

**Meeting of the Trust Board
Wednesday 22 May 2019**

Dear Members

There will be a public meeting of the Trust Board on Wednesday 22nd May 2019 at 3:00pm in the Charles West Boardroom, Great Ormond Street, London, WC1N 3JH.

Company Secretary Direct Line: 020 7813 8230

AGENDA

	Agenda Item <u>STANDARD ITEMS</u>	Presented by	Attachment	Timing
1.	Apologies for absence	Chair	Verbal	3:00pm
Declarations of Interest All members are reminded that if they have any pecuniary interest, direct or indirect, in any contract, proposed or other matter which is the subject of consideration at this meeting, they must disclose that fact and not take part in the consideration or discussion of the contract, proposed contract or other matter, nor vote on any questions with respect to it.				
2.	Minutes of Meeting held on 3 April 2019	Chair	J	3:05pm
3.	Matters Arising/ Action Checklist	Chair	K	
4.	Chief Executive Update	Chief Executive	L	3:10pm
5.	Patient Story	Chief Nurse	M	3:20pm
<u>ANNUAL REPORT AND ACCOUNTS</u>				
6.	GOSH Foundation Trust Annual Financial Accounts 2018/19 and Annual Report 2018/19 Including: <ul style="list-style-type: none"> ○ the Annual Governance Statement ○ the Audit Committee Annual Report ○ Draft Head of Internal Audit Opinion ○ Representation Letter 	Chief Finance Officer Company Secretary Audit Committee Chair	N 12	3:35pm
7.	Compliance with the Code of Governance 2018/19	Company Secretary	S	3:50pm
8.	Compliance with the NHS provider licence – self assessment	Company Secretary	O	3:55pm
9.	Quality Report 2018/19	Medical Director	P	4:05pm
<u>STRATEGY and RISK</u>				
10.	Update on implementation of EPIC (with clinical team input)	Clinical Information Director	Q	4:10pm
11.	Quality Priorities 2019/20	Medical Director	T	4:15pm
12.	Revised Risk Management Strategy	Medical Director	U	4:25pm

13.	Board Assurance Framework Update	Company Secretary	V	4:30pm
	<u>PERFORMANCE</u>			
14.	Integrated Quality and Performance Report – March 2019 including focus on clinical outcomes	Medical Director/ Chief Nurse	W	4:35pm
15.	Learning from Deaths Mortality Review Group - Report of deaths in Q3 2018/2019	Medical Director	Y	4:45pm
16.	Month 1 2019/20 Finance Report	Chief Finance Officer	Z	4:55pm
17.	Safe Nurse Staffing Report (March 2019) Nurse Establishment Review	Chief Nurse	1 11	5:05pm
	<u>ASSURANCE</u>			
18.	Annual Reports <ul style="list-style-type: none"> • Annual Freedom to Speak Up Report 2018/19 • Annual Health and Safety and Fire Report 2018/19 • Annual Sustainability Report 2018/19 	Freedom to Speak Up Guardian Director of HR and OD Director of Development	2 3 4	5:20pm
19.	Guardian of Safe Working report Q4 2018/19	Medical Director	R	5:40pm
20.	Board Assurance Committee reports <ul style="list-style-type: none"> • Audit Committee update – April 2019 meeting and May 2019 (verbal) • Quality, Safety and Experience Assurance Committee update – April 2019 meeting • Finance and Investment Committee Update – March 2019 	Chair of the Audit Committee Chair of the Quality and Safety Assurance Committee Chair of the Finance and Investment Committee	5 6 7	5:50pm
21.	Council of Governors' Update – April 2019	Chair/ Company Secretary	8	6:00pm
	<u>GOVERNANCE</u>			
22.	Declaration of Interest Register – Trust staff	Company Secretary	9	6:05pm
23.	Any Other Business (Please note that matters to be raised under any other business should be notified to the Company Secretary before the start of the Board meeting.)			6:10pm
24.	Next meeting The next confidential Trust Board meeting will be held on Thursday 18 July 2019 in the Charles West Room, Barclay House, Great Ormond Street, London, WC1N 3BH.			

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**DRAFT Minutes of the meeting of Trust Board on
3rd April 2019**

Present

Sir Michael Rake	Chairman
Mr Matthew Shaw	Chief Executive
Lady Amanda Ellingworth	Non-Executive Director
Mr James Hatchley	Non-Executive Director
Mr Chris Kennedy	Non-Executive Director
Ms Kathryn Ludlow	Non-Executive Director
Mr Akhter Mateen	Non-Executive Director
Professor Rosalind Smyth	Non-Executive Director
Dr Sanjiv Sharma	Acting Medical Director
Professor Alison Robertson	Chief Nurse
Ms Helen Jameson	Chief Finance Officer
Professor Andrew Taylor	Acting Chief Operating Officer
Ms Caroline Anderson	Director of HR and OD

In attendance

Mr Matthew Tulley	Director of Development
Ms Cymbeline Moore	Director of Communications
Professor David Goldblatt*	Director of Research and Innovation
Dr Shankar Sridharan	Chief Clinical Information Officer
Ms Claire Williams*	Interim Head of Patient Experience and Engagement
Ms Lynn Shields*	Director of Education
Dr Daljit Hothi*	Associate Medical Director
Dr Andrew Long*	Deputy Medical Director and Responsible Officer
Ms Karen Panesar*	Speak Up Project Lead
Ms Sarah Ottoway*	Associate Director of HR and OD
Dr Renee McCulloch*	Guardian of Safe Working
Mr Peter Hyland	Director of Operational Performance and Information
Dr Anna Ferrant	Company Secretary
Ms Victoria Goddard	Trust Board Administrator (minutes)
Mr Colin Sincock	Public Governor (observer)

**Denotes a person who was present for part of the meeting*

*** Denotes a person who was present by telephone*

11	Apologies for absence
11.1	No apologies for absence were received.
12	Declarations of Interest
12.1	No declarations of interest were received.

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13	Minutes of Meeting held on 7 February 2019
13.1	The minutes of the previous meeting were approved .
14	Matters Arising/ Action Checklist
14.1	The actions taken since the last meeting were noted.
15	Chief Executive Update
15.1	Mr Matthew Shaw, Chief Executive said that he had met with the Minister of State in the Department of Health and Social Care to discuss apprenticeships and had also raised the issue of the change to specialist tariff which would be very challenging for the Trust.
15.2	Mr Shaw welcomed Dr Shankar Sridharan, Chief Clinical Information Officer and Ms Caroline Anderson, Director of HR and OD to their first Board meeting and thanked Ms Alison Hall, Deputy Director of HR and OD for her work as Acting Director.
16	Patient Story
16.1	The Board received a patient story via video from Sophie whose baby Verity was admitted to GOSH at four weeks old. Although Sophie had been very happy with Verity's care she said that she had previously been admitted to her local hospital where she had been provided with a private space to breastfeed however this had not been the case at GOSH. When Sophie arrived on the ward the team had been extremely busy and had not spoken to her for the first hour. No food had been provided and she was only told about food vouchers for breastfeeding mothers until two days into her stay. Sophie said that having had a caesarean section she was not comfortable walking around the hospital alone or leaving Verity for long enough to go to the Lagoon. A swipe pass had not been provided to the ward for her to use.
16.2	Sophie said that only one parent was able to sleep in Verity's room however this was an issue when both parents, who lived a long distance from GOSH, were required to be at the Trust early in the day to be taught about Verity's treatment.
16.3	Ms Claire Williams, Interim Head of Patient Experience and Engagement said that the family had not been aware of any of the facilities available as they had not received the standard orientation when they arrived on the ward and this provided a poor start to their experience. She said that work was taking place to expand the information available on the bedside entertainment system so that families were able to access the information required. Ms Williams said that meals were not provided to families as standard but this could happen in exceptional circumstances and the catering team could have been contacted for this. Work was taking place to improve breastfeeding facilities, however facilities remained available. Accommodation for families was under discussion and a working group had been created to ensure that there was a consistent policy in place.
16.4	Discussion took place around accommodation and Mr Matthew Shaw, Chief Executive said that it was important for staff to be aware of the reasons for the accommodation policy as there were also practical considerations for parents

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	staying in the room such as space and access to the patient in case of an emergency. Ms Williams said that passes to access the ward were available however they were often accidentally taken home by families so wards struggled to maintain a supply.
16.5	Lady Amanda Ellingworth, Non-Executive Director confirmed that progress with actions arising from patients stories was reported to the Quality, Safety and Experience Assurance Committee.
17	Final GOSH Operational Plan 2019/20
17.1	Ms Helen Jameson, Chief Finance Officer said that the Trust had been through its annual business planning and budget setting cycle based on the contracts which had been negotiated and agreed in principle but not yet signed with NHS England and the Clinical Commissioning Groups. A breakeven control total had been issued which assumed the delivery of a £20million Better Value programme which was very challenging.
17.2	Professor Andrew Taylor, Acting Chief Operating Officer said that work was taking place to ensure that activity could be delivered within the current bed base and that the correct numbers of nursing staff were in the correct areas.
17.3	Mr Peter Hyland, Director of Operational Performance and Information said that since the version that had previously been seen by the Board, the activity reduction resulting from the implementation of the Electronic Patient Record had been profiled. He confirmed that activity remained the same over the year as a whole. He said that a commitment had been made to meet the RTT target by the end of the financial year. Mr Hyland added that the diagnostic standard would be delivered in May however this was also challenging due to the very small number of breaches which could take place before the overall target was not reached.
17.4	Sir Michael Rake, Chair noted the extremely challenging financial environment and emphasised the importance of driving efficiencies and continuing to discuss the tariff changes. He said that the patient story highlighted the importance of being able to provide additional services to patients and families and therefore it was vital to continue to lobby.
17.5	The Board approved the 2019/20 plan which accepted the control total.
17.6	Action: Mr Chris Kennedy, Non-Executive Director noted that £14million of Better Value schemes, including those rated as high risk, had been identified. He requested that the remaining proportion of the target to be identified was categorised within the plan to show how challenging it would be to achieve.
17.7	Ms Kathryn Ludlow, Non-Executive Director said that it was important to continue to discuss quality in related to Better Value schemes at QSEAC given the importance of reaching a significant target.
18	GOSH Draft Clinical Strategy
18.1	Dr Sanjiv Sharma, Acting Medical Director said that there were four areas which would be the clinical focus over the coming year: cancer, cardiac surgery, neuro and rare diseases. He said that the focus in each area would be around

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18.2	strengthening specialist and highly specialist services. Discussions around plans for cancer services were taking place across London and GOSH was a key part of these discussions. Mr Matthew Shaw, Chief Executive said that it was important to set out the organisation's current position and priorities and added that these would require refreshing following the review of the strategy.
19	GOSH Draft Leadership Strategy
19.1	Ms Lynn Shields, Director of Education presented the draft strategy which was aligned with the national framework for developing people and improving care. The framework focused on four key areas of leadership capability: inclusive and compassionate leadership, talent management, systems leadership and change leadership. Sir Michael Rake welcomed the approach said that the strategy was critical to support the culture change that was required.
19.2	Mr Chris Kennedy, Non-Executive Director queried how the strategy was being received when discussed with leaders. Ms Shields said that in her experience the response had been positive and Professor Alison Robertson, Chief Nurse said that much of the strategy was about bringing together activity which was already taking place in a coherent way.
19.3	Lady Amanda Ellingworth, Non-Executive Director noted that the delivery of the strategy was reliant on a grant from GOSH Children's Charity (GOSHCC) and asked for a steer on the level of risk associated with this. Ms Shields said that the strategy had been presented to GOSHCC who were supportive. A full proposal on the ambition to develop a GOSH Learning Academy is scheduled to go to the Grants Committee in June 2019. .
19.4	Mr Kennedy noted the staff survey results in relation to the high levels of bullying and harassment experienced by staff at the Trust and asked how the strategy supported leaders to have difficult conversations. Dr Daljit Hothi, Associate Medical Director said that it was vital that leaders were trained and supported to model the required behaviours and were empowered to be motivated as part of the wider hospital team. She said that whilst the Trust employed a large number of expert clinicians who were well placed to lead clinically, these individuals often did not feel that were equipped with leadership expertise.
19.5	Ms Caroline Anderson, Director of HR and OD said that it was important that the strategy aligned with HR processes to ensure that it was integrated into the Trust.
20	New and Novel Medicines
20.1	Dr Sanjiv Sharma, Acting Medical Director said that due to the complex needs of many GOSH patients clinical teams were innovative in their approaches and used treatments which had not been trialled or extensively tested. He said that this was largely in circumstances when patients would otherwise continue with a chronic illness or die. Dr Sharma said it was vital that robust governance processes were in place to consider the use of these treatments and consent must be taken in each case.

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20.2	Mr James Hatchley, Non-Executive Director queried whether the Clinical Ethics Committee should be one of the committees with which there should be liaison during decision making. He queried whether using unlicensed drugs was within the Trust's insurance provision. Dr Sharma said that work was taking place to ensure that the Ethics Committee could consider such matters in a more formalised way.
20.3	Professor Rosalind Smyth, Non-Executive Director said that the early access to drugs programme had been driven by the UK but initially had not included children. Young people had been clear that it was vital for children and young people to have the same opportunities for early access to drugs. Professor Smyth encouraged the Trust to continue to engage with children and young people about this matter.
20.4	Professor David Goldblatt, Director of Research and Innovation said that it was important for the Drugs and Therapeutics Committee to be aware of repeated requests for the same drug as this should be undertaken through a trial.
21	2018/19 National Cost Collection Presubmission (formerly Reference Costs)
21.1	Ms Helen Jameson, Chief Finance Officer said that the mandated reference cost collection had been replaced by the requirement for the Trust to submit Patient Level Costing Data for inpatient and outpatient activity. GOSH had been an early adopter of the new standard and had submitted this data for a number of years.
21.2	The Board approved the costing process and agreed to delegate to the Finance and Investment Committee to approve the 2018/19 National Patient Level Costing Collection submission on behalf of the Trust Board going forward.
22	Integrated Quality and Performance Update Report – 28 February 2019
22.1	Dr Sanjiv Sharma, Acting Medical Director presented the report which was in a new style, including quality and performance metrics in one report to support the triangulation of issues. He said that work continued around delayed discharges and the causes of this were multifactorial. The Nursing Director of Operations was leading on work to improve repatriation to local hospitals. Dr Sharma added that 22 experienced nurses had been recruited to PICU and NICU which was very positive.
22.2	Sir Michael Rake noted the central venous line infections had increased by 150% and asked for a steer on the causes and implications of this. Professor Alison Robertson, Chief Nurse said that in general GOSH had good and stable levels of CVL infection and that this particular increase was the result of one patient who was extremely unwell and contracted a number of infections.
22.3	Sir Michael noted that completion of the WHO checklist continued to be below target and Dr Sharma said that following clinical audits it was clear that the checklist was completed however this was not always recorded. He said that following Epic go-live this was a mandatory field in the system and therefore recording would be required which would improve documentation.
22.4	Action: Ms Kathryn Ludlow, Non-Executive Director noted the issues that had taken place with the occlusion and flow issues of BD pumps. It was agreed that

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	consideration would be given to whether there should be any legal recourse due to the delays and potential patient safety issues.
22.5	Professor Robertson confirmed that the response rate target for the Friends and Family Test (FFT) had been achieved for the first time in February 2019 and was on track to also be achieved in March although all the data had not been received. Support could now be focused on the two directorates which had not achieved the target and Professor Robertson emphasised the importance of receiving patient and family feedback as seen by the patient story which had originated as feedback in the FFT.
22.6	Professor Andrew Taylor, Acting Chief Operating Officer said that the 92% RTT target had been achieved for the 14 th consecutive month which was extremely positive however it continued to be challenging to meet the discharge summary and clinical letter turnaround time targets. It was confirmed that improvement in this metric would be supported by Epic.
22.7	Professor Rosalind Smyth, Non-Executive Director noted the on-going high levels of staff turnover and sickness in the IPP directorate and asked about the work that was being undertaken in this area. Professor Robertson said that good work had taken place to be clear about the reasons for staff staying and leaving and added that a lot of nurses in the IPP team were newly qualified and moved to other areas of the Trust rather than elsewhere. She said that the team were keen to explore international recruitment however this was a medium term option as the time taken from job offer to achieving NMC registration could be considerable.
22.8	Mr Chris Kennedy, Non-Executive Director asked if sufficient recruitment activity was taking place given the level of turnover and Professor Robertson said that the Trust recruited throughout the year. Professor Taylor added that the profile of nurses at GOSH was much more junior than other Trusts.
22.9	Action: Professor Smyth welcomed the style of the report but requested trend information or a summary of trend where specific work was taking place.
23	Finance Update – 28 February 2019
23.1	Ms Helen Jameson, Chief Finance Officer said that at month 11 the Trust was £0.8million behind the control total having released £3.1million from contingency in the year to date. Clinical income was ahead of target by £8.4million, however pay and non-pay spend was higher than target as a result of implementation of the national Agenda for Change pay award and provision for IPP bad debt respectively.
23.2	The Trust continues to forecast that it would meet its control total at year end however this would require control on expenditure in month.
23.3	Discussion took place around IPP debt and Ms Jameson reported that GOSH had not received a payment from one territory with a particularly high level of debt for two months. Mr Matthew Shaw, Chief Executive said that he had met with the health attaché who had assured the Trust that payment would be made.
24	GOSH Staff Survey Results 2018 and Action Plan

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24.1	Ms Caroline Anderson, Director of HR and OD said that in 2018 all staff were invited to take part in the staff survey both online and in a paper format and responses were received from approximately 50% of the workforce.
24.2	A number of significant events had recently taken place at the time of the survey which could have influenced feedback such as the clinical operations restructure, the chief executive resignation announcement and the change to some bank pay rates. GOSH scores had been below average across nine of the ten themes when compared to other specialist Trusts and average in the remaining theme. Two themes were significantly below average.
24.3	Ms Anderson emphasised the importance of developing a people strategy and highlighted that visible leadership was key. She suggested that a 'pulse' survey should be taken between annual surveys so that the direction of responses could be ascertained.
24.4	Professor Rosalind Smyth, Non-Executive Director noted that in some areas GOSH had been the worst amongst comparators. She asked whether these areas required a specific action plan. Ms Anderson said that she felt the survey response was an outcome caused by issues within all themes and that work should take place through the actions plans being developed. Mr Matthew Shaw, Chief Executive said that it was important for staff to be assured that action would be taken as a result of the survey responses.
24.5	Mr Chris Kennedy, Non-Executive Director said that he felt a response rate of 50% was low and said it should be expected that all leaders were encouraging staff to complete the survey.
25	Safety and Reliability Improvement Programme Update – Speak Up
25.1	Dr Andrew Long, Deputy Medical Director and Responsible Officer said the aim of the programme was to support staff to feel confident to speak up in the moment for the safety of patients and colleagues. Twenty volunteer safety champions had been appointed and were working alongside the freedom to speak up ambassadors.
25.2	Ms Karen Panesar, Speak Up Project Lead said that the workshops had been piloted in the Brain Directorate where 93% of had been trained, exceeding the target and good feedback had been received. Training for staff would be paused during EPR roll out and during this time focus was being placed on training volunteers. Following roll out it was anticipated that 80% of staff as a whole would be trained. Dr Long said that a culture survey was undertaken in the Brain Directorate and the results differed positively from those in the whole Trust staff survey.
25.3	Approximately 300 training sessions were scheduled to take place between June and August 2019 and Dr Long said it was vital that these went ahead. He said that the second part of the programme 'Promoting Professional Accountability' would begin later in the year.
26	CQC Readiness Update (including well led update)
26.1	Dr Sanjiv Sharma, Acting Medical Director said that the CQC would be visiting the Trust in the second half of the year. Work was taking place to identify gaps

