(35)	(73)	(38)	(30)
Private Patient Revenue	(735)	(61)	(60)	(305)	(265)	40	38
Injury Cost Recovery	(290)	(24)	(72)	(120)	(206)	(86)	(38)
Other non-NHS clinical revenue	(850)	(71)	(67)	(355)	(295)	60	56
Total Operating Income From Patient Care activities	**(322,874)**	**(26,904)**	**(29,451)**	**(134,520)**	**(135,833)**	**(1,313)**	**1,234**
Other Operating Income							
Education and Training Income	(7,631)	(636)	(767)	(3,180)	(4,057)	(877)	(745)
R&D Income	(527)	(44)	(70)	(220)	(357)	(137)	(111)
Top up Income			0		0	0	0
Funding outside of System Envelope	(3,910)	(326)	(57)	(1,630)	(1,166)	464	195
Other Income	(18,609)	(1,551)	(1,744)	(7,752)	(7,955)	(203)	(10)
Donations & Grants Received	(366)	(30)	0	(150)	(428)	(278)	(308)
Total Other Operating Income	**(31,043)**	**(2,587)**	**(2,639)**	**(12,932)**	**(13,963)**	**(1,031)**	**(978)**
Total Operating Income	**(353,917)**	**(29,491)**	**(32,091)**	**(147,452)**	**(149,796)**	**(2,344)**	**256**
Operating Expenses							
Employee Expenses - Substantive	221,172	18,237	18,248	91,070	89,652	(1,418)	(1,429)
Employee Expenses - Bank	7,150	625	671	3,197	4,902	1,705	1,659
Employee Expenses - Agency	3,653	335	809	1,715	4,541	2,826	2,352
Employee Expenses - Other	1,187	99	71	495	349	(146)	(118)
Total Employee Expenses	**233,162**	**19,296**	**19,799**	**96,477**	**99,444**	**2,967**	**2,464**
Purchase of Healthcare - NHS bodies	6,076	506	513	2,530	2,777	247	240
Purchase of Healthcare - Non NHS bodies	2,348	196	553	980	1,755	775	418
Purchase of Social Care	0	0	0	0	0	0	0
NED's	188	16	14	80	68	(12)	(10)
Supplies & Services - Clinical	24,096	2,008	1,983	10,043	10,508	465	490
Supplies & Services - General	3,225	269	248	1,345	1,251	(94)	(73)
Drugs	18,339	1,529	1,915	7,645	8,951	1,306	920
Research & Development expenses	0	0	(0)	0	9	9	9
Education & Training expenses	1,089	91	118	455	732	277	250
Consultancy costs	143	12	76	60	191	131	67
Establishment expenses	3,209	268	353	1,340	1,478	138	53
Premises	17,041	1,420	1,577	7,100	7,995	895	737
Transport	1,628	136	126	680	640	(40)	(30)
Clinical Negligence	7,923	660	561	3,300	3,202	(98)	1
Operating Leases	2,604	217	68	1,085	406	(679)	(530)
Other Operating expenses	3,967	331	271	1,655	1,705	50	109
Cost Improvement Programme	0	0	0	0	0	0	0
Reserves	0	0	0	0	0	0	0
Operating Expenses included in EBITDA	**325,038**	**26,955**	**28,175**	**134,775**	**141,110**	**6,335**	**5,115**
Depreciation & Amortisation - Purchased / Constructed	8,238	687	638	3,435	3,158	(277)	(228)
Depreciation & Amortisation - Donated / Granted	366	30	29	150	143	(7)	(6)
Depreciation & Amortisation - Finance Leases	13,569	1,131	1,130	5,652	5,651	(1)	(1)
Impairment & Revaluation	61	5	3	25	(679)	(704)	(702)
Restructuring Costs			0		0	0	0
Operating Expenses excluded from EBITDA	**22,234**	**1,853**	**1,800**	**9,262**	**8,273**	**(989)**	**(936)**
Total Operating Expenses	**347,272**	**28,808**	**29,975**	**144,037**	**149,383**	**5,346**	**4,179**
(Profit)/Loss from Operations	**(6,645)**	**(683)**	**(2,116)**	**(3,415)**	**(413)**	**3,002**	**4,435**
Non Operating							
Non-Operating Income							
Finance Income	(105)	(9)	(49)	(45)	(192)	(147)	(107)
Total Non-Operating Income	**(105)**	**(9)**	**(49)**	**(45)**	**(192)**	**(147)**	**(107)**
Non-Operating Expenses							
Finance Costs	589	49	70	245	321	76	55
Gains / (Losses) on Disposal of Assets	0	0	0	0	0	0	0
PDC dividend expense	3,156	263	263	1,315	1,315	0	0
Total Finance Costs (for non-financial activities)	**3,745**	**312**	**333**	**1,560**	**1,636**	**76**	**55**
Other Non-Operating Expenses							
Misc. Other Non-Operating expenses			0		0	0	-
Total Non-Operating Expenses	**3,745**	**312**	**333**	**1,560**	**1,636**	**76**	**55**
(Surplus) / Deficit Before Tax	**(3,005)**	**(380)**	**(1,832)**	**(1,900)**	**1,030**	**2,930**	**4,383**
Corporation Tax	1,395	116	83	580	230	(350)	(317)
(Surplus) / Deficit After Tax	**(1,610)**	**(264)**	**(1,749)**	**(1,320)**	**1,260**	**2,580**	**4,065**
(Surplus) / Deficit After Tax from Continuing Operations	**(1,610)**	**(264)**	**(1,749)**	**(1,320)**	**1,260**	**2,580**	**4,065**
Remove capital donations / grants I&E impact	0	0	(29)	0	285	285	313
Gain on disposal of assets	0	0	0	0	0	0	0
Impairements - AME	0	0	0	0	0	0	0
Loss on disposal of DHSC assets	0	0	0	0	0	0	0
Remove net impact of consumables donated from other DHSC bodies			0		0	0	0
Adjusted Financial Performance (Surplus) / Deficit	**(1,610)**	**(264)**	**(1,778)**	**(1,320)**	**1,545**	**2,865**	**4,378**

Table 1: Trust Statement of Comprehensive Income

4 Cost Reduction Programme (CRP)

4.1 Included in the Trusts 2022-23 financial plans is an annual CRP requirement of £10.939m with £5.379m planned to be achieved by August 22. As at August £0.666m has been achieved with a year-to-date adverse variance of £4.713m. On a full year effect recurring basis, a total of £1.145m has been achieved.

Business Unit	22-23 Annual Target £000's	22-23 YTD Target £000's	22-23 YTD Achieved £000's	22-23 YTD Variance £000's	22-23 FYE Achieved £000's	% FYE Achieved of Target
Chief Executive	(87)	(43)	0	(43)	0	0.0%
Chief Operating Officer	(120)	(59)	0	(59)	0	0.0%
Clinical Support & Screening	(2,627)	(1,303)	0	(1,303)	0	0.0%
Community	(898)	(445)	(26)	(419)	(62)	6.9%
Director Of Nursing	(387)	(192)	0	(192)	0	0.0%
Estates & Facilities	(134)	(56)	0	(56)	0	0.0%
Finance & Information	(473)	(245)	0	(245)	0	0.0%
Medical Director	(17)	(8)	0	(8)	0	0.0%
Medicine & Elderly	(2,131)	(1,057)	0	(1,057)	0	0.0%
People & Organisational Development	(164)	(81)	(57)	(24)	(81)	49.2%
Surgical Services	(2,414)	(1,197)	(100)	(1,096)	(241)	10.0%
Trust Financing	(1,488)	(692)	(483)	(210)	(762)	51.2%
Total	(10,939)	(5,379)	(666)	(4,713)	(1,145)	10.5%

5 Cash and Working Balances

5.1 Group cash as at 1st April 2022 totalled £55.586m. The cash position of £57.717m as at 31st August is equivalent to an estimated 60.47 days operating costs (51.32 days July) and represents a £8.731m increase from July 2022. The Trust received settlement of its £5.7m debt with the UK Health Security Agency in respect of the de-commissioned pillar 2 COVID pathology testing service together with payment from an NHS Foundation Trust in respect of the provision of Pathology services.

5.2 The liquidity metric has improved by 0.70 days against July to +12.46 days driven by a £0.619m increase in the working capital balance, this is 2.00 days better than plan (10.46 days).

5.3 The balance sheet is presented in Table 2.

Table 2 – Statement of Position

Statement of Position - August 2022

	2022/2023 July 2022 Group £000's	2022/2023 August 2022 Group £000's	Movement from Prior Month £000's	2022/2023 August 2022 QEF £000's	2022/2023 August 2022 FT £000's
Assets					
Non-Current Assets					
Investments	80	80	0	80	16,824
Property, Plant and Equipment, Net	136,790	136,577	(213)	1,292	135,285
Trade and Other Receivables, Net	2,006	2,015	9	814	1,201
Finance Lease - Intragroup				42,047	0
Trade and Other Receivables - Intragroup Loan	0	0	0		11,668
Total Non Current Assets	138,875	138,671	(204)	44,232	164,978
Current Assets					
Inventories	4,623	4,567	(56)	2,676	1,891
Trade and Other Receivables - NHS	14,478	6,947	(7,531)	548	6,399
Trade and Other Receivables - Non NHS	5,505	6,366	861	1,750	4,617
Trade and Other Receivables - Other	0	0	0		0
Prepayments	5,461	5,043	(417)	594	4,450
Cash and Cash Equivalents	48,986	57,717	8,731	5,734	51,983
Other Financial Assets - PDC Dividend	488	488	0		488
Accrued Income	3,237	2,213	(1,025)	1,611	601
Finance Lease - Intragroup				409	0
Trade and Other Receivables - Intragroup Loan					2,421
Total Current Assets	89,732	83,341	564	13,321	72,850
Liabilities					
Current Liabilites					
Deferred Income	11,217	8,403	(2,814)	191	8,212
Provisions	3,896	3,896	0	320	3,576
Current Tax Payables	4,336	4,436	100	397	4,039
Trade and Other Payables - NHS	2,324	2,016	(307)	797	1,219
Trade and Other Payables - Other	9,167	8,914	(253)	2,388	6,526
Trade and Other Payables - Capital	287	7	(280)	0	7
Other Financial Liabilities - Accruals	35,054	36,955	1,902	7,795	29,160
Other Financial Liabilities - Borrowings FTFF	999	999	0	0	999
Other Financial Liabilities - PDC Dividend	1,052	1,315	263	0	1,315
Other Financial Liabilities - Intragroup Borrowings	0	0		2,421	0
Finance Lease - Intragroup	0	0		0	409
Total Current Liabilities	75,286	66,941	(1,389)	14,309	55,462
NET CURRENT ASSETS (LIABILITIES)	14,447	16,400	1,953	(988)	17,388
Non-Current Liabilities					
Deferred Income	2,018	2,018	0	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	18,152	18,152	0	13,387	58,480
TOTAL ASSETS EMPLOYED	**135,170**	**136,919**	**1,749**	**29,857**	**123,887**
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)	(20,194)	(18,445)	1,749	21,355	(39,801)
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	135,170	136,919	1,749	38,180	115,564
TOTAL ASSETS EMPLOYED	**135,170**	**136,919**	**1,749**	**38,180**	**115,564**

6 Capital

6.1 The Trusts 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 end of August was £2.047m, £0.966m below plan. Expenditure in the period was in respect of the Maternity Theatre, building maintenance, New Operating Model, small schemes 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 reported 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, demand on unscheduled care and capacity to deliver transformation programme
- financial mitigations (Trust and ICB) assumed in plan are not realised in line with expected figures.
- cost implications associated with winter and non-funded escalation beds due to delayed discharges, not yet quantifiable.
- 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.

Kris Mackenzie, Group Director of Finance & Digital
17th September 2022

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 15

Report Title:	**Integrated Oversight Report**			
Name of Meeting:	Trust Board			
Date of Meeting:	27th September 2022			
Author:	Deborah Renwick and IOR Reporting Leads			
Executive Sponsor:	Joanne Baxter			
Report presented by:	Joanne Baxter, Gill Findley, Lisa Crichton-Jones			
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 June and July 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 7 - 13 of IOR)</u>** 6 serious incidents reported in August, open and under investigation, with 1 one open patient safety alerts not completed by deadline. No Never Events in the past 18 months. A total of 77 Medication errors were reported in August. 64 patients (83%) were deemed no harm 12 patients (15%) low harm and 1 patient (1%) moderate harm. Representing a positive reposting safety culture. The trust has had zero incidence of Healthcare Associated MRSA BSI in the preceding 12 months and no further Community cases since December 2021. 13 Healthcare associated CDI cases since April 2022, 6 of which were in July. 5 Healthcare Associated E. coli during August 2022 – 4 HOHA and 1 COHA. 1 COHA P. aeruginosa BSI during August 2022, and 3 Healthcare Associated Klebsiella BSI. **<u>Effective (pages 14 – 16 of IOR)</u>** Hospital Standardised Mortality Ratio (HSMR) continues to show more deaths than expected for this indicator. There was a deterioration in the average number of long stay patients (LOS 21+) from 73 in July to 88 patients in August. Readmissions within 30			

days remains high – impact analytical impact assessment suggests this in due to changes in counting and recording in SDEC. A detailed clinical deep dive is also underway as additional assurance.

Responsive (pages 17 – 32 of IOR)

UEC: Front of house performance measures continue to demonstrate both system and site pressures:

- 4-hour performance is at 74.5% placing the Trust 29th out of 139 NHS Type 1 providers (77.5% & ranked of 16th last month)
- 32 patients waited longer than 12 hours to be admitted
- 12 hour waits in department to discharge increased to 318 or 3.53% (207 in July)
- Ambulance handover delays are 45: 30-60 and 36: >60 mins
- Bed occupancy increased from 95.1% in July to 96% in August.

Indicative activity in August levels were overall below planned levels, with combined elective activity at 97%.

- Day cases: 102%
- Elective inpatients: 76%
- New outpatient attendances: 102%
- Follow-up attendances: 94%
- Diagnostics 110%

RTT:

- Increases in the patients waiting for treatment represents an increase in the RTT waiting list from 11,949 to 12,361.
- 52 week waiters are above planned levels –with 87 waiters over a plan of 30.
- 1 78 week waiter at the end of August
- July RTT <18 week waiter's performance at 75.8%
- June RTT <18 weeks waiter's indicative performance at 74.9%

Diagnostics: DM01 6-week performance 75.1 % June, 76.6% and 75.8% in August. Pressures in Audiology and echocardiology continue.

Cancer: Performance measures:

- 2week wait performance at 89.1% July, 84.2% indicative for August
- Faster Diagnosis Standard at 76.5% July, 80.6% indicative for August.
- 31 day standard at 98.0% July, 97.2 % indicative for August
- 62-day cancer at 63.2 % July, 56.7% indicative for August
- 62-day waiters 64 are slightly below planned for levels of 65, but increased from 60 in June.
- 104 day waiters reduced to 9 end August, from 17 end of July.

Duty of candour: Duty of Candour compliance still demonstrating concern for Jun-Aug, August compliance has improved to 83% from July 2022 but remains below the 100% compliance required.

Well led (pages 33 – 35 of IOR)

Overall sickness absence levels reduced to 4.5% in August, with reductions in QEH (4.7%) and QEF (3.5%). Special cause variation (improvement) observed since previous IOR report for Data Quality

<table>
<tr><td></td><td colspan="6">Maturity Index, no longer triggering concern and is therefore removed from this report and monitored through usual process.

<u>Benchmarking (page 8 of this report)</u>
The Trust remains in a relatively strong position against available benchmarking data. Table in page shows a worsening position in relation to our benchmarked position for A&E 4 hour standards and an improved position against the backlog of 62 day cancer waiters.</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="6">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 workforce challenges, impact on activity recovery, long waiting times and performance.</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">3.8 (F&P) Deliver operational transformation to improve productivity & efficiency
3.9 (F&P) Develop smart integrated reporting framework</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☒</td><td>Effective
☒</td><td 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">• 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 face to face capacity</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>

INTEGRATED OVERSIGHT REPORT – AUGUST 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 July and August reporting performance predominantly retrospectively where data is validated, signed off and submitted, as highlighted below. Where indicative data is provided in IOR it is identified.

IOR section	Data Item	Reporting Period	Data Quality Sign Off
Safe	SI's	August	***
Safe	Open Safety alerts	August	***
Safe	Medication errors	August	***
Safe	Infection, Prevention and Control	August	***
Effective	HMSR	Jan 21 to Jul 22	***
Effective	SHMI	Nov 19 to Apr 22	***
Effective	Long Lengths of Stay	August CDS	***
Responsive	Community	August	***
Responsive	A&E	Submitted August	***
Responsive	RTT	July (provisional) Early indications for August	**
	RTT PTL Health Inequalities	August	**
Responsive	Cancer	July(provisional) Early indications for August August	**
Responsive	Diagnostics		**
Recovery	Activity		**
Well Led	Sickness, Appraisals, training	August	***
*** 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:

- 1.8 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 7):** Six incidents have been reported in August, an increase of 1 from July, totalling 31 to date in this financial year. Five incidents in August resulted in severe/major harm and one incident relating to discharge resulted in death/catastrophic

consequences. To date there have been 3 reported incidents which resulted in catastrophic consequences. Themes include discharge, failures in reviewing and reporting tests and delays in diagnostics. Falls related incidents continues to be the highest reason behind Trust incident reporting accounting for 46% of incidents to date, followed by diagnosis 18% and test related incidents at 14%.

2.1.2 Patient Safety Alerts (page 8): One open patient safety alert**.**

2.1.3 Medication Errors (page 9): Reporting 77 medication errors in August equates to 10.54 medication errors per 1000 FCE's. 64 patients (83%) were deemed no harm 12 patients (15%) low harm and 1 patient (1%) moderate harm. Symptomatic of a positive Reporting safety culture and supports the many positive initiatives currently undertaken by the team including:

- Investment in high-risk medication areas - e.g. specialist diabetes and endocrinology pharmacist (now chairs our new diabetes safety board), medicines safety lead pharmacy technician (helping to support messaging relating to reporting and allowing 'support to report').
- F1 teaching in medicines safety including safety culture and reporting.
- Medicines safety roadshow (surgical business unit) - raising awareness and supporting teams, culture of you said we did.
- Breakout session delivered at Trust patient safety conference - supporting learning culture.
- ECC - 'pharmacy at 4 initiative' - weekly medicines learning session with ECC medical team, strong pharmacy team presence and feedback culture. Highest rates of reporting here.

2.1.4 **Infection Prevention & Control (page 10-13):** Reporting in this month's IOR has been redesigned to capture a more comprehensive set of metrics, and ensure data being presented is set against the IPC trajectories set by NHSE. Headlines from the slides: The trust has had zero incidence of Healthcare Associated MRSA BSI in the preceding 12 months and no further Community cases since December 2021. The incidence of nosocomial cases in August reflects the national reduction in prevalence. Learning from previous outbreaks advised to minimise onward transmission. The Trust has reported 13 Healthcare associated CDI cases since April 2022 against the CDI threshold for 2022/23 of 32, 6 of which were in August (4 hospital and 2 community onset). The Trust has reported 5 Healthcare Associated E. coli during August 2022 – 4 HOHA and 1 COHA. The Trust has reported 1 COHA P. aeruginosa BSI during August 2022, and 3 Healthcare Associated Klebsiella BSI.

2.2 Effective

2.2.1 **HMSR (page 14):** Continues to show more deaths than expected with an HSMR of 107.9 (Jun 22- July22) a decrease from 110.9 in the last report. The SHMI is at 0.99, and is within expected range.

2.2.2 **Long Length of Stay Patients (page 14)** - During August the Trust averaged just over 88 patients staying in hospital with a longer length of stay greater than 21 days. Representing an increase from 73 in July and 68 in June.

2.2.23 **Readmission Rates within 30 days (page 16):** Figure remains high but has reduced again in the latest month. This 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. Work continues to understand the clinical reasons contributing to the increase whilst extracting the extremely valuable learning from patient level reviews. An analytical review suggests that the increase is due to the changes in recoding from ambulatory care to SDEC, therefore this work is being undertaken alongside a report being written around the impact of SDEC.

2.3 Responsive

2.3.1 **Urgent and Emergency Care (pages 17-20):** Footfall and patient numbers decreased in August to 9,005 from 9,407 in July, although daily attendances averaged 32 per day more than August 2021. ED performance highlights in the month include:

- 4 hour performance is at 74.5% in August, deteriorating from 77.5% in July
- At 74.5% this placed the Trust 29th out of 139 NHS Type 1 providers, which is a deterioration from 16th last month
- 32 patients waiting longer than 12 hours to be admitted, up from 18 in July (June:4)
- 12 hour waits in department from arrival to discharge increased from 213 in July to 318 in August.
- 318 is equal to 3.53% of all attendees, and above the 2% target
- Ambulance delays reported: 45 between 30-60mins (down from 63 in July) and 36 delays >60 mins (down from 37 in July)
- 2nd best performing Trust in NENC & NY re: Ambulance delays
- High volumes of ambulance and regional diverts received in July (31) and August (25)
- Bed occupancy levels increased from 95.1% in July to 96% in August.
- One third of blocked beds in August were occupied by patients living out of out of the Gateshead area.
- Acuity of patients in hospital is high. HED benchmarking tool indicates that the Trust is averaging a high Charlson co-morbidity score of 6 (placing the acuity of patients in the top decile with an increased risk of death within 1 year of admission).

2.3.2 Staffing pressures across the site, resulted in an Executive decision made on the second week in August to close the escalation beds. The impact of closing the escalation beds with a peak of 77 residing who were medically optimised and no longer met the criteria to reside, resulted in exceptionally high 12-hour trolley waits and longer waits in urgent and emergency care for an admission bed. The hospital remains under significant pressure with ED, Urgent and Emergency Care, inpatient ward areas and Community continuing to care for patients with increased acuity. The Trust was at Opel level 3 for 15 days in August with limited beds, staffing pressures, higher volumes of ambulance diverts and delayed discharges continuing to be a challenge.

The average daily patient delay rate has increased from 44 patients in April to 57 patients in August. The Trust is still experiencing significant volumes of beds blocked, circa 3 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, accounting for one third of beds blocked during August.

2.3.3 **Community Teams (page 21):** Continue to support secondary care services by keeping patients in their own home. Community teams, including children's services saw 45,264 contacts in August, averaging 1,460 per day. The Rapid Response team responded to 71 two-hour crisis response referrals and achieved an indicative compliance rate of 82.1% for patients referred within 2 hours, achieving the 70% compliance rate in August. The requirement is to achieve this standard by Q3 2022)

2.3.4 **Elective activity and recovery (pages 22-23):** The expectation is to reach 104% of activity value of the 2019/20 plan. August (draft) combined **elective activity is at 97%** of 2019/20 baseline activity, which is below planned levels and an overall on July's activity. Overnight elective activity increased to 76% from 68% of baseline year. Day case treatments have increased from 85% to 102% in August. Outpatient attendances are at 102% for new 94% follow-up attendances.

2.3.4.1 Early financial indications demonstrate that the Trust has not met the value of activity (year to date) to meet elective recovery funding (ERF). However, the ICB have now formally notified Trust's to include ERF within income calculations for the first six months of 2022/23

following national and regional concerns raised concerning achievement of activity levels and pressures in M1-M6.

The Trust's elective recovery programme has been severely impacted by workforce pressures in recruitment and retention. Delivery of planned activity levels has been precarious throughout the year due to reduced theatre staffing levels. The theatre staffing team is currently running with a 19% vacancy rate, 3.6% of staff on maternity leave, 9.2% sickness rate and a 17% attrition rate. Mitigating actions include WLI's and continued use of bank and agency in the short-term. Longer term solutions include revised payment/incentive schemes in-line with the ICB patch.

Patient Initiated Follow-up (PIFU) attendances improved to 3.5%, above planned levels of 2.6%. The Trust achieved 25.15% of remote outpatient appointments against the transformational requirement of 25%.

Diagnostic activity levels improved to 110% in August. Modalities achieving their activity targets include CT 127%, colonoscopy 115%, flexi-sigmoidoscopy 122% and gastroscopy 124%. Echocardiology activity delivered is at 89%, a slight decrease from July.

2.3.5 **RTT (page 21):** Continued focus on increasing capacity to reduce patient backlogs and waiting times.

Reduced activity levels in Q1 continuing into July & August and increased referrals particularly in surgical specialties have increased the number of patients waiting for hospital treatment from 11,336 waiting at the end of April to 12,361 at the end of August* *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, 58 in June and subsequently 77 in July and 87 in August (indicative).

Performance measures demonstrate that around 75% of our patients are waiting less than 18 weeks in July and August. Trust performance remains above latest national average of 61% at the end of July, and ICB NENC average of 73.8%.

'Super September' provides continued focus upon validation, clinical prioritisation, reviewing outpatient capacity and maximising utilisation rates by preventing DNA's. Providing 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. Weekly patient level reviews continue to with a focus on long waiters and proactive care management.

Health inequalities RTT (page 26) highlights the initial performance monitoring reporting indicators for the RTT waiting list: 61% female 39% male split, white British account for 74% of the waiters, with 23% not stated. The profile of the wating list remains the same and across the Index of Multiple Deprivation (IMD) 'Did not attend' or DNA rates have increased since the pandemic; patients living the most deprived wards are more likely to not attend for outpatient appointments – current rate at 13%.

2.3.6 **Diagnostics (page 24):** Performance for the Trust remained fairly static at 75.8% in August. Whilst performance is between NENC regional average of 79% and national average of 72.1% there have been a notable improvements across a number of modalities. Shadow monitoring against the 2023/24 standard of 95% pushes all modalities into achieving the standard – with Echocardiology and audiology as the exceptions. Revised plans and recovery trajectories aim for echocardiology to be compliant against the 6 week standard by February 2023. A business case to support Audiology recovery was agreed by SMT on the 11th August, recovery trajectories will be published when revised capacity is confirmed.

2.3.7 **Cancer (pages 28-31):** Continued focus on clinical prioritisation and increasing capacity to reduce patient backlogs and waiting times.

In August performance against the **2week standard** of 93% has fallen to 84.2%. Particular capacity/performance pressures are evident in Lower GI (45.3% in August) lung (67.2% in August). Lower GI 2 week wait referrals have gradually increased by on average 75 patients per month or 136%.

Faster diagnostic standard Trust achieved 75% target in August with 80.6% and for quarter one at 78.1%. There are performance risks across the challenged tumour groups of Gynae, Lower GI, Urology and Upper GI and haematology. However, Breast, Testicular and now lung exceed the 75% target in August. Implementation of the Faster Diagnosis Best Practice Timed Pathways will support the Trust in achieving this target across the remaining tumour sites. The Trust exceeds NENC average performance of 73.3% and the national averages of 70.4%.

The trust is performing well in **the 31day standard** measuring the taken from diagnosis to treatment. The Trust has achieved this standard throughout the year and both subsequent treatment standards have been achieved. All specialties achieved this standard in July and August except Gynae and Lower GI. NOTE: July and August performance is indicative data and is subject to change following sharing of information between Trusts. The Trust continues to perform well above NENC and national averages.

62-day cancer treatment - The Trust reported 64 patients waiting over 62 days on a 2ww classic pathway in August (representing an in month decrease of 4 patients from 68 in July). 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 improved from 53.6% in June to 67.0% July (indicative), performance risks across most specialties to achieve 85% with the exception of Breast. Challenged specialties continue to be Gynae, Lower GI and Urology, Haematology & Lung.
Performance is below NENC average (60.6%) and all English Providers (59.9%).

2.3.8 **Verbal Duty of Candour (page 32):** Duty of Candour compliance for August has improved slightly to 83% but still remains below the 100% level of compliance required. The numbers of incidents requiring DOC remain low, there are 4 cases reported as non-compliant incomplete and 7 cases where there is still time to gain compliance.

2.4 Well Led

2.4.1 **Workforce (pages 33-35):** Sickness absence levels (in August) improved to 4.5% from 6.1% in July. Both QEH and QEF demonstrate improvements of 4.7% and 3.5%. Trust level appraisal compliance increased to 65.8% from 62.9% in July, 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 78.9% August (demonstrating a positive improvement trend from 68.5% in April).

2.5 Benchmarking

2.5.1 The table below has been adapted from previous reports to give an indication of trend in the benchmarking position the Trust is achieving. The table below provides the position and indication of trajectory based on the data in the last 4 IOR reports, including this month:

	GHFT Benchmarking Figure					GHFT Benchmarking Position							
	May IOR	June IOR	July IOR	Aug IOR	Sep IOR	Rank out of:	Rank is better if:	May IOR	June IOR	July IOR	Aug IOR	Sep IOR	Trajectory (May to Sept)
A&E 4 hour waiting time target	75.3%	77.9%	77.1%	77.5%	74.5%	139 - All Type 1 NHS Providers	Lower	23	20	19	16	29	Worsened
Latest weekly PTL: patients waiting > 104 weeks	0	0	0	0	0	8 Providers in ICS	Lower	1	1	1	1	1	No change
Latest weekly PTL: patients waiting > 52 weeks	50	60	73	75	58	8 Providers in ICS	Lower	2	2	3	3	2	No change
Latest weekly PTL: patients waiting > 62 days for cancer treatment	63	65	57	68	64	8 Providers in ICS	Lower	1	1	1	1	1	No change
62 day backlog as % of waiting list	8.7%	9.1%	9.3%	10.2%	8.3%	139 - top 20 under NHSE/I scrutiny	Higher	73	75	69	59	83	Improved

2.5.2 The table shows the Trust remains in a relatively strong position against available benchmarking data. While in 3 of the 5 metrics we are staying static and achieving the best rank (position 1) for 2 indicators. The table also shows a worsening picture in relation to our benchmarked position for A&E 4 hour target. However, for 62-day cancer backlog the methodology has changed nationally – now backlogs <150 are excluded from rankings for the top 20, meaning GHFT can not enter the top 20. The 'Top 20' trust rankings are adjusted with a number of trusts excluded – those ranked in the table this are not adjusted and represents our position nationally for all Trusts.

3. Recommendations

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

I. The Board should note that volume of SI's and the direction of the trend aren't triggering concern. Five incidents in August resulted in severe/major harm and one incident relating to discharge resulted in death/catastrophic consequences.

II. Medication errors reported in August have peaked, the Board should note that this is an indication of the positive safety reporting culture as the volumes of low and no harm account for 99% of the reported incidents.

III. Workforce challenges in recruitment and retention prevail across the Trust, work continues to include oversight and management of the challenges by the operational teams.

IV. Discharging patients and pressures across the Trust continue to impact on the Trust's ability to maintain patient flow. Beds blocked due to patients no longer meeting the criteria to reside coupled with increasing ambulance conveyances from patients living out of the areas has again resulted in more delayed discharges and more beds open against planned levels which will ultimately impact on Trust expenditure.

V. Whilst activity levels have increased in month, key points of delivery still remain below planned levels. Resolving theatre staffing pressures remains a key priority and continues to impact on the Trust's ability to deliver planned levels in the elective care recovery programme. Lower levels of activity during the year combined with increased referral rates in surgical specialties have resulted in an increase in in the RTT waiting list and in the number of RTT 52w long waiters. Whilst challenged cancer pathways continue to demonstrate pressures in against 2 week waits and 62 day treatment measures, the Trust is in August highlighted across the region as has achieved cancer targets against Faster Diagnostics and 31 day treatment targets, with an overall reduction of long waiters

VI. Diagnostic activity continues to perform well, and the Community Diagnostic Centre continues to support ICS improvement trajectories. Improvement trajectories for echo cardiology forecast compliance in this modality in February 2023.

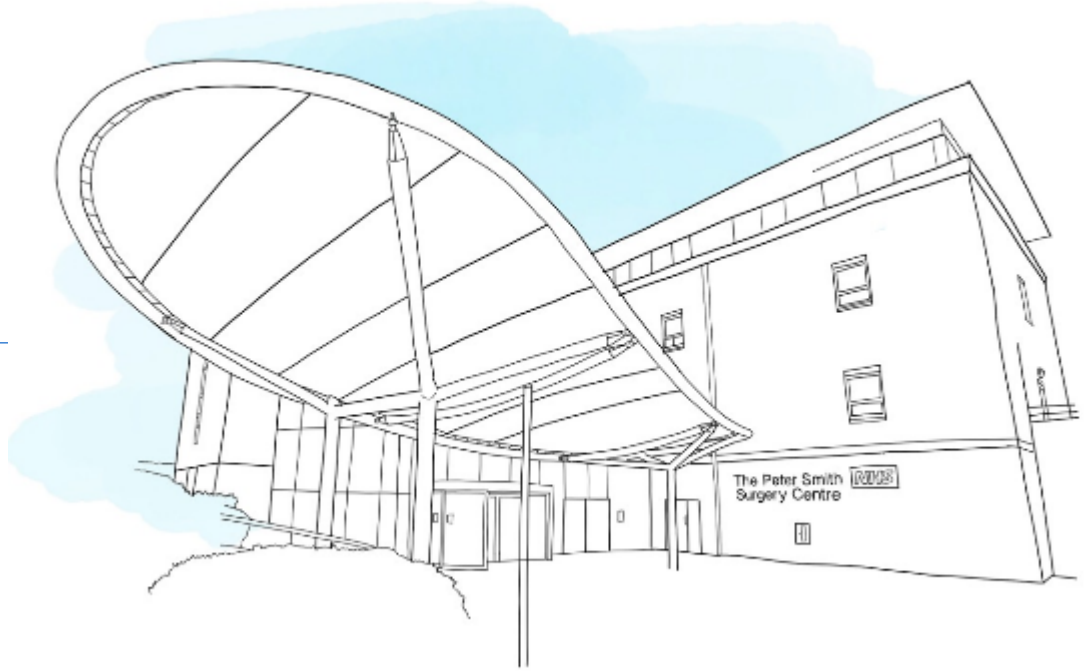
VII. The Trust has not achieved planned levels of activity to attain ERF against the 104% value attributed to ERF, (elective recovery funding) assumed in the financial plan. The ICB have recognised pressures across the patch, Trusts can now account for the income in the plan.

Gateshead Health NHS Foundation Trust

Integrated Oversight Report

September 2022 Committees

Data: July / August 2022



NHS Gateshead Health NHS Foundation Trust

CQC Rating

NHS
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.

Safety
2 of 8 applicable indicators triggering SPC/underachieving against targets

Responsive
22 of 36 applicable indicators triggering SPC/underachieving against targets

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

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

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

KLOE Summary

Gateshead Health NHS Foundation Trust

Safe

- Total number of Trust reportable **SI's: 6 are reported in month,** open and under investigation
- There is currently **one open patient safety alert** not completed by deadline
- **No Never Events** in the passed 18 months
- **Medication errors** per 1000 FCEs. 77 medication errors reported in August 2022, 10.5 per 1000 FCEs trigger special cause variation for concern.

Effective

- The Trust **Hospital Standardised Mortality Ratio** (HSMR) continues to shows more deaths than expected for this indicator.
- The **Summary Hospital Level Indicator** (SHMI) shows deaths within the expected range.
- The **Long Length of stay greater than 21 days indicator** has triggered special cause variation. There was a deterioration in the average number of Long stay patients (LOS 21+) from 72.7 in July to 88.5 in August.
- **Readmissions within 30 days** displays special cause variation (high) between September 2021 to May 2022.