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26.2	<p>arising from the provider survey which had been completed and directorates had been paired up to inspect one another to share learning and best practice.</p> <p><u>Well Led</u></p>
26.3	<p>Dr Anna Ferrant, Company Secretary said that different elements of well led requirements would be presented to the Board at each meeting. Mr Matthew Shaw, Chief Executive said that the Trust was going to work with NHS Improvement on an informal Well Led assessment however this was likely to be at a similar time as the CQC inspection. Discussion took place around whether an informal well led inspection should take place and Sir Michael Rake said that it was important to be mindful of the pressures on the Executive Team at a busy time for the Trust. He said it was vital to ensure that these matters became part of business as usual.</p>
27	<p>Safe Nurse Staffing Report (January and February 2019) including Retention Action Plan for Nursing</p>
27.1	<p>Professor Alison Robertson, Chief Nurse said that no unsafe shifts had been declared in the reporting period. Care hours per patient per day had increased based on the same period last year as a result of either greater acuity of patients or greater activity which was staffed at the same level.</p>
27.2	<p>Key areas in terms of nurse vacancies were IPP and Sky ward which had bed closures as a result, however there had been positive recruitment of a number of experienced nurses to NICU and PICU.</p>
27.3	<p><u>Retention action plan for nursing</u></p>
27.4	<p>Along with recruitment focus was being placed on retention and the Trust had joined the Capital Nurse programme which worked to ensure nurses remained in London and it had been highlighted that 25% of nurses left the role in the first year. Mr Chris Kennedy, Non-Executive Director suggested that it was important to maintain contact with former staff and to encourage former staff to return to GOSH.</p>
27.5	<p>Four primary drivers of staff leaving the Trust had been highlighted in the exit survey: career development, work-life balance, a supportive workplace and support for newly qualified nurses. The action plan that had been developed to address these four drivers had been presented to NHS Improvement and the team was awaiting feedback.</p>
27.6	<p>Professor Rosalind Smyth, Non-Executive Director welcomed the excellent work that had taken place on the retention plan. She said that the Trust did not employ as many Advanced Nurse Practitioners or Nurse Consultants as other Trusts and there was likely to be a reduction in the flow of people from abroad and the action plan could be used to support this work as well as support more senior nurses beyond bands 5 and 6.</p>
27.7	<p>Mr Matthew Shaw, Chief Executive agreed that excellent work had taken place and said that similar work was required around allied health professions and developing a modern workforce.</p>

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28	Workforce Equality Objectives Update 2018/19
28.1	Ms Sarah Ottoway, Associate Director of HR and OD said that a key objective was to increase the overall visibility of the Trust Board and Senior Leadership within the Trust. She said that within recent months there had been a positive change in the visibility of senior members of the Trust. Three staff inclusion forums had been established each with an executive sponsor who would support the development of the equality agenda going forward.
28.2	Professor Rosalind Smyth, Non-Executive Director noted that in band 5 – 6 roles 57% of applicants were from a BAME background however only 27% of appointed individuals were from a BAME background. She asked whether there was an underlying reason for this and whether any additional action was being taken. Ms Ottoway said that the data was being reviewed and added that it was important to consider the progression from shortlisted to appointed. Work had taken place on unconscious bias but more was required. Professor Alison Robertson, Chief Nurse said it was important that this work also took place in nursing as throughout London the majority of nursing roles were held by people from a BAME background however at GOSH the nursing profile was 80% white staff. She said that it was vital that recruitment of all potential staff was maximised.
28.3	<u>Equality, Diversity & Inclusion: Update against service delivery Equality Objectives</u>
28.4	Professor Robertson said that extensive work had taken place to be clear about the demographics of the patient population. She added that the objectives had been developed in 2016 and they required revision based on feedback.
29	Gender Pay Gap Report
29.1	Ms Sarah Ottoway, Associate Director of HR and OD said that the Trust had been required to report data related to the gender pay gap in line with all employers with greater than 250 staff. The Trust's gender pay gap remained, driven by the demographics of the workforce. The gap was similar to other children's hospitals but more pronounced than specialist Trusts. Ms Ottoway said that if the medical workforce was excluded, the Trust's gender pay gap was positively skewed.
29.2	Sir Michael Rake said it was imperative that staff of all genders were provided with equal opportunities to be promoted and received equal pay for an equal role. He said that work should take place to agree an appropriate target for the Trust. Ms Ottoway said that GOSH had the ability to influence Local Clinical Excellence Awards and in 2018/19 women had been more successful in achieving awards and overall the same proportion of full and part time employers achieved awards.
30	London North Genomic Laboratory Hub Governance
30.1	Ms Helen Jameson, Chief Finance Officer said that as the lead contractor of the London North Genomic Laboratory Hub (GLH), NHS England had confirmed that the senior management team of GLH would report to a responsible office at GOSH. Ms Jameson said that at the time of the operational restructure the GLH had been located within the Medicines, Therapies and Tests Directorate

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	however as a result of the size and scope of the service and the associated impact on the management team's time it was proposed that the GLH moved out of this directorate to sit alongside the directorate structure reporting to the Chief Finance Officer.
30.2	Action: Mr James Hatchley, Non-Executive Director queried whether GOSH would have oversight of individuals in their non-GOSH workplaces as the Trust would have responsibility for the governance of the GLH. Ms Jameson said that subcontracting arrangements would be in place and therefore action could be taken as required through the contract. It was agreed that Mr Hatchley and Ms Jameson would discuss the matter further outside the meeting.
30.3	The Board agreed that subject to the discussion outside the meeting they were satisfied with the proposed arrangements. <i>Professor David Goldblatt left the meeting.</i>
31	GOSH Trust Board work-plan
31.1	Dr Anna Ferrant, Company Secretary presented the revised workplan and said that the matters for consideration by the Board had been mapped to the key lines of enquiry within Well Led. The Board agreed to provide any comments to the Company Secretary and noted that this was a live document and subject to change as the year progressed.
32	Board Assurance Committee reports
32.1	<u>Finance and Investment Committee Update February 2019</u>
32.2	Mr James Hatchley, Chair of the Finance and Investment Committee said that a considerable part of the Committee's discussion had been around the control total and tariff. The Committee had also discussed the positive move to a new procurement provider and considered work to ensure that bed base was maximised relative to tariff.
33	Update from the Council of Governors' meeting on 6 February 2019
33.1	Dr Anna Ferrant, Company Secretary said that Governors had received an excellent presentation on the Children's Cancer Centre development. The appointment of a Lead and Deputy Lead Governor would be considered at the next meeting as would the appraisal results of two Non-Executive Directors.
34	Declarations of Interest Register – Trust Board members
34.1	Dr Anna Ferrant, Company Secretary said that the register of Directors' interests was a live document and requested that any amendments or updates were provided on an on-going basis.
34.2	Under NHS England guidance all the Trust's decision making staff were required to provide a declaration of interest return. Mr Matthew Shaw, Chief Executive said that given the commercial sensitivity of many projects in which Trust staff were involved it was important to have an open register. The staff register would be reported at the May 2019 Board meeting.

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35	Guardian of Safe Working
35.1	Dr Renee McCulloch, Guardian of Safe Working presented the first annual report from the Guardian of Safe Working service. She said that positive work had taken place and there was an active and engaged core group of junior doctors who had contributed significantly to the collection of exception reporting. However there remained national issues around the recruitment and retention of the junior medical workforce. Dr McCulloch said that use of exception reporting was part of the NHS long term plan and work was taking place to embed it further.
35.2	GOSH rotas were compliant when the Trust was at full establishment however significant pressure was placed on the system when gaps occurred. The vacancy rate for junior doctors was an aggregated Trust wide rate which did not reflect the differences in various areas. Dr McCulloch said that the impact on junior doctors when there were gaps could be substantial.
35.3	A plan was in place to improve rest facilities which had been an issue. The Modernising Medical Workforce Group had also been established in response to the issues raised by the Guardian of Safe Working and this was positive.
35.4	Action: It was agreed that discussion would take place outside the meeting to consider where the report would be uploaded to the website along with a narrative.
35.5	Professor Rosalind Smyth, Non-Executive Director welcomed the work that had taken place and asked when a further survey would be taking place which would show the resulting improvement. Dr McCulloch said that a survey about flow at work would be conducted as well as a survey about the wellbeing of junior doctors. Ms Caroline Anderson, Director of HR and OD suggested that pulse surveys would be useful in this situation as it provided more real time feedback and encouraged staff to engage with surveys on a more regular basis.
35.6	Mr Matthew Shaw, Chief Executive said that the overall vacancy rate had decreased substantially over the year which was extremely positive.
36	Register of Seals
36.1	The Board endorsed the use of the company seal.
37	Any Other Business
37.1	There were no items of other business.

**TRUST BOARD – PUBLIC ACTION CHECKLIST
May 2019**

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
162.5	07/02/19	Mr James Hatchley, Non-Executive Director highlighted that mental health was a key feature of the NHS Long Term Plan and said it would be helpful for the Board to receive an update on the vision for mental health provision at the Trust. Mr Shaw said that he had spoken at a meeting for the mental health services across the Trust to discuss their strategy going forward and agreed that the Chief of Mental Health Services should be invited to the Board to discuss the strategy.	AF	July 2019 – TBC	Not yet due – update on long term plan to be discussed on 23 May 2019
17.6	03/04/19	Mr Chris Kennedy, Non-Executive Director noted that £14million of Better Value schemes, including those rated as high risk, had been identified. He requested that the remaining proportion of the target to be identified was categorised to show how challenging it would be to achieve.	AT	July 2019	Not yet due
22.9	03/04/19	Professor Smyth welcomed the style of the integrated quality and performance report but requested trend information or a summary of trend where specific work was taking place.	AT, AR, SS	May 2019	On agenda
22.4	03/04/19	Ms Kathryn Ludlow, Non-Executive Director noted the issues that had taken place with the occlusion and flow issues of BD pumps. It was agreed that consideration would be given to whether there should be any legal recourse due to the delays and potential patient safety issues.	SS	May 2019	Verbal update
30.2	03/04/19	It was agreed that Mr Hatchley and Ms Jameson would discuss the London North Genomic Laboratory Hub Governance further outside the meeting.	HJ, JH	May 2019	Verbal update
35.4	03/04/19	It was agreed that discussion would take place outside the meeting to consider where the annual Guardian of Safe Working report would be uploaded to the website along with a narrative.	AF, CM, Renee McCulloch	May 2019	Actioned – on website

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Trust Board 22nd May 2019	
Chief Executive Report	Paper No: Attachment L
Submitted by: Matthew Shaw, Chief Executive	
Aims / summary Update on key operational and strategic issues.	
Action required from the meeting For noting.	
Contribution to the delivery of NHS Foundation Trust strategies and plans <ul style="list-style-type: none"> • Compliance with CQC Well-Led framework • Delivery of trust strategy 'Fulfilling Our Potential' 	
Financial implications <ul style="list-style-type: none"> • None (business as usual) 	
Who needs to be told about any decision? Not applicable	
Who is responsible for implementing the proposals / project and anticipated timescales? CEO and executive colleagues	
Who is accountable for the implementation of the proposal / project? CEO	

Attachment L

Part 1: People

1.1 Listening to staff

We have previously discussed the prominence of People issues and agreed that cultural development should be a strategic priority for the Board this year. As such, I am proposing to provide a short update on People issues to open each Board Update going forwards.

As the Board is aware, we are working to finalise a People Strategy for GOSH to articulate the importance of creating a culture of kindness and to map our journey towards building the infrastructure that ensures our staff are well led and well managed and feel supported, respected, connected and safe.

Since our last Board meeting there have been a number of staff engagement activities that have furthered our insight on some of the issues they are facing. These will inform the People Strategy and feed into our wider Strategy Refresh. We have been speaking with staff openly at our monthly all-staff Big Briefings, at the Staff Partnership Forum and other meetings about our central priority – addressing bullying and harassment – as well as issues of recruitment and retention.

Our Strategy Refresh workshops for staff to date have been well received, producing lively and interesting discussions during which staff have expressed the value to them of contributing towards building a shared vision and priorities. Themes around the importance of developing the workforce, working together towards common goals and focusing on our strengths in care, education and research have been discussed at length. An analysis of feedback will be summarised at the Board Strategy Session on 23rd May. This session will also include a discussion on Board member's perspectives on the same questions we have asked staff to consider ahead of strategy workshops, namely:

- Thinking ahead 5 years, what is it about GOSH that you would most like to see being done differently?
- Thinking ahead 5 years, what is it about GOSH that you would most like to see protected, and to stay the same?
- What language would you use to describe your ideal version of GOSH in 5 years' time?

1.2 Developing staff

The next important cultural development project is the Trust-wide roll-out of *Speak Up for Safety* workshops as part of the Safety, Reliability and Improvement Programme (SRIP). The *Speak Up* programme aims to transform culture within GOSH by supporting and encouraging our staff to speak up for patient safety. It is also part of our GOSH Strategy commitment on the 'Care' pillar – to achieve zero preventable harm and deliver the best possible outcomes through providing safe, effective and efficient care.

Over 300 mandatory workshops for staff will be run by our Patient Safety Champions between June and December 2019. Our in-house trainers have been accredited by our Cognitive Institute and Medical Protection Society partners and have already trained over 10% of the GOSH workforce in a pilot exercise with the Brain Directorate.

As part of this ongoing partnership we are also welcoming international colleagues to GOSH in June 2019 as part of the Cognitive Institute's International Study Tour. We will be joined by executive team members representing the other eight Cognitive partners to share and learn from each other's experiences of rolling out SRIP as well as wider innovations in patient safety, quality improvement and research.

Attachment L

A video promoting the programme will be played at the meeting.

1.3 Leadership development

We are delighted that our Acting Medical Director, Sanjiv Sharma has been appointed as our substantive Medical Director after leading the field of excellent candidates considered for the position.

We are grateful to the Chair and Non-Executive Directors for giving generously of their time during April and May to meet with the King's Fund team who are working with us to create a Board Development Programme in response to elements of the CQC's Well Led Framework. We will be meeting with the King's Fund team to review their recommendations for programme interventions, which we will cross reference with the leadership elements of our People Strategy. The interventions framework will be shared for comment at our meeting in July 2019. In the meantime, we are scheduling quarterly developmental sessions for the executive team focusing on the team dynamic and 'learning while doing'.

Part 2: Financial sustainability

2.1 Proposed changes to the tariff for specialised services

We have previously updated the Board on work to raise concerns about the impact of the proposed changes to the Specialised Service Tariff in discussions with NHS Improvement and other policy stakeholders. We have been advised that a joint NHSE/NHSI improvement pricing team is to consider a project on complexity and we will naturally seek to support these discussions if and when they arise.

In the meantime, we have been working with the Federation of Specialist Hospitals (FOSH) to raise awareness of the issues on the structure of services and the tariff as they affect the wider tertiary/quaternary sector. Meetings arranged by FOSH have taken place with senior specialised commissioning leads on policy and strategy at NHS England and these discussions are ongoing.

Part 3: Partnerships

Recent meetings indicate that GOSH's membership of the **Federation of Specialist Hospitals** is a helpful way for us to provide system leadership, contributing to policy discussions the role of specialised healthcare within the place-based vision for NHS services articulated within the NHS Long Term Plan (LTP). We have also convened a working group of the **UK Children's Hospitals Alliance** to meet at GOSH in June to move forward proposals for a National Paediatric Pathology Network.

GOSH has also partnered successfully with **Health Education England** to establish stakeholder dialogue on how to realise the benefits of care integration for paediatric patients with complex needs in response to drivers including the LTP. A professionally facilitated event arranged by GOSH and funded by Health Education England on 9th May 2019 brought together GOSH parents and clinical leaders with secondary care paediatricians, GP leaders and representatives from the STP and the Royal College of Paediatrics and Child Health. A report is being produced to analyse the themes that emerged and further work will be done at GOSH to explore developing a model of integrated care along a specific clinical pathway.

Attachment L

NHS England has now been confirmed that GOSH will act as the host organisation for the **North Thames Paediatric Network**. The network manager based at the Trust is making good progress on setting up clinical delivery groups. Meetings are chaired by the GOSH CEO or Medical Director and two clinical directors have been appointed to steer progress, based at GOSH and Barts. There are ongoing discussions about a Young Adult Haemodialysis Unit and transitioning children into adult care.

Professor Keith Willett, the EU Exit Strategic Commander for NHSE/I wrote to trust CEOs on 18th April to advise that there is no longer a requirement for trusts to issue daily reporting in light of the Article 50 extension to 31 October 2019. The **Department for Health and Social Care** is working with partners to assess the implications of the extension and the ongoing talks on NHS preparedness activity. The advice is that sensible preparations for a no deal exit should continue to the revised timeline and the GOSH Brexit Working Group will continue to meet periodically to maintain oversight on our own progress as well as policy developments and guidance.

[Ends]

Attachment M

Trust Board 22 May 2019	
Patient Story – KC	Paper No: Attachment M
<p>Submitted on behalf of Alison Robertson, Chief Nurse Author, Emma James, Involvement and Engagement Officer</p>	
<p>Aims / summary The Great Ormond Street Hospital Patient Experience Team works in partnership with ward and service managers, the Patient Advice and Liaison Service (PALS), and the Complaints and Patient Safety Teams to identify, prepare and present suitable patient stories which are selected to represent a range of experiences across a variety of wards and service areas spanning different directorates and ensuring that the experiences of families are captured.</p> <p>The story to be shared on 22 May 2019 is pre-recorded and details a ten year old patient's experience (Kai) over the last nine weeks. Kai is waiting for a heart transplant and has nearly had one on two occasions.</p> <p>Kai is under the care of the care of the Cardiac Team; he has hypertrophic cardiomyopathy and has suffered cardiac arrests.</p> <p>Three key messages to take away from this story are:</p> <ol style="list-style-type: none"> 1. The importance of maintaining 'everyday life' (for example going to school etc.) while in hospital 2. The challenges and measures that can be put into place to entertain long stay patients 3. The importance of technology including access to Wi-Fi to our patients and their families 	
<p>Action required from the meeting Review and comment</p>	
<p>Contribution to the delivery of NHS / Trust strategies and plans</p> <ul style="list-style-type: none"> • The Health and Social Care Act 2010 • The NHS Constitution for England 2012 (last updated in October 2015) • The NHS Operating Framework 2012/13 • The NHS Outcomes Framework 2012/13 • Trust Values and Behaviors work • Quality Strategy 	
<p>Financial implications None</p>	
<p>Who needs to be told about any decision N/a</p>	
<p>Who is responsible for implementing the proposals / project and anticipated timescales Emma James – Involvement and Engagement Officer</p>	
<p>Who is accountable for the implementation of the proposal / project Claire Williams – Head of Patient Experience</p>	

Attachment N

Trust Board 22 May 2019	
GOSH Foundation Trust Annual Financial Accounts 2018/19 and Annual Report 2018/19	Paper No: Attachment N
<p>Submitted by: Helen Jameson, Chief Finance Officer Anna Ferrant, Company Secretary</p>	
<p>Aims / summary The Trust is required to publish a Foundation Trust annual report and accounts for 2018/19. Board members will find attached the following documents:</p> <ul style="list-style-type: none"> • A copy of the annual accounts 2018/19; • A copy of the annual report 2018/19 incorporating: <ul style="list-style-type: none"> ○ the Audit Committee Report 2018/19 including the going concern statement (page xx) ○ the draft Head of Internal Audit Opinion (page xx) ○ the Annual Governance Statement (page xx). <p>The annual report will be desk top published once approved by the Trust Board. The report has been audited and any final changes arising from the audit will be raised verbally at the meeting.</p> <p>The accounts and Quality Report are provided separately on the agenda.</p> <ul style="list-style-type: none"> • A copy of the representation letter to Deloitte, the external auditor is also attached (Attachment 12). The Board is required to declare in writing that the financial statements and other related documents have been properly prepared and without omission of material facts to the best of the management's knowledge and belief. It is also used by the auditor to obtain the Board's confirmation that all necessary information has been provided to them and to confirm judgments made by management where there is no other means of obtaining definitive evidence. <p>The Audit Committee will consider the annual accounts, report and representation letter at its meeting in the morning of 22 May 2019 and will provide any comments raised at the meeting to the Trust Board that afternoon.</p> <p>The annual report and accounts will be submitted to NHS Improvement by 30 May 2019 and then submitted to the Department of Health and Social Care at the end of June, for presenting to Parliament.</p>	
<p>Action required from the meeting To consider and approve the annual accounts and report 2018/19.</p>	
<p>Contribution to the delivery of NHS / Trust strategies and plans The Annual Report publically reports on the Trust's performance against its strategic priorities and objectives.</p>	
<p>Financial implications There are no direct financial implications.</p>	
<p>Legal issues There are no direct legal implications.</p>	

Attachment N

Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place? A number of staff have contributed to the draft Annual Report. All Executive members have been asked to review the draft and any comments have been incorporated into this draft.
Who needs to be told about any decision The Company Secretary will feed back any actions required to relevant staff.
Who is responsible for implementing the proposals / project and anticipated timescales The Company Secretary is leading the coordination of the Annual Report.
Who is accountable for the implementation of the proposal / project The Chief Executive Officer is ultimately accountable for production and publication of the Annual Report.

Great Ormond Street Hospital for Children NHS Foundation Trust Annual Report and Accounts 2018/19

Cardboard cover

Blank Page – cardboard

Great Ormond Street Hospital for Children NHS Foundation Trust Annual Report and Accounts 2018/19

Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006

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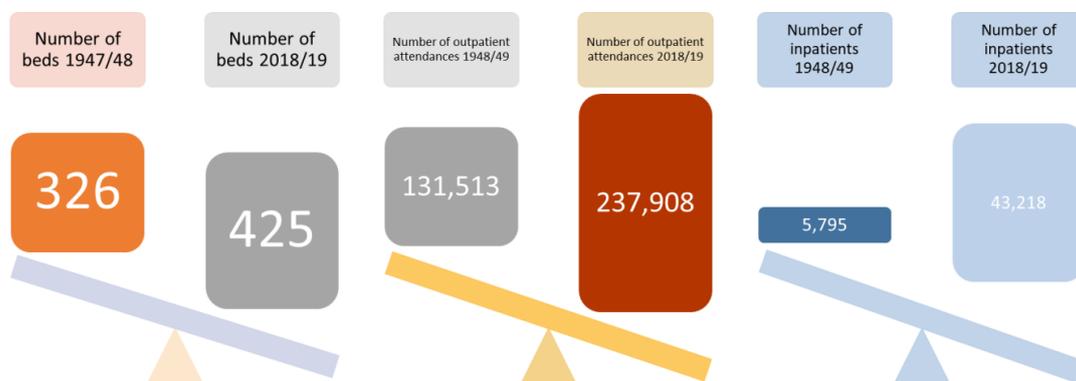
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Insert full page image

Great Ormond Street Hospital (GOSH) at a glance

(possibly in the shape of a jigsaw puzzle - TBC)? Diagram below is for a mock up

Fulfilling our potential 2018/19



Indicator	1947/48	2018/19
Number of beds	326	425
Number of inpatients	5,795	43218
Number of outpatients Attendances	131,513	237908
Number of staff		5,045
Number of patients participating in research		6049
Number of volunteers		1,192 volunteers, equating to approximately 248, 000 hours
% of patients who would recommend GOSH		Inpatients – 96.7% Outpatients – 94.1%
% of staff who would recommend GOSH		88% of staff would be happy with the standard of care if a relative needed treatment 67% would recommend the organisation as a place to work.

Insert full page image

Chair foreword

In a year characterised by economic and political uncertainty, the demand for the hospital's services remains constant. This year it provided more than 260,000 appointments and admissions, around half of which were for children and young people from outside London. Our patients, some of the most complex and seriously ill in the UK, attend for the range of specialist and sub-specialist services the hospital provides and to access cutting-edge research trials.

They often come to us after being seen by a range of healthcare providers and feel they have exhausted all other options. Yet even in these incredibly difficult and stressful circumstances our patients and their families work with us to ensure the best possible care can be delivered. At times they give us feedback on how we could do things better and it is our duty to act upon this. Many families are also incredibly generous in giving their time, not only to improve the service they have accessed, but the Trust more generally.

Our Young People's Forum epitomises this generosity. This group of incredibly positive current and former patients guide and support the hospital on a range of topics and issues, ensuring that any changes or developments align with the users of the services. This year they have worked with the hospital to introduce an online feedback tool and are now exploring ways to enhance the software in fun and engaging ways so as to encourage children under eight years old to respond.

The forum by which parents and families, older former patients and adults with an interest in the hospital can have a tangible impact is through the Council of Governors. This year the Board has made the relationship with this 27-strong elected body a priority with a series of programmes to facilitate and improve engagement. The contribution of the Governors during this period has been significant. They have worked with the Board to review and update the Trust's Constitution which was a substantial piece of work as well as contributed to the GOSH strategy and its delivery and been involved in a range of Board level appointments. I have really enjoyed working with the Council and I would like to thank each and every Governor for their time, energy and commitment.

The success of the hospital is primarily down to its dedicated staff. This year for the first time all members of staff were invited to take part in the annual staff survey. More than 2,200 responses were received- 50 per cent of the workforce. The results, while being broadly in line with previous years, were somewhat disappointing. While it is clear that most staff recognise the high standard of clinical care the hospital provides, they do not always feel it is a supportive place to work where the organisation cares about their health and well-being. Changing the culture of the organisation so it better nurtures its staff and sets clearer expectations of the behaviours it wishes to see cannot be achieved overnight but I am pleased that it is a priority for the coming year. Change of this type often needs to start at the top and I am confident this will be the case as Matthew Shaw, the hospital's former medical director and new CEO, is a strong believer in compassionate leadership. At the end of this year the organisation also appointed a new director of HR & Organisational Development - Caroline Anderson who has a strong track record in culture change and has already begun work on the organisation's People Strategy.

Building a positive and diverse culture where staff are inspired and motivated will be a central part of our People Strategy. This year we laid some foundations with the establishment of three staff inclusion forums: Lesbian, Gay, Bisexual and Transgender and Allies (LGBT+), Black Asian and Minority Ethnic (BAME) and Women's. Plans are already in place to launching a disability and long-term health conditions forum.

To underline the importance of culture and our people over the next year the Board has agreed to establish the People and Education Assurance Committee. The remit of this subcommittee is to provide assurance that the necessary structures and processes are in place to ensure a supported

and innovative workforce, an excellent learning environment for clinical and non-clinical staff and a culture that aligns with the Trust's strategy and Our Always Values.

Safety is of paramount importance at the hospital. This year much work took place to prepare for the launch of the Speaking Up for Safety in the Moment programme. This Trust-wide programme delivered with an international partner, the Cognitive Institute, will enable all staff to take responsibility and be held accountable for behaviours and attitudes that create a culture of safety and reliability. The programme was piloted and well-received across the Brain directorate and I look forward to it being rolled out across the rest of the organisation.

This work is supported by the GOSH Charity. The contribution the Charity and its donors make to ensuring the hospital is able to remain world class cannot be underestimated. This year the work it has supported includes the introduction of our electronic patient record and the exciting research platform Aridhia as well as continuing to provide funds for the chaplaincy, the Ethics Service, the play team, our social workers and our amazing army of volunteers. It also has a key role in supporting the redevelopment of the hospital's estate.

The redevelopment of estates continues to have great impact and enables us not only to accommodate patients and their families in world-class facilities but facilitates opportunities for new models of care and collaborative research environments. In 2018/19 work continued on the construction of the Zayed Centre for Research into Rare Disease in Children, the first centre of its kind in the world. The facility is a joint venture with UCL and will bring hundreds of clinicians and researchers together under one roof. We look forward to its official opening in 2019. This year we also undertook work on the new Sight and Sound Hospital and continued to develop the business case for the Children's Cancer Centre. None of these developments would be possible without our amazing Charity. On behalf of all the Board and all the staff we offer our sincerest thanks.

This year, my first full year as Chair, saw a number of experienced and talented individuals join the Board. I was delighted to welcome Chris Kennedy and Kathryn Ludlow who have a huge range of financial and legal experience between them. We were also sorry to say goodbye to Professor Stephen Smith, one of our non-executive directors who left the Board to join another NHS Trust. Within the management team, as previously mentioned, Matthew Shaw was appointed CEO replacing Dr Peter Steer, who left to return to Australia. Professor Alison Robertson joined as our Chief Nurse and Professor Andrew Taylor took up the post of acting chief operating officer. Dr Sanjiv Sharma was appointed acting medical director and at the time of going to print had just been appointed to the substantive role. I would like to all the Board for their contribution over the last year with a particular thanks to Dr Steer.

A new team with new energy and focus comes at an important time for the hospital. The political climate remains unstable and resources scarce. I would like to underline the sentiment that Matthew Shaw, our CEO, will express in his accompanying foreword, about the importance of staff from the European Union and the critical nature of our finances.

We benefit enormously from the contribution EU nationals make in all areas of our hospital and the UCL Great Ormond Street Institute of Child Health. We simply could not manage without them. It is vital that if we leave the EU, on whatever terms, we have seamless access to staff from the EU at all professional levels and that they are welcomed in this country. It is also essential from a financial perspective that there is greater realism in the setting of tariffs for hospitals like ours who face significant additional costs linked to the specialist nature of care they provide.

The Trust also expects a routine scheduled CQC inspection within the next year. Since we were last inspected in January 2018, we have made great strides in addressing the feedback we received. I join the management team in looking forward to welcoming the CQC back to re-emphasise the

exceptional quality of the care we provide and demonstrate the progress we have made in areas requiring improvement.



Chief Executive Foreword

Being part of the NHS is a fundamental part of who we are and is central to our ability to provide care for children and young people not just locally but from across the UK.

We were founded in 1852 and have been part of the NHS since its inception. This year we were very excited to join the country in celebrating its 70th birthday. As a tribute to this milestone, in this annual report we have tried to share a little about the hospital at the time the NHS was created. This includes a look at education and training, our ambitions for research and the need to rebuild our estate after the ravages of the Second World War.

Today, while some of the same challenges remain, our mission to put the child first and always endures. Moreover, we are in a very exciting time for paediatric medicine. The genomic and technological revolutions are providing unparalleled opportunities for the development of new and improved treatments for the complex and rare disease we see.

This year we were able to treat 11-year-old Yuvan with a pioneering gene therapy, known as CAR-T therapy. Yuvan, who suffers from hard to treat leukaemia, was the first UK child to receive this pioneering therapy on the NHS. Along with Royal Manchester Children's Hospital and Newcastle upon Tyne Hospitals NHS Foundation Trust, we will now provide this treatment to up to 30 patients a year. We are also very proud of another GOSH team, who in partnership with colleagues from University College Hospitals and University College London (UCL) were able to carry out the first UK in utero operations to repair damaged spinal cords of babies with spina bifida.

The hospital, with its academic partner UCL, has a particularly strong track record in the development of gene therapies and we are looking forward to amplifying our research and discoveries when the Zayed Centre for Research into Rare Diseases opens next year. Of note, its large and advanced Good Manufacturing Practice (GMP) facility will enable us to produce greater volumes of the products needed for gene therapies.

Much is being made nationally about the potential of technology to improve healthcare. This year we launched DRIVE (Digital Research, Informatics and Virtual Environments). It is a unique partnership between GOSH, UCL and leading global industry experts. It aims to take the latest technologies including artificial intelligence, virtual reality and facial recognition and develop novel ways of working to transform clinical practice and patient experience, not only for GOSH patients but across the NHS.

We also dedicated much time and energy preparing for the implementation of our electronic patient record, known as EPIC, which I am delighted to say was implemented very successfully in April. The system brings the way we record and manage information about our patients into the modern era and will allow us to improve care by providing more support to staff in clinical decisions. We hope it will also allow an increase in the time our teams have to care for the patients and improve communications.

The efforts of staff across the Trust to come together to implement EPIC represented the biggest change to clinical practices we have seen in recent memory - probably since 1948! And it has really shown what we can do when we truly work as one team. This ethos will need to be maintained in the year ahead given the continued challenging economic climate the NHS is facing. Last year we were able to finish the year with a small operating surplus after making savings of more than £12million. This year, as the NHS struggles to meet the costs of specialist care, we will in part draw on the contribution from private patients to balance our financial position. We will also have to make unprecedented efficiency savings totalling £20million. This is no small feat but one the organisation is absolutely committed to achieving.

The current political climate has also provided some instability, particularly among the European members of our workforce. At a time where many Trusts are struggling to recruit and retain staff we are extremely lucky to have a highly skilled multicultural workforce and an organisation with very low vacancy rates. We are therefore doing all we can to support our existing staff to stay with us. Looking to a future outside the EU, we have also undertaken succession planning for EU-EAA reliant staff groups and have worked with Health Education England on training provision for high-risk roles.

Our people are the hands and heart of the organisation and we want to support them to thrive. In 2018 we evaluated the way our clinical teams were working to ensure that our operational structure best supports our vision to help children with the most complex health needs fulfil their potential. The result was a new directorate structure with an increased investment in clinical leaders, new clearer lines of accountability and a reduction in the gap between Trust leadership and front-line services. The names of the teams were chosen by our young people and are simple and clear. Over the next year we are looking forward to implementing our leadership strategy and launching our Learning Academy to further support our staff.

In 2019 we will also be refreshing our strategy to ensure we better define for our people and key stakeholders our future form and direction as a provider of specialist and highly-specialist paediatric services and articulate what this means for the shape of the services we provide. This work will be done through a consultation process, involving staff from all professions – at all stages of their careers – as well as from our patients, families, members, governors and partners, collaborators, alliances and networks.

A key part of our existing strategy is to use our voice as a trusted partner to influence and improve care. This year working with Global Action Plan we launched the first ever Clean Air Hospital Framework (CAHF), a strategy aimed at improving air quality in and around hospitals. This has attracted much attention and widespread support. We have also begun a journey to highlight the importance of addressing the issue of mental health. This involved launching a Peanuts themed drop-in centre providing accessible, low-intensity early intervention services for patients and families concerned about their mental health. It was delivered in partnership with the UCL Great Ormond Street Institute of Child Health and support from our Charity. Notably our clinicians, many of whom are national or international experts in their fields, have also shared their knowledge to inform national healthcare debates including at Health Select Committees.

Our patients are treated by many parts of the NHS and it is vital that we work with a range of providers to ensure their care is comprehensive and timely. I am very pleased that this year we were able to meet the national target of treating our patients within 18 weeks. We were also very excited to help lead on the development of an important new network looking at paediatric service delivery across North London. The North Thames Paediatric Network for specialist paediatric services brings together specialist providers and district general hospitals to improve access and outcomes for children across the care pathway.

While many of our services are national, we very much want to play an active and positive role regionally. As part of the North Central London Sustainability and Transformation Partnership (STP) we participates in several important committees, looking at issues including procurement, leadership of transformation, nurse leadership and workforce.

Overview

The purpose of this section is to provide an overview of the organisation, its purpose, the key risks to the achievement of its objectives and how it has performed during the year.

Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH) is an acute paediatric provider of specialised and highly specialised treatment and care for children presenting with rare and complex diseases and conditions. This is why our vision, which sets our direction, is 'helping children with complex health needs fulfil their potential'. Our mission is to put 'the child first and always', which is supported by our 'Always Values' – to be always welcoming, always helpful, always expert and always one team.

At GOSH we provide over 50 different specialist and sub-specialist paediatric health services. This is the widest range on any one site in the UK.

More than half of our patients are referred to us from outside London and a small proportion come from overseas.

We have a long tradition of clinical research, learning from our special position of treating some of the largest cohorts in the world of children with rare diseases. We host the UK's only paediatric National Institute for Health Research (NIHR) Biomedical Research Centre (BRC) in collaboration with University College London Great Ormond Street Institute of Child Health (ICH).

Together with our partner Higher Education Institutes, we train the largest number of paediatric nurses in the UK and play a leading role in training paediatric doctors and allied health professionals.

Our history

In 1852, Dr Charles West founded the Hospital for Sick Children in his terraced house on Great Ormond Street. It was the country's first specialist medical institution for children, with just ten beds and two clinical staff.

With the generosity and foresight of early patrons such as Charles Dickens and J M Barrie, the hospital grew. Over the decades it has been at the leading edge of treatment and care of children, including pioneering paediatric cardiac surgery and treatment for childhood cancers.