Caring

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

Well Led

- Core training performance increased to 78.9%
- Appraisals increased to 65.8%
- Sickness Absence rates decreased to 4.6% above target however below the 18 month average

Responsive

- **UEC: August 22** Performance against the 4 hour standard is 74.55%. Overall activity remains (16.15%) below pre-covid levels. Footfall through UEC decreased again to 9,005 in August from 9,407 attendances in July. August activity is on average 32 attendances per day more than last year (12.6% increase). The latest national benchmarking data (August – performance of 74.5%) places the Trust at 29th of 139 Type 1 providers. The Trust reported 45 30-60 minute and 36 over 60 minute ambulance delays in August. The Trust also reported 32, 12 hour waits from decision to admit to leaving ED and 318 (3.53%) 12 hour waits in the ED (from registration to left department).
- **RTT: July 22** Performance against the 18 week standard is 75.76% with an increase of patients on the RTT waiting list from 11.604 to 11,949 and a increase to 77 patients waiting over 52 weeks, one of which was waiting for 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 August is 84.6%, below the 93% standard. In August 1,231Two week wait referrals were received which shows an increase of 32.4% in comparison to the same period last year and up by 52.5% on the same period in 2019.
- **Cancer: 62 day treatments** The Trusts position against the 62 day standard showed a slight improvement in performance in July reporting performance at 65.4% with Breast, Haematology and Testicular tumour sites above the performance standard of 85%.
- **Diagnostics:** The Trust failed the diagnostic standard in July reporting 76.63% of patients seen with 6 weeks of referral. Echocardiography continues to be the main challenge at 29.07% and Audiology is also reported below target at 57.21% and highlighted as an area of concern.
- **Duty of candour:** It has been identified that there is a need for refresher training or new staff training for DOC and this is being provided monthly by the patient safety and legal team. However a buddy system would also be a helpful addition until staff are comfortable in undertaking DOC. Review and emails to staff shows that the verbal DOC is predominantly completed and a note written in the medical notes, however this information is not then transferred into DATIX.

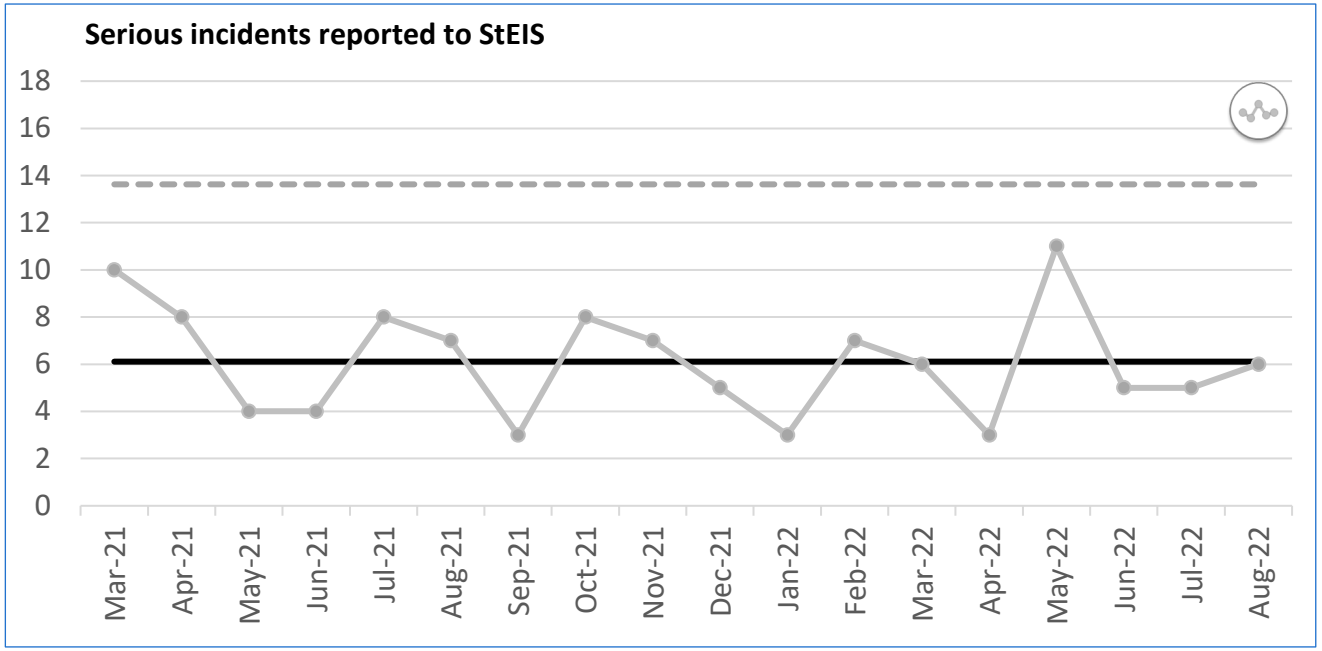
Gateshead Health NHS Foundation Trust

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.

Serious Incidents reported to StEIS

Safe

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 6 SI's declared in August – themes are listed below:

Death / Catastrophic

- 1 x Discharge - inappropriate (Death / Catastrophic)

Severe / Major Harm

- 2 x Fall on same level - cause unknown (Severe / Major Harm)
- 2 x Fall from height - toilet (Severe / Major Harm)
- 1 x Stillbirth >500g (Severe / Major Harm

Report by exception: Patient Safety Alerts not completed by deadline

Safe

Gateshead Health NHS Foundation Trust

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

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 2021. No assurance has been identified that this alert can be closed to date. This information is drawn from the National MHRA site.

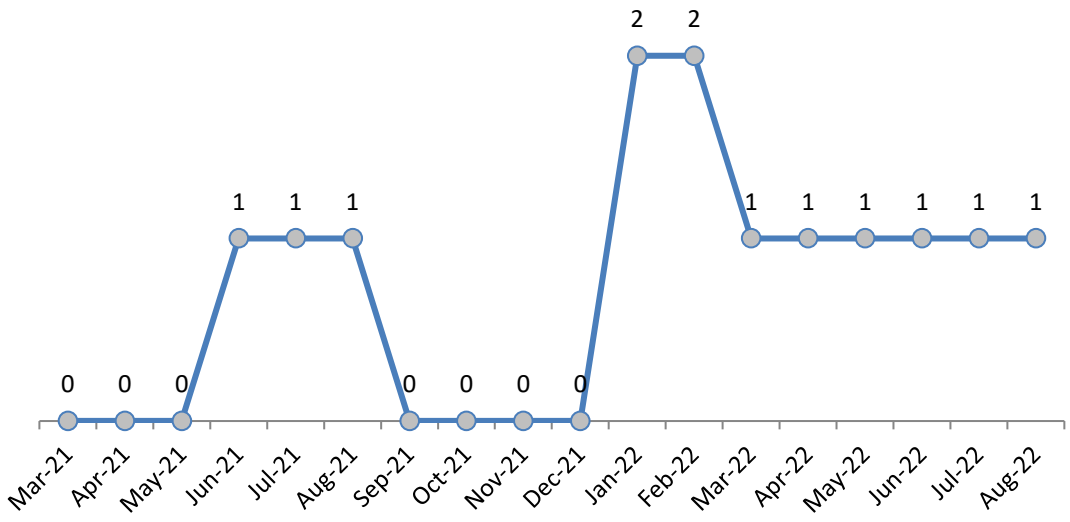
NatPSA/2021/009/NHSPS Infection risk when using FFP3 respirators with valves or Powered Air Purifying Respirators (PAPRs) during surgical and invasive procedures.

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

The incidents showing as overdue on the national system re incongruent with those shoeing as overdue internally- work is ongoing to reconcile these differences

Recommendation
- Reconciliation of internal and national databases, determination of what types of alerts require reporting for the IOR going forward
- Review of systems for data related to patient safety to ensure system expertise and the ability to triangulate data.

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



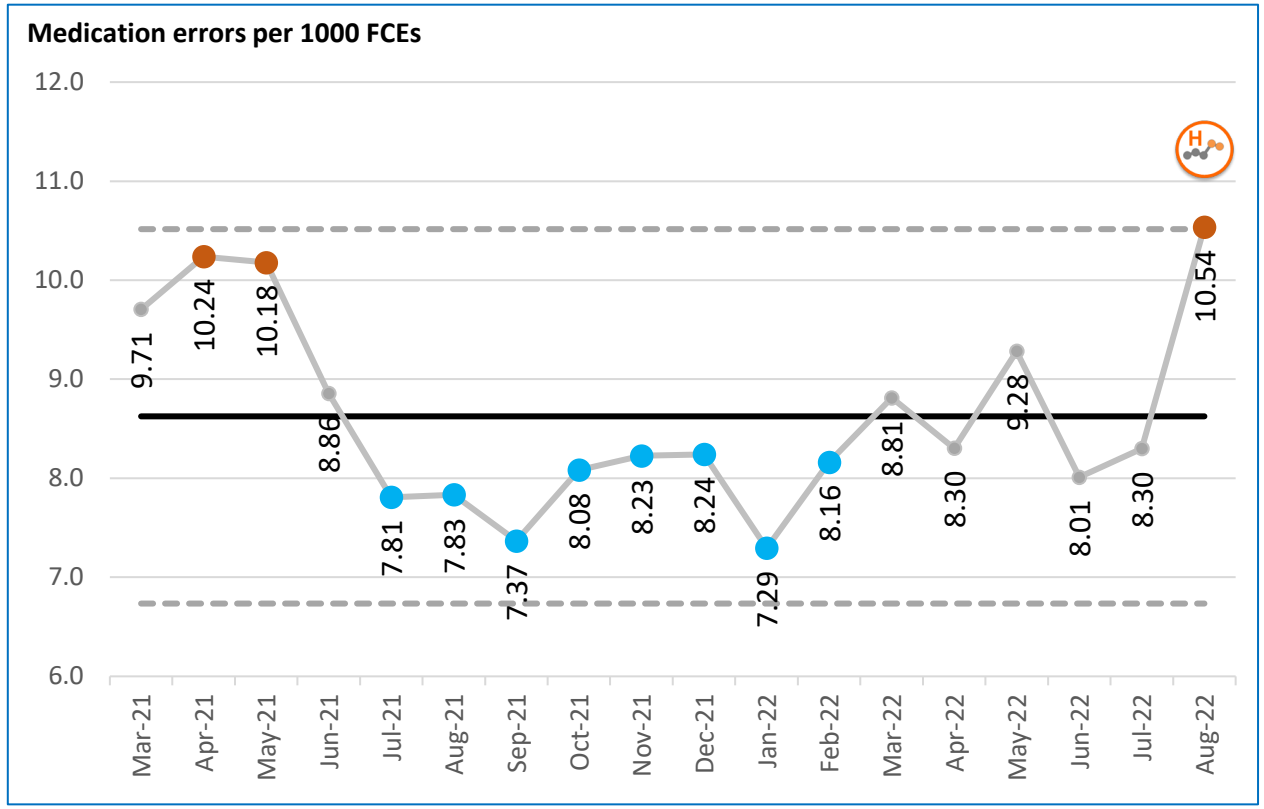
Source: https://www.cas.mhra.gov.uk/Help/AlertComplianceData.aspx

Report by exception: Medication errors per 1000 FCEs

Safe

Gateshead Health NHS Foundation Trust

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



Situation
Special cause variation (deterioration) displayed in August 2022 with 10.5 medication errors per 1000 finished consultant episodes (FCEs). Medication errors remained between the upper and lower process limits between July 2021 and February 2022, however the rate of medication errors triggered in August 2022 at 10.5 per 1000 FCEs, Matching the upper process limit.

Background
Medication error rates are monitored each month as part of a set of safety metrics, there is currently no national benchmarking of this metric. This is monitored based on comparison of the Trust incident trends.

Assessment
A total of 77 medication errors were observed in August 2022.
64 No harm, 12 low harm; 1 moderate harm.

This represents an increased level of reporting with low numbers leading to harm. Indicating a positive safety culture for the reporting of medication related incidents.

50% represented prescribing errors which is an increase in the usual 30% seen during quarterly data analysis. This may reflect the recruitment of junior medical staff within this month.
29% relate to the administration of medicines which is not out with expected numbers.

The Med 1 business unit is commended for high rates of incident reporting. Transition of care represents a safety critical point for patients and their medicines and where high volumes of prescribing occur. Recent safety initiatives in this area have supported the increase of reporting of medicines incidents including weekly MDT learning events, clinical supervision and feedback to prescribers.

Actions
Further analysis of Q2 incidents by the Trust Medicines Safety Officer for presentation and action at Medicines Governance Group.

Recommendations
Trust continues to support the reporting of all incidents and near miss events so that opportunities for learning can be identified.

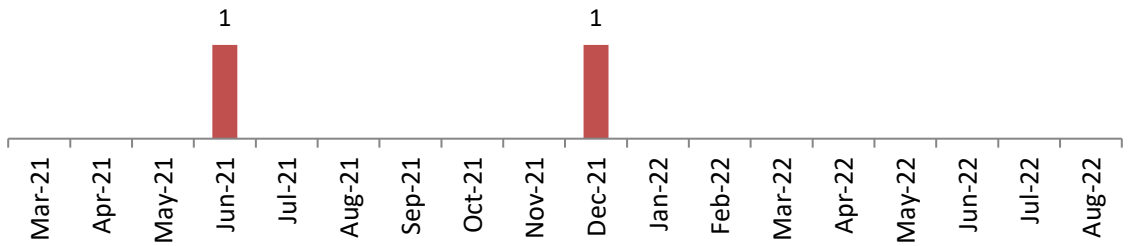
Infection Prevention & Control – Healthcare Associated Infections - MRSA & nosocomial COVID-19

Safe

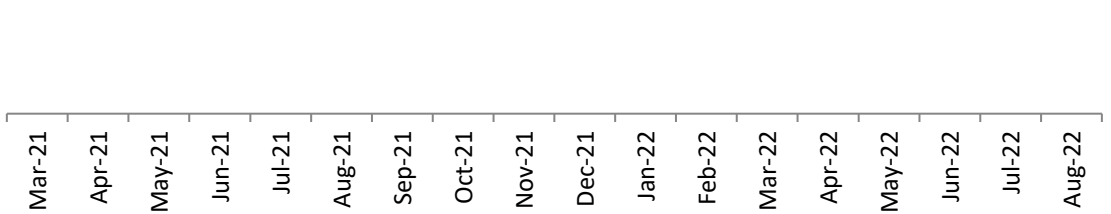
Gateshead Health NHS Foundation Trust

The Trust adopts the national aspiration of a zero MRSA blood stream infections (BSI).
The trust has had zero incidence of Healthcare Associated MRSA BSI in the preceding 12 months and no further Community cases since December 2021

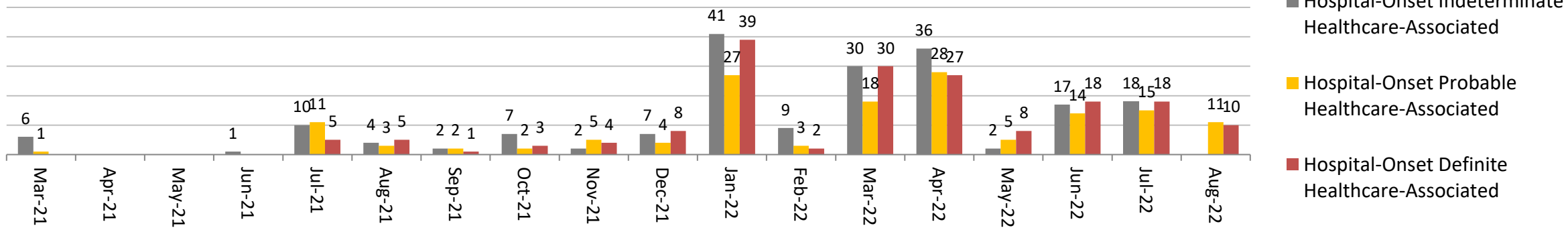
MRSA -Community Associated



MRSA- Healthcare Associated



Nosocomial COVID-19



Nosocomial COVID 19 cases
All Healthcare associated COVID cases are reported and investigated through the DATIX system.
The incidence of nosocomial cases in August reflects national reduction in prevalence. Learning from previous outbreaks advised to minimise onward transmission.

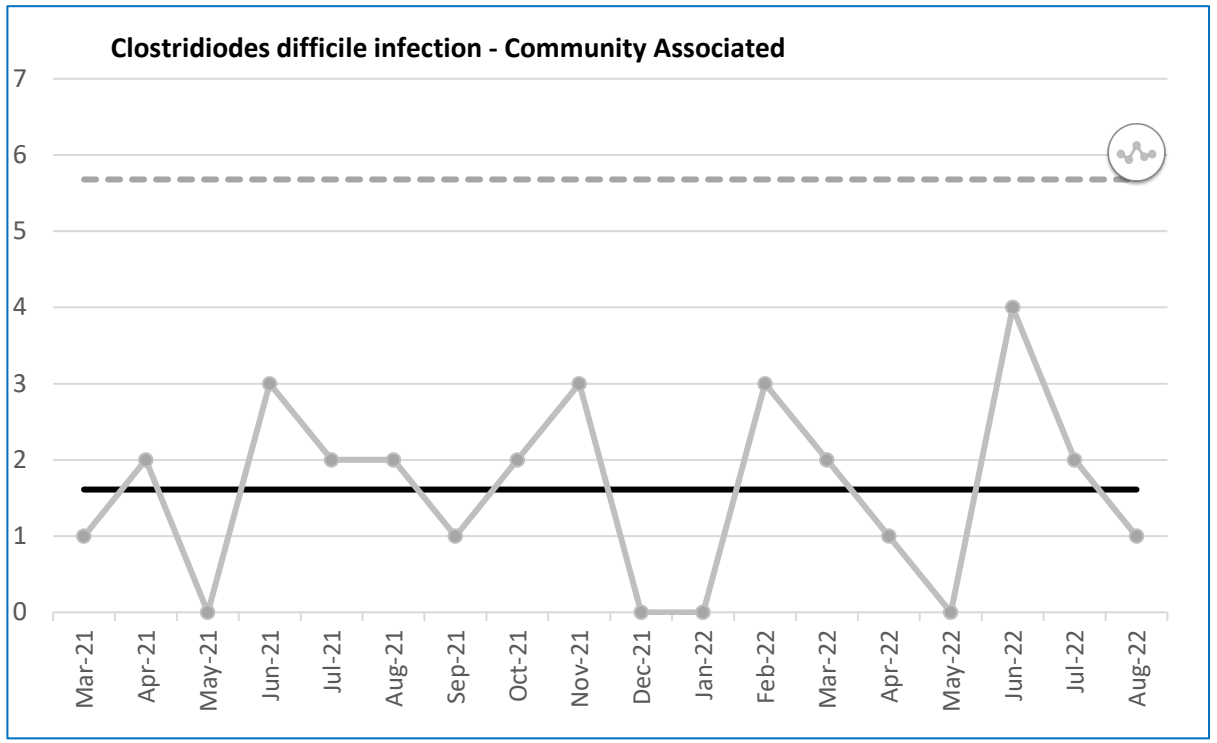
Infection Prevention & Control – Healthcare Associated Infections - Clostridiodes Difficile Infection

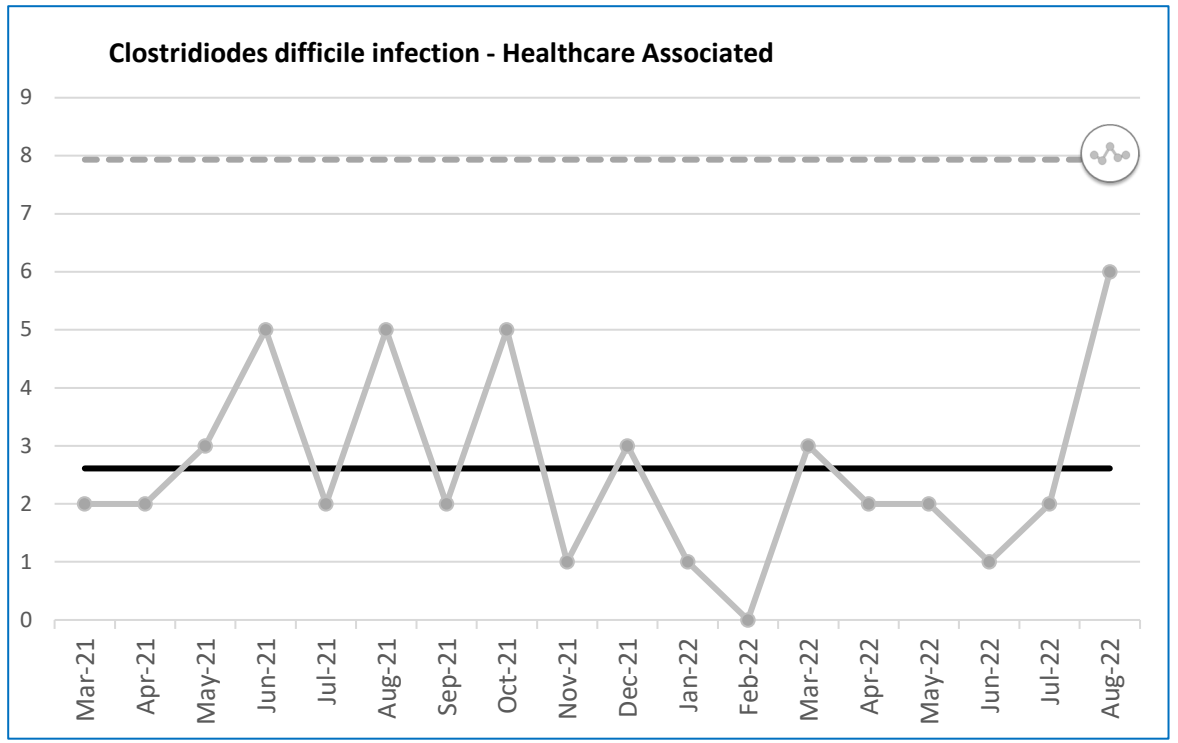
Safe

Gateshead Health NHS Foundation Trust

The Trust has reported 13 Healthcare associated CDI cases since April 2022 against the CDI threshold for 2022/23 of 32.

The 6 Healthcare Associated cases in August include 4 Hospital onset – Healthcare Associated (HOHA) and 2 Community onset – Healthcare Associated (COHA) cases.





Infection Prevention & Control – Healthcare Associated Infections - MSSA & E Coli

Safe

Gateshead Health NHS Foundation Trust

- All Healthcare associated BSI are reviewed and actions are initiated if necessary.
- NHS England has not set an Healthcare Associated MSSA BSI threshold for 2022/23
- The Trust has reported 3 Healthcare Associated MSSA BSI during August 2022
- NHS England has set the Trust a threshold of 68 Healthcare Associated E. coli BSI for 2022/23
- The Trust has reported 5 Healthcare Associated E. coli during August 2022 – 4 HOHA and 1 COHA. The increase in community E.coli BSI is possibly associated with the period of significantly hot weather.
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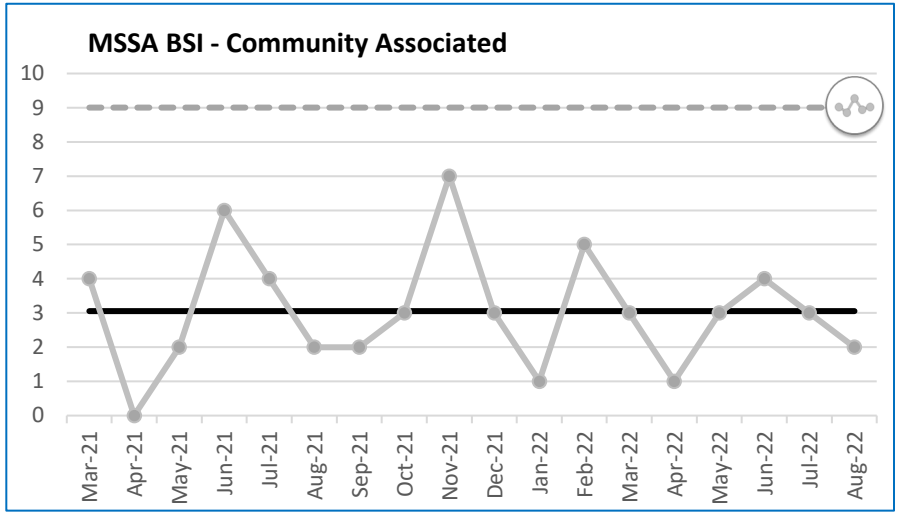
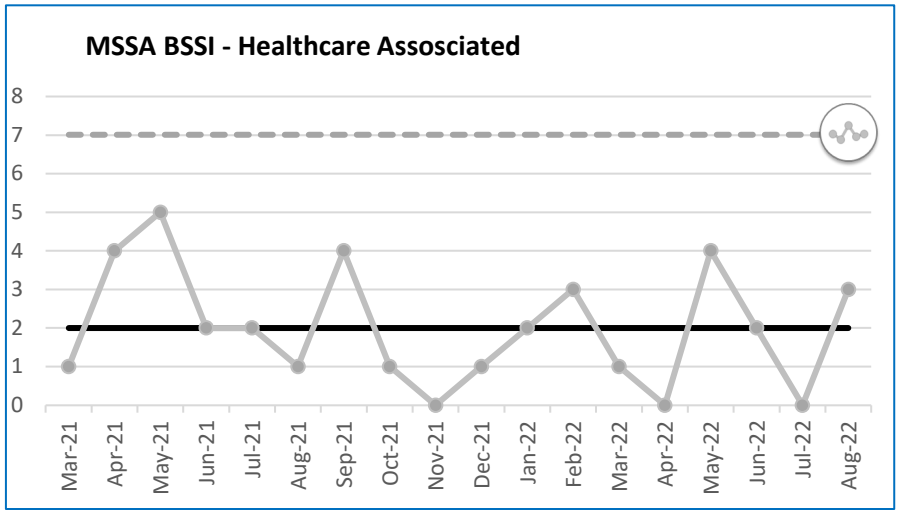
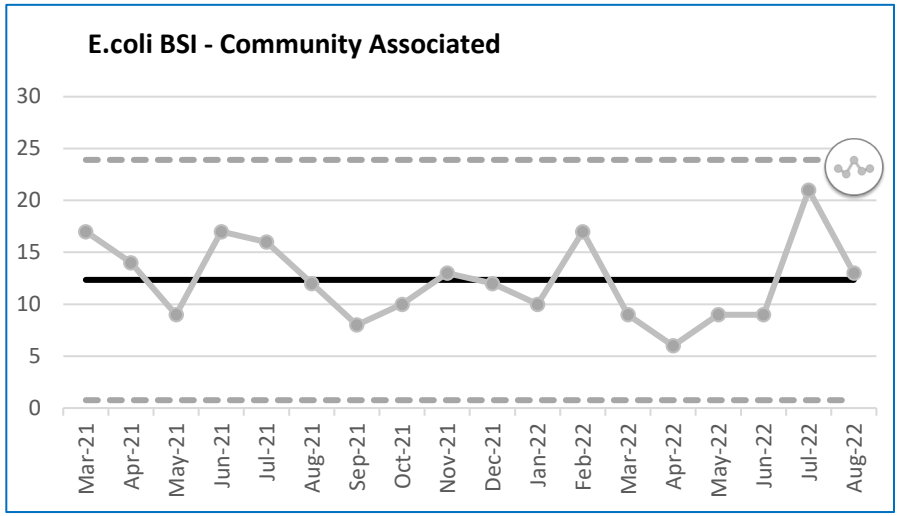
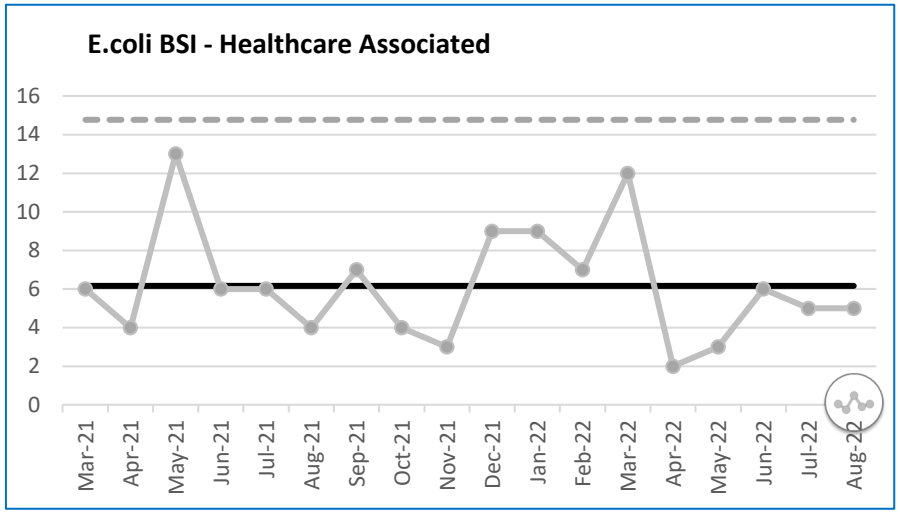




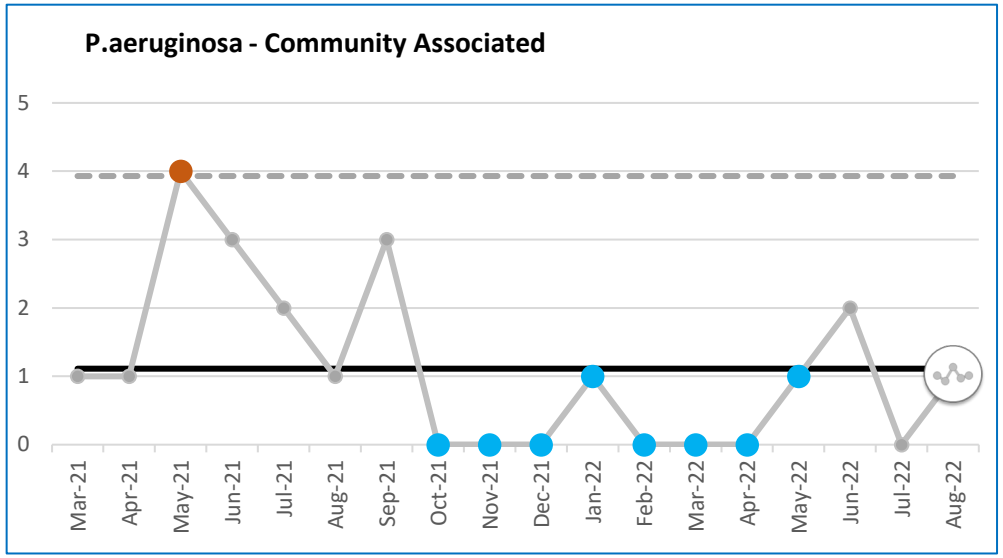


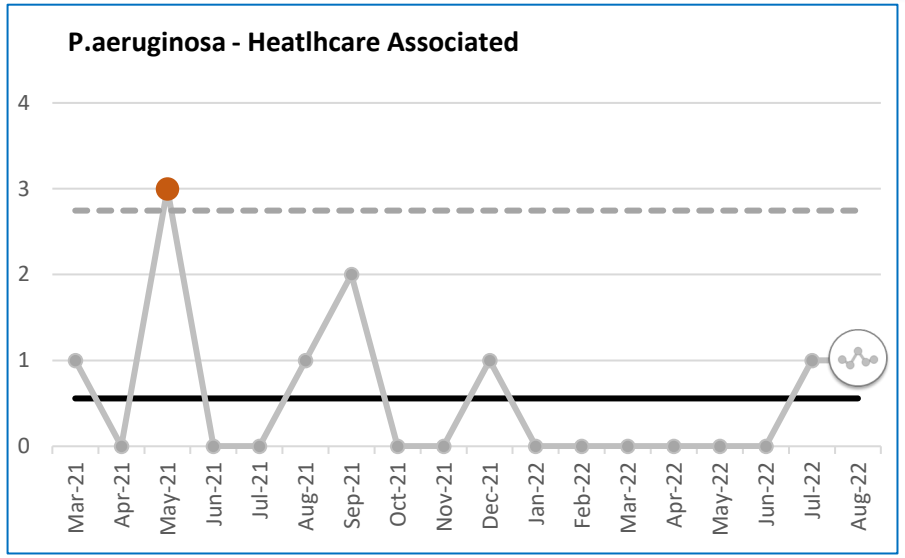


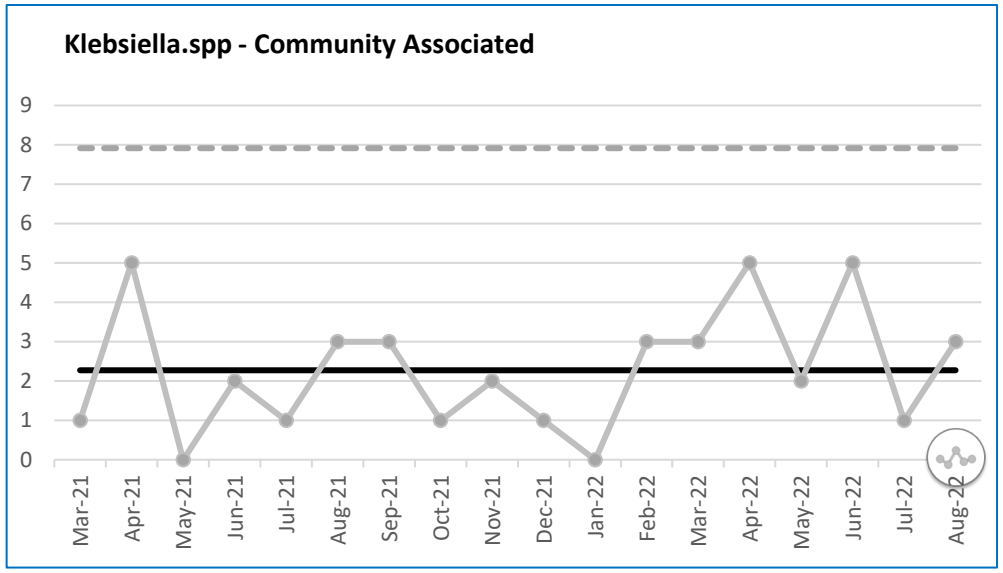
Infection Prevention & Control – Healthcare Associated Infections - P. aeruginosa & Klebsiella spp.

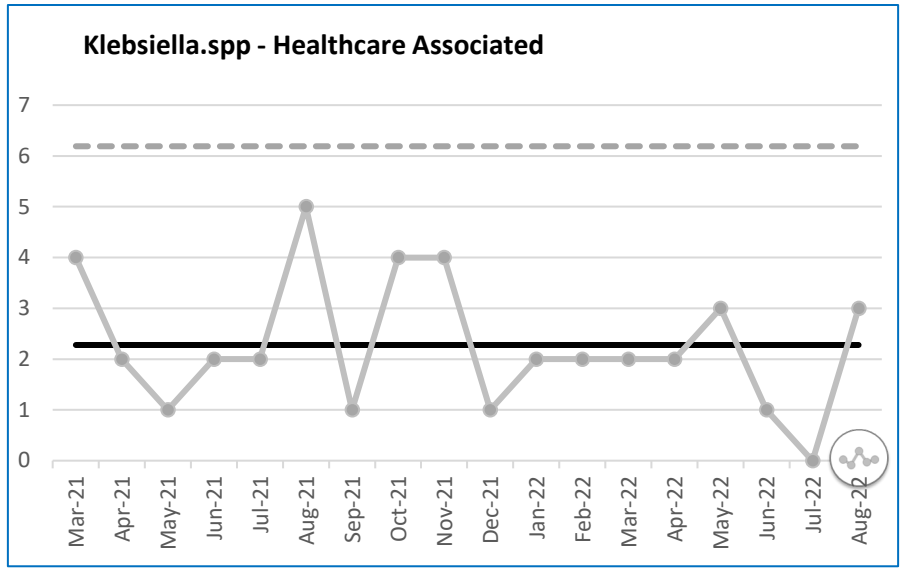
Safe

Gateshead Health NHS Foundation Trust









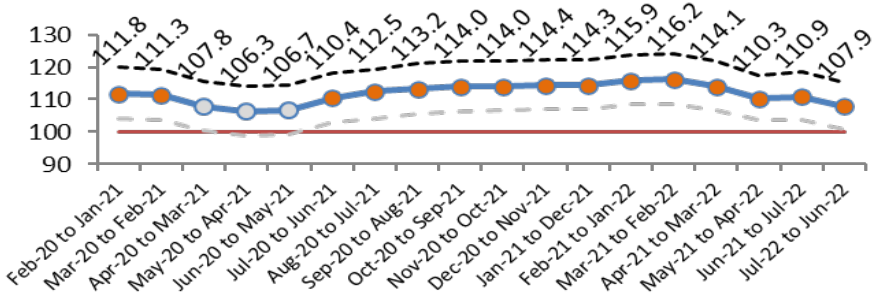
- All Healthcare associated BSI are reviewed and actions are initiated if necessary.
- NHS England has set the Trust a threshold of 8 Healthcare Associated P.aeruginosa BSI and 26 Healthcare Associated Klebsiella spp. BSI for 2022/23
- The Trust has reported 1 COHA P. aeruginosa BSI during August 2022.
- The Trust reported 3 Healthcare Associated Klebsiella BSI during August 2022.