Great Ormond Street Hospital for Children was authorised as an NHS Foundation Trust on 1 March 2012. Much has changed since 1852, but GOSH remains at the forefront of paediatric medicine and research. Every day we do everything in our power to give seriously ill children the best chance to fulfil their potential.

GOSH 70 years ago

In July 2018, the nation celebrated the 70th birthday of the National Health Service (NHS). This landmark encouraged us all to reflect Great Ormond Street Hospital for Children NHS Foundation Trust's contribution to the central tenet of the NHS – that every citizen has the right to access healthcare free at the point of use.

GOSH is proud to be part of the NHS and to play our role in developing the treatments of the future. Our staff, including researchers, clinicians, nurses and all the other professionals who contribute to providing the very best treatments for our patients, are already looking to the next 70 years of the NHS. Driving ground-breaking research that is pivotal in discovering new treatments, their pioneering work is giving hope to future generations of children across the UK with rare and often life-threatening conditions.

This shared endeavour is really something to be celebrated, so throughout this year’s annual report we have included some facts and pictures about life at GOSH for patients and staff 70 years ago.

Our structure in 2018/19

In 2018, we evaluated the way our clinical teams were working. The aim was to ensure that our operational structure best supports our vision to help children with the most complex health needs fulfil their potential.

A consultation was conducted with all staff across the Trust. After reviewing the responses, a new directorate leadership structure was introduced to improve the clarity of lines of accountability, reduce the gap between Trust leadership and front-line services, and create attractive leadership roles within the Trust. Eight directorates were established and, after consulting young people on potential names, these are:

 Brain	 Body, Bones and Mind	 Operations and Images	 Sight and Sound
 Blood, Cells and Cancer	 Heat and Lung	 International and Private Patients	 Medicines, Therapies and Tests

In addition there are nine corporate areas – Clinical Operations, Corporate Affairs, Development and Property Services, Medical, Nursing, Human Resources and Organisational Development, Research and Innovation, Finance and Communications.

Our strategy

In 2017 we refreshed our hospital’s strategy, developing and introducing the ‘strategy house’. Alongside our commitments to ‘put the child first and always’ and ‘help children with complex health needs fulfil their potential’, this set out four important priorities:

- We will provide the safest, most effective care, with the best possible outcomes.

- We will attract and retain the right people and together create a culture that enables us to learn and thrive.
- We will improve children's lives through research and innovation.
- We will harness digital technology to transform the care we provide and the way we provide it.

Insert image of strategy house

During the past two years we have embedded the strategy through designing local, service-led strategies. We have updated our business case and planning processes, and strengthened our Personal Development Reviews (PDRs). We have developed internal campaigns to share strategic insights across the Trust, and run two successful one-week long strategy events that showcased the amazing things we do in our hospital.

Through conducting this work to embed the strategy we realised we want to better define our direction for the future as a provider of specialist and highly-specialist paediatric services and what this means for the shape of the services we provide. This will also help us to define the role we play within local, national, and international healthcare.

Consequently, during 2019/20 we will refresh the strategy house through a consultation process, involving staff from all professions – at all stages of their careers – as well as from our patients, families, members, governors and partners, collaborators, alliances and networks. This process will run between May and November 2019 and involve various workshops and sessions to collect feedback that will be used to refine our vision and the strategic choices and priorities of our hospital in the future. Following formal Board approval we will launch the strategy refresh to coincide with Open House 2019 and International Day of the Child 2019.

Our business model

Our business model demonstrates how we create value for our stakeholders through our activities. The model (see page XX) shows the critical inputs and the immediate outputs for NHS services, education and research, and international and private patient activity, and how these create value. The model provides a clear focus for strategy development and identification of strategic risks.

The key outcomes we aim to deliver from our business model are as follows:

- Clinical outcomes – world-class clinical outcomes for our specialised services
- Patient and family satisfaction – high levels of patient satisfaction with our services
- Research translated into clinical practice – new and innovative specialist treatments for children with complex or rare diseases
- Education – the largest programme of specialist paediatric training and education in Europe
- Financial – financially sustainable activities with the contribution from our private patient business supporting investment in developing our services
- Reputation – a hospital for the NHS to be proud of with a worldwide reputation for excellence in providing specialist healthcare for children

Key risks and issues

Our Board Assurance Framework (BAF) details the principal risks to the achievement of our operational and strategic plans. It is informed by internal intelligence from incidents, performance, complaints and internal and clinical audit, as well as the changing external environment in which we operate. The top six risks to our operational or strategic plans in 2018–19 were identified as:

- Financial sustainability – Being able to meet the control total target set by NHS Improvement, in an environment where core services are underfunded, money available to NHS organisations is reduced, and the cost of delivering specialised services is high. Private patient work is also key to providing financial support for our NHS paediatric services. The majority of private patient service demand is from the Middle East, which carries a degree of geopolitical risk.
- Implementation of the new Trust-wide Electronic Patient Record (EPR) system. See page xx for further information.
- Management and monitoring of medicines.
- Impact of Brexit on effective patient care.
- Management of personal and sensitive personal data.
- Recruitment and retention of staff.

More detail about these risks and our mitigating actions can be found in the annual governance statement on page xx.

Going concern

Although we are operating in a particularly constrained financial environment, after making enquiries, the directors have a reasonable expectation that we have adequate resources to continue to operate for the foreseeable future. For this reason, and following reasonable enquiries, the directors continue to adopt the going concern basis for the preparation of the accounts within this report.

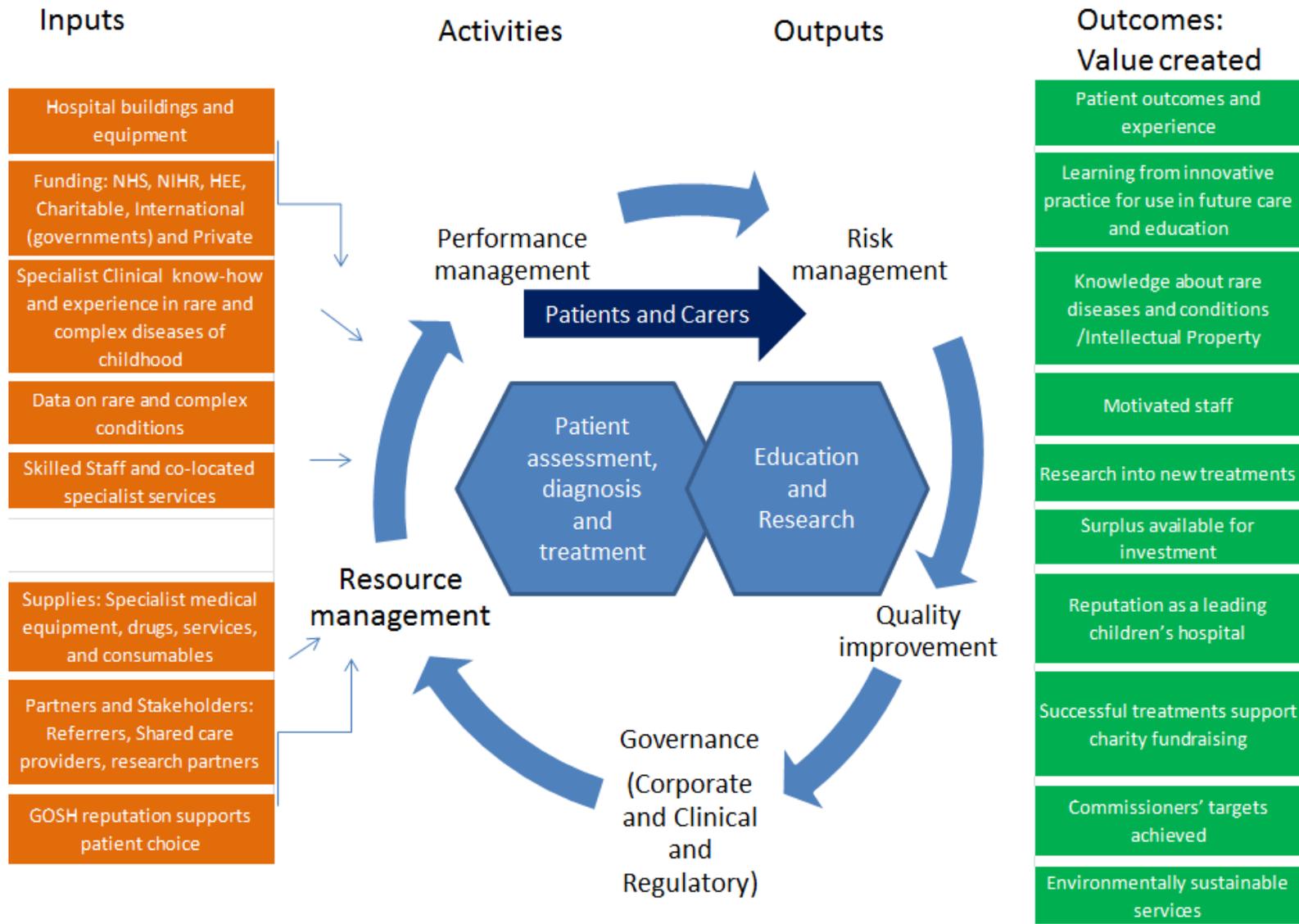
A summary of our financial position and plans can be found on page x. Full details of our income and expenditure in 2018/19 can be found in the accounts from page x.

Important events since year-end

Our EPIC EPR system went 'live' in April 2019. See page xxx for further information.

The Zayed Centre for Research into Rare Diseases in Children, is due to open in 2019/20 (date TBC).

Our substantive Medical Director, Dr Sanjiv Sharma was formally appointed on 22 May 2019.



Performance report

Overview

In 2018-19, more than 260,000 patients attended GOSH, around half from outside London. We provide over 50 different specialist and sub-specialist paediatric services – the widest range on any one site in the UK.

These factors do set us apart from other providers, but they do not hide us from the very challenging environment across the NHS. For example, the affordability of specialist work – tariffs and top-ups, problems attracting and retaining a specialist workforce, and new reforms and structures means the NHS is operating in a difficult environment. It also means GOSH will need to manage some unprecedented challenges.

Our culture

Commitment to patient care, Our Always Values and delivery of safe services have, for the past 12 months remained paramount at GOSH. However, staff have faced challenges, and, along with financial constraints faced by the NHS, these have had and will continue to have an effect on staff and how they feel in their roles. The appointment of a new management team creates an opportunity to emphasise how much we value our staff and refresh the programmes available to support, develop and retain them.

Our research

We remain committed to becoming a hospital where research is integral and drives treatment and outcomes. We have seen some exceptional research outcomes this year, many of which have immediately improved children's lives. Our research income has grown by 25% in the year to £25 million, with over 1,300 studies active during the year. See page [xx](#) for further information.

Our estate

During treatment, patients and their families might be going through the toughest times of their lives, so great importance is put on creating nurturing environments and high-quality facilities for providing specialised and highly specialised care. Our redevelopment programme aims to transform the estate to provide world-class facilities for patients, opportunities for new models of care and collaborative research environments. See page [xx](#) for further information.

Our digital future

We will use technology to move towards a digital future, to access information, share information, make decisions, engage patients and partners and drive safety. Our EPR programme aims to transform the clinical information systems of the Trust. The system went 'live' in April 2019 and therefore EPR will be one of the key focuses of the Trust in 2019/20, with a period of rapid stabilisation followed by an optimisation phase. See page [xx](#) for further information. We also launched DRIVE – (Digital Research, Informatics and Virtual Environments) – which is the first of its kind in the world. It is a unique partnership between

GOSH, University College London (UCL) and leading industry experts in technology, artificial intelligence and digital innovation

Our funding

In the context of funding pressures faced by NHS organisations, financial stability remains critical. Over 90% of our NHS funding is received from NHS England specialised commissioning. Our operating surplus (before capital donations and impairments) was £6m in 2018/19. For further information on the financial results, refer to page xx.

The funding we receive for NHS activity is not sufficient to cover the cost of delivering it, and we rely on the contribution from private patients to support the delivery of NHS services. The Trust also receives income from a portfolio of research, while the Great Ormond Street Hospital Children’s Charity helps to fund buildings, equipment and a number of other areas.

Performance analysis

Key achievements in 2018/19

Teams across the Trust have made significant progress and achievements in the second year of the operational plan 2017–2019. These achievements include:

- Reorganisation of the structure of clinical operations teams at the Trust. See page XX for further information.
- Delivery of the national Referral to Treatment target in each consecutive month of 2018/19.
- Delivery of £12.3m of savings through the Trust’s ‘Better Value’ programme.
- Completion of the EPR system design, configuration and testing as well as preparation for organisation training ahead of the April 2019 go-live.
- Progress in our redevelopment programme, including:
 - Construction of the Zayed Centre for Research into Rare Disease in Children (to open in 2019/20).
 - The new Sight and Sound Hospital (to open in 2020/21).
 - Ongoing development of the business case for construction of a new Children’s Cancer Centre.

Our plans for 2019/20

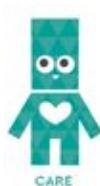
In 2019/20, these key areas will continue to be developed with plans to:

Priority	Strategic Programme
Care	Roll out the Safety and Reliability Improvement Programme across the Trust. Deliver a £20m Better Value programme.
People	Further develop a GOSH Learning Academy that will provide first-choice, multi-professional paediatric education and training, available through state-of-the-art technologies and in contemporary evidence-based designed learning environments.

Priority	Strategic Programme
	Improve recruitment and retention at the Trust, including through participating in the Nursing Retention Support collaborative with NHS Improvement
Research	Open the Zayed Centre for Research , undertaking research into rare diseases so we can more accurately diagnose, treat and cure children with rare conditions.
Technology	Successfully implement the EPR and move into the Optimisation Phase.
Voice	Exploring the thoughts and ideas of our teenage patients with the Young People's Forum to improve their experience.
Space	Complete the Outline Business Case for the Children's Cancer Centre (Phase 4).
Information	Return to compliance with the Referral to Treatment Target after an initial reduction in the EPR go-live period.

We align our strategic objectives with eight areas of focus that reflect challenges and opportunities – care, people, research, technology, voice, space, funding, and information. On the following pages, you will find more information about these eight priorities, specifically: what they are, what we have achieved and what the challenges have been.

Insert the logos for the priorities



Our Care priority: We will achieve the best possible outcomes through providing the safest, most effective and efficient care.

We aim to deliver high-quality specialised care to our patients every day. We also continuously look to the future to innovate the care that we provide. This year we have seen outstanding examples of innovation from collaboration with national and international partners to deliver world-leading paediatric care.

Objective	Achievements
<p>Be recognised for our expertise and clinical innovation in developing, delivering and leading specialised paediatric services.</p>	<ul style="list-style-type: none"> • We became the first hospital in the UK to offer a pioneering cancer therapy, known as CAR-T therapy, to NHS patients with B-cell acute lymphoblastic leukaemia. These therapies are specifically tailored for individual patients. • A team from GOSH and University College London Hospitals (UCLH) carried out the first two operations on the damaged spinal cords of babies in the womb, in what are the first surgeries of their kind in the UK (See page XX).
<p>Be recognised for our quality of care, positive health outcomes and experience for children and families.</p>	<ul style="list-style-type: none"> • We launched DRIVE (Digital Research, Informatics and Virtual Environments) which is the first of its kind in the world. It is a unique partnership between GOSH, University College London (UCL) and leading industry experts in technology, artificial intelligence and digital innovation (See page XX). • As part of a pioneering new study, GOSH launched a drop-in centre providing accessible, low-intensity early intervention services for patients and families concerned about their mental health (See page XX). • Under the staff friends and family test, 88.2% of staff would be

	happy with the standard of care provided by the organisation if a friend or relative needed treatment.
Provide timely access to care for all GOSH patients.	<ul style="list-style-type: none"> • We delivered the national Referral to Treatment target in each consecutive month of 2018/19 (see page XX). • GOSH has consistently delivered all the cancer standards throughout 2018/19 ensuring that all patients are treated in line with required standard. • We have reduced numbers of repeated laboratory sample collection procedures resulting in fewer delays in medical teams receiving results, enabling fewer delays in diagnosis, treatment and discharge (see the Quality Report on page xx).
Deliver efficient care in order to generate a sustainable surplus and allow us to invest in our transformation.	<ul style="list-style-type: none"> • Our Better Value Programme helped us deliver £12.3m savings for the year (See page XX).

Ground-breaking cancer therapy

A GOSH patient became the first NHS patient to receive a therapy that uses the body's own cells to fight cancer.

Yuvan, 11, who has a form of leukaemia, had CAR-T therapy, called Kymriah, after conventional cancer treatments failed. CAR-T involves removing immune cells and modifying them so they can recognise cancer cells. Previously it was only available as part of a clinical research trial.

Acute lymphoblastic leukaemia affects about 600 people a year, mostly children. Most are cured by conventional treatments but about 10% relapse.

In November 2018, it was announced that GOSH, along with Royal Manchester Children's Hospital and Newcastle upon Tyne Hospitals NHS Foundation Trust, would treat children with this rare form of leukaemia. Up to 30 patients a year are expected to be treated.

[Photo of Kymriah with consultant]

A mental health booth for families and patients

On 22 January 2019, GOSH launched a drop-in centre providing accessible, low-intensity early intervention services for patients and families concerned about their mental health.

It is hoped that this new research could pave the way for effective treatment of mental health conditions for children with complex physical conditions: treatment that delivers positive outcomes, while being less resource intensive.

For the study, researchers from GOSH and UCL Great Ormond Street Institute of Child Health (ICH) set up a drop-in centre, named “the Lucy Booth” after the Peanuts’ characters’ stand, in the hospital’s reception area. Although the research project is led by the ICH Psychological Medicine Research Team, the centre is run by a multidisciplinary team of volunteers and staff from research, clinical psychology and psychiatry who are available to patients and families, ad hoc throughout the day.

First UK Surgery in the womb

Photo – Dominic Thompson

A team from GOSH and UCLH have carried out the first two operations on the damaged spinal cords of babies in the womb, in what are the first surgeries of their kind in the UK.

The team repaired the holes in the babies’ spines in two 90-minute operations in summer 2018. Mums and babies are recovering well. The operations brought together NHS clinicians from GOSH and UCLH working with researchers from UCL.