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

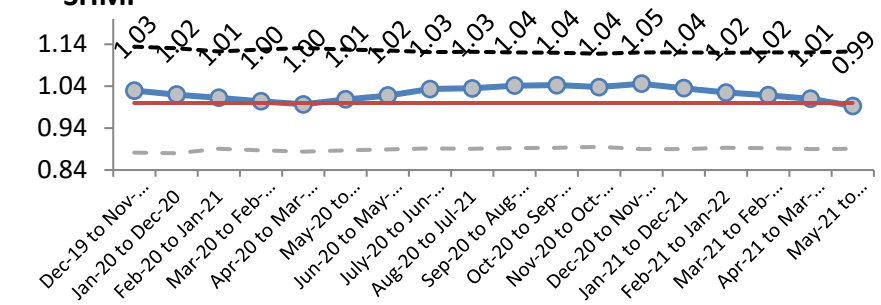
Effective

Gateshead Health NHS Foundation Trust

HSMR



SHMI



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
1186	99.9%	39.9%	42.9%	12.5%	4.7%

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
97.4%	2.4%	0.2%	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
87.7%	1.0%	9.5%	1.6%	0.0%	0.2%

The Trust HSMR is 107.9 and remains with a banding of 'More Deaths than Expected' for the most recent available period.
The Trust SHMI is 10.99 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 however the recent trend is encouraging and the indicator is close to returning to deaths within the expected range.

The SHMI is showing deaths are within the expected range with the latest figures below the national average of 1.00.
The Trust continues to trigger for patients with a Congestive heart failure diagnosis on admission. Mortality alerts are assessed and discussed at the mortality and morbidity steering group.

Mortality review data for the last 12 months demonstrates that 97.4% 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, all deaths are reviewed and cases may be escalated for additional investigations i.e. Mortality Council, patient safety investigation.

A process has now been finalised for the review of Severe Mental Illness (SMI) deaths using the NHSE criteria. Two extraordinary meetings of the Mortality Council have been arranged (29th September and 4th October) to review the backlog of 20 cases. Cases will then be added to the agenda as they arise thereafter.

Actions

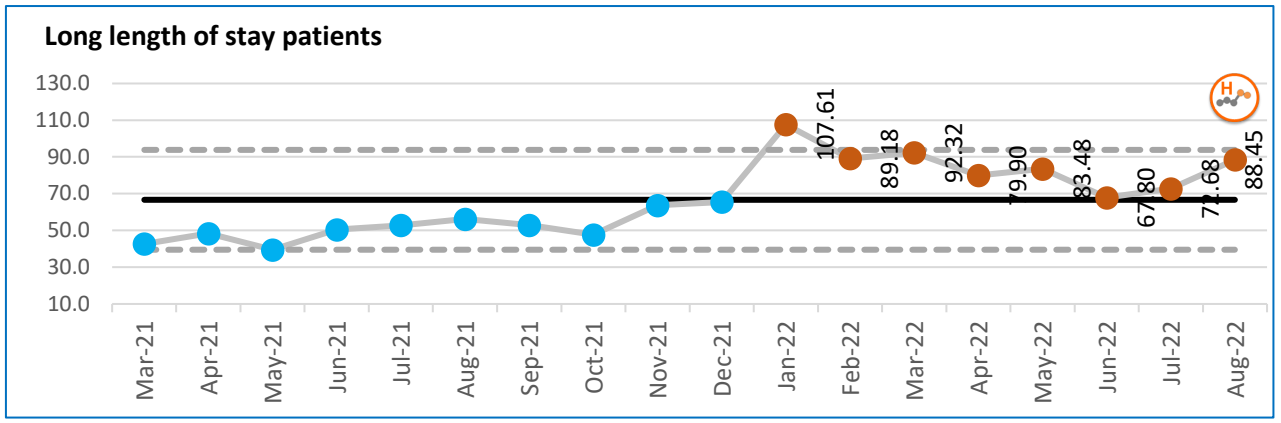
- Potential issues identified with clinical coding shared with the clinical coding team for further investigation.
- Task & Finish Group set up to incorporate the Medical Examiner Review into the level 1 process. A large proportion of deaths are expected and well managed, particularly in the Medical 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. UPDATE – new process to go live on 3rd October 2022.
- 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

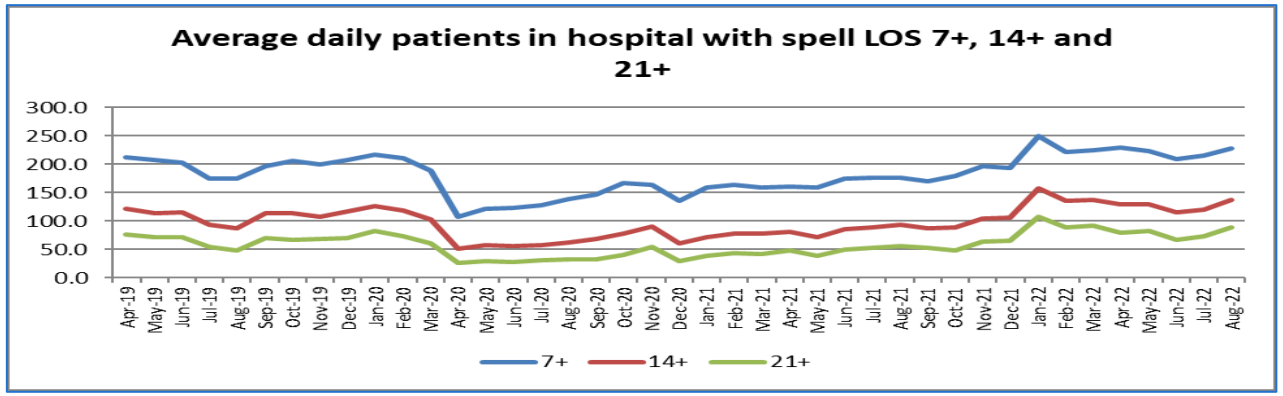
Recommendation - Continue to inform & note actions undertaken at Mortality and Morbidity steering group and Quality Governance Committee via the Integrated Oversight Report and Mortality Paper.

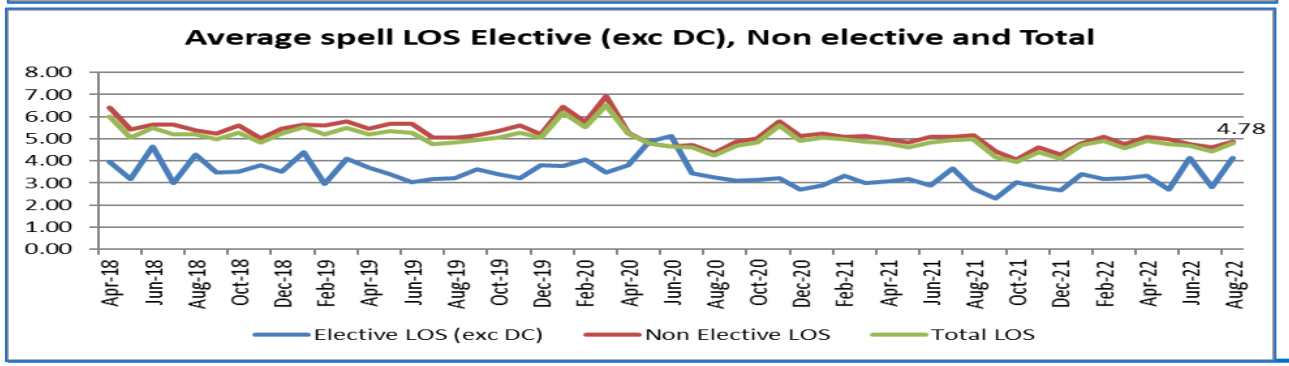
Report by exception: Long Length of Stay Patients

Effective

Gateshead Health NHS Foundation Trust







Situation The average number of patients in hospital with 21+ days LOS is currently triggering special cause variation (concern). A reduction since January 2022 is observed however the 2022 figures are above the upper process limit.

The ECIST existing target of 59 is subject to either pass or fail based on common cause variation.

There was a continued deterioration in the average number of Long stay patients (LOS 21+) from 72.7 in July to 88.5 in August.

Background
An expectation that the daily average number of patients staying 21+ days would not exceed 59.

Assessment
Complex high acuity patients requiring multi faceted treatment plans genuinely do require longer lengths of stay in hospital – these patients are deemed as meeting the right to reside in hospital criteria. However, patients who no longer meet the criteria to reside (and are medically optimised) are usually more complex discharges where external delay factors such as limitations on packages of care and the ability to place patients into a care homes are the usual reasons behind the delays.

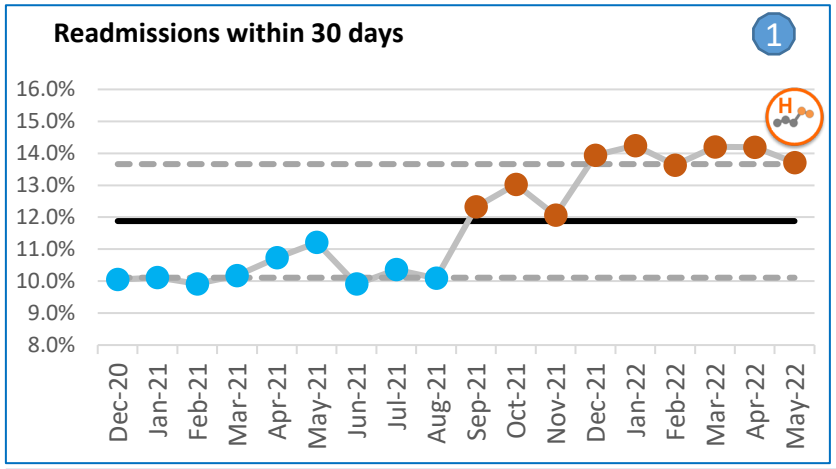
Long lengths of stay patients continue to be reviewed as part of the Improving the patient journey task & finish group as a number of workstreams are affected. A specific workstream to review the super stranded patients - length of stay over 21 days as part of the second priority.

Recommendation
Review as part of Discharge workstream under the Urgent and Emergency Care Board

Report by exception: Readmissions within 30 days

Effective

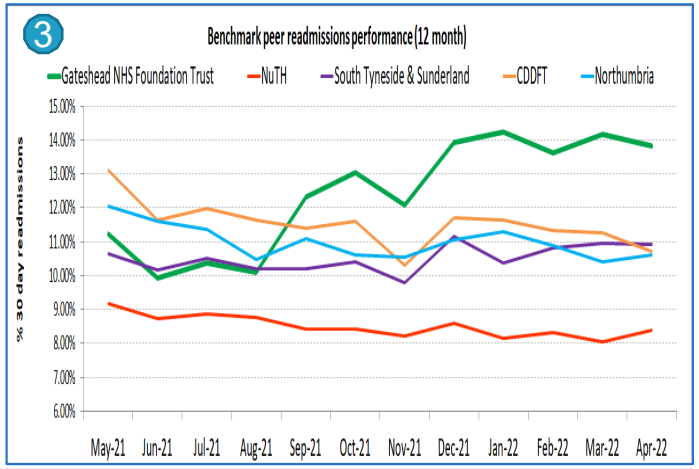
Gateshead Health NHS Foundation Trust



Latest benchmarking data available April 22

TRUST

	Gateshead NHS Foundation Trust			2		Lower than GHFT / Higher than GHFT	
	Discharges	Readmissions	%age	NuTH	S'Tyneside & S'land	CDDFT	Northumbria
May-21	4602	516	11.21%	9.16%	10.63%	13.09%	12.03%
Jun-21	4993	495	9.91%	8.73%	10.15%	11.64%	11.59%
Jul-21	4644	481	10.36%	8.86%	10.50%	11.96%	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%	8.42%	10.40%	11.59%	10.61%
Nov-21	5156	623	12.08%	8.23%	9.78%	10.29%	10.55%
Dec-21	5043	703	13.94%	8.59%	11.15%	11.70%	11.06%
Jan-22	4664	663	14.22%	8.14%	10.37%	11.65%	11.30%
Feb-22	4535	617	13.61%	8.31%	10.82%	11.34%	10.88%
Mar-22	5402	766	14.18%	8.03%	10.95%	11.26%	10.41%
Apr-22	4758	657	13.81%	8.39%	10.91%	10.72%	10.60%



Situation
Special cause variation (high) observed in 30 day readmissions from September 2021 to April 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 benchmarking data (April 22) shows Surgery accounts for 46.3% of discharges, and 31.8%% if readmissions, while Medicine accounted for 49.8% of discharges and 67.9% of readmissions, meaning medicine continue to account for a disproportionate high number, and increasing, 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 24.1%, accounting for 49.2% of all readmissions. **Gastroenterology** - discharge percentage 11.6%, accounting for 7.5% of readmissions. **General Surgery** - discharge percentage 11.2%, accounting for 13.4% of readmissions. **Clinical oncology** - discharge percentage 8.6%, accounting for 3.0% of readmissions. Gynaecology - discharge percentage 7.8%, accounting for 4.3% of readmissions.

Recommendation
Working continues to understand the reasons behind the headline performance figures, and what may have impacted to cause the sudden increase seen in September 2021. Trending was created to identify speciality areas which disproportionately impacted performance, in order do focussed case audit work in these specialities (by Audit and operational staff) to help better understand the influencing factors. This work will also consider any relevant learning from the SDEC analysis being undertaken in, given the correlation between the local increase in our performance value and the start of SDEC in September 2021.

UEC Measures

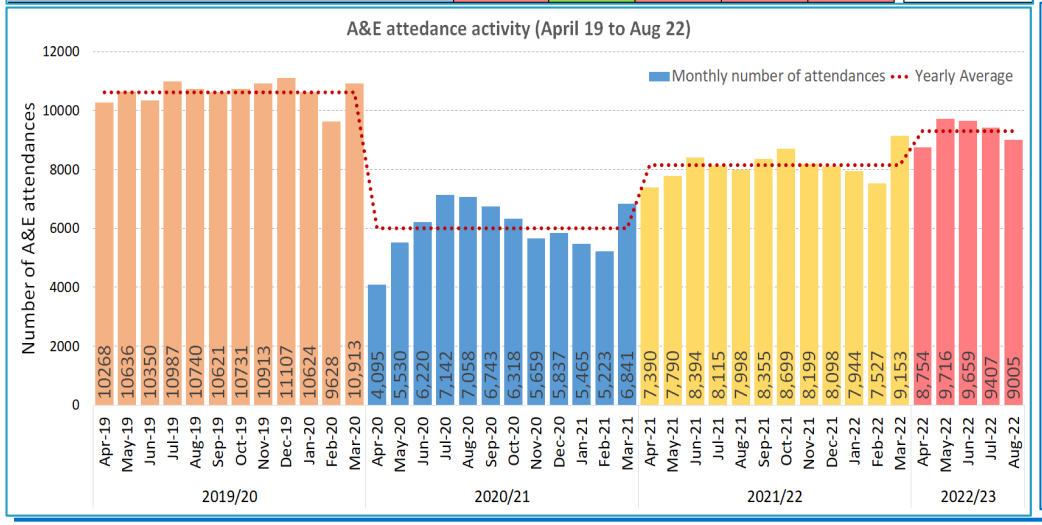
Responsive

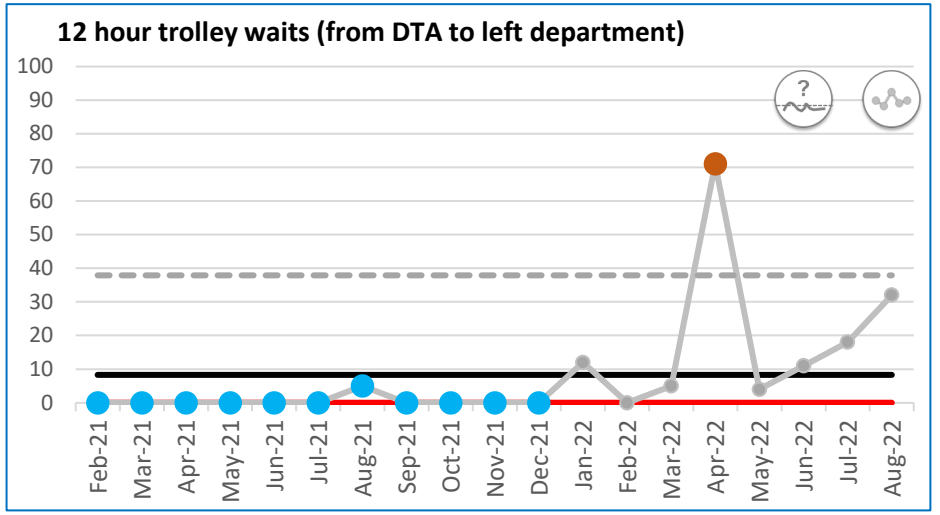
Gateshead Health NHS Foundation Trust

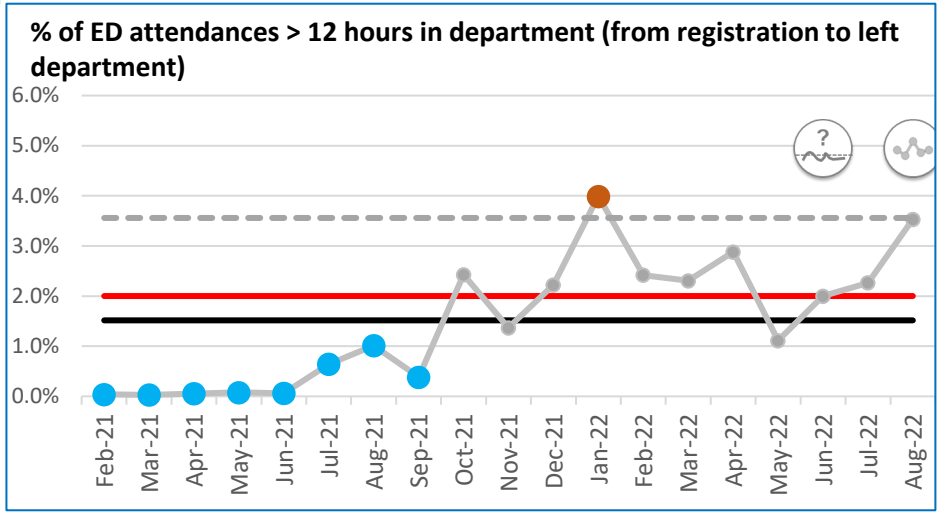
NHSI SOF Operational Performance & National Operational Standards

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 waits in department > 12 hours
5. No of waits in department waiting longer than 12 hours for a bed

A&E Indicators	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Monthly Trend
Attendances: Type 1	5431	6098	6090	6051	5686	
Attendances: Type 3	3323	3618	3569	3356	3319	
Total Attendances	8754	9716	9659	9407	9005	
Total Breaches	2164	2148	2212	2116	2292	
Trust Total - % seen in 4 hours	75.3%	77.9%	77.1%	77.5%	74.5%	
National Rank (Accute trusts - Lower is better)	23	20	19	16	29	
12 hour trolley waits (DTA breaches)	71	4	11	18	32	
Volumne in department > 12hours	252	108	193	213	318	
A&E >12hour waits (target <2%)	2.88%	1.11%	2.00%	2.26%	3.53%	







Situation

- Footfall and patient numbers decreased in August to 9005 from 9407 in July, although daily attendances averaged 32 per day more than August 2021 (representing an increase of 12.6%)
- 4 hour performance 74.5%, reduction from July at 77.5% - latest national benchmarking data places the Trust at 29th of 139 Type 1 providers
- The target for 12 hr dept times of no more than 2% of all attendances has not been met since May and increased to 3.53% in August from 2.26% in July (318 actual patients)
- Overall time in the department remains high, (non-admitted 2 hours 32 minutes, admitted 7 hours 28 minutes)
- 32 x 12 hour trolley breaches recorded in the month, increase from 18 in June. Figures have increased each month since May – Tuesdays remain problematic.

Context:

- Urgent and Emergency Care remains under pressure with increased and sustained activity levels, along with long waits for beds
- Trust average daily bed occupancy remains high increasing from 95.1% in July, to 96.0% in August
- The Trust was at OPEL 3 for 14 out of 31 days in August.

UEC Measures - Ambulance Handover Delays

Responsive

Gateshead Health NHS Foundation Trust

NHSI SOF Operational Performance & National Operational Standards
1. No. of ambulance delays
2. No. of ambulance diverts

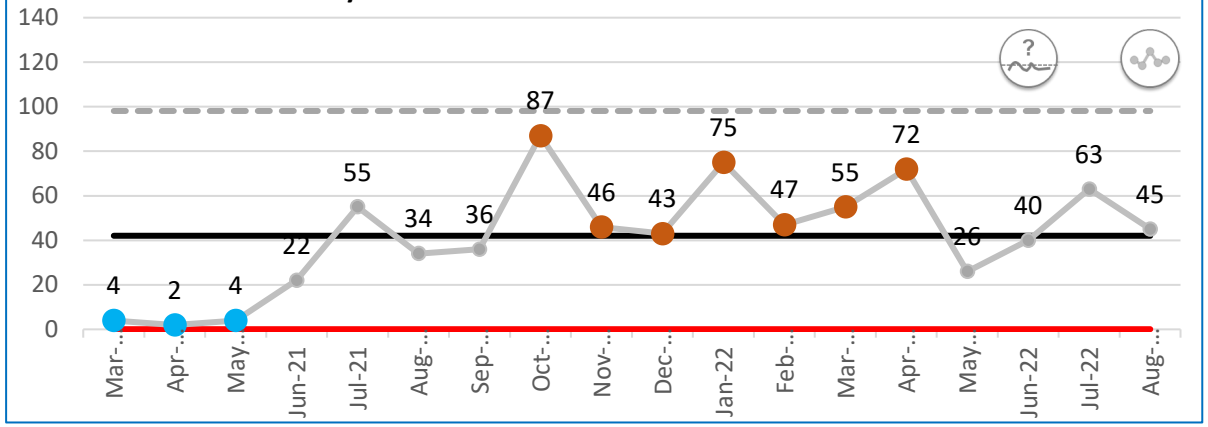
Ambulance Arrivals and handover delays	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Monthly Trend
No. Patients arriving by Ambulance	1619	1803	1733	1748	1760	
% of handovers <15 Minutes	44.1%	46.7%	45.1%	42.5%	45.8%	
Number of >30 Minute Breaches	72	26	40	63	45	
Number of >60 Minute Breaches	62	10	17	37	36	

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.

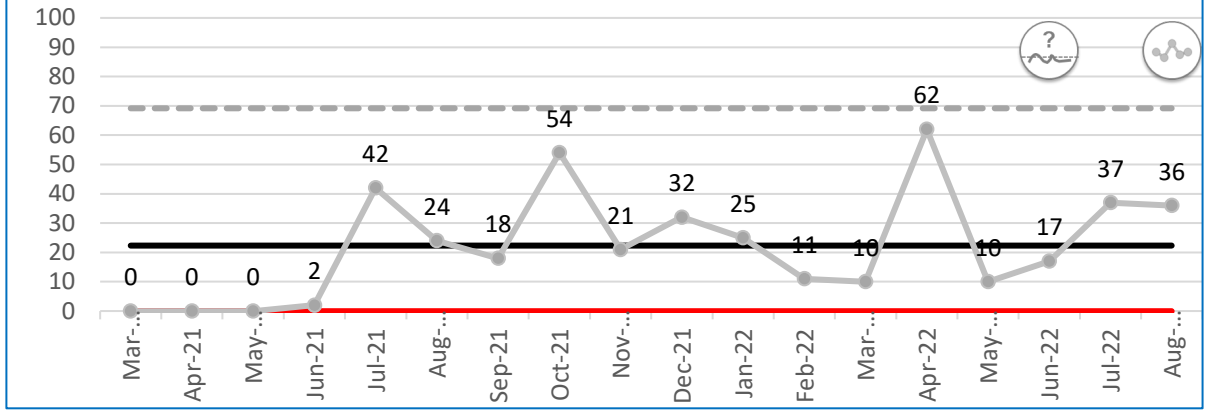
There is now greater focus on reducing ambulance delays following AACE publication of clinical review which states that the review should take 15 mins with no patients waiting more than 30 minutes. In 2022/23 an expectation of 65% of handovers should take place within 15 minutes, 95% within 30 minutes 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 decreased slightly in August 22, with 45 reported. Over 60 minute delays is displaying common cause variation with 36 delays in August 22. Despite the increase the Trust is still a high performer in the region, which may account for the high volumes of ambulance diverts the Trust undertakes.

Ambulance handover delays 30-60 minutes



Ambulance handover delays 60 minutes +



UEC activity heatmap – last 3 months

Responsive

NHS Gateshead Health NHS Foundation Trust

Gateshead UEC and Acute Activity - Daily June - Aug 22

June

	Wed-01/06/2022	Thu-02/06/2022	Fri-03/06/2022	Sat-04/06/2022	Sun-05/06/2022	Mon-06/06/2022	Tue-07/06/2022	Wed-08/06/2022	Thu-09/06/2022	Fri-10/06/2022	Sat-11/06/2022	Sun-12/06/2022	Mon-13/06/2022	Tue-14/06/2022	Wed-15/06/2022	Thu-16/06/2022	Fri-17/06/2022	Sat-18/06/2022	Sun-19/06/2022	Mon-20/06/2022	Tue-21/06/2022	Wed-22/06/2022	Thu-23/06/2022	Fri-24/06/2022	Sat-25/06/2022	Sun-26/06/2022	Mon-27/06/2022	Tue-28/06/2022	Wed-29/06/2022	Thu-30/06/2022
		BH	BH																											
No. of A&E Attendances	277	299	304	305	320	379	339	329	298	283	321	330	357	351	328	331	299	289	293	373	330	316	294	340	346	327	349	345	315	292
No. of admissions	98	71	79	69	64	114	118	116	113	110	75	84	96	116	95	103	101	69	56	92	110	99	94	118	75	45	113	103	94	108
No. of discharges	108	74	74	65	43	101	135	110	107	105	71	50	110	106	112	95	116	76	35	96	108	100	91	122	80	36	95	111	100	87
No. of emergency admissions	80	68	76	68	62	101	101	93	96	91	71	62	83	96	83	86	86	63	55	80	87	86	72	104	72	42	100	84	84	84
No. of emergency admissions via A&E	48	54	52	57	52	62	73	64	64	58	61	48	53	64	60	59	54	46	47	52	66	57	50	78	56	34	68	53	57	61
No. of patients arriving by Ambulance	58	59	63	59	51	66	71	55	57	49	69	73	57	58	55	68	51	47	61	57	63	67	53	69	64	41	49	52	51	40
No. of 4 Hour Wait Breaches	60	59	46	40	69	93	114	77	70	79	102	91	64	91	74	94	65	30	55	75	78	80	54	98	80	46	84	80	56	76
No. of waits for admission 4-12 hours from DTA	30	39	24	5	10	32	41	22	41	35	36	36	23	43	37	40	36	11	17	31	35	36	33	44	38	23	34	22	34	30
No. patients waiting over 12 hours in department	7	1	0	1	0	5	21	0	0	2	0	7	5	0	16	7	7	0	0	19	13	2	1	17	13	0	16	25	7	1
No. of waits for admission from DTA over 12 hours	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	11	0	0
No. of patients who do not meet the criteria to reside	45	46	40	36	37	36	31	31	26	36	38	40	41	41	50	47	51	51	47	45	49	46	48	51	47	45	46	53	50	58
No of beds open	437	439	435	436	442	443	451	451	436	436	440	454	450	449	444	443	444	437	434	440	441	441	437	437	428	430	432	440	439	435
No of beds open (variance to plan)	3	5	1	2	8	9	17	17	2	2	6	20	16	15	10	9	10	3	0	6	7	7	3	3	-6	-4	-2	6	5	1
% Beds Occupied	92.0%	91.3%	92.2%	92.7%	95.7%	98.0%	94.0%	92.2%	95.6%	94.5%	97.0%	97.6%	94.4%	95.5%	92.8%	94.6%	90.8%	92.0%	97.0%	95.5%	93.2%	93.4%	94.5%	91.3%	94.2%	96.0%	99.1%	95.9%	94.5%	95.2%

July

	Fri-01/07/2022	Sat-02/07/2022	Sun-03/07/2022	Mon-04/07/2022	Tue-05/07/2022	Wed-06/07/2022	Thu-07/07/2022	Fri-08/07/2022	Sat-09/07/2022	Sun-10/07/2022	Mon-11/07/2022	Tue-12/07/2022	Wed-13/07/2022	Thu-14/07/2022	Fri-15/07/2022	Sat-16/07/2022	Sun-17/07/2022	Mon-18/07/2022	Tue-19/07/2022	Wed-20/07/2022	Thu-21/07/2022	Fri-22/07/2022	Sat-23/07/2022	Sun-24/07/2022	Mon-25/07/2022	Tue-26/07/2022	Wed-27/07/2022	Thu-28/07/2022	Fri-29/07/2022	Sat-30/07/2022	Sun-31/07/2022
No. of A&E Attendances	286	317	292	344	396	297	288	282	257	320	355	309	306	288	261	261	246	323	314	348	316	314	293	283	334	280	322	278	273	339	285
No. of admissions	106	87	76	101	112	94	102	100	76	59	90	98	85	93	89	62	48	91	104	116	100	91	70	48	104	109	112	109	88	82	51
No. of discharges	144	70	59	97	114	97	109	104	59	50	108	95	88	86	107	54	34	88	104	93	106	100	63	41	106	110	116	98	108	64	40
No. of emergency admissions	95	85	72	89	98	80	85	91	73	57	77	83	76	80	81	62	46	80	81	102	88	86	69	46	90	92	101	90	79	77	49
No. of emergency admissions via A&E	55	64	55	56	74	51	52	54	57	50	53	60	57	55	54	47	37	51	56	69	57	55	60	37	65	51	56	45	53	62	39
No. of patients arriving by Ambulance	57	63	55	46	69	33	60	52	55	48	52	65	48	58	51	66	56	51	66	68	53	61	60	44	65	52	67	46	65	58	58
No. of 4 Hour Wait Breaches	77	34	54	69	86	56	62	62	67	71	61	93	73	63	58	32	22	67	75	85	56	75	85	84	80	76	71	62	68	90	70
No. of waits for admission 4-12 hours from DTA	35	17	25	20	46	22	36	36	41	29	19	27	24	24	26	13	7	31	42	45	38	21	23	14	35	32	38	24	33	30	25
No. patients waiting over 12 hours in department	11	0	0	5	16	2	5	4	1	0	0	1	0	1	1	0	0	22	13	20	11	30	5	14	24	8	4	0	7	2	6
No. of waits for admission from DTA over 12 hours	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	14	2	0	0	0	0	0	0	0	0
No. of patients who do not meet the criteria to reside	57	49	48	45	43	43	39	50	69	63	59	52	60	55	51	47	47	46	48	46	46	50	49	49	49	50	45	46	50	52	53
No of beds open	443	442	441	440	442	436	436	435	441	444	442	425	427	430	429	429	428	431	443	452	445	445	448	448	449	452	443	451	439	439	448
No of beds open (variance to plan)	9	8	7	6	8	2	2	1	7	10	8	-9	-7	-4	-5	-5	-6	-3	9	18	11	11	14	14	15	18	9	17	5	5	14
% Beds Occupied	86.5%	90.5%	93.7%	97.3%	93.4%	94.0%	93.6%	94.3%	93.4%	95.5%	92.5%	97.4%	96.7%	95.8%	93.7%	93.7%	93.7%	98.1%	93.9%	96.0%	98.0%	98.2%	96.2%	96.4%	97.1%	96.0%	96.4%	95.3%	96.1%	96.4%	96.7%

August

	Mon-01/08/2022	Tue-02/08/2022	Wed-03/08/2022	Thu-04/08/2022	Fri-05/08/2022	Sat-06/08/2022	Sun-07/08/2022	Mon-08/08/2022	Tue-09/08/2022	Wed-10/08/2022	Thu-11/08/2022	Fri-12/08/2022	Sat-13/08/2022	Sun-14/08/2022	Mon-15/08/2022	Tue-16/08/2022	Wed-17/08/2022	Thu-18/08/2022	Fri-19/08/2022	Sat-20/08/2022	Sun-21/08/2022	Mon-22/08/2022	Tue-23/08/2022	Wed-24/08/2022	Thu-25/08/2022	Fri-26/08/2022	Sat-27/08/2022	Sun-28/08/2022	Mon-29/08/2022	Tue-30/08/2022	Wed-31/08/2022
																													BH		
No. of A&E Attendances	326	339	275	297	283	277	277	336	292	284	257	268	293	304	338	285	269	277	265	285	275	318	281	285	252	275	287	298	299	338	270
No. of admissions	93	110	105	105	98	71	57	83	83	101	104	87	63	53	113	105	93	99	96	69	53	102	94	141	111	91	58	74	63	98	97
No. of discharges	104	95	101	105	120	59	51	79	87	107	100	111	56	39	112	81	101	88	130	62	30	105	99	106	113	108	43	58	53	86	110
No. of emergency admissions	83	86	97	91	92	70	56	78	71	84	83	78	63	51	97	86	82	81	89	67	52	89	81	97	94	81	58	73	63	82	83
No. of emergency admissions via A&E	55	64	62	57	59	54	44	56	52	51	56	50	49	38	64	57	51	59	57	48	42	54	48	55	63	55	46	60	42	52	51
No. of patients arriving by Ambulance	55	59	63	61	65	52	58	53	58	53	43	43	67	59	64	69	58	69	59	57	58	58	45	54	56	49	46	68	43	55	63
No. of 4 Hour Wait Breaches	87	94	84	79	64	78	61	84	82	82	57	43	76	92	97	113	59	62	61	42	44	63	62	73	84	62	71	90	52	92	67
No. of waits for admission 4-12 hours from DTA	29	38	42	39	36	35	23	31	39	26	39	30	38	26	27	39	22	32	24	19	9	26	29	36	43	33	33	28	18	25	29
No. patients waiting over 12 hours in department	7	15	16	30	11	17	1	2	8	8	6	4	0	12	28	35	25	1	1	1	1	2	17	11	6	1	6	0	0	20	26
No. of waits for admission from DTA over 12 hours	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	4	12	0	0	0	0	0	0	0	0	0	0	0	0	8	5
No. of patients who do not meet the criteria to reside	54	52	48	52	49	46	50	48	54	56	58	53	58	57	56	57	70	65	77	67	66	67	64	71	68	60	52	49	47	47	45
No of beds open	446	447	452	454	455	452	447	446	447	445	437	437	433	436	434	448	452	447	439	439	441	444	459	452	444	444	444	444	451	450	451
No of beds open (variance to plan)	12	13	18	20	21	18	13	12	13	11	3	3	-1	2	0	14	18	13	5	5	7	10	25	18	10	10	10	10	17	16	17
% Beds Occupied	96.9%	96.4%	97.3%	96.5%	92.3%	93.8%	97.8%	98.9%	96.6%	95.3%	96.8%	93.4%	95.2%	97.0%	98.6%	98.2%	95.8%	97.5%	93.4%	92.9%	97.7%	97.7%	94.1%	95.1%	95.0%	90.1%	94.1%	97.3%	98.4%	99.3%	97.1%

Totals

	Total June	Total July	Total Aug
No. of A&E Attendances	9659	9407	9005
No. of admissions	2798	2753	2770
No. of discharges	2719	2712	2699
No. of emergency admissions	2416	2460	2438
No. of emergency admissions via A&E	1708	1687	1651
No. of patients arriving by Ambulance	1733	1748	1760
No. of 4 Hour Wait Breaches	2180	2084	2257
No. of waits for admission 4-12 hours from DTA	918	878	943
No. patients waiting over 12 hours in department	193	213	318
No. of waits for admission from DTA over 12 hours	11	18	32
No. of patients who do not meet the criteria to reside	44	50	57
No of beds open	440	440	446
No of beds open (variance to plan)	6	6	12
% Beds Occupied	94.4%	95.0%	96.0%

Pressures

Gateshead Health NHS Foundation Trust

Operational Performance Pressures & Operational Supporting Standards

1. No. of ambulance diverts
2. No. of Beds Open over Planned Levels
3. No. of patients no longer meeting the Criteria to Reside
4. Patients discharged who no longer met the criteria to reside

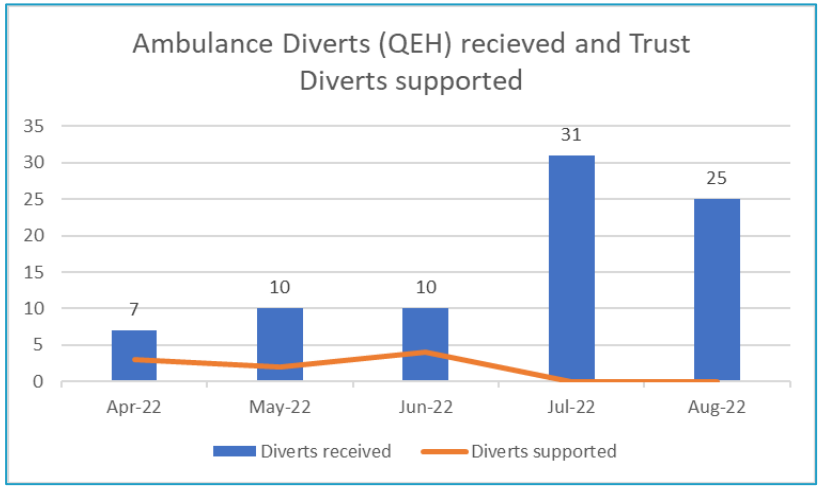
Situation

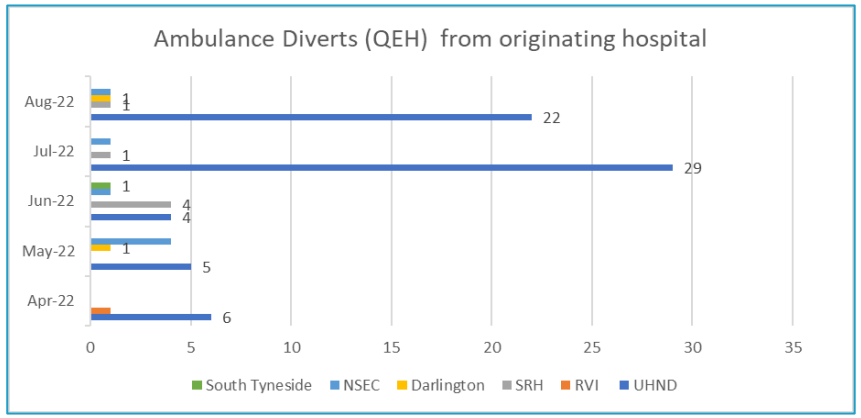
- Trust is 2nd top performing Trust in the (ICS) region for 30-60m Ambulance hand-over times.
- Ambulance diverts received have increased to 31 in July and 25 in August.
- Patients who no longer meet the criteria to reside remain problematic, peaking at 77 patients per day (average 57 patients)
- In August, out of area patients account for 1/3 of the patients & 1/3 of blocked beds (majority are pathway 1's)
- Estimated cost of blocked beds in August is £1.2m across all pathways.
- Additional beds are open over planned levels to accommodate patients who we are unable to discharge.

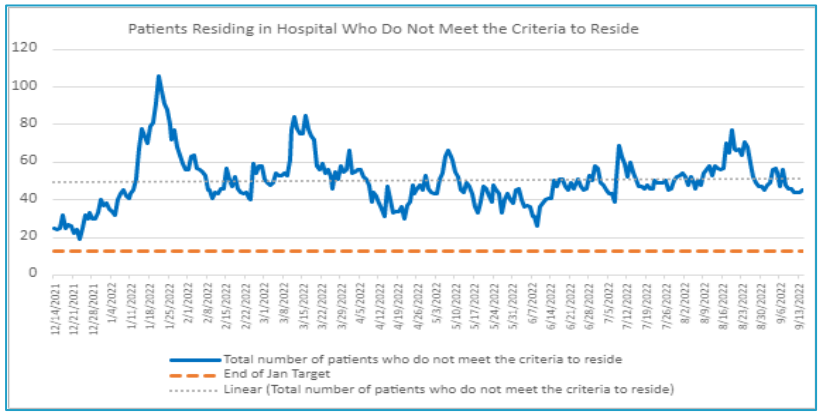
Context:

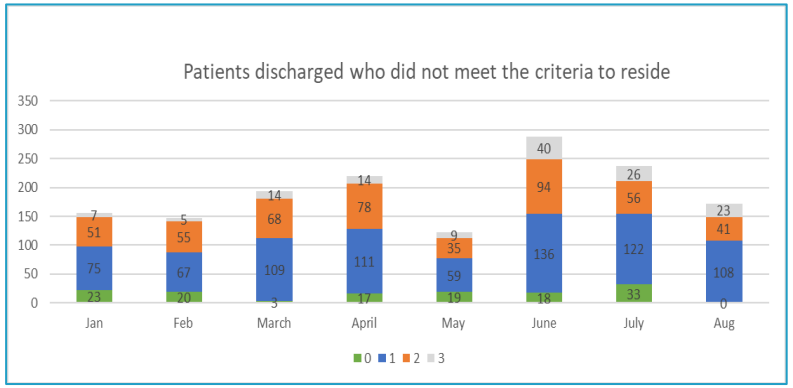
- Highest bed occupancy levels in ICS (2nd highest NENC& NY)
- Site pressures continue with beds blocked due to difficulties discharging patients
- The Trust receives more ambulance diverts due to regional pressures: 1/3 of beds were blocked by out of area patients.

Handover Delays	2019/20																	
Provider	Avge	Min	Max	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Gateshead Health NHS Foundation Trust	40	5	99	22	52	34	36	87	46	43	87	47	55	72	26	40	63
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	93	65	109	114	139	115	94	116	97	66	102	83	123	90	84	90	107
Northumbria Healthcare NHS Foundation Trust	472	283	723	233	350	343	418	427	334	399	276	352	531	398	578	442	587
South Tees Hospitals NHS Foundation Trust	138	105	184	129	128	195	149	175	163	151	179	170	210	200	206	231	260
North Tees & Hartlepool NHS Foundation Trust	64	42	116	31	71	46	45	24	48	100	65	19	44	35	34	68	41
County Durham & Darlington NHS Foundation Trust	313	165	438	400	475	498	460	356	426	345	374	437	325	365	238	346	365
South Tyneside and Sunderland NHS Foundation Trust	313	208	471	359	532	380	332	419	463	501	464	373	292	363	354	493	446
North Cumbria University Hospitals NHS Trust	405	265	559	107	239	187	170	200	190	157	222	238	246	282	248	201	207
NENC	1836	1308	2612	1395	1986	1798	1704	1804	1767	1762	1789	1719	1826	1805	1768	1911	2076









Community Teams and Rapid Response

Gateshead Health NHS Foundation Trust

Community Teams

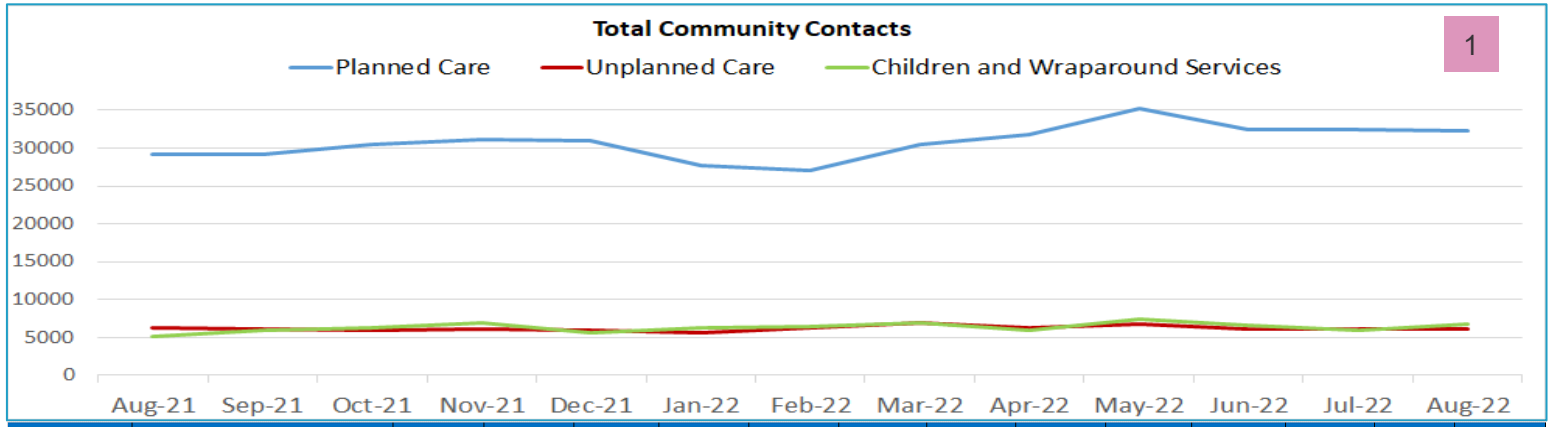
Community teams work with patients from birth to end of life to provide care to patients in their place of residence, clinic or education setting. The aim is to provide care close to home, avoiding admission, support early discharge and support patients to reach their maximum potential and independence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

The graphic (right) provides activity data for each of the areas above, for the past 12 months.



	Team	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
Total contacts	Planned care	29247	29181	30548	31232	31055	27739	27134	30418	31771	35205	32527	32394	32359
	Unplanned care	6283	6043	5878	6042	5932	5635	6316	6901	6238	6819	6114	6128	6109
	Children & Wraparound serv	5056	5877	6243	6962	5620	6239	6370	6907	5983	7329	6525	5928	6796

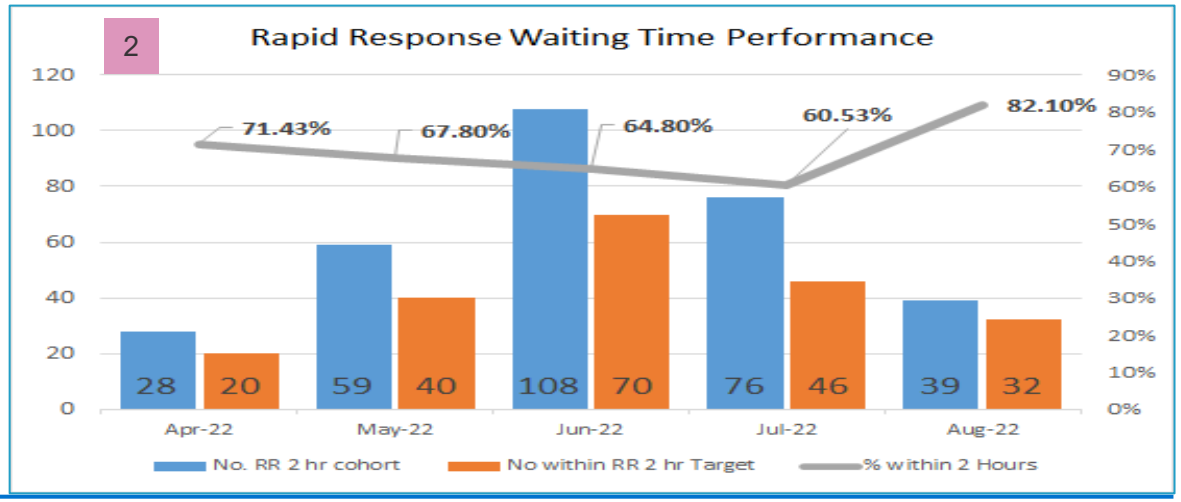
Rapid Response

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.

Monthly updates have been provided in the IOR since April around 2 hour performance, on an individual monthly basis. The graphic (right) collates monthly validated monitoring data for this measure since April. With the exception of April and the most recent month of August, the 70% target has not been met. Between April and July overall performance trajectory has been downwards month on month. Improvement was noted in August to 66.7% however activity was lower than previous months.



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.

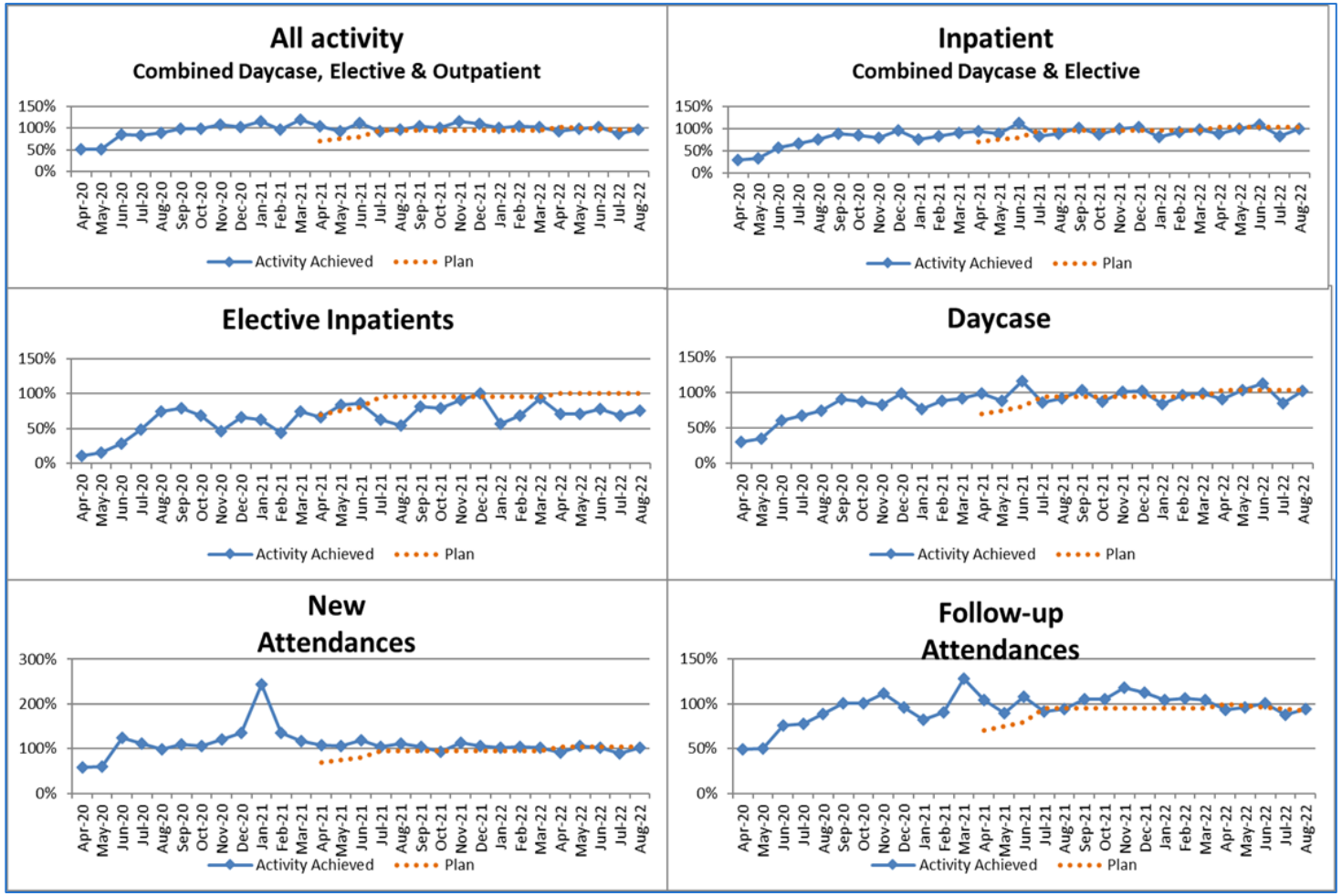
Elective Activity	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Monthly Trend
Total - Comined Elective Activity	94%	98%	102%	84%	97%	
Daycase	90%	103%	113%	85%	102%	
Elective Overnights	71%	71%	78%	68%	76%	
Outpatient - New	92%	106%	103%	88%	102%	
Outpatient - Followup	93%	96%	100%	84%	94%	
Total Outpatient	93%	98%	101%	88%	96%	

Indicative

August Activity: (DRAFT) - Activity is below planed levels, however has improved across the board from July activity:

Combined elective activity 97%
- **Day cases 102%**
- **Elective inpatients 76%**
- **New Outpatients 102%**
- **FU Outpatients 94%**

Other key requirements:
- The Trust is reporting 25.15% of all outpatient attendances conducted remotely, which is in-line with 25% expectation.
- 3.5% of all OP recorded as Patient Initiated Follow-Up – which is above planned levels of 2.6% and the expectation.



Activity & Recovery - Diagnostic

Gateshead Health NHS Foundation Trust

The expectation is to deliver 120% ICS diagnostic activity across the ICS. Trusts are expected to deliver as much as they can to support elective recovery. Overall August activity levels are at **110%** of activity in same period 19/20, **Endoscopy: 142%** of activity in same period 19/20, **Echocardiography: 89%** of activity in same period 19/20.

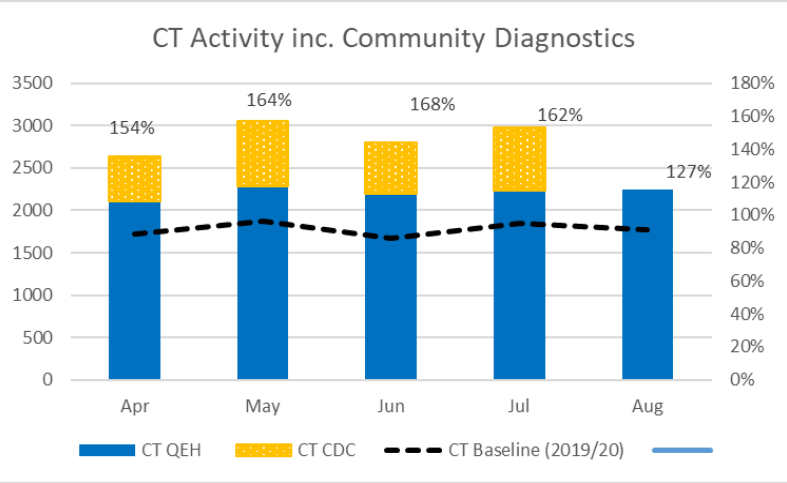
Diagnostic Activity Delivered	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Monthly Trend
Total - Total (100%)	100%	112%	110%	102%	110%	
MRI (120%)	91%	101%	100%	103%	105%	
CT (120%)	122%	122%	131%	121%	127%	
Colonoscopy (100%)	92%	106%	130%	90%	115%	
Non Obs Ultrasound (100%)	85%	100%	96%	83%	88%	
Flexi Sigmoidoscopy (100%)	66%	86%	73%	82%	122%	
Gastroscopy (100%)	86%	108%	109%	81%	124%	
Echo (100%)	73%	83%	76%	95%	89%	

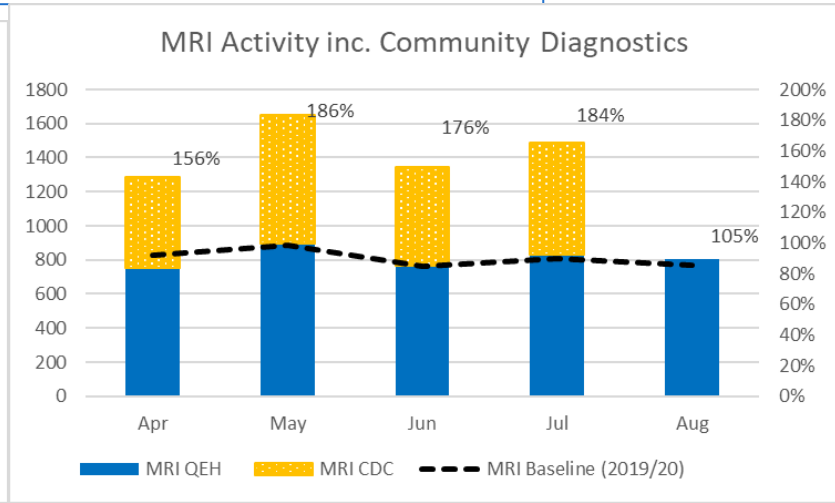
Indicative

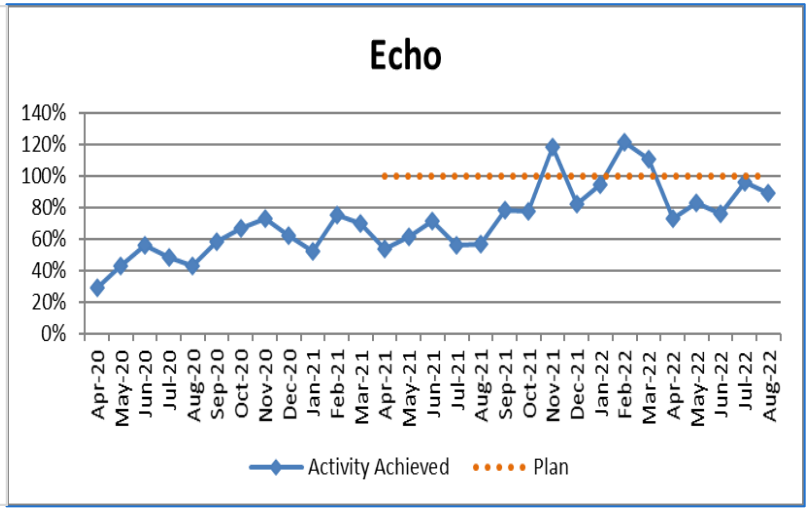
As part of a national initiative to manage diagnostic risk, the Trust is required to review and clinically prioritise (as with inpatient waiters) all waiters over 6 weeks.

The diagnostic modalities most at risk are echocardiology with a higher proportion of waits over six weeks (slide 26)

When Community Diagnostic Centre* modality activity is included – percentages are increased in excess of the required 120% activity levels. July reports CT at 162% and MRI at 184%.







Referral to Treatment

Responsive

Gateshead Health NHS Foundation Trust

RTT % Within 18 weeks (92%)	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Monthly Trend
Trust	74.2%	75.9%	76.3%	75.8%	74.9%	
General Surgery	79.5%	80.4%	79.0%	75.8%	77.6%	
Gynaecology	72.8%	77.3%	80.8%	80.2%	76.9%	
Trauma & Orthopaedics	64.2%	66.7%	67.0%	66.2%	64.3%	
Urology	77.7%	78.2%	73.3%	74.8%	75.1%	
Paediatrics	76.3%	74.6%	74.8%	73.3%	69.1%	
Cardiology	76.5%	78.7%	76.4%	74.5%	71.9%	
Gastroenterology	72.7%	78.1%	87.7%	90.0%	88.7%	
General Medicine	64.0%	78.1%	75.0%	86.2%	96.2%	
Geriatric Medicine	87.3%	91.2%	95.4%	89.7%	88.1%	
Respiratory Medicine	68.9%	69.1%	66.2%	65.2%	67.8%	
Rheumatology	83.5%	84.3%	80.1%	81.0%	83.1%	
Other	75.3%	73.3%	72.2%	71.9%	70.2%	

Indicative

Waiters at month end		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Trend
Total Waiters	Actual	11336	11542	11604	11949	12361	
52w waiters	Plan	50	45	40	35	30	
	Actual	52	71	58	77	87	
General Surgery	Actual	13	12	8	12	10	
Gynaecology	Actual	7	2	1	2	1	
Trauma & Orthopaedics	Actual	16	21	25	31	27	
Urology	Actual	4	4	1	0	1	
Paediatrics	Actual	0	14	12	13	19	
Cardiology	Actual	1	0	0	3	4	
Gastroenterology	Actual	5	5	3	1	4	
General Medicine	Actual	0	0	0	0	0	
Respiratory Medicine	Actual	3	4	4	7	6	
Other	Actual	3	9	4	8	15	
78w waiters	Plan	1	1	0	0	0	
	Actual	3	5	2	1	1	

Indicative

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

Trust's RTT performance

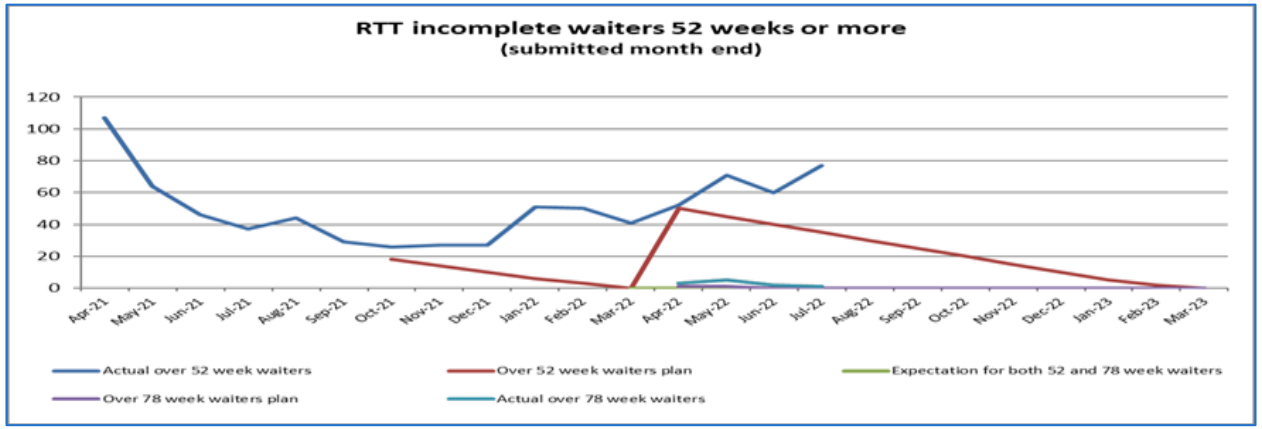
- August 74.9% indicative, compared with July 74.9% however well below the 92% target
- At 75.9% Trust performance was above latest national average 63.5% in May, and ICB average of 74.9%
- Total waiting list increased from 11,949 in July to 12,361 in August (indicative)
- 52 week waiters continues to increase since June. August figure 87 indicative (detail by specialty below)
- 1 patient waiting over 78 weeks end of August (indicative) under a General Surgery speciality

Main Risks

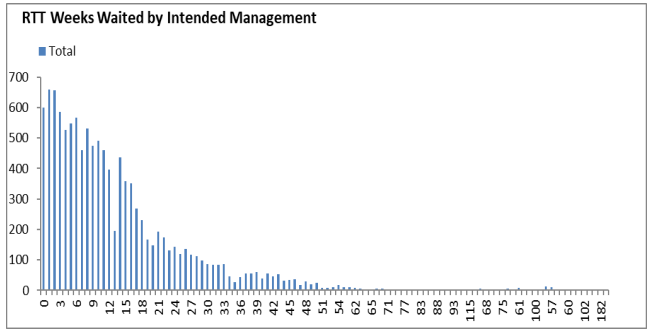
- Outpatient capacity to review the backlog
- Theatre capacity / Theatre workforce
- Staffing pressures
- Capacity for autism assessments in Paediatric 52 week patients

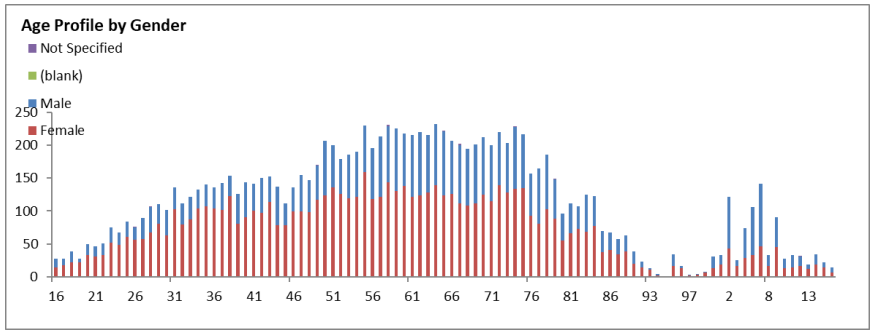
Risks: Continues Increases in > 52 weeks over planned levels from 77 July to 87 in August (indicative)

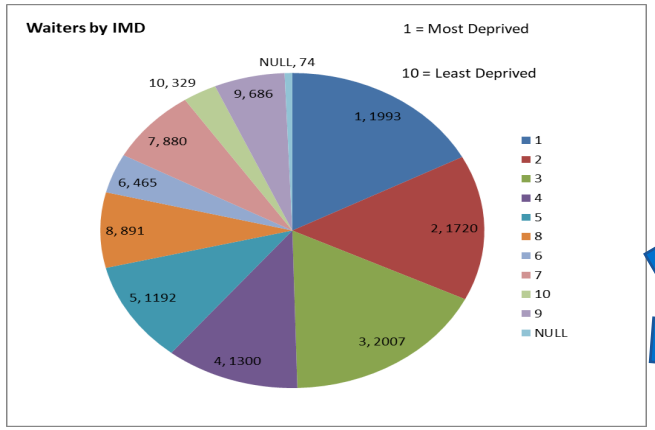
- T&O 29 (+4), Paediatrics 13 (+1), General Surgery 11 (+3), Gynaecology 2 (+1), Cardiology 3 (+3), Respitory medicine 7 (+3), Other 8 (+4)



Health Inequalities Data: RTT Waiters (Aug)







gender

IMD

ethnicity

DNA's

- 61% waiters are female / 39% male
- Patients living in the most deprived wards account for 17% of RTT waiting list.
- Patients who registered as white British account for 74% of the RTT waiting list *(23% are unknown/not stated)*
- More RTT waiters than pre-pandemic (*similar profile)*
- DNA rates have increased since the start of the pandemic. Patients from the most deprived areas have higher DNA rates (13%) - increase of 3% since 2019/20

Ethnic Originby IMD	1	2	3	4	5	6	7	8	9	10	NULL	Grand Total
Mixed White and Asian	1	3	5	0	0	0	1	0	1	0	0	11
White Irish	3	3	3	2	4	0	3	1	1	0	0	20
White British	1513	1275	1530	942	894	336	644	660	491	248	33	8566
Not Stated	360	371	402	315	263	122	218	211	178	76	40	2556
Mixed White and Black Caribbean	0	1	0	1	3	0	2	0	0	0	0	7
Mixed White and Black African	2	6	3	1	0	0	0	0	0	0	0	12
Indian or British Indian	6	3	3	3	2	2	0	2	1	0	0	22
Chinese	7	1	2	2	1	0	0	2	0	1	0	16
Black African or Black British African	9	5	2	3	0	0	0	0	0	0	0	19
Bangladeshi or British Bangladeshi	9	3	2	2	2	1	1	1	0	0	0	21
Asian - other	4	3	8	7	2	0	1	4	2	1	0	32
Any other White background	34	26	19	12	3	2	4	7	6	2	1	116
Any other mixed background	11	2	6	0	4	0	0	0	3	0	0	26
Any other ethnic group	28	14	14	7	12	1	3	1	3	0	0	83
Any other Black background	1	0	1	2	0	0	0	0	0	0	0	4
Pakistani or British Pakistani	4	2	6	1	2	1	3	2	0	1	0	22
Black Caribbean or Black British Caribbean	1	2	1	0	0	0	0	0	0	0	0	4
Not Set												0

Ethnic Origin by RTT Weeks Waiting	0-17	18-25	26-39	40-51	52+	Grand Total
Mixed White and Asian	6	1	3	1	0	11
White Irish	15	2	2	1	0	20
White British	6363	947	808	300	147	8565
Not Stated	1906	307	232	79	30	2554
Mixed White and Black Caribbean	7	0	0	0	0	7
Mixed White and Black African	6	2	2	1	1	12
Indian or British Indian	12	1	4	2	3	22
Chinese	14	2	0	0	0	16
Black African or Black British African	13	4	1	1	0	19
Bangladeshi or British Bangladeshi	15	4	1	1	0	21
Asian - other	23	4	4	1	0	32
Any other White background	81	16	13	4	2	116
Any other mixed background	19	1	3	3	0	26
Any other ethnic group	65	10	7	0	1	83
Any other Black background	4	0	0	0	0	4
Pakistani or British Pakistani	16	3	2	0	1	22
Black Caribbean or Black British Caribbean	2	2	0	0	0	4
Not Set						0

Performance Monitoring & Assurance

Data and intelligence has a crucial role in supporting and informing the development and delivery of Health Inequality plans. Recognising that good quality data is vital to understanding and improving health and care outcomes for the whole population: our data and BI plans are to:

- Expand our current reporting arrangements to include a comprehensive set of DQ measures covering: quality, completeness and scope across multiple datasets. Highlighting data issues and gaps to prioritise improvement.
- Develop regular (monthly/quarterly/annual) reporting which will bring together existing and developing (local & national) measures of health inequality covering deprivation, sex, age and ethnicity. These reports will service to signpost and highlight key messages – whilst evidencing change.
- Develop BI dashboards to empower operational teams in support of Access requirements
- Quantify and report on the impact of actions to reduce health inequalities.
- Explore investment opportunities in wider systems such as Population Health Management PHM to explore opportunities beyond reporting activity based reporting and move into access and outcome measures to support local discussions to promote equality and reduce health inequalities to enable informed health decisions and actions.

Maximum 6-week wait for diagnostic procedures

Responsive

NHS Gateshead Health NHS Foundation Trust

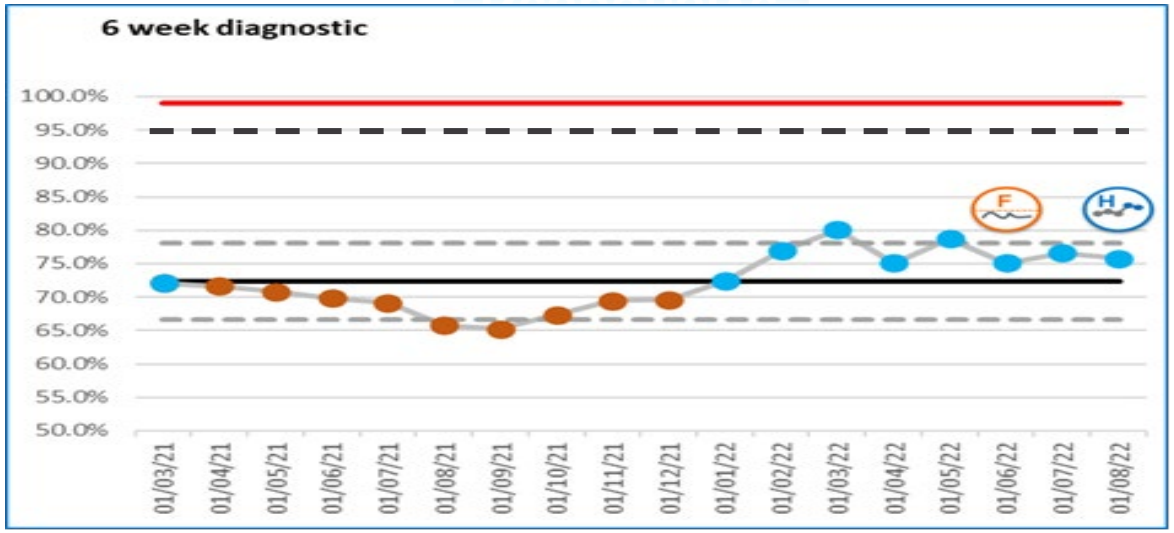
NHSI SOF Operational Performance & National Operational Standard

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% moving to 5% by March 2023)
4. Number of diagnostic tests/procedures carried out in month

Trust's Diagnostic performance is overall stable with some significant modality improvements.

- 75.1% in June to 76.6% in July to 75.8% in August
- Trust performance is below NENC average of 79% and above national average of 72.1%
- Total waiting has decreased from 6,050 in April to 5,574 in August . Volumes of patients waiting > 6 weeks decreased from 1508 in April to July 1452 and August 1350
- Echocardiology and Audiology continue to contribute to risk in achieving this standard. Echocardiology recovery plan aims to recover the long waiters by February 2023.