Delivering efficient care to invest in our transformation

The Trust has delivered the highest contribution from efficiency achieved in recent years. Better Value schemes valued at £12.3m were delivered over the year. This was achieved through:

- £0.9m resulted from our continued work to improve patient flow, particularly through improving theatre and bed booking and utilisation, reducing last minute cancellations, and reducing the number of admissions from other providers refused due to capacity issues.
- £1.7m was achieved from our central programme to reduce non-pay spend. Further benefits are anticipated through the Smart Together procurement partnership service, run by Guy’s and St Thomas’ NHS Foundation Trust, which GOSH joined in August 2018. A further £0.5m was delivered from a range of local non-pay initiatives delivered by our directorates.
- £2.1m was delivered through reviews of vacancies, staffing and skill mix.
- £1.2m resulted from a range of additional income schemes including new areas of international and private practice, the establishment of second opinion services and new service level agreements for outreach services.
- £5.9m was generated from a wide range of other local efficiencies led by directorates.

The Better Value Programme Office also oversees the quality impact assessment process which reports to the Medical Director and Chief Nurse. This process ensures that we consider the quality impact of all cost saving initiatives and mitigate any emerging risks.

Diagnostic waits

GOSH aims to ensure that waiting times are minimised across all areas, however achievement of the diagnostic six week standard has been a consistent challenge for the Trust throughout the year. This is in part driven by the small allowance of patients waiting over six weeks that the Trust is permitted to have, less than six breaches per month. In addition the GOSH identified a number of issues in the main related to administration process issues which have now been addressed. The Trust is currently working to deliver a recovery plan and projects a return to previous performance in early 2019/20.

The Play Team

While children and young people are in the hospital environment, separated from their familiar and comforting surroundings, it can be difficult to play spontaneously. The Play Team create relaxed conditions by building rapport and sourcing materials children and young people like. Development happens through playing and at crucial points in life. To miss out on this can have serious consequences. Even when children are isolated in their beds we find a way to make play possible.

Care at GOSH 70 years ago – The Gastro–Enteritis Flying Squad

When the hospital joined the NHS, an innovative project was the ‘Gastro-Enteritis Flying Squad’. The squad was established by enterprising junior doctor John Black, later an eminent consultant paediatrician at Sheffield and Glasgow. A specially equipped adapted ambulance, manned by Black, an assistant and two specialist nurses, would cover a 30-mile radius around London to treat urgent cases on site or bring them to the hospital if necessary.

INSERT PICTURE OF Gastro flying squad



Our People priority: We will attract and retain the right people through creating a culture that enables us to learn and thrive.

Every day our staff help children and young people with rare or complex conditions fulfil their potential. Attracting, retaining and developing the best people across our clinical and supporting workforce is vital. Additionally, education, teaching and learning are critical to our work.

Some of the ways we have attracted and retained the best staff are:

Objective	Achievements
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<p>Use our values and behaviours to build a positive and diverse culture where staff are inspired to give their best</p>	<ul style="list-style-type: none"> • Launched three staff inclusion forums (Lesbian, Gay, Bisexual and Transgender and Allies (LGBT+), Black Asian and Minority Ethnic (BAME) and Women’s) and will shortly be launching a disability and long-term health conditions forum. • Trained 484 staff on Speaking up for Safety (see page xx).
<p>Be renowned for our talented staff and for the ever-improving quality of work they do.</p>	<ul style="list-style-type: none"> • Welcomed 1,333 new starters to GOSH. • Implemented a new Rostering system that will enable more effective rostering, as well as supporting improved work life balance for our staff.
<p>Have leaders at all levels of the Trust who are effective, visible, supportive and respected by their teams.</p>	<ul style="list-style-type: none"> • Developed leadership strategies targeted at leaders at all levels of the organisation (see page xx for plans to establish our Learning Academy). • Restructured our clinical leadership teams to create a strengthened and empowered leadership model capable of leading us well in the future.
<p>Provide our staff with the skills and capabilities needed to deliver exceptional care from world-class facilities.</p>	<ul style="list-style-type: none"> • Maintained above target statutory and mandatory training throughout the year. • Delivered training for 4,500 staff on our new EPR system.

Impact of Brexit

One of our key challenges has been that our workforce relies on staff from the European Union (EU) and European Economic Area (EEA). Therefore, Brexit presents a potential risk that we lose staff and find it harder to recruit to posts. To ensure we can cope with these changes, we have undertaken workforce and succession plans for EU and EEA-reliant staff groups. We have also worked with Health Education England (HEE) on training provisions for high-risk roles, worked closely with services and areas (e.g. nursing) to develop strategies to reduce turnover, and designed and run leadership development programmes. As part of our ongoing support to EU staff we ran a number of drop-in clinics helping staff with their settled status applications in December 2018.

Volunteering at GOSH

GOSH has the largest volunteer programme of any NHS Trust in greater London. In the last year, we increased our total number of active, regular volunteers to 1,192. We attract skilled, motivated and enthusiastic people to the GOSH volunteer programme and offer extensive, valuable training and support to individual volunteers. We also increased the variety of roles that people can choose as a volunteer, from 127 last year to 132. These roles range from those working directly with patients and families, to those supporting back office staff and departments.

We estimate that our volunteers donated approximately 249,000 hours of their time to supporting the hospital, providing services for patients and families. This volunteer effort equates to £2,696,000 of donated time, based on the London Living Wage.

Leadership

In line with the publication of the Trust Strategy and approval of the GOSH Learning Academy (see page xx), a collaborative effort was taken across the three education teams to formulate a new *GOSH Leadership Strategy*.

The strategy describes our ambition for a contemporary leadership development offer: *Accelerating journeys towards exemplary leadership*. A strategic framework has been developed to guide the delivery of this ambition.

Delivery of some areas has already started, including the implementation of the Senior Leadership Development Programme. This was developed following a directorate restructure in 2018/19 and addresses key elements within the Care Quality Commission (CQC) *Well Led Framework*.

Children's Hospital Education Specialist Symposium

GOSH was delighted to host the first ever Children's Hospital Education Specialist Symposium (CHESS), a national one-day forum championing paediatric education, backed by the Children's Hospital Alliance.

Education and training for healthcare professionals has remained a vital cornerstone of the NHS over its 70-year history, recognised as integral to providing excellent and safe services for patients. Through CHESS, education colleagues at GOSH invited children's hospitals around the UK to come together to discuss and collaborate around the opportunities and challenges often faced in specialist paediatric education.

Safety and Reliability Improvement Programme

Our Safety and Reliability Improvement Programme aims to transform culture, by developing our leadership capability and enabling all staff, including front-line staff, to take responsibility and be held accountable for behaviours and attitudes that create a culture of safety and reliability. In January 2018, we embarked on a partnership with The Cognitive Institute to deliver the Safety and Reliability Improvement Programme. During 2018/19, workshops took place for senior leaders, and we launched our Speak up for Safety Programme with selection of safety champions. A pilot in the Brain directorate commenced towards the end of

2018 and will be rolled out Trust-wide in 2019 alongside the Promoting Professional Accountability programme.

Launch of three staff inclusion forums

We want every child and young person who comes to GOSH to fulfil their potential – we can only do this by acknowledging the diversity of our patients and staff and adjusting our services to meet their needs.

The GOSH BAME forum, supported by its executive sponsor and the hospital's Chief Nurse, was launched and announced its intention to support the best interests of BAME members and help the Trust in playing its part in building a sustainable, better future for all.

Insert picture of BAME forum

The GOSH Women's Staff forum was launched on International Women's Day (Friday 8 March 2019). The plan for the forum is to focus on how to support women working at GOSH. Initial suggestions have included menopause support, returning to work after having a baby, and career progression.

The aim of the LGBT+ forum is to ensure the Trust recognises and involves staff and volunteers who identify as lesbian, gay, bisexual, transgender or non-binary, relationship diverse or as an LGBT+ ally.

Insert picture of Jamie and Laura at Pride?

For the first time in 2018, GOSH had a presence at Pride in London – a great day was had by all and our aim is to support annual staff attendance.

We are working on launching a forum for staff with disabilities and long-term health conditions in 2019.

Further information can be found in the Quality Report on page xx.

Muslim prayer facility

A new multi-faith room was officially unveiled at GOSH following a generous donation from a leading UK Muslim charity. Al-Khair Foundation's £300,000 grant has made it possible for patients, family and staff to enjoy a new, dedicated space for prayer and reflection at the world-renowned hospital in London. The new space complements the spiritual and religious support provided to families by the hospital's chaplaincy team.

[Photo]

Education and training at GOSH in 1948

Education and training for healthcare professionals looked a little different at the birth of the NHS in 1948, but it had similar challenges to the ones we face today. Here at GOSH, the Institute of Child Health—at that time, a singular room in the lower levels of the Southwood Building—reported in the *GOSH Annual Report, 1947* how they struggled to host medical

students and their important projects, such as follow-up of cases of chronic chest disease (tuberculosis).

Despite some differences, other aspects remain the same—students were still receiving lectures, observing procedures, and undertaking assessments. Nor has our purpose changed today—we continue to aim to provide the skills and capabilities for our staff to provide excellent patient care.

Caption: Nursing staff at training in 1948



Our Research priority: We will improve children’s lives through research and innovation

Working in partnership with the UCL Great Ormond Street Institute of Child Health, the hospital is the largest paediatric research and training centre in the UK and one of a very small number of internationally recognised centres of excellence in the field of child health.

Our framework for supporting high quality research is underpinned by a continued focus on communication and education. This supports us in achieving a step-change in staff awareness, attitudes and involvement in research.

Some of the ways we have successfully implemented research and innovation are:

Objective	Achievements
Accelerate the translation of all research into improved patient outcomes.	<ul style="list-style-type: none"> • 1,349 open research projects • 6,049 patients participated in research • Over 1,000 papers published in collaboration with UCL
Build a culture of innovation and continuous improvement where the talent and creativity of all staff is harnessed.	<ul style="list-style-type: none"> • Launched Digital Research Environment and DRIVE (see page xx) • NICE approval for the use of burosumab to treat X-linked hypophosphataemia in children and young people. The drug became available on the NHS from January 2019, only four years after the phase 2 trial first started at the NIHR Clinical Research Facility (CRF).

We are making good progress towards achieving our vision of GOSH as a research hospital where:

- Research is an integral part of the working lives of our staff and the patients and families we treat and see. It is fully integrated into every aspect of the hospital, to improve the treatment and outcomes for our patients
- We learn from every patient we see, using the knowledge gained to improve our patients’ health and the health of future patients.
- Staff, patients and families understand the opportunity and importance of research. Research is seen to benefit and not compromise NHS clinical activity.

- We support, value and train all those involved in research. Research is considered as a core component when recruiting leaders across the organisation.
- We lead the way in involving patients and families in research design, delivery and strategy. We continue to develop creative ways to ensure equitable involvement.
- All clinical directorates and services develop and own their research agenda and are supported to do this.

Participant recruitment

During the last year, our research activity has continued to thrive, with 1,349 open research projects and an increased focus on early-phase translational research, for example novel therapies. These studies are often intensive and complex, with clinical trial patients in hospital overnight or for longer stays in our NIHR CRF or on our wards.

In 2018/19, 6,049 patients and their families took part in research at GOSH. We are now expanding this by offering all patients the opportunity to participate by giving us generic consent to use clinical data and excess tissue for research. The pilot has now moved to inpatients, with further areas to now also consent patients.

Funding

This year we saw an overall 25% growth in our research income to £25 million, which supports research infrastructure and projects across the Trust. This has been in part due to a higher than anticipated growth in commercial income of 13%, through attracting an increased number and value of commercial studies to the Trust as well as extensive work to improve the effectiveness of commercial income recovery. 2018/19 was the second year (out of five) of our third funding term of the NIHR BRC and of our new NIHR CRF.

Innovation

The Trust continues to focus on innovation, through the GOSH Innovation Hub overseen by the Intellectual Property (IP) Oversight Group. This reviews our IP portfolio and makes strategic recommendations to the Research and Innovation Board for support of innovation with commercial potential. In particular, the implementation of the Trust's EPR system, in April 2019, has a specific research workstream with input from across research and innovation. This allows much greater alignment across research and clinical practice, with clinical data extracted into the Trust's **Digital Research Environment**, linked to a high-performance analytical platform produced in collaboration with Aridhia and our dedicated DRIVE team.

ADD Photo of DRIVE being opened

In the coming year, we will be continuing to focus on driving forward our research hospital strategy with many exciting initiatives on the horizon. Our capacity to deliver rare disease research will be significantly expanded with the opening of the Zayed Centre for Research into Rare Disease in Children. This will be a world-leading centre of excellence that will tackle some of the most challenging scientific questions. It will enable scientists

and clinicians to more accurately diagnose, treat and cure children and young people with rare diseases.

Research in 1948

The hospital had been aspiring to open a specialist research centre since the 1920s, but a formal Institute of Child Health was only established as a branch of the University of London at the end of the Second World War. The Institute was initially housed in just one room in the hospital's Southwood Building, and did not obtain its own premises until the present building was opened on Guilford Street in 1965.

INSERT PIC of the door and old guy



Our Technology priority: We will transform care and the way we provide it through harnessing technology.

We are continuing on our journey towards a more ambitious digital future, transforming the way in which our patients and families experience our services. Through enhanced technology across our hospital, we will ensure we have the facility to improve our productivity and patient outcomes. For example, DRIVE has increased our focus on digital research, innovation, and other technologies. Through these technological improvements, we remain committed to ensuring the integrity and safety of all our data.

In 2018/19 we successfully harnessed technology in the following ways:

Objective	Achievements
Become a digitally mature organisation, radically transforming patient, family and staff experience of our services.	<ul style="list-style-type: none"> • The GOSH DRIVE opened in October 2018. Collaboration with UCL Computer science, industry partners and Health Data Research UK has seen a large number of innovative projects being run through the unit.
Ensure rapid uptake of the latest clinical and non-clinical technologies to improve patient outcomes and our productivity.	<ul style="list-style-type: none"> • We are continuing to invest in our cyber defences with state-of-the-art systems designed to detect and thwart attacks. • The DRE continues to mature and has been cited in numerous external reports as an exemplar for how to manage patient data for research.

Electronic Patient Record

We launched our Epic Electronic Patient Record (EPR) on 19 April 2019. Deployment of the EPR is a critical and core requirement to move towards being a digital hospital. This will enable improvements in quality of care, operational efficiencies, and development of new models of care and treatments. It will improve communication with our families and patients, and implement a platform to enhance innovative research and enhanced analytics. The potential benefits are enormous, and an immense amount of work has taken place across the Trust in 2018/19 to develop this and ensure operational readiness. The EPR will:

- **Improve communication with our families and patients.** The patient portal will transform the way we communicate with patients and families, empowering them to plan and manage their own care.
- **Allow us to improve patient experience.** As well as releasing additional 'time to care', traditionally manual processes will become more automated and digital, allowing us to engage more widely with families meaning we will be better informed about patients' preferences, and patients will be fully aware of the next steps in their treatment plan.
- **Provide better decision support and care pathways, reducing unwarranted clinical variation.** We will design and embed standard treatment protocols and best practice guidance within the system, enabling clinicians to become more efficient in the way they administer day-to-day patient care.

Digital Research, Informatics and Virtual Environments (DRIVE)

DRIVE is GOSH's new Digital Research, Informatics and Virtual Environments unit, which will foster collaboration between GOSH, academic colleagues in UCL and leading industry experts in technology and digital innovation.

The space houses the latest technologies including artificial intelligence, virtual reality and facial recognition. It aims to develop novel ways of working and transform clinical practice and patient experience, not only for GOSH patients but across the NHS.

The aim is to use technology and data to provide safer, better care that is clinician-focused and patient-centred. DRIVE provides the capability to develop scalable solutions to improve healthcare. GOSH patients are digital natives, which means they and their families are early adopters of technologies. They will naturally embrace the new devices and apps the unit develops. These young people are our future in so many ways – and of course the future patients of the NHS for the next 50 years.

Projects that have already come through DRIVE and are being used within the hospital to help with patient outcomes and experience include:

- Project Fizzyo, which is helping researchers look at how physical activity and airway clearance relates to changes in the health of children with cystic fibrosis, using chipped sensors inside airway clearance devices.
- Through DRIVE, the whole of GOSH has been recreated in a Minecraft world where patients are able to virtually explore before they visit the hospital and virtually meet and befriend other patients who are at the hospital to help improve their patient experience.

Insert Pic of Drive and the logo

Becoming a digitally mature organisation

Following the agreement of the digital strategy in 2017, we continued to work on improving our overall digital maturity. We have made tremendous progress in supporting infrastructure, governance and readiness in preparation for the move to the full EPR next year.

EPIC is going to change the way the organisation develops in ways that we cannot imagine at the moment, as the use of the new system matures and we start to analyse the rich data that it provides we will find more and more ways of improving the hospital.



Our Voice priority: We will use our voice as a trusted partner to influence and improve care.

GOSH cares for more children with rare and complex conditions than anywhere else in the UK and most of Europe, together with our research partnership with the UCL Great Ormond Street Institute of Child Health. The reputation and reach of the organisation combine with a powerful brand that is carefully cultivated by our charity partners to support essential fundraising for research, equipment, buildings and patient experience.

We aim to use this profile responsibly to draw attention to the issues that are important to our patients, families and staff and advance a wide range of causes that will support them in fulfilling their potential.

Objective	Achievements
<p>Use the voice of GOSH to promote issues that directly affect the children and families who need us the most.</p>	<ul style="list-style-type: none"> Featuring patient stories regularly across our own communication channels and in partnership with media and production companies is a powerful way to connect GOSH with the general public. Programmes like <i>Paul O’Grady’s Little Heroes</i>, which tell these stories and offer wide benefits. They can help to reassure a family who is due to attend an appointment. They can demonstrate the value of the care we offer to funders and policy makers. They can improve staff morale. In September 2018 we joined forces with NHS Blood and Transplant to highlight the importance of organ donation. We released a touching video of patients on the waiting list for organs singing and signing a specially–written song alongside the families and staff that care for them.
<p>Play a leading role in the UK system and International Children’s Alliance, and to ensure our networks across the UK best serve the patient’s needs</p>	<ul style="list-style-type: none"> Memberships of various national and international partnerships and organisations including UCL Partners; North Central London Sustainability and Transformation Partnerships (STP), Children’s Alliance, administering the North Thames Paediatric Network for Specialist Paediatric Services, European Children’s Hospital Organisation (ECHO) (see page XX).

Paul O’Grady’s Little Heroes – A unique insight into GOSH

Photo: Paul and Mackenzie

In this ITV series, which premiered in August 2018, Paul O’Grady brought his unique blend of warmth and humour to the hospital as he met a number of children from all corners of the UK. Each 30-minute episode focused on 2–3 children and their journey through their specialist and pioneering treatment.

In the first episode Paul got a glimpse of pioneering surgery after meeting 13-year-old Mackenzie (pictured) who was at the hospital to have his ear reconstructed after being born with Microtia. The condition means those affected are born with a small ear that doesn’t develop properly.

The second series which will air in summer 2019 on ITV.