Diagnostic waiters <6 weeks (99%)	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Monthly Trend	Latest Month
Diagnostic waiters <6 weeks (2023: 95%)							2023 target
Trust Total	75.1%	78.7%	75.1%	76.6%	75.8%		75.8%
Barium Enema	99.4%	99.5%	99.0%	99.6%	96.6%		96.6%
CT	99.4%	99.5%	99.0%	99.6%	99.5%		99.5%
MRI	96.7%	97.6%	99.6%	99.2%	98.0%		98.0%
Non-Obstetrc Ultrasound	89.9%	99.6%	99.0%	99.2%	98.5%		98.5%
Audiology	56.7%	57.1%	55.5%	57.2%	57.6%		57.6%
Urodynamics	86.7%	90.0%	88.2%	100.0%	100.0%		100.0%
Colonoscopy	95.6%	97.7%	98.7%	94.8%	96.2%		96.2%
Flexi-Sig	94.3%	93.5%	97.7%	100.0%	98.2%		98.2%
Gastroscopy	95.0%	96.8%	98.1%	98.4%	98.2%		98.2%
Dexa	97.2%	97.9%	98.8%	99.2%	98.3%		98.3%
Echo Cardiology	32.6%	38.4%	30.0%	29.1%	30.6%		30.6%
Cystoscopy	83.5%	85.7%	89.6%	94.2%	96.7%		96.7%
					Final		



Echocardiology 6 Week Performance Recovery Trajectory:

Month End	Waiters	Waiters 6 weeks +	Waiters under 6	Performance
Sep-22	1,294	744	550	42.50%
Oct-22	1,143	505	638	55.82%
Nov-22	828	194	634	76.57%
Dec-22	646	62	584	90.40%
Jan-23	499	5	494	99.00%

Cancer Standards - 2 Week Waits

Responsive

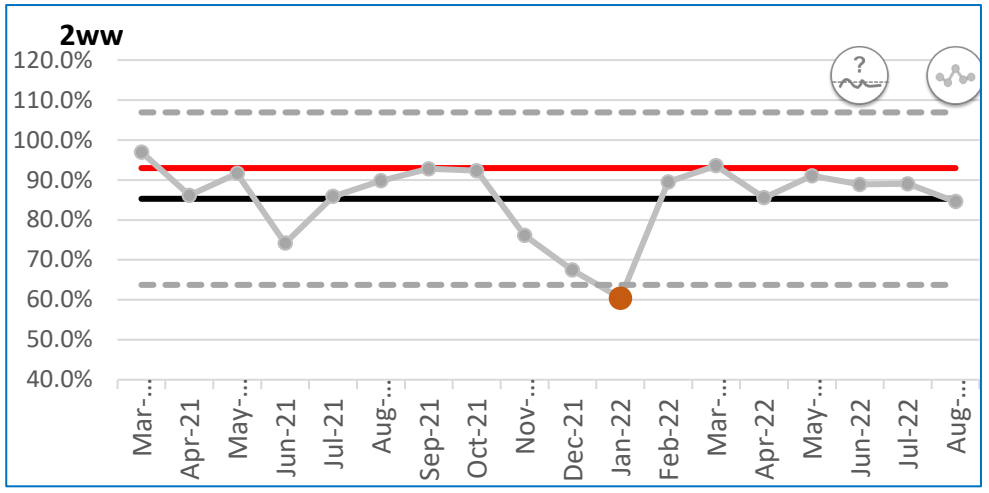
NHS Gateshead Health NHS Foundation Trust

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

2ww performance - target 93%	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Monthly Trend
Trust	84.8%	89.4%	88.8%	89.1%	84.2%	
Breast	92.4%	97.4%	94.9%	97.0%	96.6%	
Gynae	78.3%	95.5%	89.8%	82.4%	86.8%	
Lower GI	87.4%	80.0%	82.8%	67.6%	45.3%	
Testicular	70.0%	85.7%	100.0%	100.0%	100.0%	
Urology	84.2%	79.0%	71.2%	83.2%	83.7%	
Haematology	100.0%	100.0%	88.9%	100.0%	92.3%	
Lung	21.7%	43.1%	65.7%	77.4%	67.2%	
Upper GI	83.5%	82.1%	79.5%	86.5%	84.8%	
Symptomatic Breast	96.8%	97.8%	93.6%	94.5%	95.0%	

Indicative



Trust's 2 week wait Cancer performance

- Relatively stable performance averaging 87.8% over quarter 1, and latest month July achieving 89.1%, slight increase from 88.8% in June
- 89.1% in July still below the 93% requirement

Tumour Update:

- Breast, Haematology and Testicular tumour sites exceeding the 93% target. Pressures in July in all other tumour sites . Clinic attendances in July were overall above pre COVID levels, capacity issues still prevail related to rising demand, outpatient capacity remains problematic for some specialities and workforce pressures across the services prevail.

Referrals continue to increase:

- In general up 22% on pre covid referrals: Breast (34%) and lung (21%) , Lower GI (136%) referrals

Risks

- Referral pathway management: pro-forma review, choice delays and timely capacity release
- Capacity / summer holidays and shared pathways (urology/lung)
- Outpatient capacity
- Workforce pressures across tumour groups (lung)

volumes as a % of 2019/20 Activity	Apr-22	May-22	Jun-22	Jul-22	Aug-22
Trust Total	99%	121%	125%	104%	134%
Breast	102%	122%	151%	126%	138%
Gynae	110%	141%	154%	129%	169%
Lower GI	108%	114%	88%	60%	115%
Urology	87%	132%	96%	117%	141%
Haematology	125%	144%	129%	100%	186%
Lung	98%	138%	102%	63%	133%
Upper GI	80%	101%	106%	84%	110%

Cancer Standards - Faster Diagnosis

Responsive

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%)

Trust's 2 Faster Diagnosis performance:

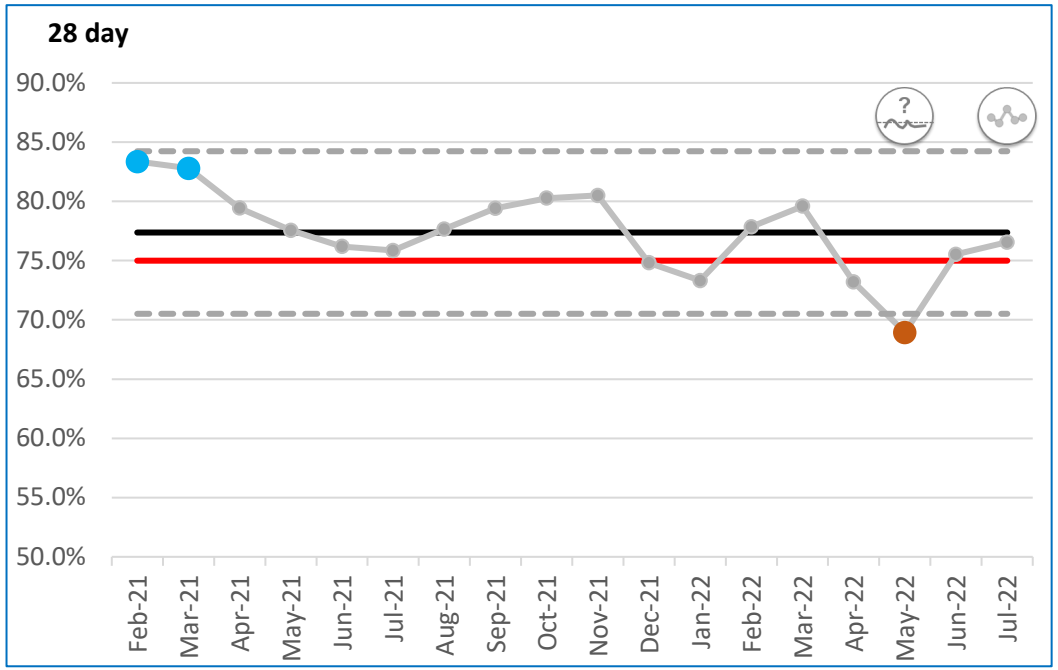
- Trust achieved 75% target in June July & August with 75.6% and for quarter 1 at 78.1%.

Tumour Update:

- Historically Trust was achieving this target – performance deterioration from March 2022
- Performance Risks across most specialties - Particular challenged specialties include Lung, Gynae, Lower GI, Urology and Upper GI
- However Breast, Testicular & now lung tumour sites exceeding the 75% target
- Lung are the first to go-live with Best Practice Timed Pathways
- Implementation of BPTP in the remaining tumour groups is underway

Risks

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



Faster Diagnosis Standard - target 75%	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Monthly Trend
Trust	73.2%	69.0%	75.5%	76.5%	80.6%	
Breast	96.8%	96.6%	96.9%	99.0%	98.9%	
Gynae	49.1%	46.0%	59.5%	64.4%	70.9%	
Lower GI	46.0%	36.1%	42.7%	43.4%	52.3%	
Testicular	100.0%	100.0%	66.7%	100.0%	100.0%	
Urology	28.1%	27.0%	30.4%	44.4%	54.3%	
Haematology	81.8%	100.0%	87.5%	66.7%	50.0%	
Lung	36.0%	38.1%	73.9%	65.4%	77.5%	
Upper GI	53.1%	51.2%	53.8%	52.7%	55.6%	
Symptomatic Breast	100.0%	100.0%	100.0%	100.0%	100.0%	
				Indicative		

Cancer Standards - 31 Day Waits

Responsive

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%)

Trust's 31 day cancer performance:

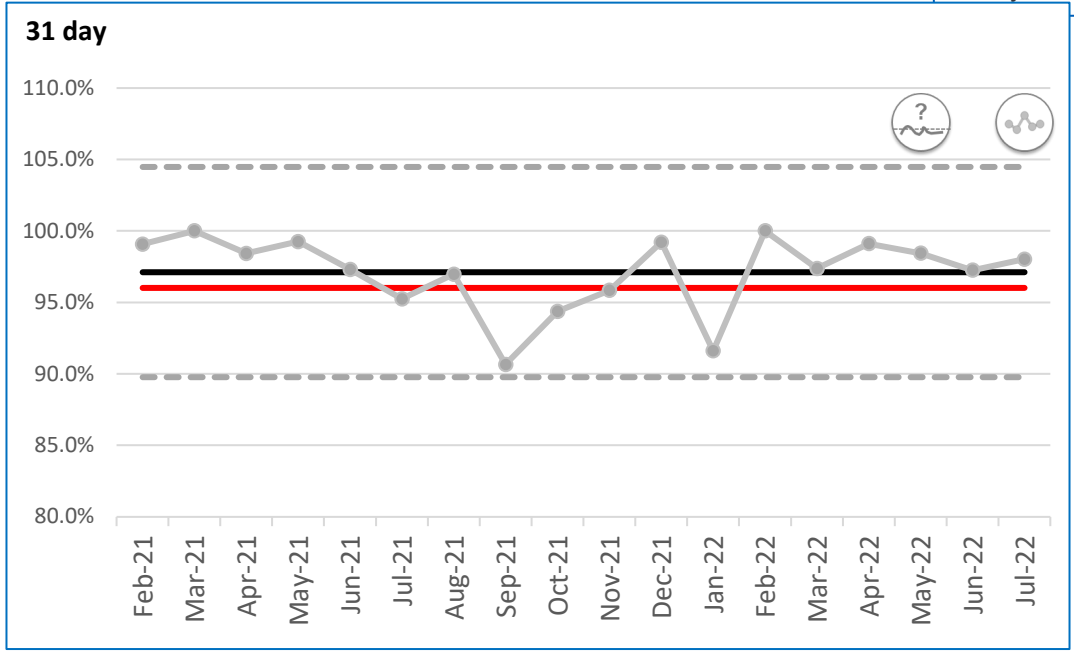
- Trust's Cancer performance for July is 98% against the 31 Day standard, and both subsequent treatment standards have been achieved in July.
- **NOTE:** June and July is indicative data* and is subject to change following sharing of information between Trusts
  - August data is not yet finalised re: shared breaches across shared pathways.

Tumour Update:

- 31 Day All specialties achieved this standard in June - except Gynae – which did not meet the standard since April
- All tumour sites achieved subsequent treatment regimes

Risks

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



31 day performance - target 96%	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Monthly Trend
Trust	99.1%	98.4%	97.2%	98.0%	97.2%	
Breast	97.7%	100.0%	100.0%	100.0%	98.6%	
Gynae	100.0%	92.6%	89.3%	93.9%	95.0%	
Lower GI	100.0%	100.0%	100.0%	94.1%	92.9%	
Urology	100.0%	100.0%	100.0%	100.0%	100.0%	
Haematology	100.0%	100.0%	100.0%	100.0%	100.0%	
Lung	100.0%	100.0%	100.0%	100.0%	100.0%	
Sarcoma	100.0%		100.0%			
Upper GI	100.0%	100.0%	100.0%	100.0%	83.3%	
Other		100.0%		100.0%	100.0%	
				Indicative		

Susequent Treatments	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Monthly Trend
Surgery	94.7%	100.0%	100.0%	96.7%	100.0%	
Drug	100.0%	100.0%	100.0%	100.0%	100.0%	

Cancer Standards - 62 Day Waits

Responsive

Gateshead Health NHS Foundation Trust

Trust's 2 62 day cancer performance

- 52.4% for quarter 1, improvement from 53.6% to 67.0% indicative for July
- The Trust reported 68 patients waiting over 62 days on a 2ww classic pathway (177 on all pathways) in July
- Within the operational guidance 'Systems are being asked to plan to restore >62-day backlogs to the relative backlog using urgent suspected cancer referral volumes seen in Q3 2019/20 compared to the overall national backlog for the w/e 16th February'; for Gateshead this was a position of 55 however due to the pressures supporting the ICS the Trust submitted a plan of 70 at July 2022, reporting 68 for the month, the plan has been met.
- The number of long waits (> 104 days) on a 62 day (2ww) pathway at the end of July had increased to 17 patients (68 on all pathways)

Tumour Update:

- Performance Risks across most specialties to achieve 85% with the exception of Breast.
- Challenged specialties continue to be Gynae, Lower GI and Urology, Haematology & Lung

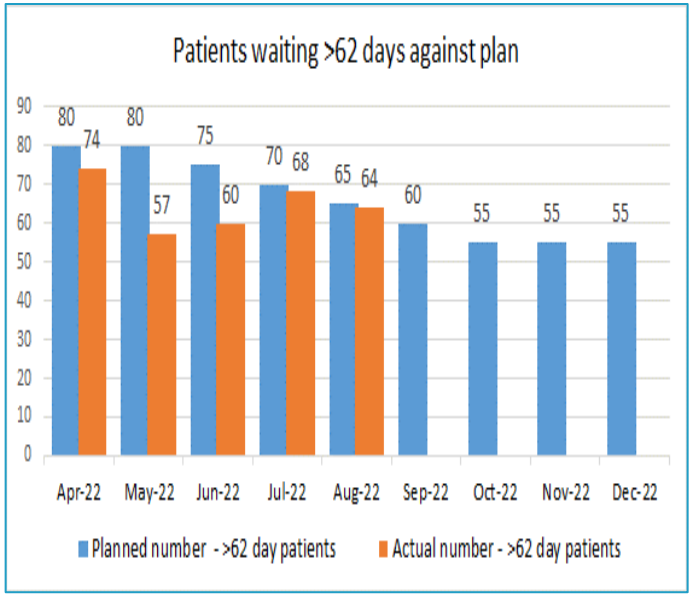
Risks

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

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

62 day performance - target 85%	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Monthly Trend
Trust	67.2%	34.5%	53.6%	63.2%	56.7%	
Breast	93.3%	91.7%	81.1%	96.6%	78.7%	
Gynae	44.4%	4.2%	20.0%	54.2%	54.5%	
Lower GI	NA	0.0%	53.3%	16.7%	55.0%	
Urology	13.6%	20.0%	22.2%	21.4%	22.9%	
Skin	NA	0.0%	NA	NA	NA	
Haematology	80.0%	66.7%	75.0%	NA	100.0%	
Lung	54.5%	30.0%	40.0%	42.9%	61.5%	
Sarcoma	100.0%	NA	100.0%	0.0%	NA	
Upper GI	100.0%	NA	100.0%	57.1%	0.0%	
Other	100.0%	NA	100.0%	100.0%	0.0%	
				Indicative		

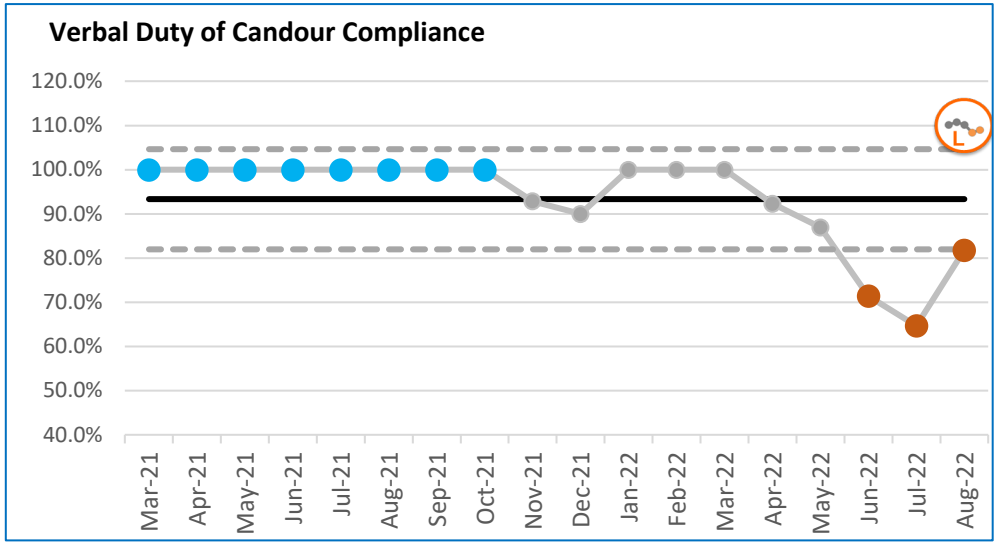


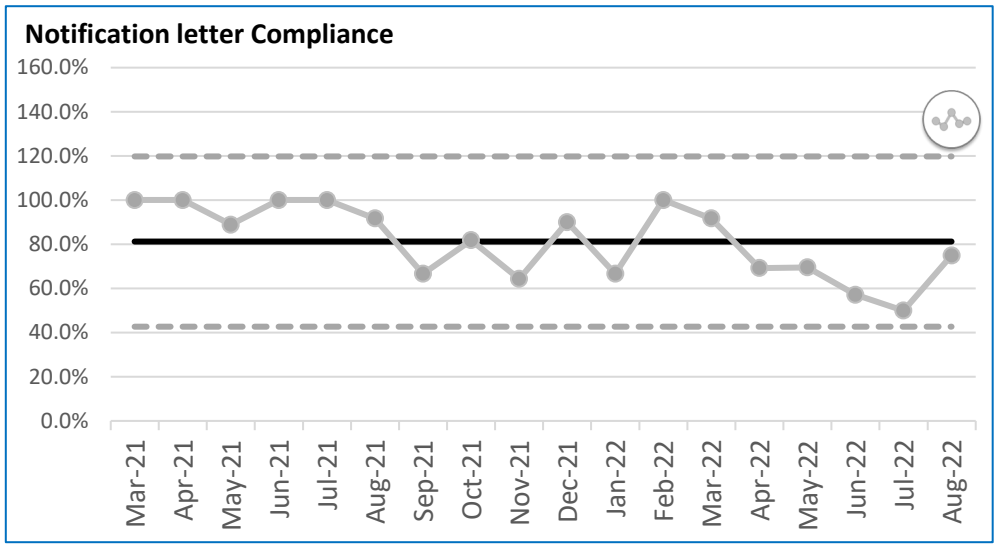
Cancer - Patients waiting more than 62 days					
63 to 104 days	April	May	June	July	Aug
Breast	4	2	1	7	4
Gynaecological	15	4	11	5	11
Haematological	8	4	1	3	0
Lower Gastrointestinal	5	3	6	6	8
Lung	4	6	1	3	4
Upper Gastrointestinal	7	8	6	11	16
Urological	14	17	26	15	12
Other	1	1	0	0	0
63 to 104 days total	58	45	53	51	55
Over 104 days	April	May	June	July	July
Breast	1	1	0	0	1
Gynaecological	7	3	1	3	1
Haematological	2	2	0	1	0
Lower Gastrointestinal	0	1	0	1	1
Lung	2	1	1	1	1
Upper Gastrointestinal	0	0	1	1	4
Urological	3	3	3	9	1
Other	1	1	1	1	0
Over 104 day total	16	12	7	17	9
Total No. Patients	74	57	60	68	64

Report by exception: Duty of Candour Verbal Compliance

Responsive

NHS Gateshead Health NHS Foundation Trust





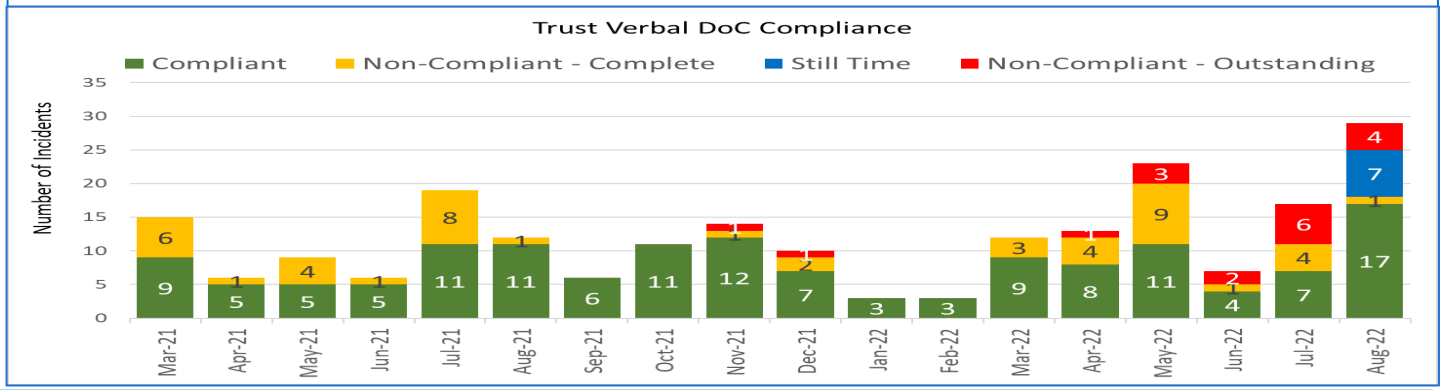
Situation
Verbal Duty of Candour compliance is displaying special cause variation for concern in June, July, and August 2022

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' professional duty only.

Assessment
Duty of Candour compliance for August has improved slightly from July 2022 however, remains below the 100% compliance required. The numbers of incidents requiring DOC are slightly higher than in July, however, there is only 1 case reported as non compliant but complete- this relates to an incident regarding complications during surgery. It should also be noted that 4 of the verbal DOC due were still in time at the time of reporting. There is one outstanding Notification letter at the time of writing.

It has been identified that there is a need for refresher training or new staff training for DOC and this is being provided monthly by the patient safety and legal team. However a buddy system would also be a helpful addition until staff are comfortable in undertaking DOC.
Review and emails to staff shows that the verbal DOC is predominantly completed and a note written in the medical notes, however this information is not then transferred into DATIX

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

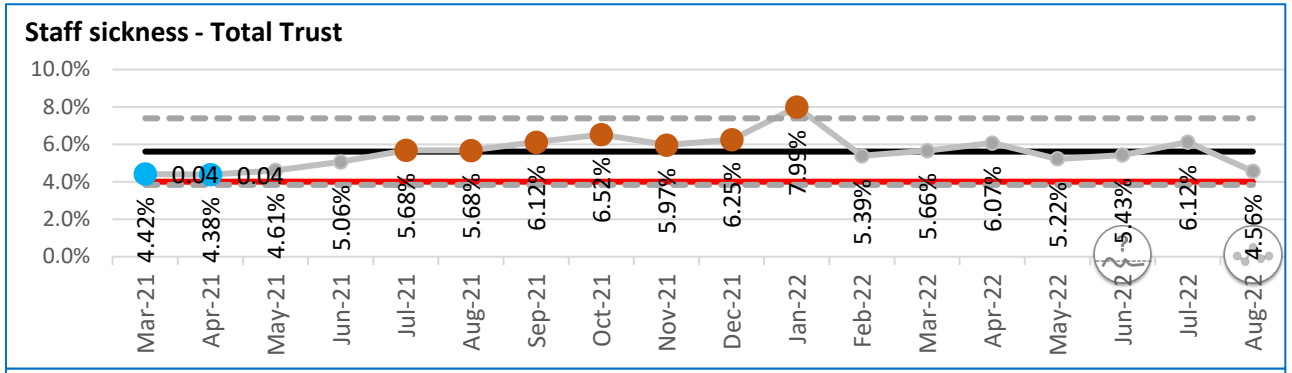


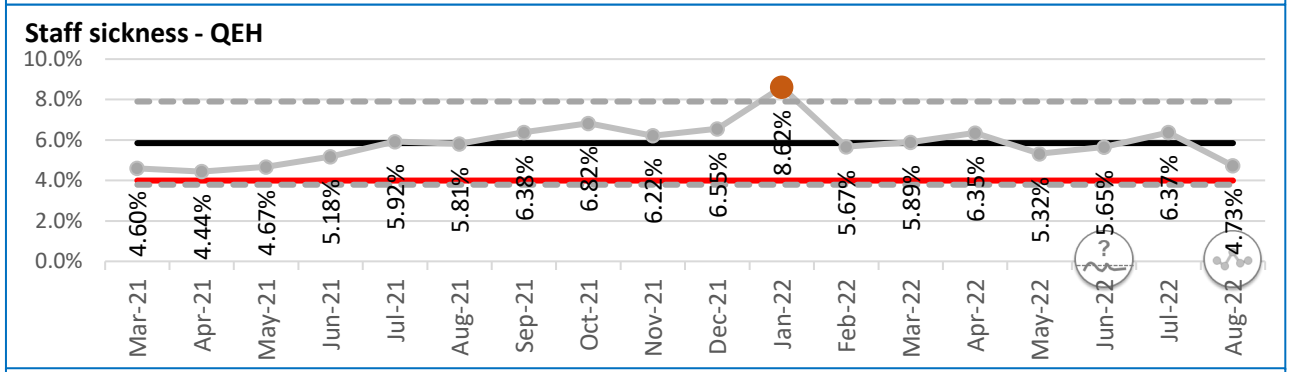
Report by exception: Well led – Sickness Absence

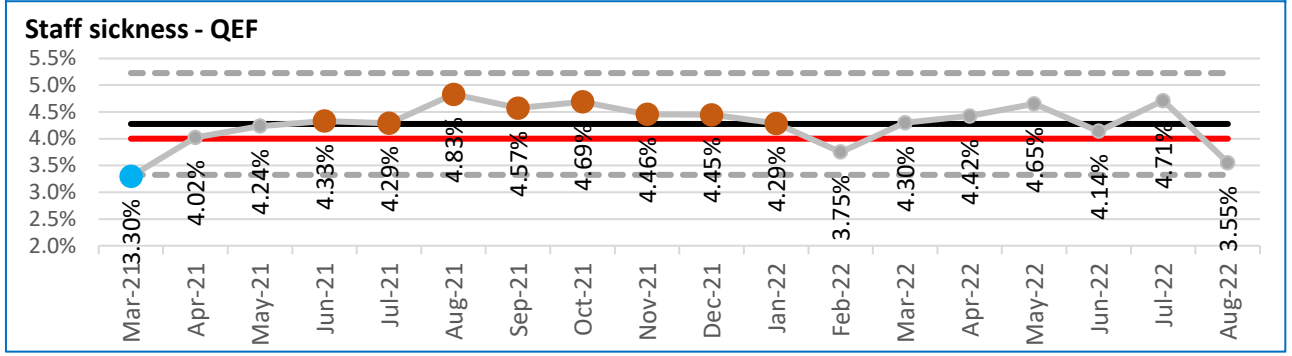
Detail on this measure is included because the target will either be achieved or failed based on variation within the performance.

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 4.6% 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

- Following the launch of the Promoting and Supporting Attendance Policy in June 2022 absence rates increased slightly in July but reduced in August 2022.

Actions

- The Promoting and Supporting Attendance policy was launched on 1st June with a refresh and amendments confirmed from 06th September 2022 and a training programme for managers has commenced and will be updated to reflect changes.
- The POD advisory teams are running clinics for managers and working closely with teams to manage absence. Managers guidance has been prepared and discussions with staff side are ensuring a collaborative and supported approach to supporting attendance is embedded
- Case reviews with POD Advisory Team are being redesigned
- New model of delivery and refocused approached is being discussed with the POD Advisory team.

Recommendation

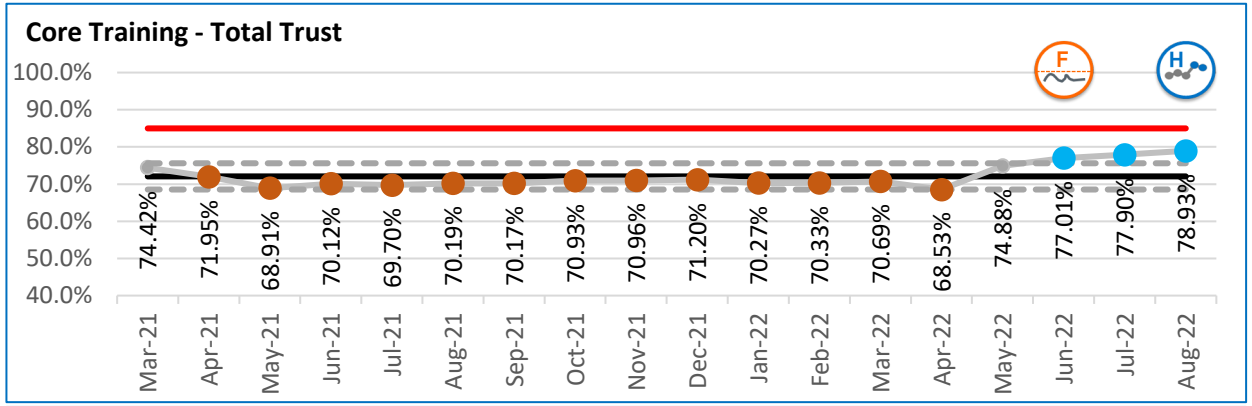
- Continue support and roll out of the new approach as per the policy.
- Continue to monitor sickness levels at POD committee, SMT and operational Business Unit & Corporate meetings.
- Launch new model of delivery with the Business Units and POD Advisory teams

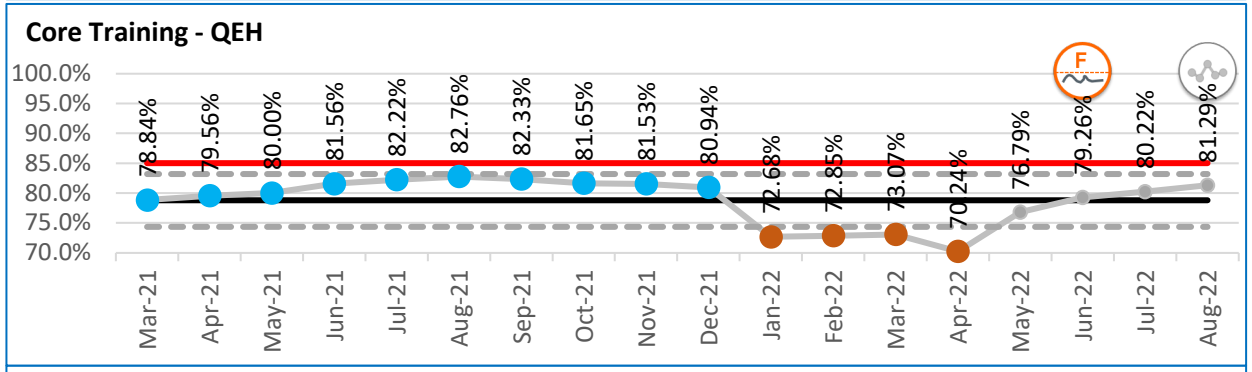
Report by exception: Well led – Core training

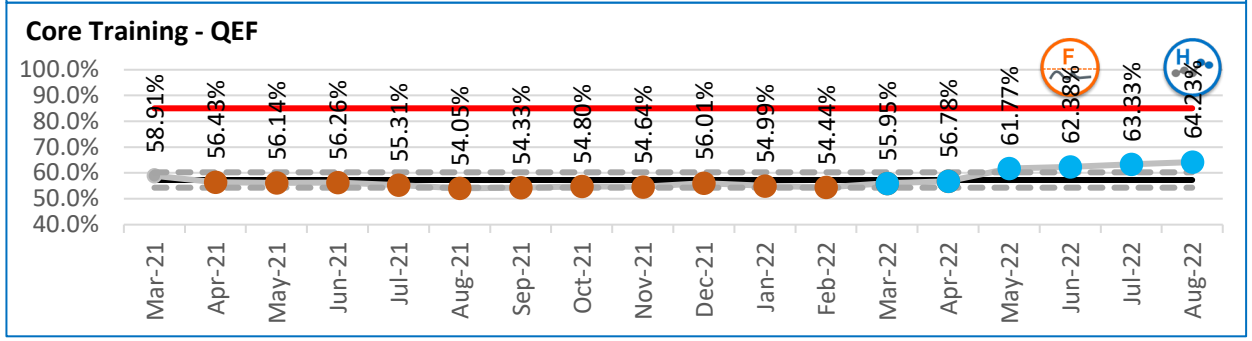
Detail on this measure is included because the target is no longer being met and special cause variation indicates a shift in performance.

Well Led

NHS Gateshead Health NHS Foundation Trust







Situation
A shift in core skills compliance is observed between April 2021 and April 2022 with special cause variation (deterioration) triggering.

The latest two months are triggering special cause variation for improvement

QEH figure displaying common cause variation for August 2022
QEF figures displaying special cause variation (improvement) from March to August 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.