Campaigning for the issues that matter to our patients, families and staff

The GOSH calendar is packed with activities that celebrate, educate and raise awareness of the issues that matter to our staff, patients and families. For example:

- Each year in February we mark Rare Disease Day to highlight the collective impact that this group (of over 6,000 conditions) has on our patients. We celebrate research and clinical progress in diagnosing and treating paediatric rare diseases. This day is also a chance to raise awareness of specific conditions.
- In March 2018, Jim Blair, Consultant Nurse, Intellectual (Learning) Disabilities took over the @NHS Twitter account to highlight important issues faced by children and families.
- Celebratory events and communications activities were also arranged to celebrate International Nurses Day, National Play Day, Restart a Heart Day, Children’s Takeover Day, Nutrition and Hydration Week and many more.
- GOSH is also fortunate to be able to welcome influential and high-profile visitors to the hospital to mark significant national milestones. During National Apprenticeship Week in March 2019 we were delighted to welcome the Rt Hon Stephen Hammond, Minister for Health, met with GOSH apprentices, visited some of our families and discussed workforce and funding issues with our Chair and Chief Executive.
- Secretary of State for Health and Social Care, Jeremy Hunt, visited GOSH on Thursday 29 March 2018 to talk to staff on the topic of patient safety and recognise their effort in this area. He was accompanied by Professor Russell Viner, the newly elected President of the Royal College of Paediatrics and Child Health. They were greeted by seven-year-old patient Shiloh, who has Cystic Fibrosis and has been treated at GOSH since she was 18 months old.

Working in partnership with the wider healthcare system to improve quality and access and expedite discovery

As a specialist paediatric hospital with a national and international footprint GOSH has a responsibility to work in partnership with the wider healthcare system to share innovation

and best practice and develop the system architecture that is essential to improve things for children with complex health needs, wherever they access their care.

As a community of healthcare leaders, our people are represented across hundreds, if not thousands, of regional, national and international committees – evidence of their passion for learning from others, sharing their own knowledge and working collaboratively towards solutions.

During 2018/19 our clinicians were able to contribute to raising awareness of some essential child health debates. They shared their knowledge to help ensure balanced media reporting and well-informed academic and policy statements. For example:

- Professor Helen Cross, a consultant in paediatric neurology and the Prince of Wales' Chair of Childhood Epilepsy, was able to inform the public debate on the safe use and benefits of cannabidiol (a drug derived from cannabis) for children with epilepsy, based on ground-breaking clinical trial evidence. Her findings were shared in a public statement on our website in June 2018. Helen has since taken part in several media interviews, spoken at conferences and presented evidence to the Health Select Committee in March 2019.
- GOSH's new DRIVE Unit featured in a Government 'state of the nation' report on the future of technology in healthcare (see page xx).

The GOSH Chief Executive is a member of the UCL Partners (UCLP) Board. This academic health science partnership works to transform the health and wellbeing of the population. UCLP involves more than 40 NHS, social care and academic organisations across north and central London, south and west Hertfordshire, south Bedfordshire and south west and mid Essex. It has made significant progress during 2018/19 in supporting the adoption and spread of new products and pathways, building improvement capability and highlighting the successes of its vibrant clinical research community. Together with the UCL Great Ormond Street Institute for Child Health, GOSH hosts one of UCLP's six specialist programmes – or Academic Medical Centres (AMCs), which advance pan-London collaborative research initiatives on child health and supports shared learning.

Regional partnerships to deliver on the NHS vision for integrated care

The NHS Long-Term Plan, published in January 2019, set out an ambitious ten-year vision for the health system in England that consolidates previous calls for a greater focus on out-of-hospital care and services to be designed around patient needs rather than institutional boundaries. The intention is that regional partnerships of NHS organisations and local councils (known as Sustainability and Transformation Partnerships) will develop into Integrated Care Systems that will have more control over how the care for their local population is delivered and how NHS resources are distributed.

Although just 4% of GOSH patients come from within the North Central London Sustainability and Transformation Partnership, national policy direction means that our contribution to this local network is very important. GOSH participates in several of its committees, looking at issues including procurement, leadership of transformation, nurse leadership and workforce.

During 2018/19 GOSH has led on the development of an important new network looking at paediatric service delivery across North London. The North Thames Paediatric Network for specialist paediatric services is administered by GOSH. It brings together specialist providers and district general hospitals to improve access and outcomes for children across the care pathway.

National system leadership

GOSH is part of the UK Children's Hospitals Alliance – a group of children's hospitals across the UK that includes Alder Hey, Birmingham, Southampton, Manchester, Evelina London, Leeds, Sheffield, The Great North Children's Hospitals and Bristol Royal Hospital for Children. The group acts as a unified voice advocating for children and young people's services and runs a variety of projects to share learning, innovation and best practice.

A group of finance experts from the Alliance hospitals has been working with the pricing team at NHS England and NHS Improvement on a review of tariffs and payments. Their aim is to work towards a budgeting framework that better reflects the complexities and high cost of care for children with complex health needs. This will safeguard services and improve the financial sustainability and viability of specialised children's hospitals.

In February 2019 GOSH was delighted to invite members of the Alliance, along with other partners across the UK, to the first ever Children's Hospital Education Specialist Symposium (CHESS), a national one-day forum championing paediatric education. Opened by Camilla Kingdon, Vice President at the Royal College of Paediatrics and Child Health, the event covered the opportunities and challenges for specialist paediatric education and multidisciplinary ways of working. Delegates and speakers came from a range of disciplines including general paediatric, nursing, allied health, healthcare science, surgery, and anaesthetics.

Learning and sharing with experts from around the world

GOSH is a founding member of European Children's Hospital Organisation (ECHO), a partnership of 10 of the foremost specialist paediatric hospitals in Europe. During 2018/19 the organisation created a governance structure and strategic framework which lays out priority workstreams and shared goals. ECHO's Quality, Safety, Outcomes and Value working group has established a project to benchmark clinical outcomes and work is underway to develop a shared statement on the rights of children in hospital.

GOSH clinicians participate in a number of the European Reference Networks (ERN), which are European Commission-funded partnerships seeking to improve access, diagnosis and outcomes for rare disease patients across Europe. Professor Helen Cross is the coordinator for EpiCARE, the ERN which brings together 28 highly specialised centres in 13 European countries, which are collaborating on care, research, education and training to benefit patients with rare and complex epilepsies.

In October 2018 GOSH hosted a transatlantic knowledge-sharing conference. This was attended by delegations of healthcare leaders, clinician-scientists and donor families from the children's hospital communities of Seattle Children's Hospital, Rady Children's Hospital, San Diego, the National Children's, Washington DC and Benioff Oakland Children's

Hospital, California. The programme featured presentations and networking events to inspire philanthropy, collaboration and debate to advance innovation in children's healthcare. It was developed as a result of GOSH's participation in the Children's Hospital's International Executive Forum.

Consulting and engaging with patients on the quality of their care

The Young People's Forum (YPF) is a group of current and former patients who have left within one year (aged 10 to 21), who guide and support the hospital on a range of topics and issues, ensuring that any changes or developments align with the users of the services. Further information about the work of the YPF can be found on page XX.

The YPF has been given specific roles in the recruitment processes of Board members. This direct approach has allowed the voice of the patient to be heard and considered by recruitment panels, giving patients the power to influence the future workforce of the hospital. Having young people involved in recruitment ensures that candidates who are selected have personal skills and qualities that suit the needs of children and young people as well as the competencies required by the Trust.

The YPF assisted the recruitment of the following roles:

- Chief Executive
- Chief Finance Officer
- Non-Executive Director (legal portfolio)
- Non-Executive Director (social work portfolio)

Insert Pic of YPF panel for NED interviews



Our Spaces priority: We will create inspiring spaces with state-of-the-art equipment to enhance care delivery and learning.

We are committed to creating world-class, leading facilities for patient care and research including cutting-edge equipment.

Below is a summary of how we have enhanced our spaces at GOSH in 2018/19:

Objective	Achievements
Be recognised as the most environmentally sustainable healthcare provider in the UK with all staff recognising their stewardship role.	<ul style="list-style-type: none"> In March 2019 GOSH and Global Action Plan launched the first ever Clean Air Hospital Framework (CAHF), a strategy aimed at improving air quality in and around hospitals in order to create a healthier environment for patients and their families, staff, and the local community (see page XX).
Maximise our hospital site’s potential to meet the current and future healthcare needs.	<ul style="list-style-type: none"> The Zayed Centre for Research into Rare Disease in Children is due for completion in 2019/20. The Italian Hospital on Queen Square is being developed into the Sight and Sound Centre for GOSH with visual or hearing impairment (see page xx).
Provide our clinical teams with the equipment they need to deliver cutting-edge care to our patients.	<ul style="list-style-type: none"> The Zayed Centre for Research into Rare Disease in Children includes a dedicated facility comprising seven ‘cleanrooms’ where gene and cell therapy medicinal products can be made to treat children compassionately or on a clinical trial. Started construction on the Southwood Courtyard Building which will house an interoperative MRI (iMRI) scanner and operating theatre. The iMRI facility will allow surgical teams to ensure that they have performed the correct intervention and will reduce repeat operations for children undergoing neurosurgery including epilepsy surgery. The building will also provide new clinical facilities for our physiotherapy teams including a new gym and gait analysis room.

Zayed Centre for Research into Rare Disease in Children

The construction of the Zayed Centre for Research into Rare Disease in Children has continued with Skanska and is set to complete early in 2019/20.

The Zayed Centre for Research into Rare Disease in Children will bring clinicians and scientists together to develop our understanding of rare paediatric diseases and rapidly translate findings into new treatments. It will provide outpatient clinic space, research laboratories and 'cleanrooms' licensed to create specialist products for treatments and clinical trials.

The facility will be transformational in terms of the space for clinicians and researchers to progress their work, which will ultimately transform lives. The building communicates this work through the integration of art work celebrating team work, AI and robotics. Children and young people will have their own laboratory benches in outpatients to explore some of the key research themes. Twenty-one consulting rooms provide extensive accommodation for patients and their families. Three floors of smart workspace, including a café and garden, supplement the clinic and laboratory space and provide the ideal environment for collaboration and interaction.

ADD Picture of Zayed Centre

Sight and Sound Hospital at GOSH

Work is underway to convert the Italian Hospital on Queen Square into an exemplar Sight and Sound Centre for GOSH with visual or hearing impairment. This project, supported by Premier Inn recreates the 'grand house on the square' as requested by the Expert Patient Group, who has been embedded in the design process.

Children's Cancer Centre

In December 2018 it was confirmed by the GOSH Trust Board that the scheme previously referred to as Phase 4 would be known as the Children's Cancer Centre at GOSH. This ambitious project will provide all the inpatient, day care and outpatient space required for this service. It will also create an exciting and first of kind Children's Medicine Centre at GOSH. This will replace the highly successful hospital school accommodation and provide a new and fitting main entrance for the hospital. It is due to open in 2026/2027.

Disney Reef

The Disney Reef, a colourful, underwater-themed outdoor play area, was unveiled in June 2018. Positioned in the heart of the hospital, designed by Walt Disney Imagineers, the Disney Reef was created in collaboration with the hospital's dedicated Play Team and patients. It was born as the result of Disney UK's multi-year partnership with Great Ormond Street Hospital (GOSH) Children's Charity. It was inspired by Walt Disney's first visit in 1951 and is a part of The Walt Disney Company's recently announced global commitment to reimagining children's patient journeys in and out of hospitals.

Photo – Elliott/Tess

The GOSH estate in 1948

The hospital became part of the NHS in a physically battered state in 1948. The major rebuild programme in the 1930s had been curtailed by the Second World War. The new main clinical block (today's Southwood Building), opened in 1938, had its western wing gutted by bombing in September 1940, and the planned new outpatient wing had only been completed to basement level. The basement had been used as a casualty clearing station for local Blitz victims during the war. The two original Victorian clinical blocks, dating from 1875 and 1893 were still in use, but already very shabby. The 1893 block, today's Paul O'Gorman Building was also blast-damaged.

Insert PIC of POG building

Sustainability report

We continue to develop our spaces to provide a holistic therapeutic environment supporting our patients, families and staff. Our priorities not only include the design and provision of clinical spaces but also support services which contribute to the overall hospital experience and a consideration of the wider environment.

Having been a founding supporter of National Clean Air Day we have taken the next step to delivering solutions that will improve air quality by launching the world's first Clean Air Hospital Framework (CAHF) for use across the health sector. We are also in the process of updating our overarching Sustainable Development Management Plan (SDMP) with the latest guidance from NHS Improvement so that GOSH can deeply integrate sustainability into our culture, practice and training. However, our holistic vision does not stop there and includes a focus on reaching outwards. We do this through sharing practice and partnering with others, linking with academic institutions to study topics including climate adaptation, to design research projects or run community activities. Overall, we intend to test the boundaries of what's possible and our influence in this crucial arena.

This approach is supported not only by our Board and staff but by our children and young people, reminding us of our guiding principle of 'the child first and always'.

Who's accountable?

Progress against our SDMP and CAHF is reported to our Executive Management Team and Operational Board as well as our Board of Trustees on an ongoing basis. Active support for this agenda is being harnessed within clinical teams, through our Green Champions network, contractors, external partners and patient's through our YPF and Play Services.

Our context: Using information and data

During 2019/20 to expand our information gathering with relevant stakeholders in order to plan and deliver our sustainability ambitions through our SDMP.

This year GOSH developed a travel plan that committed us, over the next five years, to all but eradicate staff commuting in cars. We are also committed to reducing staff use of the underground by 5% in favour of walking and cycling. We will reduce single occupancy visitor car use by 6% and increase public transport use in its favour. A new yearly staff survey will measure this. The development and ongoing delivery of our CHAF) involves regular dialogue

with stakeholders including our Young People's Forum, Executive Management Team and Boards as well as the local community. For example, beyond face to face contact through staff, we will use our patient bedside displays to engage with patients about air pollution and wider sustainability.

We will enhance the existing process, analysis and use of data around utilities consumption and will begin to use our imminent supply of air quality data to inform decisions and messaging wherever possible.

Stakeholder engagement

To successfully deliver our ambitious sustainability agenda we'll enhance existing relationships with partners. GOSH teams and leadership, Green Champions network, volunteers, patients and families, contractors, health sector and academic peers, Camden Council, NHS bodies, specialist businesses and third sector organisations, our local community and central government are all key to this.

Barriers and challenges to overcome

Ever increasing energy demands and costs mean that we need to continue broadening our scrutiny of energy procurement, energy efficiency investment and renewable energy innovations.

Poor local air quality in our central London location presents a challenge and opportunity to work collaboratively on improvements to protect our staff, patients and the local community.

An unstable national waste processing market continues to highlight vulnerability across NHS trusts, necessitating an increased need for collaboration around innovation and security.

Development of our staff Green Champions and the creation of a young person's programme will be important for the success of our sustainability agenda over the years ahead. Increasing reach and relevance will enhance the effectiveness of this important driver of the change we are planning.

Taking further ownership of our Scope 3 (indirect) emissions via our procurement framework is an important challenge and opportunity for the year ahead.

Embedding these into our SDMP and connections to the UN Sustainable Development Goals gives us the framework to progress and lead the sustainability agenda.

Structure

The backbone for demonstrating our progress is our SDMP and CAHF reporting into the Trust Executive Management Team and Board. Delivering it in concert with staff and young people is key to its integrity. We support local and national programmes including the London Borough of Camden Clean Air Action Plan which we are named as leaders within, the London Mayor's Breathe London Project, Camden 2025 commitments, National Clean Air Day and NHS Sustainability Day.

Further integration

We will further integrate sustainability throughout the Trust via continuation of ‘Gloves are off’, which this year has produced a staggering reduction of 2.1 million plastic gloves purchased (and associated environmental impacts) since last year. We will investigate delivering a Green Wards Competition supporting staff identification of everyday process efficiencies that result in environmental and financial savings. We are also considering activity around optimisation of energy use in theatres, a specific Green Nephrology programme and delivering a broad green communications strategy.

The Clean Air Hospital Framework

This year GOSH staff worked with Global Action Plan to develop the Clean Air Hospital Framework.

The World Health Organisation (WHO) and UK Government recognise air pollution as the largest environmental health risk we face. It causes heart and lung diseases, is linked to mental health issues, low birth weight and effects on children’s lung development. It is estimated to cause 36,000 deaths in the UK every year.

Action in hospital is particularly important as pollution has a detrimental effect on patients. The CAHF is a free resource conveying the vision of a clean air hospital and steps to achieving it, including methods to reduce the pollution hospitals create and messages to help people protect their health. Hospitals are able to self-assess their progress against seven elements. They can develop an action plan to benefit the health of staff, patients, visitors and the local community. They can also assign ownership and track/report progress, including their ability to mobilise others.



CAHF’s development involved workshops across the Trust, including our Young Person’s Forum, contractors and external stakeholders, including the WHO, NHS Improvement and NHS England, the NHS Sustainable Development Unit, Royal College of Physicians, Royal College of Paediatrics and Child Health and London Borough of Camden.

Trust teams and external partners are organising a GOSH clean air play street locally and with a specialist partner, we're designing research around home indoor air quality impacts on patient health. We're installing outdoor monitoring equipment through the Mayor's Breathe London project and trialling indoor monitors and purifiers in some communal areas.

The CAHF uses a points system. GOSH's baseline score in February was 158 points –rated as a hospital that is 'starting out', and we are targeting 540 points, rated as 'Good', within 18 months.

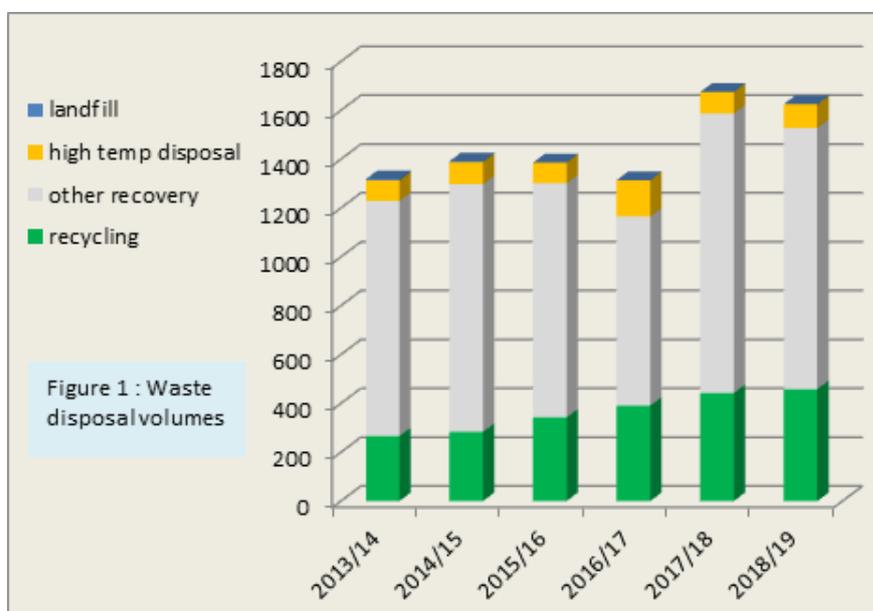
Waste minimisation and management and the GOSH Green Champions:

It has been a successful year for the Green Champions, who have implemented initiatives to reduce, reuse and recycle bulk waste including an innovative online platform to redistribute it. Items suitable for reuse are offered to staff, supporting GOSH's 'Zero Waste' strategy and budget savings through unnecessary new purchases. Remaining items are passed to charity and social enterprises for reuse or to assist fundraising for their core work.