Assessment
Current compliance is at 78.9% against an 85% target which is a sustained improvement

Actions
Recovery plans were requested and have been received. Compliance is increasing slowly however we have seen sustained improvement. 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

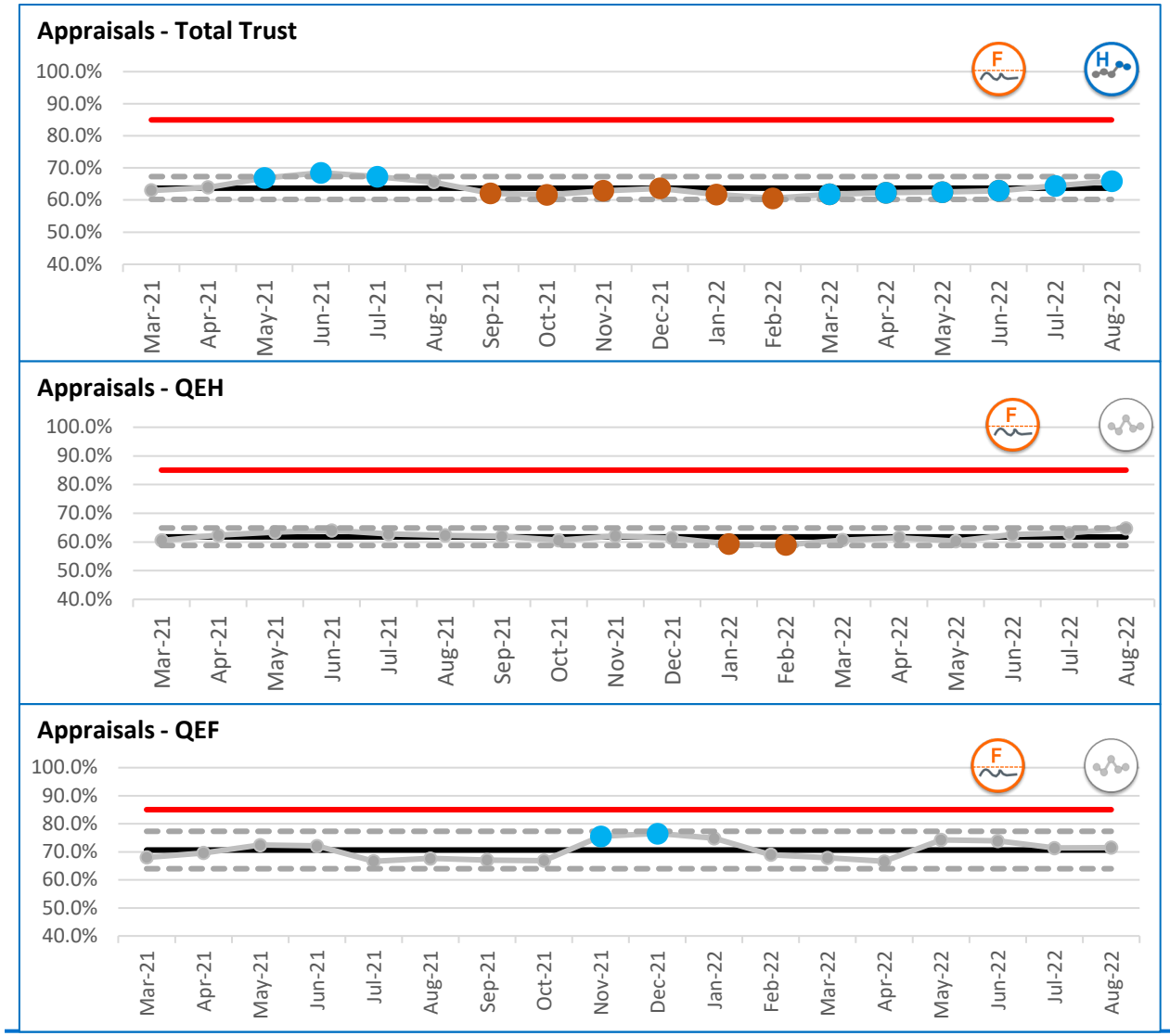
Recommendation
Review, management and oversight at Senior Leadership Team and continued management by operational teams.

Report by exception: Well led – Appraisals

Well Led

Gateshead Health NHS Foundation Trust

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



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 65.8% against an 85% target which is a slight improvement. 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 Sept 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.

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 16

Report Title:	Ockenden Next Steps Assurance and Support Visit Gateshead Health NHS Foundation Trust on 16th June 2022			
Name of Meeting:	Trust board meeting			
Date of Meeting:	27 September 2022			
Author:	Regional team/Summary L Heelbeck			
Executive Sponsor:	Gillian Findley			
Report presented by:	Lesley Heelbeck			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☒
	The Trust board are advised that a copy of this report will be shared with the regional chief nurse Margaret Kitching and her team, the LMS, MVP, ICB, along with key findings and learning points from the whole region to facilitate shared learning and collaborative working. Findings will be shared as requested with the national maternity team through national governance architecture. The recommendations of the review team will be incorporated into our Ockenden Action plan and our cycle of audit reviewed to include the continuous audit of complex pregnancies and risk assessments.			
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*	Power point overview and recommendations presented to Quality Governance Committee in August 2022			
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*	Following our visit the regional team **recommendations were to** consider how the maternity service can: − Continue audit to demonstrate embedding and sustainability of interventions and support QI methodology − Consider investment in audit/guidelines personnel to support above and support ongoing assurance − Consider how you can involve service user voice in triumvirate and maternity safety champions meetings			

<table>
<tr><td>• Equality, diversity and inclusion</td><td colspan="5">− Work on embedding MVP co-production and involvement in governance, guidelines, complaints and information materials
− Consider gaps to the RCM Midwifery 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</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="5">To note the recommendations and receive the report for assurance.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="4">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td colspan="4">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☐</td><td colspan="4">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☒</td><td colspan="4">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☐</td><td colspan="4">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="5">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☒</td><td>Effective
☒</td><td>Safe
☒</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td colspan="5"></td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes
☒</td><td colspan="2">No
☒</td><td>Not applicable
☐</td></tr>
</table>

Ockenden Next Steps Assurance and Support Visit Gateshead Health NHS Foundation Trust on 16th June 2022

1. Executive Summary

The Regional Maternity team visited Gateshead Maternity services to assess compliance with the 7 immediate and essential actions from the first Ockenden report published December 2020.

The visit was supported by LMS teams, CCG teams and the MVP. This visit was intended to be supportive.

Purpose

The Insight Visit Team used an appreciative enquiry and learning approach to foster partnership working to ensure that the actions taken to meet the initial 7 IEA's within Ockenden recommendations were in place and becoming embedded in practice.

Key findings

Exceptionally friendly, open and honest MDT. Good working relationships were 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, Badgernet has been a great asset to this element
- Good communication and feedback with all staff groups, especially around 'closing the loop' with complaints and escalations. Good relationship from ward to board
- The NED 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

2. Introduction

In the first Ockenden report there were outlined the Local Actions for Learning, (LAfL) and 7 Immediate and Essential Actions, (IEAs) to be implemented at the Trust and across the wider maternity system in England. The second report builds upon the first report in that all the LAfL and IEAs within that report remain important and must be progressed.
There are a further 15 IEA/recommendations which will be further subdivided into actions from this second report for the system and an equal number of Local Actions for the Trust under investigation.

The National team expectations are that designated Regional maternity teams led by the Chief midwives will conduct assurance and support visits to Maternity units in England at

least annually to ensure that the 7 IEA's from the first report are embedded into maternity services as culture and practice to prevent repetition and failure to learn from previous investigations and prevent the need for these in the future.

3. Key issues / findings

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, Badgernet has been a great asset to this element
- Good communication and feedback with all staff groups, especially around 'closing the loop' with complaints and escalations. Good relationship from ward to board
- The NED 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

Details of Regional team findings in relation to each of the 7 immediate and essential actions can be found in the attached document.

4. Solutions / recommendations

A copy of this report will be shared with the regional chief nurse Margaret Kitching and her team, the LMS, MVP, ICB, along with key findings and learning points from the whole region to facilitate shared learning and collaborative working.

Findings will be shared as requested with the national maternity team through national governance architecture.

The maternity service will embed the 7 IEA's into our quality improvement audit cycle.

NHS England North East and Yorkshire

August 2022

Re: Ockenden Next Steps Assurance and Support Visit Gateshead Health NHS Foundation Trust on 16th June 2022

Dear Yvonne Ormston and Gill Findley

We visited your services to assess compliance with the 7 immediate and essential actions from the first Ockenden report published December 2020. The visit was supported by LMS teams, CCG teams and the MVP. This visit was intended to be supportive.

The Insight Visit Team used an appreciative enquiry and learning approach to foster partnership working to ensure that the actions taken to meet the Ockenden recommendations were in place and becoming embedded in practice.

Thank you to you and your team for your support and hospitality on the day of the visit, we appreciate the time this took as well as the preparations you made in advance.

We have reviewed both your self-assessment and the evidence you shared with us and together with the information we gathered on the day, we now enclose additional details of our findings to support your continued work towards implementation of the 7 IEA's.

We were extremely grateful to all the individuals who gave up their time to speak to us on the day, an open and honest culture was clearly evident and commitment to high quality compassionate maternity care was positive to see.

With regard to our **findings**, we particularly noted

- 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, Badgernet has been a great asset to this element
- Good communication and feedback with all staff groups, especially around 'closing the loop' with complaints and escalations. Good relationship from ward to board
- The NED 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

Details of our findings in relation to each of the 7 immediate and essential actions can be found on the attached document.

Following our visit our **recommendations** for your service would be that you consider how you can:

- Continue audit to demonstrate embedding and sustainability of interventions and support QI methodology
- Consider investment in audit/guidelines personnel 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

We hope that you find this feedback supportive and helpful. As a regional maternity team we are keen to support you to bridge any gaps identified in the implementation and embedding of these recommendations. Support is also available from the LMS and your MVP.

A copy of this report will be shared with the regional chief nurse Margaret Kitching and her team, the LMS, MVP, ICB, along with key findings and learning points from the whole region to facilitate shared learning and collaborative working.

Findings will be shared as requested with the national maternity team through national governance architecture.

With best wishes

Tracey

Dr Tracey Cooper MBE, Chief Midwife for North East and Yorkshire

CC - HoM / CD

Trust: Gateshead Health NHS Trust Site: Queen Elizabeth Hospital

Date: 16th June 2022

Colour key for areas	
Meeting	
Virtual	

Visiting Team:

Dr Tracey Cooper – Regional Chief Midwife, Claire Keegan – Regional Deputy Chief Midwife, Debi Gibson – Regional Senior Midwife, Lily Cooper - Regional Admin Officer, Sarah Wall – Regional Maternity Team MVP Lead, Nicola Jackson- Joint Programme Lead NENC, Lesley Young- Workforce Lead HEE, Michelle Henderson - Senior Nurse Manager (Nursing & Quality), Jennifer Mason- MVP Co-chair, Gayle Moneypenny- MVP Co-chair

IEA Qu	KLOE	Visiting Team Met with	Evidence submitted prior to visit	Triangulation at visit	Self-assessment December 2021 Met Partially Met Not Met	Compliance at visit Met Partially Met Not Met	Comments and observations
Safety Action 1 Enhanced safety							
Q1							
Q1	Are maternity dashboards a formal item on LMNS agendas at least every 3 months?		LMNS Agenda		**Met**	**Met**	Yes
	Are you able to meet as a triumvirate monthly and minute meetings?	Triumvirate	Board minutes	Met to discuss		**Met**	Yes – Evidence shared with action log and minutes. Good governance arrangements for reporting. Consistent leadership demonstrated with clear messaging. In relation to the Ockenden action plans the trust should consider how they demonstrate actions being closed and the effect of any interventions made.
	Is there evidence of actions taken, and where is this shared?						
	In relation to the Ockenden action plan, where and how often is this tabled for discussion and what are your concerns?						

	What other concerns are raised on your Ockenden action plan?						Auditing, action plans and action logs need to provide explicit assurance and 'the so what' of closing the loop.
Q2	How is triangulation of incidents/complaints and claims achieved?	Triumvirate	Governance papers	Met to discuss		**Met**	Triangulation of incidents and complaints was well narrated, how triangulation of claims is triangulated would benefit from strengthening. Good communication and feedback with all staff groups, especially around 'closing the loop' with complaints and escalations. Good relationship between ward to board. 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.
	Is there external clinical specialist opinion from outside the Trust (but from within the region), mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death?		Minutes of PMRT discussions/review	Met to discuss	**Partially Met**	**Met**	Yes. There was evidence of this with learning points, no actions were noted or follow up. The trust should consider how they strengthen this area.
Q3	Are all maternity SI reports (and a summary of the key issues) sent to the Trust Board and the LMNS quarterly?	Triumvirate	Trust Board minutes LMNS Board minutes	Met to discuss	**Partially Met**	**Met**	Process clearly articulated and board papers seen.
Q4	Are all PMRT cases reviewed to the required standard?	Triumvirate	Ratified SOP/Guideline Audit timetable and actions Audit with 95% compliance	Met to discuss	**Partially Met**	**Met**	Comprehensive PMRT review report shared and process clearly articulated.

Q5	Are you submitting data to the Maternity Services Dataset to the required standard?	Triumvirate	Confirmation of compliance Action plan if improvements needed	Met to discuss	**Met**	**Met**	Yes
Q6	Have all HSIB cases been reported?	Triumvirate	Audit timetable Audit demonstrating 100% compliance	Met to discuss	**Met**	**Met**	Yes
Q7	Has the Perinatal Clinical Quality Surveillance Model been implemented June 2021?	Triumvirate	Ratified Trust SOP/Guideline Trust Governance structure	Met to discuss	**Partially Met**	**Met**	Yes
			Ratified LMNS SOP/Guideline Minutes agreed ICS sign off				
Q8	Are all maternity SIs shared with Trust boards at least quarterly and the LMNS?	Triumvirate	Ratified Trust SOP/Guideline of how SI's are shared monthly with Trust Board and LMNS Board Agenda to include SI's as an item Minutes to include, summary, learning and actions		**Partially Met**	**Met**	Yes

Q9	What other concerns are raised on your Ockenden action plan?	Triumvirate	Action Plan				Yes
Safety Action 2 Listening to women & families							
Q 10							
Q 11	Is there an allocated Non-Executive at Board level who works collaboratively with the maternity safety champions?	NED		JD and date appointed Activities Attendance at meetings Recorded output of meetings presented to Board and evidence of action from the interactions	**Partially Met**	**Met**	NED in post and well engaged– linked in with safety champions and provides a bi monthly report up to board.
				Interactions with staff, services users and MVP			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
Q 12	Is the PMRT tool used to review perinatal deaths to the standard required including women and families involvement?	Triumvirate	Ratified SOP/Guideline Audit timetable and actions Audit with 95% compliance		**Partially Met**	**Met**	See Q4
Q 13	What is the mechanism for service user feedback, and how this is obtained through MVP to coproduce maternity services?	Triumvirate MVP		Meeting with Triumvirate and MVP Chair	**Met**	**Met**	Well established MVP, further work needed to fully embed co-production throughout, including early involvement.

							Developmental support to enable service user voice representation at Governance and Safety meetings.
				How is user feedback obtained?			Friends and family tests, 15 steps, Facebook page, CQC maternity survey
				Examples of co-production			Implemented innovative blog as way of communicating and getting messages back from clinical staff.
Q 14	Do the Trust safety champions (MW /Obstetrician/Neonatal) meet bimonthly with Board level safety champions and escalate concerns, issues and blockers to improvement work	Safety Champions		Review talk through ratified SOP/Guideline/ TOR	**Partially Met**	**Met**	There is regular meetings and NED's & Safety champions are visible to all staff groups Good communication and consistent messaging Programme is consistent and embedded. The overall impression was that Maternity is front and centre of discussion and support within this trust.
				Minutes of meetings Action Log			
				Evidence of action and improvement from the meetings			
Q 15	What is the mechanism for service user feedback, and how this is obtained through MVP to coproduce maternity services?	Triumvirate MVP		How is user feedback obtained?	**Met**	**Met**	See Q13
				Examples of co-production			
Q 16	Does the non-executive director support the Board level safety Champion who works collaboratively with the maternity safety champions to bring challenge and ensure all voices are heard?	NED Safety Champions		JD and date appointed	**Met**	**Met**	See Q11
				Activities			Attend safety champions meetings, trust board, walkarounds and engagement sessions Evidence of NED at safety champion meetings There have been 'walkabouts' and engagement events. Continuation of these to become business as usual would be beneficial to staff, women, service users and the organisation so that these voices are heard directly at board level.
				Attendance at meetings			
				Interactions with staff, services users and MVP			
				Evidence of check and challenge as a result			

Safety Action 3 Staff training and working together							
Q 17	What MDT training does the maternity service provide?	Triumvirate PDM	Agenda LMNS Board Minutes LMNS Board	Meet PDM: View TNA How is training decided? Ask staff: How effective is the training?	**Met**	**Met**	Refreshed TNA and development plan Records of MDT attendance kept with trajectory in place to meet required standard post Covid pandemic. Training records maintained by Lead Midwife for Quality Risk and Safety. Clear links to appraisal- good practice point. Live drills evidenced and evidence of baby abduction training and learning identified and shared Feedback from staff at the visit was that training was valued and that learning from incidents and national reports was considered and included which made learning meaningful and relevant.
Q 18	Have you implemented a day and night Consultant led MDT ward round on the LW?	Staff		Ask staff what time the MDT ward round is and who attends? Review ward round sign in sheet	**Met**	**Met**	Twice daily ward rounds established Assurance evidence of MDT ward rounds needs improving.
	Do you have a dedicated obstetric governance lead? Do they have protected PA's?			What difference have you seen in outcomes since the introduction e.g. incident reduction, women's experience Look at Job plans and discuss with General Manager/Consultant clinical		**Met**	Evidence of governance lead who has sufficient PA's allocated. It was discussed that the service and organisation should consider how they themselves triangulate the effectiveness of having a dedicated obstetric governance lead and the impact this has on quality and safety.

				director/governance consultant who has oversight			
Q 19	Is all external funding allocated for training ring fenced and confirmation from the Finance Director?	Triumvirate	Ratified SOP/Guideline Invoices Budget spending plans Confirmation from FD Spend reports to LMNS		**Partially Met**	**Met**	External funding for training ringfenced
Q 20	Have 90% of each maternity unit staff group attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	PDM		Report of attendance records Trajectory Audit demonstrating 90% of each staff group attendance	**Met**	**Met**	See Q17
Q 21	Is MDT schedule for training in place?	Triumvirate	Agenda LMNS Board Minutes LMNS Board		**Met**	**Met**	See Q17
		PDM Staff		View TNA How is training decided? Ask staff: How effective is the training?			
Q 22	See question 18						
Q 23	See question 19						
Safety Action 4 Managing complex pregnancy							

Q 24	Is there an agreement for the criteria for cases referred to the tertiary level Maternal Medicine Centre?	Consultant Fetal Medicine Lead / AN screening coordinator		Discuss referral pathway	**Met**	**Met**	Referral pathways discussed. Continued engagement with the LMS will help progress this service. Regional pathway in place, working closely with system to implement maternal medicine networks.
				Review audit programme Review audit results of compliance and action plans		**Partially Met**	Now developing audit cycle for embedding. Some audits completed and actions implemented. Consideration should be given to all elements within the Ockenden 7 IEA's being continually audited until embedding and sustainability is evidenced and trust board has assurance of this.
Q 25	Do women with complex pregnancies have a named Consultant lead?	Consultant Fetal Medicine Lead/AN screening coordinator		Discuss referral pathway Review audit programme Review audit results of compliance and action plans	**Partially Met**	**Partially Met**	Referral pathway clearly articulated. Now developing audit cycle for embedding. Some audits completed and actions implemented. Consideration should be given to all elements within the Ockenden 7 IEA's being continually audited until embedding and sustainability is evidenced and trust board has assurance of this.
Q 26	Do women with complex pregnancies receive early intervention?	Consultant Fetal Medicine Lead/AN screening coordinator		Discuss referral pathway Review audit programme Review audit results of compliance and action plans	**Partially Met**	**Partially Met**	See Q25
Q 27	Can you demonstrate compliance with all five elements of the Saving	Leads for SBLCBv2		Discuss referral pathway	**Partially Met**	**Met**	Yes

	Babies' Lives care bundle Version 2?			Review audit programme Review audit results of compliance and action plans			
Q 28	Do all women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place?	Consultant Fetal Medicine Lead/AN screening coordinator		Discuss referral pathway Review audit programme Review audit results of compliance and action plans	**Not Met**	**Partially Met**	See Q25
Q 29	Do you have agreed maternal medicine specialist centre?	Consultant Fetal Medicine Lead/AN screening coordinator		Discuss referral pathway Review audit programme Review audit results of compliance and action plans	**Partially Met**	**Met**	Plans are in progress within the LMS to fully implement the maternal medicine service. Regional pathway in place, and working closely with system to implement maternal medicine networks
Safety Action 5 Risk assessment throughout pregnancy							
Q 30	Does the AN RA include the ongoing review of place of birth?	Triumvirate		Discuss pathway for out of guidance births Review ratified SOP/Guideline	**Partially Met**	**Met**	Supporting women's choice guideline in development All elements around antenatal risk assessment require consistent audit to evidence and assure embedding and sustainability of these elements Consideration should be given to all elements within the Ockenden 7 IEA's being continually audited until embedding and sustainability is evidenced and trust board has assurance of this.

Q 31	Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	Triumvirate		Discuss pathway for out of guidance births	**Partially Met**	**Met**	See Q30
				Review ratified SOP/Guideline			
				Audit timetable			
				Audit results and action plan			
Q 32	Are you compliant with all 5 elements of SBLCBv2?	Leads for SBLCBv2		Ratified SOP/Guidelines for all 5 elements	**Partially Met**	**Met**	See Q27
				Audit results for all 5 elements (local and regional audit)			
				Review of impact on perinatal mortality Deep dive results			
Q 33	Is a RA review and discussion of place of birth recorded at every contact with a Personalised Care Support Plan	Triumvirate		Discuss pathway for PCSP Review ratified SOP/Guideline Audit timetable Audit results and action plan	**Partially Met**	**Met**	All elements around antenatal risk assessment require consistent audit to evidence and assure embedding and sustainability of these elements Consideration should be given to all elements within the Ockenden 7 IEA's being continually audited until embedding and sustainability is evidenced and trust board has assurance of this.
Safety Action 6 Monitoring fetal wellbeing							
Q 34	All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated	Lead Midwife and Lead Obstetrician		Rotas/duties	**Partially Met**	**Met**	Evidence of RM JD was seen. LMNS support could enable obtaining of a consultant JD.

	expertise to focus on and champion best practice in fetal wellbeing.			Examples of roles Incident case reviews			Refreshed TNA and development. Good use of escalation of risk register re-concerned regarding this evidence. Training records maintained by Lead Midwife for Quality Risk and Safety. Regular positive forums in place for sharing learning- visual, learning points, feedback to governance all utilised to 'close the loop'. Regular fetal wellbeing review meetings on Teams, but also have innovative solutions for increasing attendance of all professions. Utilise positive experiences to reinforce quality improvement methodology- and good practice.
Q 35	Do the leads demonstrate sufficient seniority and expertise?	Lead Midwife and Lead Obstetrician	Job Description for both roles and confirmation that roles are in post		**Partially Met**	**Met**	See Q34
Q 36	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	Leads for SBLCBv2		SOP's Audits for each element Guidelines with evidence for each pathway	**Partially Met**	**Met**	See Q27
Q 37	Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	PDM		Training compliance	**Met**	**Met**	See Q17

Q 38	Element 4 we are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.	Lead Midwife and Lead Obstetrician		Lead midwife and obstetrician in place to lead best practice, learning and support Training sessions Reviews		**Met**	See Q34 Regular positive forums in place for sharing learning- visual, learning points, feedback to governance all utilised to 'close the loop'. Regular fetal wellbeing review meetings on Teams, but also have innovative solutions for increasing attendance of all professions. Welcoming of a system approach for learning. Encourage and welcome external attendance Utilise positive experiences to reinforce quality improvement methodology- and good practice.
Safety Action 7 Informed Consent							
Q 39	Do you have accessible information to enable informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery?	Triumvirate		Demonstration of the information service users can access for mode of birth in all formats Review CS information MVP review of information	**Met**	**Met**	Further work required on the Trust website. Ensure that information is available to all service users, including those who are digitally excluded. Trust have requested MVP user review of digital leaflets and website - good practice, proactive co-production.
Q 40	Do you have accessible information to enable accurate evidence based information including all care AN, Intrapartum & PN?	Triumvirate		Demonstration of the information service users can access for evidence based information in all formats	**Met**	**Met**	See Q39
				Review information including all care AN, Intrapartum & PN			

				MVP review of information			
Q 41	Can women participate equally in all decision-making processes and make informed choices about their care?	Triumvirate		Ratified SOP for decision making process and informed choice Review of last CQC maternity survey and action plan Audit timetable	**Partially Met**	**Met**	Trust investing in 'Birth Rights' informed consent training for staff, this was viewed as excellent practice. Various methods of obtaining user feedback demonstrated. Continue to develop and identify how service user feedback is acted upon. (Work on leaflet from service user good example) Explore how to audit can assure compliance of these elements, including service user self evaluated measures. The service were keen to consider and develop methods of gaining feedback around this element that reflected the lived experience perspective.
				Audit results and action plan			Consideration should be given to all elements within the Ockenden 7 IEA's being continually audited until embedding and sustainability is evidenced and trust board has assurance of this.
Q 42	Are women's choices respected following informed discussion and decision made?	Triumvirate		Ratified SOP for decision making process and informed choice and how choices are respected Audit timetable Audit results and action plan	**Not Met**	**Met**	It was clear from discussion that this service is forward thinking in supporting women's choices and use language within guidance which is considered and respectful. Audit of this needs to be strengthened.

Q 43	What is the mechanism for service user feedback, and how this is obtained through MVP to coproduce maternity services?	Triumvirate MVP		How is user feedback obtained? Examples of co-production	**Met**	**Met**	See detail in Q13
Q 44	Are pathways of care clearly described in written information in formats consistent with NHS policy and posted on the trust website.	Triumvirate		Demonstration of the information service users can access for evidence based information in all formats MVP review of information If gaps identified action plan	**Met**	**Met**	See Q39
Workforce Planning/Guidelines							
Q 45	Is the clinical workforce planning to the required standard?	Triumvirate	Review BR+ report how current and accurate is it? Trust Board minutes to fund Six monthly reviews LMNS/ICS workforce plans				No evidence seen, the trust advised at visit that this is work in progress
Q 46	Is the midwifery workforce planning to the required standard?	Triumvirate	Review BR+ report how current and accurate is it? Trust Board minutes to fund				Birthrate plus has been completed. It would be helpful if the trust could demonstrate how they plan to meet the ask with the RCM leadership manifesto by sharing their action plan in respect to this.

	Can you describe the pathway for transitional care and how do you audit this?	Triumvirate		Transitional Care Guidelines and Pathways staffing model for transitional care evidence of incident reporting and management of incidents that cross maternity and neonatal care audits of infant outcomes on the transitional care pathways			Pathways in place which have been audited
Q 47	Is the HOM/DOM responsible/accountable to an executive director?	Triumvirate	Review the JD to ensure accountability is to an executive director Ask how this translates in practice				HoM accountable to chief nurse.
Q 48	Is the maternity leadership in line with the RCM Strengthening midwifery leadership: a manifesto for better maternity care: 1. A Director of Midwifery in every trust and health board, and more Heads of Midwifery across the service	Triumvirate	Review the gap analysis				Consider gaps to the RCM leadership manifesto in relation to what is currently in place within the organisation to provide further support to the HoM.

	2. A lead midwife at a senior level in all parts of the NHS, both nationally and regionally 3. More Consultant midwives 4. Specialist midwives in every trust and health board 5. Strengthening and supporting sustainable midwifery leadership in education and research 6. A commitment to fund ongoing midwifery leadership development 7. Professional input into the appointment of midwife leaders		If gaps identified action plan to address				
Q 49	Where non-evidenced based guidelines are utilised, is there a robust assessment process before implementation and ensures that the decision is clinically justified.	Triumvirate	Review ratified SOP Identify if national guidance not followed Evidence of risk assessments if national guidance not followed How many guidelines are out of date				Guidance complies with national guidance. System in place for flagging guidance which is due for renewal**.** Consider investment in audit/guidelines midwife to support ongoing assurance.

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 17

Report Title:	**Nursing Staffing Exception Report**			
Name of Meeting:	Board of Directors			
Date of Meeting:	September 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 AHP's			
Report presented by:	Gillian Findley, Chief Nurse and Professional Lead for Midwifery and AHP's			
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. August demonstrated some improvement in staffing fill rates compared to June and July. There are still ongoing staffing challenges as we experience the continuation of managing COVID-19 activity within the organisation, periods of increased patient activity with surge pressure resulting in escalation areas alongside managing delays in transfers of care. This has affected staffing resource and the clinical operating model, which is supportive of maintaining elective recovery. Staffing challenges remain due to vacancies however; we continue focused work around the recruitment and retention of staff and managing staff attendance. 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			

<table>
<tr><td></td><td colspan="5">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.</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="5">The Board are asked to:
receive the report for assurance
note the work being undertaken to address the shortfalls in staffing</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="4">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td colspan="4">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td colspan="4">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
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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>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">There were 6 staffing incidences raised via datix throughout the month of August of which there was no moderate harm incident identified.</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☐</td><td>Not applicable
☒</td></tr>
</table>

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

1. Introduction

This report details the staffing exceptions for Gateshead Health NHS Foundation Trust during the month of September 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. Maternity use the Birth Rate Plus tool and this has been reported to Quality Governance Committee and the Trust Board separately.

2. Staffing

The actual ward staffing against the budgeted establishments from August are presented in Table 1. Whole Trust wards staffing are presented within this report in appendix 1, broken down into each ward areas staffing. In addition, the Trust submit monthly care hours per patient day (CHPPD) as a national requirement to NHS Digital.

Table 1: Whole Trust wards staffing August 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 (%)**
79.5%	**116.3%**	**91.4%**	**104.0%**

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 removed covid and operational pressures to maintain adequate staffing levels.

Exceptions:

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

A Safer Nursing Care Tool (SNCT) data collection was undertaken throughout the month of January and again in July (collected on bi annual basis). Data was triangulated with key performance indicators and professional judgement templates in line with the Developing Workforce safeguards and safe staffing recommendations (NHSi 2018). The outcome and recommendations from the January review were presented at Trust Board in May 2022.

The Community Business Unit received training on the Mental Health Optimal Staffing Tool (MHOST) in July. The first data collection for a staffing establishment review is planned throughout October following the roll out of the tool.

Contextual information and actions taken

Cragside have demonstrated fill rates of 68.7% throughout August. They have a sickness absence rate of 28% in August, of which is predominantly long-term sickness absence.

JASRU have 4.87 WTE registered staff vacancies. JASRU continue to support ward 12 medicine with one registered nurse. They demonstrate sickness absence rates throughout August at 15.8% for registered staff. JASRU have two registered staff due to start in post in September. Bespoke support is in place from the matron, OH and POD to manage attendance.

Ward 25 currently have 3.32 WTE registered vacancies. They also demonstrated 7.5% sickness absence throughout August.

Ward 10 have 3.99 WTE Registered Nurse vacancies, contributing to reduced fill rates throughout August. They demonstrated an increase in staff annual leave percentage due to previously honoured annual leave requests.

Ward 11 experienced 8.83% sickness absence for registered staff and they currently have 3.55 WTE registered vacancies.

Emergency Care Centre 01 & 02 demonstrated 75% fill rate in August. They have been supporting other areas within the trust throughout August, with 42 registered nurse redeployments.

The exceptions to report for August are as below:

August 2022	
Qualified Nurse Days	**%**
Cragside	68.7%
Emergency Care Centre 01 & 02	75.0%
JASRU	67.4%
Ward 10	63.8%
Ward 11	71.8%
Ward 25	68.1%
Qualified Nurse Nights	**%**
N/A	
Healthcare Assistant Days	**%**
N/A	
Healthcare Assistant Nights	**%**
N/A	

In August, 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 August, 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 August, the Trust total CHPPD was 7.9. 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 thresholds that trigger when a staffing related DATIX should be submitted 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.

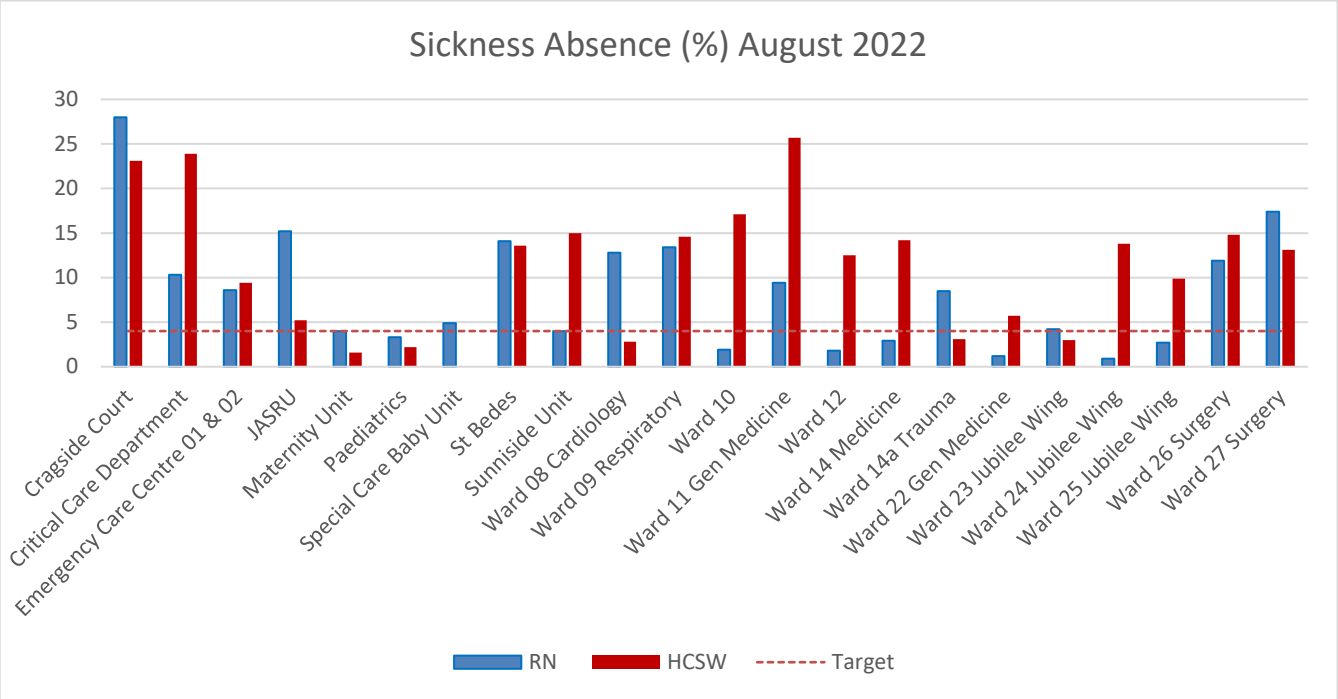
A task and finish group to streamline data capture and explore these potential emerging themes is being set up, alongside reviewing the potential to triangulate this data against a number of potential care quality measures to truly explore any impacts of staffing challenges on patient care, and to enable targeted support for staff.

A report of staffing concern related incidents is generated monthly and discussed at the Nursing Professional Forum.

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 fourth wave of COVID 19. The number of Registered Nurse vacancies also contribute to this.

5. Attendance of Nursing workforce

The below table displays the percentage of sickness absence per staff group for August. This includes Covid-19 Sickness absence.



6. Governance

Actual staff on duty on a shift-to-shift basis compared to planned staffing is demonstrated within the Safecare Live system. Staff are required to enter twice-daily acuity and dependency levels for actual patients within their areas/department, to support a robust risk assessment of staff redeployment.

7. Conclusion

This paper provides an exception report for nursing and midwifery staffing in August 2022, and provides assurance of ongoing work to triangulate workforce metrics against staffing and care hours.

8. Recommendations

The Board is asked to receive this report for assurance.