We are also working with an upholsterer upgrading existing furniture and furnishings to 'as new' standard at a significant reduction to a new purchase cost. The total savings from this scheme was £6,775.

The Green Champions were given a Green Apple environmental best practice award for our furniture restoration process at the Houses of Parliament.

Last year 1,625 tonnes of waste was produced in the Trust, an increase of 9%. Figure 1 shows the volume of wastes and destinations. Recycling continues to rise this year with an increase of approximately 42%. Waste sent to landfill is slightly up this year at just over 1 tonne, due to an overall increase in waste produced. It is still our aim to achieve zero waste sent to landfill, and we continue to work towards this target. Waste sent to 'Other Recovery' has reduced due to an audit and engagement programme conducted this year around better staff segregation of clinical waste.



	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Recycling	265.8	283.02	342.03	390.02	442.67	458.46
Other recovery	963.4	1014.2	958.95	774.93	1144.07	1068.97
High temp disposal	83.52	91.29	84.39	147.98	87.71	96.94
Landfill	6.03	2.88	0.99	0.99	0.99	1.36

It has been a challenging year in the clinical waste industry, threatening service resilience GOSH is working with partners to identify clinical, hazardous and sharps waste innovation opportunities.

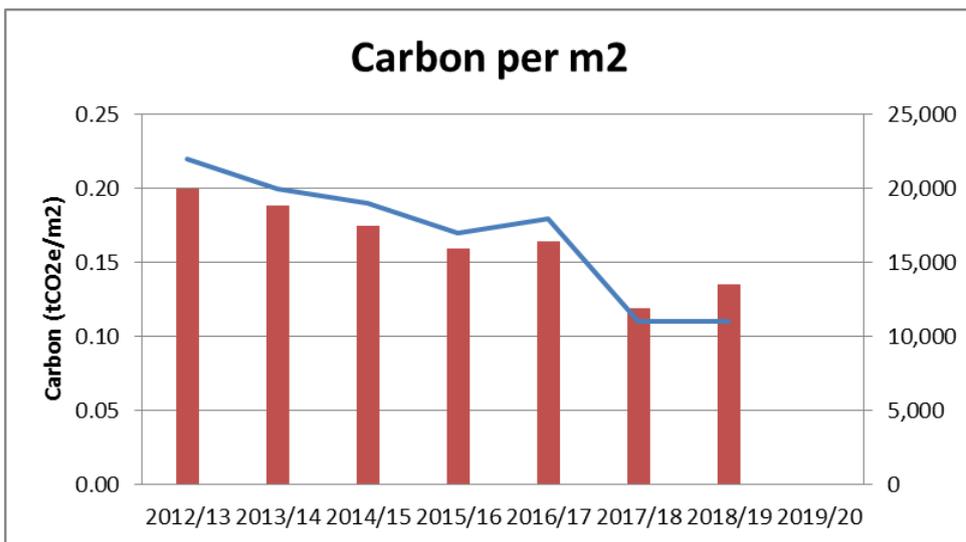
CO₂ emissions

Our environmental impact is proportionate to staff numbers and building floor space. The table shows floor space relatively unchanged for four years. It has increased by 14,045.67 m², due to the Premier Inn Clinical Building (PICB) opening last year and staff numbers have risen to 5,045.

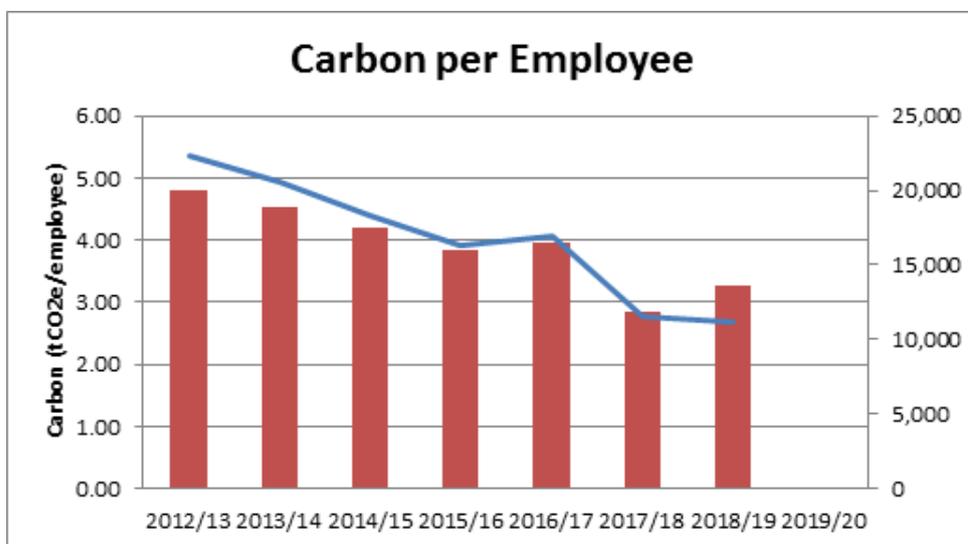
Context Info	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Direct Emissions (tCO₂e)	19,947	18,836	17,448	15,950	16,468	11,893	13,547
Floor Space (m²)	92,199	92,125	93,752	92,501	92,501	111,913	125,959
Total number of staff (headcount)	3731	3900	4082	4123	4436	4787	5045

This data has been used to normalise direct emissions and compare against our 34% reduction target by 2019/20. Below shows that we retain an on-target profile despite estate changes. The organisation is normalised by floor space and slightly better when normalised by employee number. The percentage reduction for each year is shown in the corresponding bar below.

The percentage tCO₂e change for each year is shown in the corresponding bar below.



Normalised direct emissions – tCO2e by m2 (LHS), line shows reduction glide path



Normalised direct emissions – tCO2e by employee, line shows reduction glide path

The increase in normalised carbon emissions is due to opening the Premier Inn Clinical Building and a significant reduction in electrical output from the Combined Heat and Power (CHP) plant against full potential. Electrical infrastructure issues requiring six months main CHP downtime led to grid electricity imports and therefore greater carbon emissions.

The remainder of this report uses figures that have been compared directly to the previous years, with no normalisation for floor area or staff numbers, so the year-on-year changes can be clearly seen.

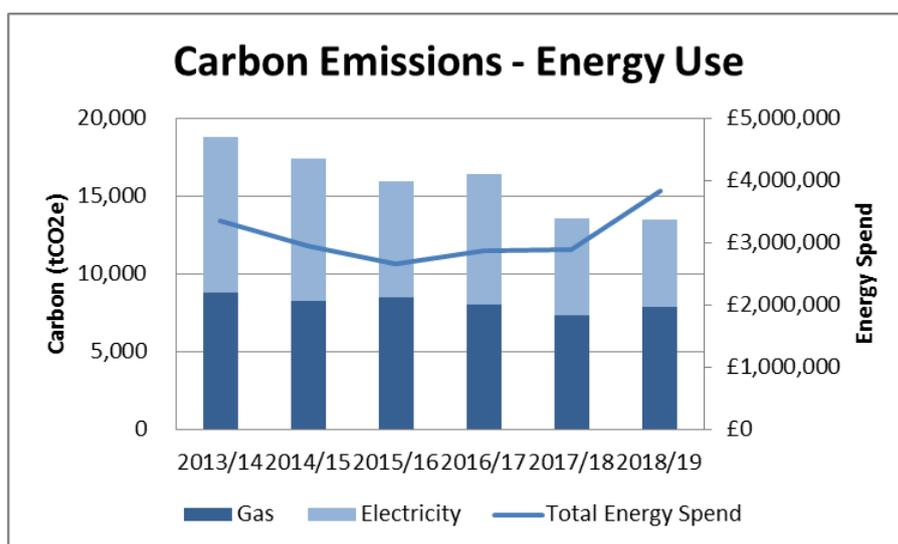
Energy use

This looks at carbon emissions from energy, total energy spend and a view of energy type used. The biggest change to the Trust usage profile is the CHP engine installation at the end of 2011, which significantly changed the proportions of gas and electricity used by the Trust. In 2018/19 the engine generated 39% of electricity requirements but consumed natural gas to achieve this.

Below shows we spent £3,847,204 on energy in 2018/19, an increase from the previous year. This is due to PICB using more electricity due to it becoming fully functional in 2018/19 compared to 17/18 as well as the six month CHP downtime. This meant relying on higher cost grid energy and therefore higher utility costs than expected. Additionally before final decommissioning, our Enpod energy centre was also offline for four months. Therefore, there were higher utility costs than expected.

As a result we experienced a significant reduction in onsite electricity generation (from 10,643 Mwh to 7,746 Mwh) which was replaced by grid electricity down and an increase in gas use. We were also unable to realise the benefit of the CHP and the loss in heat generation from it, which is typically used to run our chillers. This and the high ambient summer temperatures resulted in using further grid electricity.

With the CHP back online and the decommissioning of Enpod, an increase in electrical power and decrease in gas volume should normalise our energy use going forward. Operation and maintenance costs for the CHP engine are still incurred while it is offline.



Resource		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Gas	Use (kWh)	41,492,485	39,444,385	40,657,465	38,603,045	39,587,133	42,929,340
	tCO2e	8,802	8,276	8,530	8,068	7,335	7,897

Electricity	Use (kWh)	27,649,236	25,675,114	24,828,164	27,087,839	22,042,240	19,961,112
	tCO ₂ e	9,993	9,172	7,441	8,400	6,262	5650
Total energy tCO₂e		18,795	17,448	15,971	16,468	13,957	13,547
Energy Spend		£3,360,678	£2,952,472	£2,663,725	£2,881,300	£2,900,919	£3,847,204

Last year 7,746 Mwh of electricity was generated from the CHP engine, equivalent to 39% of our total site electricity usage compared to 48% the year before. The site did consume all the generated electricity, reducing carbon emissions from the use of grid power. However, this was only half the reduction projected, due to the CHP outage.

Generated electricity from the CHP is shown below. It produced significantly less electricity than last year due to the six-month outage this year (7,746Mwh compared to 10,643Mwh) compared to only two months last year.

Output of 10,500– 12,000 MWh per year depending on performance and maintenance requirements is expected. In March 2019 we installed a second CHP which will further reduce energy costs next year.

Our 37kWp of photovoltaic cells are now functioning to capacity since the removal of shading caused by Variety Club Building chiller scaffolding.

[Sustainable Development Management Plan \(SDMP\)](#)

Our new SDMP is near completion and will form the basis of our reporting structure for 2019/20 and beyond. Actions to progress it are based on the three factors of Environmental, Social and Financial impact which are contained under 10 areas of focus. These include our Corporate Approach, Asset Management and Utilities, Travel and Logistics, Adaptation (to future climatic conditions), Capital projects, Green Space and Biodiversity, Sustainable Care Models, Our People, Sustainable use of Resources and Carbon and Greenhouse Gases.

We will consider each in relation to four cross cutting themes – our governance and policy, GOSH’s core responsibilities, our procurement and supply chain and working with our patients, staff and local communities.

[Creating healing environments](#)

Working with UCL Centre for Resource Efficiency and the Environment we were the industry partner for five Masters Level Environmental Engineering and Science students. Their focus is, “*Climate change pressures on the built environment in the UK: Implications for well-being of sick children and mitigation strategies for the Great Ormond Street Hospital*”. This resulted in individual technical reports based on the design of our proposed Children’s Cancer Centre development. These covered internal air quality, ventilation, building envelope, water harvesting and indoor temperature control. The students combined these into a joint report helping to guide our thinking on climate change adaptation for future new developments.

We're also investigating research opportunities around access to natural light and virtual reality experiences in wards.



Our Information priority: We will provide timely, reliable and transparent information to underpin care and research.

Objective	Achievements
<p>Develop the Business Intelligence Unit to be the single integrated source of accurate, timely and reliable performance data (incorporating operations, finance and workforce).</p>	<ul style="list-style-type: none"> • Close working across multiple Informatics teams to an aligned work plan and set of principles supporting the EPR implementation. • Following implementation of the EPR a formal review is underway to develop an aligned vision and framework to deliver consistent and robust information throughout the Trust.
<p>Create a comprehensive, unified electronic single patient record, providing the single reliable source of clinical data to maximise staff productivity and deliver excellent care.</p>	<ul style="list-style-type: none"> • System design, configuration, testing and training was completed in 2018/19. • The vast majority of the system build related to EPR was completed in 2018/19. • The EPR System went live successfully in April 2019 (see page xx).
<p>Combine advanced analytics with a comprehensive set of data to inform and improve care for our patients.</p>	<ul style="list-style-type: none"> • Industry links have been developed with leaders in the field including Samsung and Microsoft. • Formal opening of the DRIVE Centre in 2018/19. • Go live of the Digital Research Platform to support the data and informatics needs of the organisation, supporting improved children’s care. <ul style="list-style-type: none"> • An example of a project is the whole of GOSH has been recreated in a Minecraft world (see page xx).

Centralised Business Intelligence Unit (BIU)

GOSH aspires to be a world class organisation; therefore it must aspire to have world class information. The Trust has been on a digital journey over the past few years, including the establishment of the EPIC EPR and DRIVE. Information is the life blood of any organisation and good quality accurate data used by skilled staff is crucial to the delivery of effective and safe patient care and the running of a sophisticated and progressive organisation. World class information supports world class patient care, information can be used to run our

services efficiently including timely access to services as well as flagging care quality issues and predicting trends in order to take early action.

The establishment of a Centralised Business Intelligence Unit is a core to this, to ensure that the Trust has robust and consistent information throughout the organisation, ensuring that all informatics professionals are working from consistent systems, agreed processes and an established governance framework. Following the implementation of the EPR system, a formal review of the current processes will be undertaken to ensure that we have an aligned vision and structure across the organisation to meet the requirements of GOSH. The approach will be rolled out to all areas, including operations, finance and workforce teams.

Advanced Analytics

Our clinical and managerial operations are complex and in many cases we want to know why certain things happen and if they will happen again, which is why we want to move beyond analysis and understanding the past, to strengthening our analytics (e.g. knowing why demand has grown, if patients will continue to wait longer than usual for treatment, and if their future experiences can be improved through specific service changes).

Therefore, through our proposed BIU, new systems like EPIC's EPR, cloud-based research platforms, Digital Research Environment, and Digital Research, Informatics, and Virtual Environment unit (DRIVE) we will have access to tools, models, artificial intelligence, and partnerships that will allow us to focus on projecting future trends, events, and behaviours. The DRE and DRIVE units have allowed us to develop industry links with leaders in the field including Samsung and Microsoft and we hope to revolutionise clinical practice and enhance the patient experience, not only for GOSH patients but across the wider NHS (see page xx).



Our Funding priority: We will secure and diversify funding so we can treat all the children that need our care.

Financial sustainability remains a key challenge for NHS organisations particularly in specialist services where real-term funding continues to decrease alongside increasing costs and medical and technological advancements. We continue to review our cost base and look for new ways to deliver efficiencies whilst ensuring high clinical standards and patient and family experience.

Objective	Achievements
<p>Develop and negotiate a funding model which reflects the true cost of care, the new collaborative clinical pathways, and allows capacity to be flexed for variable levels of demand.</p>	<ul style="list-style-type: none"> • Continued to refine the long-term (i.e. five year) funding model linked to agreed strategic revenue and capital initiatives. • Finalised a local pricing review to support the business’s understanding of the risks within its funding model and contract pricing. • Detail modelling of future NHS tariff proposals to understand the proposed impact on services and linked with the Children’s Alliance to develop further understanding of the different regional funding mechanisms • Worked with commissioners to develop funding models for new services in year • Partook in the national pilots for Patient Level Costing (PLiCs) and education and training reference cost to support their mandatory introduction in future years • Scored 1 for finance and use of resources under NHS Improvement’s Single Oversight Framework
<p>In conjunction with GOSH Charity, maximise value and impact of charitable funding in support of the GOSH strategy.</p>	<ul style="list-style-type: none"> • Worked with the GOSH Charity to develop a prioritisation process aligned to both organisations strategies to enable medium to long term investments that will maximise value for money and impact. • Completed the medical equipment replacement plan to ensure the most effective investment of funds. • Actively linked and liaised with the GOSH Charity around investment in the Children’s Cancer Centre

<p>Develop and grow new sources of commercial income within the UK and internationally by making the best use of our specialist expertise in patient care, education, diagnosis and research.</p>	<ul style="list-style-type: none"> • The organisation has successfully continued to grow private patients with a focus on new UK and international markets, whilst identifying education and research opportunities, including fellowships. • Work continues to ensure the organisation gets maximum benefit from any Intellectual Property it may develop
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GOSH funding model

For many years the Trust has received income from a variety of sources that has enabled it to provide high quality of care to Children and Young People with complex and rare diseases. Unfortunately NHS funding alone has not enabled the totality of these costs to be covered. In 2018/19 alternative funding sources over and above NHS Income (£377m) included:

- Contribution from private patients
- Commercial Research
- Investment from the GOSH Charity in the hospitals infrastructure enabling the estate and equipment to be of much better quality/experience for the patient, families and staff
- The Charity funding services over and above those in the NHS service specification that enable an improved patient experience e.g. parent accommodation, chaplaincy, Play Service

In 2018/19 this approach has continued to enable the Trust to remain within financial balance and meet the financial and performance targets set by the NHS. However with step changes to NHS tariff in 2019/20 and beyond, this approach will become more challenging and will need to be continually reviewed.

Maximise value and impact of charitable funding

We continue to work closely with the GOSH Charity and have developed a prioritisation steering group which includes members of the Trust Board and Charity Trustees to ensure maximum impact and value for money from any investments made in the medium and long term.

International Private Patient Service

We are internationally-renowned for cutting-edge treatment of children and young people with rare and complex conditions. We worked with governments and other sponsors to welcome 5,034 children with 116 different nationalities last year, who access our services

from countries that lack the facilities and expertise to treat rare and complex paediatric conditions.

The International and Private Patient Service treated 1,113 inpatients and delivered 18,206 outpatient appointments, generating income of £63.3m in dedicated and funded facilities at GOSH in 2018/19.