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

Appendix 1- Table 3: Ward by Ward staffing August 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
Cragside Court	68.7%	170.4%	86.7%	214.4%	316	4.8	11.5	16.3
Critical Care Dept	80.5%	112.0%	89.2%	70.7%	276	26.1	4.8	30.9
Emergency Care Centre - Ward 01 & 02	75.0%	117.5%	75.2%	114.0%	1351	5.5	4.2	9.7
JASRU	67.2%	114.2%	100.6%	125.8%	586	2.9	5.3	8.2
Maternity Unit	128.0%	143.5%	98.0%	95.8%	596	12.9	4.9	17.8
Paediatrics	102.3%	136.4%	100.8%		32	66.0	24.9	90.9
Special Care Baby Unit	91.6%	112.0%	99.9%	93.1%	99	17.4	6.4	23.7
St. Bedes	81.7%	121.9%	99.1%	127.7%	290	4.8	5.1	9.9
Sunniside Unit	105.0%	99.5%	102.6%	127.9%	214	8.6	5.6	14.2
Ward 08 Cardiology	88.6%	126.1%	102.8%	100.5%	631	3.2	3.4	6.6
Ward 09 Respiratory	79.1%	159.2%	140.4%	88.7%	854	2.5	2.9	5.3
Ward 10	63.8%	126.0%	107.1%	109.6%	707	2.4	3.1	5.5

	Day		Night		Care Hours Per Patient Per Day (CHPPD)			
Ward	**Average fill rate - nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Cumulative patient count over the month**	**Registered midwives / nurses**	**Care Staff**	**Overall**
Ward 11 Gen Medicine	71.8%	118.4%	107.9%	126.4%	855	2.1	2.9	5.0
Ward 12	86.3%	134.4%	101.7%	136.8%	839	2.4	3.4	5.7
Ward 14 Medicine	82.4%	128.3%	134.9%	118.3%	663	3.2	3.7	6.9
Ward 14A Trauma	81.5%	166.1%	103.6%	105.7%	837	2.4	4.0	6.3
Ward 22 Gen Medicine	75.5%	110.8%	114.1%	89.4%	862	2.4	3.3	5.7
Ward 23 Jubilee Wing	76.8%	154.6%	100.5%	99.3%	708	2.4	4.4	6.8
Ward 24 Jubilee Wing	85.6%	101.1%	103.7%	93.8%	907	2.4	3.0	5.4
Ward 25 Jubilee Wing	68.1%	106.8%	103.0%	95.9%	951	1.9	3.0	4.9
Ward 26 Gynae	83.3%	110.5%	104.6%	111.1%	811	2.7	3.2	5.9
Ward 27 Treat/Centre	75.5%	94.9%	102.1%	95.7%	886	2.3	2.5	4.8
QUEEN ELIZABETH HOSPITAL - RR7EN	**79.5%**	**116.3%**	**91.4%**	**104.0%**	**14271**	**4.1**	**3.9**	**7.9**

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 18

Report Title:	**EPRR Core Standards Self-Assessment 2022-23**			
Name of Meeting:	Trust Board			
Date of Meeting:	27 September 2022			
Author:	David Patterson, EPRR and BC Manager Tom Knox, Head of EPRR			
Executive Sponsor:	Joanne Baxter, Chief Operating Officer			
Report presented by:	Joanne Baxter, Chief Operating Officer			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☐
	The purpose of this report seeks the endorsement from Trust Board for the EPRR Core Standards self-assessment 2022-23 prior to submission to NHSE.			
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:	Executive Risk Management Group members in September 2022 Trust Resilience Group members in September 2022 Strategic EPRR Committee held on 21 September 2022 Senior Management Team held on 22 September 2022			
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 asks the board to consider that:** • The headline is that the Trust continues ***'on a journey, making good progress'*** • NHS England (NHSE) have increased the number of standards requiring self-assessment and have requested additional evidence for the 2022-23 submission • A review of the EPRR core standards has been undertaken and the Trust's current compliance is **78%** which provides an overall grading of **Partial compliance** • The trust is fully compliant with **50 of 64** standards • The trust is partially compliant with the further **14** standards or **22%** • The trust is non-compliant with none of the standards • The trust is compliant with **10 of 13** standards within the deep dive self-assessment			

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- The report documents the specific actions the trust are taking to address outstanding issues and provides an indicative timeline on when they will be achieved
- An internal audit has been undertaken on the trust's self-assessment which has received some initial positive feedback with official findings report to follow at a later date
- This year's assurance process will reflect the establishment of integrated care boards (ICBs) as Category 1 responders and their local NHS leadership role. This includes the requirement to undertake a self-assessment against the core standards; and lead the NHS locally to agree the process to gain confidence of organisational ratings in a peer review approach – this is being scheduled to take place during October 2022.
- Consultation has taken place with NHSE EPRR regionally and other EPRR stakeholders. Our intended approach to planning and self-assessment was ratified by this group.

</td></tr>
<tr><td>Recommended actions for this meeting:</td><td colspan="6">The Trust Board are asked to review and endorse the attached EPRR Core Standards self-assessment 2022-23 prior to submission to NHSE.</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">List corporate objective reference and headline – e.g. 1.4 Maximise the use of Nervecentre to improve patient care</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">An assessment of trust position against the trust standards has been undertaken with any associated risks added to the organisational risk register</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>

EPRR Annual Assurance Statement 2022

1. Introduction and context

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

The EPRR assurance process is based on the NHS England Core Standards for EPRR that cover 10 core domains:

1. governance
2. duty to risk assess
3. duty to maintain plans
4. command and control
5. training and exercising
6. response
7. warning and informing
8. co-operation
9. business continuity
10. chemical biological radiological nuclear (CBRN) and hazardous material (HAZMAT).

For 2022-23, NHS England (NHSE) have added a number of standards to self-assess against (in 2021-22 there was 46 to self-assess, this year an increase to 64 to self-assess) and also additional evidence is now required for the 2022-23 submission.

A deep dive review is also conducted to gain additional assurance into a specific area, the subject for this year's submission is 'Evacuation and Shelter'.

This report is based upon the full set of standards and deep dive review.

Organisational assurance rating

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

This is explained in more detail below:

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

The following EPRR assurance statement provides a current position:

*The trust continues **'on a journey, making good progress'.** EPRR assurance action plans have been reviewed in order to improve the level of compliance against 2022-23 EPRR Assurance Core Standards, and where non-compliance was reported as part of the overall assurance rating, that an updated and reviewed assurance level is provided with an ongoing action plan.*

A Gateshead Health Action Plan is attached to this document (as appendix A) detailing the core standards and the Trust's current compliance setting out actions and timeline to identify additional work to enhance Trust resilience.

The trust self-assessment key includes:

- The red text highlights the specific changes from last year's standards and the extra evidence required
- The blue text is the trust self-assessment, with the current organisational evidence, action to be taken, lead and timescale.
- The last column 'comments' denotes a comparison from 2021-22. The highlighted green boxes show where the trust has made progress over the last 12 months.

2. Assurance Elements

2.1 EPRR Core Standards and Action Plan review

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

The trust has been through a rapid period of change and has been faced with the many challenges of responding to reoccurring waves of operational pressures and response to Covid-19.

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

With the introduction of the Health and Care Act 2022, this year's assurance process will reflect the establishment of integrated care boards (ICBs) as Category 1 responders and their local NHS leadership role. This includes the requirement to undertake a self-assessment against the core standards; and lead the NHS locally to agree the process to gain confidence of organisational ratings in a peer review approach – this is being scheduled to take place during October 2022.

In addition, an internal audit has been undertaken on a sample of the Trust's self-assessment which has received some initial positive feedback with official findings report to follow at a later date

A summary of the standards submission assessment scores against the respective core standards is provided overleaf:

Please choose your | Acute Providers

Domain	Total Applicable Standards	Fully Compliant	Partially Compliant	Not Compliant	Not Applicable
Governance	6	6	0	0	0
Duty to risk assess	2	2	0	0	0
Duty to maintain plans	11	8	3	0	0
Command and control	2	1	1	0	0
Training and exercising	4	2	2	0	0
Response	7	7	0	0	0
Warning and informing	4	4	0	0	0
Cooperation	4	3	1	0	0
Business continuity	10	6	4	0	0
CBRN	14	11	3	0	0
Total	64	50	14	0	0

Deep Dive	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant	Not Applicable
Evacuation and Shelter	13	10	3	0	0
Total	13	10	3	0	0

Percentage Compliance	78%
Overall Assessment	Partially Compliant

The trust's current compliance is **78%** which provides a rating of **Partial compliance** (as of 20 September 2022) with the following highlights:

- The trust is fully compliant with **50 of 64** standards
- The trust is partially compliant with the further **14** standards or **22%**
- The trust is non-compliant with none of the standards

Deep Dive
The trust has self-assessed against 13 standards within the deep dive with the following highlights:

- The trust is fully compliant with **10 of 13** deep dive standards
- The trust is partially compliant with **3** deep dive standards
- The trust is non-compliant with none of the standards

This is an evolving assessment as work progresses and the compliance percentage may positively change before the final NHSE submission of 31 October 2022.

2.2 EPRR Annual Assurance Statement and work-plan for 2022-23

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

- A number of the EPRR standards have been recently assessed, revised and have received sign-off at the trust Strategic EPRR committee.
- Acknowledgement and implementation of the structural and guidance changes within NHSE and UKHSA, and the implementation of the ICBs and ICPs
- The implementation and the roll-out of the new Principles of Health Command and National minimum occupational training standards ensuring the trust is working towards national recognised competency
- The comprehensive review of the Evacuation and Shelter, and CBRN HAZMAT response plans brings the trust in line with revised national guidance, doctrine and frameworks ensuring additional trust response capacity, capability and resilience

Domain 1 – Governance

- The Trust EPRR Policy Statement has been revised to consider national and local changes with the implementation of the Integrated Care Boards (IBCs), revised NHSE EPRR Framework, a revised Northeast and Yorkshire (NEY) Risk management Framework, the implementation of new minimum occupational training standards and the Principles of Health Command training programme.
- The trust Incident Response Policy has been revised to consider national and local changes with the implementation of the Integrated Care Boards (ICBs), revised NHSE EPRR Framework and subsequent changes to incident response.
- The trust has developed a Debrief Protocol (May 2022) that provides a framework for debriefing following an incident, event or exercise including criteria, objectives, planning, the process and governance process of reporting and monitoring actions and learning

Domain 2 – Duty to risk assess

- The EPRR Risk Register continues to be embedded, regularly reviewed and presented to the Strategic EPRR Committee and Trust Resilience Group for oversight, before presentation to the Executive Risk Management Group (ERMG) to provide risk mitigation assurance
- The implementation of a revised Northeast and Yorkshire (NEY) Risk management Framework to complement the trust approach
- The trust are a standing member and participant in the Northumbria LRF Risk Assessment Working Group reviewing community and national risk registers.

Domain 3 – Duty to maintain plans

- Collaborative planning continues with internal and external stakeholders to ensure a holistic approach to EPRR planning
- The trust's updated Incident Response Plan (ratified in May 2022) demonstrates effective arrangements in place to define and respond to Business Continuity, Critical and Major incidents as defined within the EPRR Framework. The Incident

Response Plan is referenced within other plans and protocols across the trust as the central element for escalation and response.

- A validation of emergency plans and action cards to assess trust capabilities, is scheduled within the EPRR teamwork-plan for 2022-23 with a focus on mass casualty, evacuation and shelter, adverse weather and CBRN/HAZMAT
- An addendum/appendix is to be added to the Incident Response Plan to formalise the approach of how the trust would respond to a new and emerging pandemic following the organisational learning of the response to Covid-19

Domain 4 – Command and Control

- The trust's On-Call mechanism is explicitly described within the revised Incident Response Plan [May 2022] and within a specific trust On-Call Framework [May 2022] developed for the On-Call Team. Within this the On-Call Standards and expectations are set out which includes the 24 hours arrangements for alerting, roles, responsibilities and a rota
- On-call training and exercising has taken place in November 2021 and May to Sept 2022 which included alignment to the National Occupational Standards
- The new National Minimum Occupational Standards have been mapped onto ESR to provide a comprehensive record of command training undertaken by trust staff required to carry out an on-call role.
- Trust Strategic and Tactical commanders are to attend the mandatory Principles of Health Command training sessions between September and November 2022 hosted by NHSE

Domain 5 – Training and Exercising

- The trust has developed a formal training plan to support the delivery of principles of health command training in line with minimum and national occupational standards and will develop a Personal Development Plan (PDP) to ensure comprehensive personal skills sets for all relevant staff
- The new National Minimum Occupational Standards have been mapped onto ESR to provide a comprehensive record of command training undertaken by trust staff required to carry out an on-call role.
- The trust has participated in six-monthly communications tests with NEAS (December 2021 and May 2022); an annual tabletop exercise with the on-call team (May to Sept 2022) and a mass casualty exercise with Emergency Department staff in July 2022
- Plans are in place to develop a future live exercise and command post exercise as part of the training plan in the next 12 months
- On-call training has taken place in November 2021 and May to Sept 2022 which included alignment to the National Occupational Standards
- Training sessions have taken place (including a short tabletop exercise) during May and June 2022. Principles of Health Command (PHC) Train the Trainer sessions have been completed, with Strategic and Tactical Command roll out planned
- A number of trust staff from across various disciplines and specialities undertook the Hospital Major Incident Medical Management and Support (HMIMMS) training programme on Thursday 14 and Friday 15 July 2022

- Members of the trust have also undertaken recent EMERGO training and future legal training will attended by the Accountable Emergency Officer and EPRR Team
- The EPRR Team has also supported training and exercising including cyber incident response with digital services; the massive haemorrhage protocol with transfusion services and ED; RAMGENE monitoring, CBRN IOR/PRPS, and decontamination shelter deployment as examples

Domain 6 – Response

- The Incident Response Plan (May 2022) details the establishment of the Incident Coordination Cell (ICC) including the role, membership and how this is activated.
- The trust has a dedicated ICC (within the EPRR Hub) which has all the required equipment to assist the team in dealing with any incidents.
- Further work is to take place on training and exercising the role and function of the ICC with key stakeholders internally
- A teams share-point has been established to store all information electronically with grab bags provided for all members of the EPRR, SRT and On-Call Team to utilise in a response
- Trained Loggists are available in the trust, who have received previous training however accessing them on a 24:7 basis is problematic. The role of Loggist has Minimum Occupational Standards under Principles of Health Command and will require specific action/attention over the next 12 months.

Domain 7 – Warning and Informing

- The major incident communication plan was updated in April 2022. The service provided during an incident would include providing strategic communications advice, providing information for staff, communicating with the public, liaising with our partners and being part of an incident coordination centre. This will require some testing and exercising during 2022-23 workplan.
- As part of the major incident communications plan there has been a process developed around social media and also how we will link with our partners and provide information. This includes setting up protocols for using social media.
- The trust has identified and provided media training to our key spokespeople that are able to represent the organisation during a major incident.
- Communications channels will continue to be reviewed to assess their effectiveness

Domain 8 – Cooperation

- The newly reformed ICS Local Health Resilience Partnership (LHRP) met for the first time since the Covid pandemic on 30 May 2022. The trust were represented and revised draft terms of reference were presented
- The trust EPRR & BC Manager is the current chair of the Northumbria Local Resilience Forum (NLRF) Tactical Business Management Group and participates on a regular basis. Updates are provided to the Gateshead Multi-Agency Resilience and Emergency Planning Group with system representation
- Although fully compliant, the current internal approach to Mutual Aid and staff Action Cards require review and updating, and aligned to the Incident Response Plan, and will feature as a action for 2022-23 workplan.

Domain 9 – Business Continuity

- A revised group Business Continuity Policy has been developed that has been ratified by the trusts internal Policy Review Group (July 2022) and Senior Management Team (August 2022)
- The Policy will fully be implemented following the sign off of the Business Continuity Management System Business Case for a system solution that was deferred by the trust's internal Senior Management Team (August 2022)
- A range of Business Continuity (BC) plans (SOP-QE-BCP) are in place across the trust to respond to a BC incident whether planned or unplanned, these are reviewed and updated as necessary and are based on ISO 22301

Domain 10 – CBRN

- A new CBRN/HAZMAT plan has been produced and is in the process of validation
- The new plan includes a Joint Decision Model (JDM) format, a bespoke assessment of threat and risk to Gateshead, and a full appreciation of the link between Initial Operational Response (IOR) and more complex decontamination processes
- A fully functionally decontamination shelter has been purchased by the trust and has replaced the previous equipment. Training is currently underway for a cross section of trust staff
- Relevant Emergency Department (ED) and Site Resilience Team (SRT) staff have received training during 2022 in Powered Respirator Protective Suits (PRPS) and Ramgene radioactivity detection equipment. These staff will cascade the above training to all ED and SRT staff to increase capability, capacity and resilience in line with NHSE guidance
- A review of all trust CBRN/HAZMAT related equipment has taken place with ownership allocated to ED and/or QEF (Medical Engineering). This includes maintenance programmes and a revitalisation of the Major Incident (‘MAJAX’) store post-covid.

Deep dive

- A draft evacuation and shelter plan based on the 2021 guidance is complete (v3). It awaits some minor changes (based on consultation) and adoption prior to an exercise/validation process. This will replace the existing 2014 plan (reviewed in 2019).
- Both the existing plan and the draft plan incorporate the NHSE Healthcare Patient Evacuation Triage Priorities. This is based on mobility and takes into account different characteristics of evacuated patients. The draft plan directly replicates that of the 2021 guidance.
- The evacuation plan HAS NOT been exercised in the last three years. The draft plan will be exercised as part of its validation process during the 2022-23 workplan.

3. Conclusion

The EPRR Team have continued to use the EPRR standards as a benchmark for directing the priorities of the trust workplan; indicate a measure of progress and to identify and embed organisational learning and opportunities for improvement.

This report is provided for consideration and as an assurance that tangible progress has been made with EPRR standards during the reporting period for 2022-23.

Please choose your: Acute Providers

Domain	Total Applicable Standards	Fully Compliant	Partially Compliant	Not Compliant	Not Applicable
Governance	6	6	0	0	0
Duty to risk assess	2	2	0	0	0
Duty to maintain plans	11	8	3	0	0
Command and control	2	1	1	0	0
Training and exercising	4	2	2	0	0
Response	7	7	0	0	0
Warning and informing	4	4	0	0	0
Cooperation	4	3	1	0	0
Business continuity	10	6	4	0	0
CBRN	14	11	3	0	0
Total	64	50	14	0	0

Deep Dive	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant	Not Applicable
Evacuation and Shelter	13	10	3	0	0
Total	13	10	3	0	0

Percentage Compliance	78%
Overall Assessment	Partially Compliant

Assurance Rating Thresholds
- Fully Compliant = 100%
- Substantially Compliant =99-89%
- Partially Compliant = 88-77%
- Non-Compliant = 76% or less

Notes
Please do not delete rows or columns from any sheet as this will stop the calculations
Please ensure you have the correct Organisation Type selected
The Overall Assessment excludes the Deep Dive questions
Please do not copy and paste into the Self Assessment Column (*Column T*)

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of	Action to be taken	Lead	Timescale	Comments
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Y	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description	Jo Baxter as Chief Operating Officer [COO] is the executive board level member that is the identified **Accountable Emergency Officer [AEO]** for Gateshead Health NHS Foundation Trust. The AEO responsibitilies are documented within the trust's EPRR Policy.	Fully Compliant	Further clarification if AEO responsibilities are within a role/job description	Accountable Emergency Officer with Head of EPRR	31 March 2023	Remains as compliant
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	Y	The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised • Include references to other sources of information and supporting documentation. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	The trust's **EPRR Policy statement [OP89]** provides an overview of governance, roles and responsiblities and a trust commitment to emergency planning, business continuity, training, exercising and debrief - copy available on request The trust's **Incident Response Policy** (November 2020) provides the framework, roles, responsibilities with resources as to how the trust responds to an incident - copy available on request Both policies have a review schedule and version control; unambiguous terminology; clear responsibitilies for update, review and testing; and include references to other sources of information and supporting documentation.	Fully Compliant	Both policies are currently in an internal governance review following the publication of updated NHSE EPRR guidance (released 29 July 2022), the Principles of Health Command training (July 2022) and the implementation of the ICBs (on 1 July 2022). Governance timeline in place.	EPRR Team	30 November 2022	Remains as compliant
3	Governance	EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	Y	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activitites.	The EPRR portfolio area reports in the trust Executive Risk Management Group which reports to the trust Executive Board. Update reports to the group are scheduled every 6 months and are presented by the AEO. This is explicitly described within the EPRR Policy statement. The previous **annual trust board report** was presented by the Accountable Emergency Officer on 28 September 2021. The report provided an overview of assurance on EPRR Core standards compliance with identified actions for the future EPRR work programme. The board report is presented in part 1 of the public Trust Board. A copy of the board report and minutes are available on request.	Fully Compliant	A governance timeline for 2022-23 has been developed, and the annual board report will presented on 27 September 2022 The board report will reference the significant changes to the core standards and self-assessment process; the publication of updated NHSE EPRR guidance (released 29 July 2022), the Principles of Health Command training (July 2022) and the implementation of the ICBs (on 1 July 2022).	Accountable Emergency Officer with Head of EPRR	27 September 2022	Remains as compliant
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Y	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan	The trust has a current **EPRR work plan** with the reporting process explicity described within the EPRR policy statement. The current reiteration of the work plan is v4 29 July 2022 - copy available on request.	Fully Compliant	The EPRR Annual work plan for 2022-23 will be reviewed following the completion of the self-assessment and submission of the standards	Head of EPRR and EPRR Team	31 October 2022	Remains as compliant
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Y	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group	The trust's **EPRR Policy statement [OP89]** provides an overview of governance, roles and responsiblities and a trust commitment to to emergency planning, business continuity management, risk, training and exercising identified learning and debrief. This provides an internal governance process chart. The **Incident Response Policy** was signed off by the trust EPRR Committee [delegated responsibiity on behalf of the Trust Board] in June 2021 which provides an assessment of roles and resources, the organisation structure chart and internal governance structure - copy available on request An **EPRR Team is** in place that is within the Chief Operating Officer (AEO) function with role descriptions and an organisation structure chart - copies are available on request	Fully Compliant	Both policies are currently in an internal governance review following the publication of updated NHSE EPRR guidance (released 29 July 2022), the Principles of Health Command training (July 2022) and the implementation of the ICBs (on 1 July 2022). Governance timeline in place.	EPRR Team	30 November 2022	Remains as compliant
6	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Y	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations	The trust has developed a **Debrief protocol (May 2022)** that provides a framework for debriefing following an incident, event or exercise including criteria, objectives, planning, the process and governance process of reporting and monitoring actions and learning - copy available on request. A number of debriefs have been udertaken along with improvement plan implementation. As an example, a trust internal debrief was undertaken following a power outage in March 2022, this was debriefed and reported to the Executive Management Team highlighting the learning to the Trust Board - copies of reports available on request The trust EPRR Team **are structured debrief trained and also utilise the NE LRF Debrief Protoco**l for regional participation and sharing lessons with partner organisations where appropriate - a copy is available on request	Fully Compliant	No action at this time			Remains as compliant
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather	EPRR risks are regularly reviewed, considered on a quarterly basis and recorded on the **trust's Risk Register** - this is reported to the Executive Risk Management Group and trust Executive Board by exception. A specific **EPRR Risk Register** with an overview of EPRR Risks is produced on a quarterly basis to the Trust Resilience Group and Strategic EPRR Committee for any risks identified so there is relevant assurances over delivery of actions to mitigate risks within the governance arrangements - copies available on request The trust are a standing member and participant in the **Northumbria LRF Risk Assessment Working Group** which looks at the community and national risk registers.	Fully Compliant	No action at this time			Remains as compliant
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Y	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	As above all EPRR risks are included on the trust's Risk Register. The process for risk management follows the **trust's Risk Management Policy [RM01]** and the EPPR Portfolio is referenced within this along with trust's revised **EPRR Policy statement [OP89]** - copies available on request.	Fully Compliant	No action at this time			Remains as compliant
9	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders to ensure the whole patient pathway is considered.	Y	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded	Internally the EPRR Team have been actively engaged with various stakeholders, for example, digital services, clinical colleagues and the Safeguarding Team to ensure a holistic approach to EPRR planning. Externally, Gateshead Health NHS Trust are part of the Northumbria Local Resilience Forum governance structure and in regular contact with multi-agency partners, as well as the Gateshead Multi-Agency Resilience and Emergency Planning Forum which serves as a conduit for engagement with partners within the planning process	Fully Compliant				New standard introduced - assessed as compliant
10	Duty to maintain plans	Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Y	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The trust has an Incident Response Plan (May 2022) that demonstrates effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework. A hard copy of the plan was provided to the site resilience team and on-call teams with training and exercising taking place between June and September 2022. The Incident Response Plan is referenced within other plans and protocols across the trust as the central element for escalation and response. The plan is available for access on the trust intranet and was ratifed by the Senior Management Team in June 2022. Copies of the Incident Response Plan and training and exercising material are available on request.	Fully Compliant	Wider awareness across the trust embedding it as a core knowledge area for relevant commanders across the trust.	EPRR Team	30 June 2023	Revised standard - compliant

11	Duty to maintain plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Y	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire.	The trust has Adverse Weather Emergency Preparedness that includes a **Heatwave and Cold Weather plan**. This has been developed in line with current national practice; in line with risk assessment; signed off; shared appropriately; outlines any equipment required and provides specific departmental action cards. The plans have been tested through extreme events including heatwave (June 2022) and are reviewed on an annual basis in line with updates to national guidance - copy available on request.	Fully Compliant	Work is ongoing to review and combine plans and reassess risks The next scheduled update to the Cold Weather Plan is October 2022 following the release of UKHSA Cold Weather Plan 2022-23 - the trust plan will be refreshed A staff programme of training and exercising is required and will be developed to test and validate any updated plans. This will include a winter surge event exercise to test a cold weather scenario is October / November 2022 as part of the winter planning process.	Associate Director for Estates and Facilities and EPRR Team	31 October 2022	Revised standard - compliant
12	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles.	The trust has a current provides an infection prevention and control framework for dealing with new cases of Covid-19 infection and/or Covid-19 outbreaks within the organisation. It seeks to ensure that measures are taken to reduce the risk of onward transmission of Covid-19 in the hospital setting following a single new case of infection in either a patient or a member of staff. The policy defines what constitutes an outbreak and goes on to describe our current strategy for managing Covid outbreaks - copy available on request. The trust has a current patient pathway of transfer to Newcastle Hospitals NHS Foundation Trust for patients with suspected or confirmed High Consequence Infectious Disease, such as Ebola, MERS-CoV and Avian Influenza. Any infectious disease presentations are discussed with the RVI and if they require admission, for their primary concern being ID or isolation, a transfer to the RVI will be arranged who would be transferred via ambulance - copy of NUTH policy available on request	Fully Compliant	No action at this time			Revised standard - compliant
13	Duty to maintain plans	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Any new pandemic which is declared would require DIPC and IPC interpretation of national/local guidance. Under the auspices of the Incident Response Plan, an Incident Management Team with the key stakeholders would be established to implement and operationalise the guidance, agree changes to the operational model, and this be cascaded to the trusts operational teams.	Partially Compliant	An addendum/appendix is to be added to the Incident Response Plan to formal the approach	Head of IPC/Head of EPRR	30 November 2022	New standard introduced
14	Duty to maintain plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.	Covid-19 and staff influenza vaccination programmes are in place and are mobilisation as and when required. This is a well established process based on the last 24 months. There is reference to accessing mass countermeasures within the CBRN Plan - request available on request	Fully Compliant				Revised standard - compliant
15	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.	A **draft Mass Casuality Plan** has been drafted for the trust, and has been tested and exercised with Emergency Department staff in July 2022. Further additions to the plan are to be undertaken and the plan will be presented through the trust governance process, with further training and exercising to be developed. This will be presented to the Trut Resilience Group during October 2022 - copy available on request The trust has a **Patient Identification Policy [RM40]** which includes the use of specific wrist bands, and pre-printed folders using a unique name, date of birth, gender which allows the patient to be registered as quickly as possible which then gives prompt access to systems, tests and treatment e.g. blood etc. - copy available on request	Partially Compliant	Whilst plans are current and subject to consultation, further training and exercising is required to embed some minor changes	EPRR Team	31 October 2022	Remains as partially compliant
16	Duty to maintain plans	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The trust has a **Hospital Evacuation and Sheltering Plan** in place to evacuate ward and areas as necessary that have been previous used and tested - copy available on request The plan is currently being updated to include the 2021 guidance and changes to the estate - copy available on request The trust has a current fire policy that has recently been reviewed that includes processes for fire evacuation. Fire safety is a standing agenda item at the Corporate Health and Safety Committee including staff training - copy available on request	Partially Compliant	Once the new plan is signed off, a programme of training and exercising is to be undertaken with key stakeholders involved in the plan	EPRR Team	31 December 2022	Change to compliant
17	Duty to maintain plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust has a **Lockdown Procedure** that is reviewed regularly and updated accordingly - last review was April 2022. A lockdown risk profile will be produced by the Local Security Management Specialist and the Health and Safety/Risk Management Team to make sure that any assessment made on the Trust's ability to lockdown is accurate and achievable in line with the security management guidance - a copy is available on request The Security Team receive relevant national initial training in relation to CT matters as part of their SIA qualification (the qualification also applies to agency staff). Lock down is an integral part of this training. The team's Action Card for Major Incidents provides specific locations for security staff in order to establish a lock down. The locations will also apply as a default response to other incidents requiring lock down which do not meet the threshold of Critical/Major Incidents. All staff are aware of these locations. There is no requirement for specialist equipment. Whilst there is no regular test of the procedure its successful use has been consolidated through live operations (recent examples are held by the Head of Security) and will feature in the trust's exercise programme 2022-23. The team carry out annual tests in relation to the Maternity Unit.	Fully Compliant	Further testing and exercising programme 2022-23	Head of Security EPRR Team	31 May 2023	Remains as compliant
18	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Based on a revised risk assessment, the existing plan was reviewed and rewritten to more accurately reflect the EPRR framework, safeguarding guidance, and further contingencies (HMP patients within the trust). This was approved at the trust's Safeguarding Committee and Policy Review Group - copy available on request	Fully Compliant	Wider awareness across the trust	EPRR Team	31 December 2022	Remains as compliant
19	Duty to maintain plans	Excess fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Y	Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The trust is part of NLRF Death Management Group Concept of Operations that provides an overview of regional planning arrangements within Northumbria and considerations to augment current bereavement services capacity. The document was developed to provide guidance to responding organisations and personnel within Northumbria on how local arrangements will support national arrangements set out under HM Government Managing the Deceased During a Pandemic: Guidance for planners in England.	Fully Compliant	Local review to be undertaken	Northumbria Local Resilience Forum	30 June 2023	Revised standard - compliant
20	Command and control	On-call mechanism	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners	The trust's **On-Call mechanism** is explicitly described within the revised **Incident Response Plan** [May 2022] and within a specific trust **On-Call Framework** [May 2022] developed for the On-Call Team. Within this the On-Call Standards and expectations are set out which includes the 24 hours arrangements for alerting, roles, responsibilities and a rota - copies available on request	Fully Compliant	Annual review of documents	EPRR Team	31 May 2023	Remains as compliant

21	Command and control	Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	Y	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.	On-call training and exercising has taken place in November 2021 and May to Sept 2022 which included alignment to the National Occupational Standards - a copy of the training materials is available on request. The new National Minimum Occupational Standards have been mapped onto ESR to provide a comprehensive record of command training undertaken by trust staff required to carry out an on-call role. Training sessions have taken place (including a short TTX) during May and June 2022. Principles of Health Command (PHC) Train the Trainer sessions have been completed, with Strategic and Tactical Commander roll out planned	Partially Compliant	Further on-call training and exercising is to be scheduled with the on-call team as part of the training plan 2022-23 Strategic and Tactical commanders are to attend the mandatory Principles of Health Command training sessions between September and November 2022	EPRR Team Strategic and Tactical Commanders	31 December 2022	Revised standard - compliant
22	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Y	Evidence • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	The trust has developed a formal training plan to support the delivery of principles of health command training in line with minimum and national occupational standards, and will develop a Personal Development Plan (PDP) to ensure comprehensive personal skills sets. This will be presented to the Trut Resilience Group and raitified by the EPRR Committee during September 2022 - copy available on request	Fully Compliant	Ongoing work with the trusts Learning and Development Team within the governance process	EPRR Team Learning and Development Team	31 March 2023	Revised standard - compliant
23	Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Y	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. Evidence • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning	The trust has participated in six-monthly communications tests with NEAS (December 2021 and May 2022); annual table top exercise with the on-call team (May to Sept 2022). Debrief reports were/will be produced from this exercising once complete. Plans are place to develop a future live exercise and command post exercise as part of the training plan in the next 12 months - copy of material available on request The trust has developed a formal training plan that includes trust-wide exercising. The EPRR Team also support other teams and departments with their individual exercising. This will be presented to the Trust Resilience Group and raitified by the EPRR Committee during September 2022 - copy available on request	Partially Compliant	A future live exercise and command post exercise will be developed in the next 12 months as part of the training plan	EPRR Team	30 June 2023	Revised standard - compliant
24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Y	Evidence • Training records • Evidence of personal training and exercising portfolios for key staff	On-call training and exercising has taken place in November 2021 and May to Sept 2022 which included alignment to the National Occupational Standards - a copy of the training materials is available on request - The new National Minimum Occupational Standards have been mapped onto ESR to provide a comprehensive record of command training undertaken by trust staff required to carry out an on-call role. Training sessions have taken place (including a short TTX) during May and June 2022. Principles of Health Command (PHC) Train the Trainer sessions have been completed, with Strategic Command roll out planned	Partially Compliant	Additional mapping of training will continue throughout the year	EPRR Team	31 July 2023	Revised standard - compliant
25	Training and exercising	Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	Y	As part of mandatory training Exercise and Training attendance records reported to Board	A number of trust staff from across various disciplines and specialities undertook the **Hospital Major Incident Medical Management and Support (HMIMMS)** training programme on Thursday 14 and Friday 15 July 2022 - copy of programme available on request **On-call training and exercising** has taken place in November 2021 and May to Sept 2022 which included alignment to the National Occupational Standards - a copy of the training materials is available on request - Various other training has taken place throughout 2021-2022 including RAMGENE monitoring, CBRN IOR/PRPS, Decontamination tent as exmaples The trust has developed a formal training plan to support the delivery of principles of health command training in line with minimum and national occupational standards, and will develop a Personal Development Plan (PDP) to ensure comprehensive personal skills sets. An overview of trust staff awareness and training completed in 2021-2022 will be incorporated into the trust board report for September 2022.	Fully Compliant	The trust has developed a formal training plan to support the delivery of principles of health command training in line with minimum and national occupational standards, and will develop a Personal Development Plan (PDP) to ensure comprehensive personal skills sets.	EPRR Team	30 June 2023	Revised standard - partially compliant
26	Response	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	Y	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.	The Incident Response Plan (May 2022) details the establishment of the **Incident Coordination Cell (ICC)** including the role, membership and how this is activated. The trust has a dedicated ICC (within the EPRR Hub) which has all the required equipment to assist the team in dealing with any incidents. This has been activated to manage a recent case of monkeypox. Alternative venues have also been identified as secondary areas for strategic, tactical and operational cells to support the ICC when required, however further work is required to formalise.	Fully Compliant	Further work is to take place on training and exercising the role and function of the ICC with key stakeholders internally	31 October 2022	EPRR Team	Remains as compliant
27	Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Y	Planning arrangements are easily accessible - both electronically and local copies	A teams share-point has been established to store all information electronically with grab bags provided for all members of the EPRR, SRT and On-Call Team	Fully Compliant	No action at this time			Revised standard - compliant
28	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes	A range of Business Continuity (BC) plans (SOP-QE-BCP) are in place across the trust to respond to a BC incident whether planned or unplanned, these are reviewed and updated as necessary and are based on ISO 22301 - a sample copy is available on request. The plans are being updated that will be complete by 31 October 2022. The escalation of a business continuity incident is included as part of the trust Incident Response Plan (May 2022) - copy available on request	Fully Compliant	A revised group Business Continuity Policy has been developed that has been ratified by the trusts internal Policy Review Group (July 2022) and Senior Management Team (August 2022) - copy available on request This will be implemented following the sign off of the Business Continuity Management System Business Case for a system solution that was deferred by the trust's internal Senior Management Team (August 2022) - copy available on request	EPRR Team'	30 June 2023	Remains as compliant
29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	Y	• Documented processes for accessing and utilising loggists • Training records	On-Call response staff have been provided with their own personal log books which has the required guidance included within. Trained Loggists are available in the trust, who have received previous training however accessing them on a 24:7 basis is problematic. A copy of the personal log book, current loggist list and previous training is available on request	Fully Compliant	The role of Loggist has Minimum Occupational Standards under Principles of Health Command and will require specific action/atttention over the next 12 months.	EPRR Team	31 July 2023	Revised standard - compliant
30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	Y	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep Template	The trust has a process in place for receiving, completing authorising and completing **Situation Reports** that are completed by the trust Information teams and via the ICC / Site Resilience Team with a sign-off in place by exception dependant upon the request The trust uses SBAR for critical incident and METHANE for major incident reporting which is embedded into the Incident Response Plan - copy available on request	Fully Compliant	No action at this time			Revised standard - compliant
31	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Y	Guidance is available to appropriate staff either electronically or hard copies	A version of the guidance is available **electronically and as a hard copy** as part of the trust Incident Response Plan and Action Cards https://www.england.nhs.uk/wp-content/uploads/2018/12/B0128-clinical-guidelines-for-use-in-a-major-incident-v2-2020.pdf	Fully Compliant	No action at this time			Remains as compliant
32	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	Y	Guidance is available to appropriate staff either electronically or hard copies	This document is available on the internal trust document management system PANDORA (http://pandora/docs/trust-clinical-guidelines/Pages/Home.aspx) and will be a link on the electronic version of the CBRN plan. There are also hard copies within the EPRR Team	Fully Compliant	No action at this time			Remains as compliant

33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	Y	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.	The head of communications and communications manager are representatives for communications as part of the organisations EPRR. As a key member of the organisations response to incidents there are mechanisms in place to ensure that incidents are appropriately described. Out of hours communications is provided by strategic on-call. The process for logging for communications request is part of the organisational EPRR response.	Fully Compliant	Out of hours communications will continued to be strengthened by providing further guidance.	Head of Communications and Head of EPRR	31 March 2023	Revised standard - compliant
34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	Y	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).	The major incident communication plan has been updated in April 2022. The service provided during an incident would include providing strategic communications advice, providing information for staff, communicating with the public, liaising with our partners and being part of an incident coordination centre. Action cards have been developed for communications and is part of the incident plan suite of materials - copy available on request	Fully Compliant	Although currently fully complaint, the major incident communications plan will need to be re-tested during the year.	Head of Communications and EPRR Team	31 March 2023	Revised standard - compliant
35	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	Y	• Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications • A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. • A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident • Appropriate channels for communicating with members of the public that can be used 24/7 if required • Identified sites within the organisation for displaying of important public information (such as main points of access) • Have in place a means of communicating with patients who have appointments booked or are receiving treatment. • Have in place a plan to communicate with inpatients and their families or care givers. • The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements	Communication between partner organisations is identified in the trust Incident Response Plan and Major Incident Plan, and has an individual communications team plan to support the trust response. The trust has a dedicated **Social Media Policy (OP79)** specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response - a copy is available on request The trust also has a MAJAX email box which is specifically used during major incidents. Information and communications are shared through the various meetings (e.g. LHRP & LRF) that are attended by Trust representatives where partner organisations are also in attendance, where plans, policies and procedures can be shared and reviewed. Debriefing and using organisational learning is an essential stage of the Incident Response Plan to inform the development of future incident response communications	Fully Compliant	Communications channels will continued to be reviewed to assess their effectiveness	Head of Communications and Head of EPRR	31 March 2023	Revised standard - compliant
36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	Y	• Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • Social Media policy and monitoring in place to identify and track information on social media relating to incidents. • Setting up protocols for using social media to warn and inform • Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response	As part of the major incident communications plan there has been a process developed around social media and also how we will link with our partners and provide information. This includes setting up protocols for using social media. We have identified and provided media training to our key spokespeople that are able to represent the organisation during a major incident. The trust has a dedicated Social Media Policy (OP79) specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response - a copy is available on request. We have also developed a flowchart about how senior staff can use social media to amplify and respond if necessary to key messages	Fully Compliant	Further training required for senior staff on social media	Head of Communications and Head of EPRR	31 March 2023	Revised standard - compliant
37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	Y	• Minutes of meetings • Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.	The ICS LHRP met for the first time since the Covid pandemic on 30 May 2022. The trust were represented and revised draft terms of reference were presented - copy of notes available on request	Fully Compliant	Further internal discussion to take place to review representation, trust governance arrangements and statutory status and responsibilities.	Accountable Emergency Officer with Head of EPRR	31 October 2022	Revised standard - compliant
38	Cooperation	LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	Y	• Minutes of meetings • A governance agreement is in place if the organisation is represented and feeds back across the system	The trust EPRR & BC Manager Is the current chair of the NLRF Tactical Business Management Group and participates on a regular basis. Updates are provided to the Gateshead Multi-Agency Resilience and Emergency Planning Group with system representation - copies of minutes from both groups are available on request.	Fully Compliant	Further scoping to take place with implementation of the ICBs (1 July 2022)	Head of EPRR	31 March 2023	Revised standard - compliant
39	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Templates and other required documentation is available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate	There is NHS England and Improvement for the North East and Yorkshire - **'Incident Management for Escalation and Mutual Aid Plan'** to support local systems across the Region - copy available on request Northumbria LRF also have a Multi-Agency Mutual Aid Agreement for it's constitute partner organisations which are formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Fully Compliant	Although fully compliant, the current internal approach to Mutual Aid and staff Action Cards require review and updating, and aligned to the Incident Response Plan A staff programme of training and exercising is required and will be developed to test and validate the updated plan	EPRR Team	31 March 2023	Remains as compliant
43	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004	The trust signed up to the **Northumbria Local Resilience Forum Information Sharing Protocol** that was developed in March 2014 - a copy is available on request This evidences the consideration of the relevance guidance including the Freedom of Information Act 2000 and the Civil Contingencies Act 2004 'duty to communicate with the public'. The trust has provided comments and agreement to sign up to the revised version - awaiting final sign off from all Northumbria Local Resilience Forum partners.	Partially Compliant	This version is outdated and a review is currently ongoing within Northumbria LRF to bring the protocol in date with organisational changes and in line with General Data Protection Regulation (GDPR) regulations which will require internal trust consultation before final approval.	Northumbria Local Resilience Forum	31 March 2023	Remains as partially compliant
44	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	Y	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning	The Trust has a **Business Continuity Policy statement [RM66]** in place based on ISO 22301 and was developed circa 2018. This has been updated and ratified by the Policy Review Group, Senior Management Team, Trust Resilience Group and EPRR Committee (July to September 2022) - copy available on request.	Fully Compliant	A revised group Business Continuity Policy has been developed that has been ratified by the trusts internal Policy Review Group (July 2022) and Senior Management Team (August 2022) - copy available on request This will be implemented following the sign off of the Business Continuity Management System Business Case for a system solution that was deferred by the trust's internal Senior Management Team (August 2022) - copy available on request	EPRR Team'	30 June 2023	Remains as compliant
45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organisation	The trust has a **Business Continuity Policy Statement [OP66]** and **Incident Response Plan (May 2022)** which includes the scope, BIA process, roles and responsibilities, identification of business threats and risk assessment, KPI's, training and communication. The **Business Continuity Policy** has been updated and ratified by the Policy Review Group, Senior Management Team, Trust Resilience Group and EPRR Committee (July to September 2022) - copy available on request.	Fully Compliant	A revised group Business Continuity Policy has been developed that has been ratified by the trusts internal Policy Review Group (July 2022) and Senior Management Team (August 2022) - copy available on request This will be implemented following the sign off of the Business Continuity Management System Business Case for a system solution that was deferred by the trust's internal Senior Management Team (August 2022) - copy available on request	EPRR Team'	30 June 2023	Remains as compliant
46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	Y	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.	The trust has a **Business Continuity Policy Statement [OP66]** and **Incident Response Plan (May 2022)** which includes the scope, BIA process, roles and responsibilities, identification of business threats and risk assessment, KPI's, training and communication. The **Business Continuity Policy** has been updated and ratified by the Policy Review Group, Senior Management Team, Trust Resilience Group and EPRR Committee (July to September 2022) - copy available on request.	Fully Compliant	A revised group Business Continuity Policy has been developed that has been ratified by the trusts internal Policy Review Group (July 2022) and Senior Management Team (August 2022) - copy available on request This will be implemented following the sign off of the Business Continuity Management System Business Case for a system solution that was deferred by the trust's internal Senior Management Team (August 2022) - copy available on request	EPRR Team'	30 June 2023	Remains as compliant

47	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices	A range of **Business Continuity (BC) plans** (SOP-QE-BCP) are in place across the trust to respond to a BC incident whether planned or unplanned, these are reviewed and updated as necessary and are based on ISO 22301 - a sample copy is available on request. The plans are being updated that will be complete by 31 October 2022.	Fully Compliant	A revised group Business Continuity Policy has been developed that has been ratified by the trusts internal Policy Review Group (July 2022) and Senior Management Team (August 2022) - copy available on request This will be implemented following the sign off of the Business Continuity Management System Business Case for a system solution that was deferred by the trust's internal Senior Management Team (August 2022) - copy available on request	EPRR Team'	30 June 2023	Remains as compliant
48	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Y	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief Evidence Post exercise/ testing reports and action plans	A range of **Business Continuity (BC) plans** (SOP-QE-BCP) are in place across the trust to respond to a BC incident whether planned or unplanned, these are reviewed and updated as necessary and are based on ISO 22301 - a sample copy is available on request. The plans are being updated that will be complete by 31 October 2022.	Partially Compliant	A revised group Business Continuity Policy has been developed that has been ratified by the trusts internal Policy Review Group (July 2022) and Senior Management Team (August 2022) - copy available on request This will be implemented following the sign off of the Business Continuity Management System Business Case for a system solution that was deferred by the trust's internal Senior Management Team (August 2022) - copy available on request This will include a formal testing and exercising schedule	EPRR Team'	30 June 2023	Remains as partially compliant
49	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Evidence • Statement of compliance • Action plan to obtain compliance if not achieved	The trust has to submit an action plan to NHS Digital for "3.3.2 The organisation has appropriately-qualified technical cyber security specialist staff and/or service". A new Cyber Security Specialist joined the trust post Feb 2022 and hasn't completed all his courses yet	Partially Compliant	A new Cyber Security Specialist joined the trust post Feb 2022 and hasn't completed all his courses yet. NHSD have accepted our action plan which is reflected in the Approaching Standards status. – the Due date is Feb 2023 for this to be completed when it will change to Standards met – no technical/governance issues are outstanding	Informance Governance Manager	28 February 2023	change from compliant to partially compliant
50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	• Business continuity policy • BCMS • performance reporting • Board papers	The trust has a **Business Continuity Policy Statement [OP66]** and **Incident Response Plan (May 2022)** which includes the scope, BIA process, roles and responsibilities, identification of business threats and risk assessment, KPI's, training and communication. This has been updated and ratified by the Policy Review Group, Senior Management Team, Trust Resilience Group and EPRR Committee (July to September 2022) - copy available on request.	Partially Compliant	A revised group Business Continuity Policy has been developed that has been ratified by the trusts internal Policy Review Group (July 2022) and Senior Management Team (August 2022) - copy available on request This will be implemented following the sign off of the Business Continuity Management System Business Case for a system solution that was deferred by the trust's internal Senior Management Team (August 2022) - copy available on request This will include a formal monitoring and evaluation schedule	EPRR Team'	30 June 2023	Remains as partially compliant
51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	Y	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme	The **BCMS is part of the trust Audit plan** and is audited by 'Audit One' - an external audit company commissioned by the trust. Previous outcomes from audits have been reported to the internal EPRR Committee and Executive Risk Management Group by exception with clear timescales for improvement and resolution - a copy of the recent audit report is available on request.	Partially Compliant	A revised group Business Continuity Policy has been developed that has been ratified by the trusts internal Policy Review Group (July 2022) and Senior Management Team (August 2022) - copy available on request This will be implemented following the sign off of the Business Continuity Management System Business Case for a system solution that was deferred by the trust's internal Senior Management Team (August 2022) - copy available on request This will include a formal auditting process within the new approach	EPRR Team'	30 June 2023	Remains as partially compliant
52	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance • Management review • Debriefs • After action reviews • Lessons learned through exercising or live incidents	The Trust has a **Business Continuity Policy statement [RM66]** in place based on ISO 22301 and was developed circa 2018. This has been updated and ratified by the Policy Review Group, Senior Management Team, Trust Resilience Group and EPRR Committee (July to September 2022) - copy available on request.	Fully Compliant	A revised group Business Continuity Policy has been developed that has been ratified by the trusts internal Policy Review Group (July 2022) and Senior Management Team (August 2022) - copy available on request This will be implemented following the sign off of the Business Continuity Management System Business Case for a system solution that was deferred by the trust's internal Senior Management Team (August 2022) - copy available on request	EPRR Team'	30 June 2023	Remains as compliant
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	Y	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers	The Trust has a **Business Continuity Policy statement [RM66]** in place based on ISO 22301 and was developed circa 2018. This has been updated and ratified by the Policy Review Group, Senior Management Team, Trust Resilience Group and EPRR Committee (July to September 2022) - copy available on request. The trust has a **Third Party Supplier Questionnaire [IG20 v3.0]** that must be completed and signed by any third party who is entering into an agreement or contract with the Trust and where they will have access to personal and/or confidential information. Part I asks if they have BCPs in place - copy available on request.	Fully Compliant	A revised group Business Continuity Policy has been developed that has been ratified by the trusts internal Policy Review Group (July 2022) and Senior Management Team (August 2022) - copy available on request This will be implemented following the sign off of the Business Continuity Management System Business Case for a system solution that was deferred by the trust's internal Senior Management Team (August 2022) - copy available on request	EPRR Team'	30 June 2023	
55	CBRN	Telephony advice for CBRN exposure	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Y	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements	The trust **CBRN plan** has reference to telephone numbers for UKHPA, ToxBase, ECOSA and others (including Radiation advice) - copy available on request	Fully Compliant	No action at this time			Remains as compliant
56	CBRN	HAZMAT / CBRN planning arrangement	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Y	Evidence of: • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	The trust has a new stand alone **Hazmat /CBRN response plan** that references (and compliments) its Incident Response Plan (with its C4 arrangements). The plan has specific action cards for responders, including those with a C4 function. The cards detail the principles of response, locations, equipment, access control, waste, and details of where technical advice may be found. Copy available on request.	Fully Compliant	Training and exercising is to take place to test the various elements of the plan and will included in the training plan 2022-23	EPRR Team	31 March 2023	Change to compliant
57	CBRN	HAZMAT / CBRN risk assessments	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	Y	• Impact assessment of CBRN decontamination on other key facilities	A bespoke assesment of threat/risk for Gateshead is within the revised plan. Documented sytsems of work are available with the PRPS's. Competencies have been created on ESR, and will be updated with details of all ED staff trained. QEF have confirmed processes in place for the disposal of any non-evidential hazardous waste.	Fully Compliant	Annual review of risk assessments in line with natinal threat assessment	EPRR Team	31 May 2023	Change to compliant

58	CBRN	**Decontamination capability availability 24 /7**	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	Y	Rotas of appropriately trained staff availability 24 /7	The ED store maintains equipment commensurate with Initial Operational Response arrangements. In addition the trust has a decontamination shelter, and 23 PRPS'. Additional staff training is required.	Partially Compliant	Staff training programme to be undertaken and rotas to be developed - will included in the training plan 2022-23	EPRR Team	31 March 2023	Remains as partially compliant
59	CBRN	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/ourwork/eprr/hm/ • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/ https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	Completed equipment inventories; including completion date	The trust has appropriate equipment supplies of paper towels, Ramgene monitors, FFP3 masks, paper boiler suits and also a UK Reserve National Stock is established for rapid deployment in major incidents, including mass casualty situations. - Each Pod is for the needs of 100 people with a 24hour-7 day-a-week response capability. Deployment of all Pods will be the responsibility of North East Ambulance Service. - The equipment Pods are managed by ambulance services. - The modesty Pods are managed by ambulance services. - The Nerve Agent Antidote Pods are managed through Blood Services, but accessed via ambulance services. - The Biological Pods can be mobilised by Directors of Public Health and Consultants in Public Health Medicine, but accessed via the ambulance services The Trust has 24 PRPS suits (as at August 2022) which is the required minimum number these are included in a monthly check by the medical devices team to ensure they are in date and services are carrried out as and when required. The trust uses an asset management inventory system and undertakes monthly visual checks of equipment that is scheduled and undertaken by our Medical Engineering Team. Annual maintenance is undertaken as per the manufacturers recommendations. The full list of recommended equipment has been disseminated to ED and QEF with identified 'ownership'. There are only limited outstanding items.Reference to the 'Pods' and accessing them is within the Trust plan.	Fully Compliant	Monthly checks of equipment is to continue to be undertaken with any issues to be flagged	QEF Medical Engineering		Remains as compliant
60	CBRN	**PRPS availability**	The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment. There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date.	Y	Completed equipment inventories; including completion date	The trust holds 24 sealed PRPS's, all of which were new in 2022 (and thus have a shelf life until 2031). No suits are approaching thier end of life.	Fully Compliant	No action at this time			Revised standard - compliant
61	CBRN	**Equipment checks**	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	Y	Record of equipment checks, including date completed and by whom.	The NHSE list of recommended equipment has been assessed and responsibilities identified (with owners in ED and QEF). The store has an ED Sister in charge of the store who maintains control of its contents and checks on a very regular basis. The Trust now has a 2-line decontamination shelter. This will be moved to the 'Majax Store' by September 2022 and will be subject of regular checks by QEF (and ongoing training which will also highlight any technical issues). The trust purchased a maintanance package with the sheter. The Ram-Gene equipment is checked by QEF annually as part of ongoing checking/maintainance. Folowing training in August ED staff will also be able to check the equipment.	Fully Compliant	Annual review and audit of equipment	ED Sister in charge	31 May 2023	Change to compliant
62	CBRN	**Equipment Preventative Programme of Maintenance**	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment	Y	Completed PPM, including date completed, and by whom	There is a **preventative programme of maintenance in place (PPM)** in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment. The trust uses an **asset management inventory system** and undertakes monthly visual checks of equipment that is scheduled and undertaken by the Medical Engineering Team in QEF. This is relation to PRPS suits and the RAMGENE Monitors. Annual maintenance is undertaken as per the specfifc manufacturers recommendations.	Fully Compliant	No action at this time			Remains as compliant
63	CBRN	**PPE disposal arrangements**	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Y	Organisational policy	There is an **agreed disposal of PRPS suits** which are used for training purposes internally and externally with partner organisations. This was provided by UKHSA and email correspondance is available on request	Fully Compliant	No action at this time			Remains as compliant
64	CBRN	**HAZMAT / CBRN training lead**	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training	Y	Maintenance of CPD records	3 senior nurses were trained by NEAS to National Ambulance Resilience Unit (NARU) standards in June 2022. Their competency has been added to ESR.	Fully Compliant	No action at this time			Change to compliant
65	CBRN	**Training programme**	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programmes should include training for PPE and decontamination.	Y	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • A range of staff roles are trained in decontamination techniques • Lead identified for training • Established system for refresher training	Training is regularly discussed at the Emergency Department/EPRR Major Incident meetings. ED staff deliver Primary Care and IOR training internally. ED have the NOS for CBRN responders. Radiation Training is provided by Head of Nuclear Medicine to ED staff for the RamGene equipment. Additional work is required to formailse the induction training, refresher training, and departmental response.	Partially Compliant	Additional work is required to formalise staff training (initial and refresher).	EPRR Team / ED SLM	31 December 2022	Revised standard - partially compliant
66	CBRN	**HAZMAT / CBRN trained trainers**	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	Y	Maintenance of CPD records	An Emergency Department [ED] Ward Manager, Sister and SRT Band 6 Nurse have been recently trained [17 June 2022] as PRPS/IOR trainers. This training will be augmented to ensure Skills For Health EC25 are complied with in Emergency Department. This support has been offered to ED by the EPRR team.	Fully Compliant	Annual review and audit of training	EPRR Team	31 May 2023	Change to compliant
67	CBRN	**Staff training - decontamination**	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Y	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011). Found at: http://www.londoncn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf • A range of staff roles are trained in decontamination technique	ED staff deliver Primary Care and IOR training internally. ED have the NOS for CBRN responders. Radiation Training is provided by Head of Nuclear Medicine to ED staff for the RamGene equipment.	Partially Compliant	Additional work is required to formailse the induction training, refresher training, and departmental response.	EPRR Team	31 December 2022	Remains as partially compliant
68	CBRN	**FFP3 access**	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.	Y		**FFP3 masks** are made available for any trust staff that require them and fit tests are carried out. Training is delivered by the PCAS Unit	Fully Compliant	No action at this time			Remains as compliant

Ref	Domain	Standard	Deep Dive question	Further information	Acute Providers	Organisational Evidence - Please provide details of arrangements in order to capture areas of good practice or further development. (Use comment column if required)	Self assessment RAG Red (not compliant) = Not evidenced in evacuation and shelter plans or EPRR arrangements. Amber (partially compliant) = Evidenced in evacuation and shelter plans or EPRR arrangements but requires further development or not tested/exercised. Green (fully compliant) = Evidenced in plans or EPRR arrangements and are tested/exercised as effective.	Action to be taken	Lead	Timescale	Comments
DD1	Evacuation and Shelter	Up to date plans	The organisation has updated its evacuation and shelter arrangements since October 2021, to reflect the latest guidance.	https://www.england.nhs.uk/publication/shelter-and-evacuation-guidance-for-the-nhs-in-england/	Y	A draft evacuation and shelter plan based on the 2021 guidance is complete (v3). It awaits some minor changes (based on consultation) and adoption prior to an exercise/validation process. This will replace the existing 2014 plan (reviewed in 2019).	Partially Compliant	Draft Plan to be adopted and validated.	EPRR Team	31 December 2022	
DD2	Evacuation and Shelter	Activation	The organisation has defined evacuation activation arrangements, including the decision to evacuate and/or shelter by a nominated individual with the authority of the organisation's chief executive officer.		Y	The Medical Director (their deputy) or Strategic On Call can make the decision to evacuate.	Fully Compliant	None at this time	EPRR Team		
DD3	Evacuation and Shelter	Incremental planning	The organisation's evacuation and shelter plan clearly defines the incremental stages of an evacuation, including in situ sheltering, horizontal, vertical , full building, full site and off-site evacuation.		Y	Both the existing plan and the draft plan incorporate the incremental stages of evacuation.	Fully Compliant	None at this time	EPRR Team		
DD4	Evacuation and Shelter	Evacuation patient triage	The organisation has a process in place to triage patients in the event of an incident requiring evacuation and/or shelter of patients.		Y	Both the existing plan and the draft plan incorporate the NHSE Healthcare Patient Evacuation Triage Priorities.	Fully Compliant	None at this time	EPRR Team		
DD5	Evacuation and Shelter	Patient movement	The organisation's arrangements, equipment and training includes the onsite movement of patients required to evacuate and/or shelter.		Y	Both the existing plan and the draft plan incorporate a transport plan template based on triage priorities (mobility/acuity). Some further equipment and training is required as a contingency for vertical evacuation on one ward (Jubilee W23).	Partially Compliant	Work is ongoing with QEF and Ward 23 to establish additional fire safety measures, and equipment for vertical evacuation.	QEF	31 March 2023	
DD6	Evacuation and Shelter	Patient transportation	The organisation's arrangements, equipment and training includes offsite transportation of patients required to be transferred to another hospital or site.		Y	Both the existing plan and the draft plan incorporate a transport plan template based on triage priorities (mobility/acuity).This includes arrangements for transporting patients off site.	Fully Compliant	None at this time	EPRR Team		
DD7	Evacuation and Shelter	Patient dispersal and tracking	The organisation has an interoperable patient tracking process in place to safely account for all patients as part of patient dispersal arrangements.		Y	Both the existing plan and the draft plan incorporate guidance on patient tracking and notes. The system uses CarePlow and paper based notes (overseen by a Patient Dispersal Team) within the Incident Management Team.	Fully Compliant	None at this time	EPRR Team		
DD8	Evacuation and Shelter	Patient receiving	The organisation has arrangements in place to safely receive patients and staff from the evacuation of another organisations inpatient facility. This could with little advanced notice.		Y	The revised plan refers to the reception of patients from elsewhere. It signposts the trust Incident Response Plan as the mechanism for establishing this with the Site Resilence Team (SRT) central to coordinating patient flow.	Fully Compliant	None at this time	EPRR Team		
DD9	Evacuation and Shelter	Community Evacuation	The organisation has effective arrangements in place to support partners in a community evacuation, where the population of a large area may need to be displaced.		Y	The revised plan refers to the possible involvement of the trust in a Community Evacuation (and it's responsibilities).	Fully Compliant	None at this time	EPRR Team		
DD10	Evacuation and Shelter	Partnership working	The organisation's arrangements include effective plans to support partner organisations during incidents requiring their evacuation.		Y	In the same way that the revised plan refers to the reception of patients from elsewhere. It signposts the trust Incident Response Plan as the mechanism for establishing this with the Site Resilence Team (SRT) central to coordinating patient flow.	Fully Compliant	None at this time	EPRR Team		
DD11	Evacuation and Shelter	Communications-Warning and informing	The organisation's evacuation and shelter arrangements include resilient mechanisms to communicate with staff, patients, their families and the public, pre, peri and post evacuation.		Y	The trust uses Vocera on a daily basis. It is capable of delivering a site wide message to key departments that would become involved in the managment of an evacuation. The trust has a number of UHF radios that can be deployed to support communications between the Incident Management Team/Patient Dispersal Team and Evacuation Clearing Stations. The trust has a Communications and Engagement Team and well established practices in relation public communications through social media. The draft plan provides communication advice based on the 2021 guidance.	Fully Compliant	None at this time	EPRR Team		
DD12	Evacuation and Shelter	Equality and Health Inequalities	The organisation has undertaken an Equality and Health Inequalities Impact Assessment of plans to identify the potential impact evacuation and shelter arrangements may have on protected characteristic groups and groups who face health inequalities.		Y	Both the existing plan and the draft plan incorporate the NHSE Healthcare Patient Evacuation Triage Priorities. This is based on mobility and takes into account different characteristics of evacuated patients. The draft plan directly replicates that of the 2021 guidance.	Fully Compliant	None at this time	Communications and Engagement Team		
DD13	Evacuation and Shelter	Exercising	The evacuation and shelter arrangements have been exercised in the last 3 year. Where this isn't the case this will be included as part of the organisations EPRR exercise programme for the coming year. Please specify.		Y	The evacuation plan HAS NOT been exercised in the last three years. The draft plan will be exercised as part of its validation process.	Partially Compliant	Evacuation will form part of the trusts internal training for Health Commanders in the next 12 months.	EPRR Team	31 March 2023	

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Report Cover Sheet Agenda Item: 19

Report Title:	Green Plan Update			
Name of Meeting:	Board of Directors – Part 1			
Date of Meeting:	27 September 2022			
Author:	Sarah Medhurst, Sustainability and Waste Manager QE Facilities			
Executive Sponsor:	Anthony Robson, Managing Director QE Facilities			
Report presented by:	Anthony Robson, Managing Director QE Facilities			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	The report provides an update on the Green Plan 2022-2025 sets out the significant progress in reducing our emissions from our own activities in recent years.			
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 contents of the Green Plan are broad-ranging, covering models of care, estates and facilities, travel and transport through to medicines, supply chain, food and nutrition. • The Trust's Green Plan has been be shared with the North East and North Cumbria Integrated Care System. • The Green Plan covers a 3 year period and annual updates will be provided to the Trust Board to provide assurance over progress towards achieving the objectives and measurable targets outlined within the Plan.			
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Board of Directors is requested to receive the update for assurance.			

Trust Strategic Aims that the report relates to:	**Aim 1** ☒	We will continuously improve the quality and safety of our services for our patients			
	Aim 2 ☐	We will be a great organisation with a highly engaged workforce			
	Aim 3 ☐	We will enhance our productivity and efficiency to make the best use of resources			
	Aim 4 ☒	We will be an effective partner and be ambitious in our commitment to improving health outcomes			
	Aim 5 ☒	We will develop and expand our services within and beyond Gateshead			
Trust corporate objectives that the report relates to:	5.7 – improving efficiency through use of the Washington warehouse 5.9 – provision of safe and efficient transport through the transport hub				
Links to CQC KLOE	Caring ☐	Responsive ☒	Well-led ☒	Effective ☒	Safe ☒
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks and DATIX reference)	None identified on organisational risk register.				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

Green Plan Progress Update

Exec Summary

This report provides an overall brief summary of key areas of progression against the Green Plan which was approved in March of this year. The main highlights are as follows:

- Majority of Trust & QEF Board have completed Carbon Literacy training and awaiting certification.
- Scope 3 procurement data is now being calculated and full report should be available next year.
- Reapplication of car parking permits is nearly complete with charging to commence next month, followed by ICS wide travel survey.
- Support from AHSN to implement the NENC Clean Air Framework
- Solar panels and air source heat pumps installed helping decarbonise our onsite energy.
- Habitat creation and management plans for all sites to improve and increase biodiversity.
- Work underway to remove piped nitrous oxide from Theatres
- Majority of procurement and estates staff are certified as carbon literate.

Introduction

The Green Plan was approved by the Trust board in March 2022, setting out targets and actions as we look to meet the long term objective of reaching net zero for our NHS carbon footprint by 2040 and NHS carbon footprint plus by 2045. Since the plan was approved and published on both the Trust website and Trust intranet work on the key focus actions and targets within the plan have begun to be put into motion, governed and monitored by the Sustainability Committee. This report will briefly look at each of the key areas of focus and provide an update on the agreed targets and actions including any issues which may prevent them from being met on time.

Ares of Focus

1. **Workforce System & Leadership**
   A key area of progression in this sector relates to the second target with the majority of both the Trust & QEF board undertaking carbon literacy training in August. It should be noted though the target is for 100% of board members to be trained and this may not be completed by the March target date unless funding and dates can be agreed for another training session.

   Unfortunately no progress has been made in relation to the ESR ‘Building a Net Zero NHS’ module becoming mandatory for all staff as it is not listed under Core

Skills for Health which the Trust follows, this will impact the agreed targets being met. It does however remain as mandatory for all new starters are to complete it, with figures held by Learning & Development.

Green Champions continue to be promoted but uptake is small, there is no branding yet as it was believed this would be led by the ICS and there is no update on this at present.

Carbon data proves to be challenging for some aspects such as procurement and business mileage. We are currently progressing with the company CO2 analysis regarding procurement emissions however this is a very large exercise and will take some time to get the results of the last few years. Business mileage data is also proving to be challenging as the data is held by NTW who manage expenses and they do not calculate the emissions, resulting in this work being completed by the Sustainability Manager. On a positive note the new car parking permit system will provide carbon emission information on staff commute going forward, capturing the emissions for those staff that drive to work.

2. **Sustainable Models of Care**
   Little progress has been made across this sectors actions as there is no engagement from clinical teams in the Sustainability Committee. This isn't to say work may not be happening but there isn't the communication between parties.

3. **Digital Transformation**
   Work in this sector is progressing with the digital transformation team and the upgrades of Building Management Systems within estates. Teams meeting continue to be widely use and many staff continue to work flexibly with many still working from home full time reducing travel although this may change over the winter period.

   However going forward the digital transformation team is to be invited to the Sustainability Committee to provide better analysis on how the actions are progressing and the potential to include the actions within their internal meetings as well.

4. **Travel & Transport**
   In regards to travel and transport the main target which is nearly complete is the review and reapplication staff car parking permits and charging for parking. Firstly this is likely to encourage staff to review how they travel to site as well as providing valuable data on emissions from staff commute. The ICS is receiving funding to complete an ICS wide travel survey via Mobility Ways hopefully later this year, hopefully the data gathered from the Trust along with discussions at relevant meetings will help identify areas that could be reviewed or improved to encourage staff to change their mode of travel. It is also hope

this data will help Local Authorities and travel networks the wider improvements needed to establish change across the region and improve air quality.

The ICS has also been provided a project resource from the AHSN to start to implement the NENC Clean Air Framework, this will help establish a baseline of where everyone is and the actions we can look to work on and share best practice or seek funding for extra resources in Trusts to implement measures.

Within our Trust work is underway to install new cycle lockers across the site and additional electrical charging points for staff. However it should be noted that the electrical demand required to meet the action point regarding the percentage of charging points on site is too great and unlikely to be possible without significant investment to increase the electrical infrastructure. As staff can access charging points within their home or other public areas priority should focus on charge points for Trust fleet vehicles and NEAS vehicles which will become electric and require faster charging demand.

Engagement with procurement and pharmacy is also underway to look at suppliers and consolidating deliveries where possible.

5. Estates & Facilities

Significant progress has been made in this field with the recent installation of air source heat pumps and solar panels helping decarbonise areas of the site, hopefully in the coming months we will have data to measure the benefits of their installation on our emissions.

Alongside this Durham Wildlife Services have undertaken ecology surveys of the QE Hospital, Bensham and Spire House providing habitat creation and management plans to improve biodiversity across the sites. These plans will create a priority action plan of measures and the potential cost, although it is hoped most can be done in house through QE Facilities. QE Facilities also partook in the “30 Days Wild” campaign, undertaking beach cleans, on site litter picks, installation of bird feeders, bug house and sowing wild flower seeds in long grass beds.

QE Facilities also applied for funding as part of the Healthier Futures Fund for an online reuse platform to help encourage the circular economy and reuse to prevent usable items being disposed of unnecessarily. It won’t be known until at least October if the funding is successful or not, if not a business case may be put together for internal funding.

It is hoped further down the line that the ICS will create repair hubs so that items can readily be repaired and remanufactured/upholstered further improving the circular economy and reducing waste.

6. Medicines

An application to the Healthier Futures Fund was also made for a mobile destruction unit for Maternity to use to reduce the impact of Entonox on our emissions. If successful in receiving the funding for the one year trial and it meets the overall objective funding would then be sought to expand and install on a permanent basis. If unsuccessful there are machines currently on trial in Newcastle so it may be possible we could trial it for a short period from Newcastle. These machines will also help the occupational hazard of poor air quality within maternity rooms from Entonox.

Alongside this work on Entonox there are also plans to remove piped nitrous oxide from theatres and switch to cylinders due to the impact of leaked nitrous oxide on the emissions.

Pharmacy and the respiratory nurses are also engaging in upcoming plans to implement inhaler recycling scheme and promote and try to increase the use of dry powder inhalers where possible.

7. Supply Chain & Procurement

Earlier this year the majority of procurement and estates also undertook specific carbon literacy training to help engage and educate on their impacts and how they can help within their role. This training will be supported by ICS led training on social value and support from the Sustainability Manager to ensure the new PPN notices are being implemented to the best of their ability and environmental and social issues are taken into consideration in large procurement contracts.

Scope three emissions from procurement are also being measured from previous years now CO2 Analysis have been provided the data following structural and managerial changes within the department. These changes have also impacted the progress of other actions across this sector over the last few months.

8. Food & Nutrition

Due to changes within catering little progress has been made within this areas, despite efforts to look at areas such as food waste collections. Some discussions were made with a local charity to deliver any leftover sandwiches near expiry or best before but this will be minimal as majority of food waste can't be reheated or is plate waste.

Hopefully progression can be made over the next 6 to 12 months in this area particularly on areas such as refill stations which would provide massive benefit in any future heatwaves similar to what was experienced this year.

9. Adaptation

Adaptation and planning is complex and requires a multitude of parties to be involved and as a result little progress has been made but In October there is a North East and Yorkshire ICS even to discuss adaption planning and hopefully help provide a starting point to begin from.

There is also likely to be some learning from the impacts of the summer heatwaves we experienced and its impact on patients and staff and how best we can tackle this going forward particularly when building or refurbishing areas. Later in September the capital team will be attending an event and learning about Passivhaus standards and net zero, which should link into these actions along with the overall decarbonising of the estate from its design to its use.

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 20

Report Title:	**Register of Official Seal**			
Name of Meeting:	Board of Directors			
Date of Meeting:	27th September 2022			
Author:	Diane Waites, Corporate Services Assistant			
Executive Sponsor:	Yvonne Ormston, Chief Executive			
Report presented by:	Kirsty Roberton, Deputy Director of Corporate Services and Transformation			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☒
	To receive details of the use of the official seal between September 2021 and September 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*				
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*				
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Board is asked to note the details of use of the official seal for September 2021-2022			

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:	*List corporate objective reference and headline – e.g. 1.4 Maximise the use of Nervecentre to improve patient care*				
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** ☐

Gateshead Health NHS Foundation Trust

Register of Official Seal

1 September 2021 – 31 August 2022

Seal No	Date	Description	Signed	Attested
319	09.08.2022	Lease agreement between Siemens Financial Services Ltd and QE Facilities (Ref 8239069 & 8312612)	Mrs A Marshall	Miss L Swann

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

	Lead	Type of item	Public/Private	Sep-21	October 21 (extra Board)	Nov-21	Jan-22	Mar-22	April 22 (ext)	May-22	June 22 (year end)	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 March 23 and Sept 23)	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													
Register of Official Seal	Company Secretary	Item for Information	Part 1	√									√			
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					√								√
Ockenden Next Steps and Assurance Visit	Chief Nurse	Item for Assurance	Part 1										√			