We continue to explore new territories and diversify our offering, in order to continue the income growth seen in recent years needed to support NHS activities. We can assist in the training of medical and other clinical staff, assist with complex case diagnosis and treatment and help to develop research capability.

We are in discussions with overseas hospitals about collaborative opportunities, where we may enable these hospitals to develop their specialist paediatric services by accessing the expertise and experience which we can offer.

We have introduced, with world-leading clinical colleagues, novel therapies and treatments like Tisagenlecleucel (CAR-T cell) for treating relapsed or refractory B-cell acute lymphoblastic leukaemia and MRI Guided Laser interstitial thermal therapy (LITT or Laser Ablation) for treatment of epileptogenic lesions.

The international medical fellowship programme continues to be led by the service and provides overseas doctors the opportunity to receive sub-speciality training from us through one or two year fellowship appointments with clinical teams at GOSH. The success of this programme has been replicated in other clinical professions and we have developed and delivered the first senior nurse leadership training placement with positive feedback.

Procurement

In August 2018, the Trust joined SmartTogether, a procurement shared service hosted by Guy's and St Thomas's NHS Foundation Trust, which also includes Lewisham and Greenwich NHS Trust, Dartford and Gravesham NHS Trust, and South London and Maudsley NHS Foundation Trust. The procurement department is ranked second in the country in the latest version of the NHS Improvement Model Hospital Procurement League Table.

Since the transfer, GOSH has experienced a demonstrable improvement in procurement service standards including reduced turnaround times for processing purchase orders. A new catalogue has improved accuracy and streamlined processes leading to fewer invoice queries for Accounts Payable. The shared service provides an opportunity for GOSH to work in collaboration with Evelina Children's Hospital at St Thomas's to reduce price variation and deliver savings.

Over the next 12 months GOSH intends to complement its procurement transformation programme with further improvements to its materials management function and its electronic procurement system. These initiatives, together with the current work to reduce price variation and improve catalogue management align with the 2016 Carter Report recommendations.

Anti-bribery

We are committed to delivering good governance and have always expected our directors and staff to meet the highest standards of business conduct.

The Bribery Act 2010 came into force on 1 July 2011. The Act aims to tackle bribery and corruption in both the private and public sector. We are committed to ensuring compliance with the Act and have a zero tolerance approach to fraud, corruption and bribery.

We follow the Ministry of Justice guidance and NHS Counter Fraud service guidance to prevent and detect fraud, corruption and bribery and have robust controls, policies and procedures in place to prevent fraud, corruption and bribery. Our Local Counter Fraud Specialist can be contacted if members of staff have any concerns of fraud corruption or bribery.

Trust finances in 1947/48

The hospital's final annual report before joining the NHS for 1947/8 indicates that its annual expenditure was £268,301.7/3, with an additional £34,768.4/7 for the Tadworth Court 'Country Branch'. The total number of patients admitted to the hospital's 326 beds was 5,795. There were 39,454 new outpatients registered, and 131,513 individual outpatient attendances.

Statement from directors

The directors consider that this annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for readers to assess our performance, business model and strategy.

Signed by the Chief Executive on behalf of the Trust Board of Great Ormond Street Hospital for Children NHS Foundation Trust.

Mr Mathew Shaw

Chief Executive

XX May 2019

Accountability report

Directors' report

In this section of the accountability report we provide an overview of our governing structures. We outline how we ensure we are involving, listening and responding to the groups that have a stake in what we do, particularly our patients and their families, our staff and our members.

How we are governed

Our Trust Board is responsible for overseeing our strategy, managing strategic risks, and providing managerial leadership and accountability. Our Executive Team has delegated authority from our Board for the operational and performance management of clinical and non-clinical services of the Trust. It is responsible for coordinating and prioritising all aspects of risk management issues that may affect the delivery of services.

In 2018 a new directorate leadership structure was introduced to improve the clarity of lines of accountability, reduce the gap between Trust leadership and front-line services, and create attractive leadership roles within the Trust (see page xx). Our Operational Board, comprising members of the senior clinical and corporate leadership teams, reports to our Executive Team and provides a regular forum for discussing and making decisions on a range of issues relevant to day-to-day operational management, including quality, efficiency and effectiveness.

The Trust Board – who we are and what we do

The Board is normally comprised of a chair, deputy chair, senior independent director (SID), four additional independent non-executive directors (NEDs), and six executive directors. One of the non-executive directors is appointed by University College London.

Mr Chris Kennedy joined the Board as a non-executive director on 1 April 2018 and Ms Kathryn Ludlow joined as a non-executive director from 6 September 2018. From 31 May 2018 until the appointment of Ms Kathryn Ludlow, the Board comprised a chair and five non-executive directors, including one appointed by the University College London.

All Board members have been assessed against the requirements of the fit and proper person test.

Trust Board members 2018–19

Non-executive directors

<p>Sir Michael Rake FCA FCGI</p> <p>Term: 1 November 2017 – 31 October 2020</p> <p>Chair of the Trust Board and Council of Governors</p> <p>Attended 6 out of 6 Board meetings in 2018/19</p> <p>Chair of:</p> <ul style="list-style-type: none"> • Trust Board Nominations Committee (attended 1 meeting of 1 in 2018/19) • Council of Governors (5 meetings of 5 in 2018/19) • Council of Governors’ Nomination and Remuneration Committee (2 meetings of 2 in 2018/19) <p>Experience:</p> <ul style="list-style-type: none"> • Chairman of BT Group Plc until 2017 • Chairman (both UK and international), KPMG (2002–2007) • Chairman, Easy Jet (2009–2013) • Chairman Worldpay Group plc (2015–2018) • Chairman, Phoenix Global Resources • Chairman, NewDay Ltd 	<p>Insert image</p>
<p>Insert image</p>	<p>Mr Akhter Mateen</p> <p>Deputy Chair and Chair of the Audit Committee</p> <p>Term: 28 March 2015 – 27 March 2021</p> <p>Attended 6 out of 6 Board meetings in 2018/19</p> <p>Chair of Audit Committee (attended 4 meetings of 4 in 2018/19)</p> <p>Member of:</p> <ul style="list-style-type: none"> • Finance and Investment Committee (attended 8 meetings of 8 in 2018/19) • Trust Board Remuneration Committee (attended 1 meeting of 1 in 2018/19)

	<ul style="list-style-type: none"> • Trust Board Nominations Committee (attended 1 meeting of 1 in 2018/19) • Attendee of Council of Governors (4 meetings of 5 in 2018/19) <p>Experience</p> <ul style="list-style-type: none"> • Group Chief Auditor of Unilever (2011–2012) • Senior Global and Regional Finance roles Unilever, leading finance teams in Latin America, South East Asia and Australasia (1984–2011) • Non–Executive Director, Centre for Agriculture and Biosciences International • Trustee, Malala Fund UK • Trustee, Developments in Literacy (DIL) UK
<p>Professor Rosalind Smyth CBE FMedSci</p> <p>Non–Executive Director</p> <p>Term: 1 January 2013 – 31 December 2019</p> <p>Attended 5 out of 6 Board meetings in 2018/19</p> <p>Member of:</p> <ul style="list-style-type: none"> • Quality, Safety and Experience Assurance Committee (attended 4 meetings of 4 in 2018/19) • Board of Directors’ Remuneration Committee (attended 1 meeting of 1 in 2018/19) • Board of Directors’ Nominations Committee (attended 0 meetings of 1 in 2018/19) • Attendee of Council of Governors (3 meetings of 5 in 2018/19) <p>Experience:</p> <ul style="list-style-type: none"> • Director of the UCL Great Ormond Street Institute of Child Health • Honorary Consultant Respiratory Paediatrician at Great Ormond Street Hospital. • Chair of the MRC Clinical Training and Careers Panel • Chair of the Paediatric Expert Advisory Group of the Commission on Human Medicines (2002–2013) • Previously the Director of the UK Medicines for Children Research Network 	<p>Insert image</p>

<ul style="list-style-type: none"> Trustee, Cystic Fibrosis Trust 	
Insert image	<p>Mr James Hatchley</p> <p>Senior Independent Director</p> <p>Term: 1 September 2016 – 31 August 2019</p> <p>Attended 6 of 6 Board meetings in 2018/19</p> <p>Chair of:</p> <ul style="list-style-type: none"> Finance and Investment Committee (attended 8 meetings of 8 in 2018/19) Trust Board Remuneration Committee (attended 1 meeting of 1 in 2018/19) <p>Member of:</p> <ul style="list-style-type: none"> Audit Committee (attended 4 meetings of 4 in 2018/19) Quality, Safety and Experience Assurance Committee (attended 4 meetings of 4 in 2018/19) Trust Board Nominations Committee (attended 0 meeting of 1 in 2018/19) Attendee of Council of Governors (5 meetings of 5 in 2018/19) <p>Experience:</p> <ul style="list-style-type: none"> Qualified accountant Former independent member of the GOSH Quality, Safety and Experience Assurance Committee Group Strategy Director 3i Group Plc and member of the 3i Group Plc Investment Committee Chief Operating Officer KKR (2014–2016)
<p>Lady Amanda Ellingworth</p> <p>Non-Executive Director</p> <p>Term: 1 January 2018 – 31 December 2020</p> <p>Attended 6 of 6 Board meetings in 2018–19</p> <p>Chair of Quality, Safety and Experience Assurance Committee from 1 June 2018 (attended 4 meetings of 4 in 2018–19)</p> <p>Member of:</p>	Insert image

<ul style="list-style-type: none"> • Trust Board Remuneration Committee (attended 1 meeting of 1 in 2018–19) • Trust Board Nominations Committee (attended 1 meeting of 1 in 2018–19) • Attendee of Council of Governors (4 meetings of 5 in 2018/19) <p>Experience:</p> <ul style="list-style-type: none"> • Previously a senior social worker focusing on children and families • Deputy Chair, Barnardo’s - current • Director, Plan International UK – current • Trustee, Plan International UK - current • Deputy Chair Ernest Cassel Foundation – current • Advisory Board Charityworks - current • Lay Adviser Royal College of Emergency Medicine to 2018 • Chair The Guinness Partnership to 2016 • Chair The Caldecott Foundation to 2012 • Deputy Chair Yeovil Healthcare to 2010 • Chair Guinness Care and Support to 2014 	
<p>Insert image</p>	<p>Mr Chris Kennedy</p> <p>Non-Executive Director</p> <p>Term: 1st April 2018 – 31st March 2021</p> <p>Attended: 5 of 5 Board meetings in 2018–19</p> <p>Member of:</p> <ul style="list-style-type: none"> • Audit Committee (attended 4 meetings of 4 in 2018–19) • Finance and Investment Committee (attended 6 out of 8 meetings in 2018–19) • Trust Board Remuneration Committee (attended 1 meeting of 1 in 2018–19) • Trust Board Nominations Committee (attended 1 meeting of 1 in 2018–19) • Attendee of Council of Governors (2 meetings of 5 in 2018/19) <p>Experience:</p> <ul style="list-style-type: none"> • Qualified accountant • Chief Financial Officer, ITV PLC

	<ul style="list-style-type: none"> • Chief Financial Officer, Micro Focus (2018–2019) • Non–Executive Director, Whitbread PLC • Chief Financial Officer, ARM Holdings (2015–April 2017) • Chief Financial Officer, EasyJet (2010–2015)
<p>Ms Kathryn Ludlow</p> <p>Non–Executive Director</p> <p>Term: 1 September 2018 – 31 August 2021</p> <p>Attended: 4 of 4 Board meetings in 2018–19</p> <p>Member of:</p> <ul style="list-style-type: none"> • Quality, Safety and Experience Assurance Committee (attended 2 meetings of 2 in 2018/2019) • Trust Board Remuneration Committee (attended 1 meeting of 1 in 2018/19) • Trust Board Nominations Committee (not in post for meeting in 2018/19) • Attendee of Council of Governors (3 meetings of 3 in 2018/19) <p>Experience:</p> <ul style="list-style-type: none"> • Partner, Linklaters (1997–2017) • Special Adviser to G3, the Good Governance Group • Trustee of the International Rescue Committee, UK 	<p>Insert image</p>
<p>Insert image</p>	<p>Professor Stephen Smith DSc FMedSci FRCOG</p> <p>Non–Executive Director and Chair of the Quality and Safety Assurance Committee (now known as the Quality, Safety and Experience Assurance Committee) (from 1 May 2017 until 31 May 2018)</p> <p>Term: 1 March 2016 – 31 May 2018</p> <p>Attended 0 out of 1 Board meetings in 2018/19</p> <p>Chair of Quality, Safety and Experience Assurance Committee until 31st May 2018 (attended 1 meeting of 1 in 2018–19)</p> <p>Member of:</p>

	<ul style="list-style-type: none">• Trust Board Remuneration Committee (not in post for meeting in 2018/19)• Trust Board Nominations Committee (not in post for meeting in 2018/19)• Attendee of Council of Governors (0 meetings of 1 in 2018-19) <p>Experience:</p> <ul style="list-style-type: none">• Professor of Obstetrics and Gynaecology• Chief Executive, Imperial Healthcare NHS Trust (October 2007–December 2010)• Dean, Faculty of Medicine Dentistry and Health Sciences, University of Melbourne (September 2013–October 2015)• Chairman of the Melbourne Academic Centre for Health (July 2014–October 2015)
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Executive directors

<p>Insert image</p>	<p>Mr Matthew Shaw</p> <p>Chief Executive (from 15 December 2018)</p> <p>Medical Director (until 14 December 2018)</p> <p>Matthew is responsible for delivering the strategic and operational plans of the hospital through the Executive Team.</p> <p>Attended 6 Board meetings of 6 in 2018/19</p> <p>Attendee of:</p> <ul style="list-style-type: none"> • Quality, Safety and Experience Assurance Committee (4 meetings of 4 in 2018/19) • Audit Committee (1 meeting of 1 in 2018/19) • Finance and Investment Committee (2 meetings of 2 in 2018/19) • Trust Board Remuneration Committee (attended 1 meeting of 1 in 2018/19) • Trust Board Nominations Committee (not in post for meeting in 2018/19) <p>Experience</p> <ul style="list-style-type: none"> • Orthopaedic surgeon • Clinical Director of the spinal unit at the Royal National Orthopaedic Hospital (2011 – 2018) • Medical Director for Health Provision, BUPA UK until April 2018.
<p>Professor Alison Robertson</p> <p>Chief Nurse from 9 April 2018</p> <p>Alison is responsible for leading the nursing workforce and developing standards of practice. She is also the lead executive responsible for patient experience, safeguarding, infection prevention and control and end of life care.</p> <p>Attendee of:</p> <ul style="list-style-type: none"> • Quality, Safety and Experience Assurance Committee (attended 4 meetings of 4 in (2018/19) <p>Experience</p>	<p>Insert image</p>

<ul style="list-style-type: none"> • Registered adult and children’s nurse • Executive Director of Nursing, Al Wakra Hospital, Hamad Medical Corporation, Qatar until 2018 • Chief Nurse and Director of Operations, St. George’s Healthcare NHS Trust (2010-2014) • Chief Nurse, Brighton and Sussex University Hospitals NHS Trust ((2005-2010) • Chief Nurse, Surrey and Sussex NHS Trust (2003-2005) • Director of Nursing & Deputy Chief Executive , Queen Victoria Hospital NHS Trust (2001-2003) • Visiting Professor School of Health Sciences, City University. 	
<p>Insert image</p>	<p>Ms Helen Jameson</p> <p>Chief Finance Officer</p> <p>Helen is responsible for the financial management of the Trust, as well as leading on contracting, estates and facilities management.</p> <p>Attended 6 Board meetings of 6 held in 2018/19</p> <p>Attendee of:</p> <ul style="list-style-type: none"> • Finance and Investment Committee (attended 8 meetings of 8 in 2018/19) • Audit Committee (4 meetings of 4 in 2018/19) <p>Experience:</p> <ul style="list-style-type: none"> • Director, UCL Partners • Established the North Central and East London office of Health Education England • Lead on finance and governance of the London wide education commissioning system Strategic Health Authority (London Region). • Former Deputy Director of Finance and Joint Divisional Manager for Surgery and Critical Care at Kingston Hospital NHS Trust <p>Former Assistant Director of Financial Planning and Reporting for South East Coast Ambulance Service NHS Trust</p>
<p>Professor Andrew Taylor</p> <p>Acting Chief Operating Officer (from 17 December 2018)</p>	<p>Insert image</p>

<p>Andrew is responsible for the operational management of the clinical services within the Trust. He is the named Senior Information Risk Owner.</p> <p>Attended 0 out of 1 Board meeting in 2018/19</p> <p>Attendee of:</p> <ul style="list-style-type: none"> • Quality, Safety and Experience Assurance Committee (attended 0 meetings of 1 in 2018/19) • Finance and Investment Committee (attended 2 meetings of 2 in 2018/19) • Audit Committee (attended 1 meeting of 1 in 2018/19) <p>Experience</p> <ul style="list-style-type: none"> • GOSH Clinical Director of Operations (until 16 December 2018) • Head of Department, Children’s Cardiovascular Diseases, UCL Institute of Cardiovascular Science • Acting Medical Director, GOSH (2016) • North London Representative, NHSE National Clinical Reference Group for Paediatric Cardiology 	
<p>Insert image</p>	<p>Dr Sanjiv Sharma</p> <p>Acting Medical Director from 17 December 2018</p> <p>Sanjiv is responsible for performance and standards (including patient safety) and leads on clinical governance.</p> <p>Attended 0 out of 1 Board meeting in 2018/19</p> <p>Attendee of:</p> <ul style="list-style-type: none"> • Quality, Safety and Experience Assurance Committee (attended 0 meetings of 1 in 2018/19) <p>Experience</p> <ul style="list-style-type: none"> • Consultant in Paediatric and Neonatal Intensive Care • Deputy Medical Director for Medical and Dental Education (2016–2018)
<p>Ms Caroline Anderson</p> <p>Director of HR and OD from 18 March 2019</p>	<p>Insert image</p>

<p>Caroline is responsible for the development and delivery of a human resources strategy and organisational development programmes.</p> <p>No Board meetings held during tenure in 2018/19.</p> <p>Attendee of:</p> <ul style="list-style-type: none"> • Quality, Safety and Experience Assurance Committee (not in post for meeting in 2018/19) • Trust Board Remuneration Committee (not in post for meeting in 2018/19) • Trust Board Nominations Committee (not in post for meeting in 2018/19) <p>Experience</p> <ul style="list-style-type: none"> • Director of HR, OD and Corporate Communications, HM Land Registry (2013–2019) • Assistant Director, HR and OD, London Borough of Hackney (2007–2013) 	
<p>Insert image</p>	<p>Dr Peter Steer</p> <p>Chief Executive until 31 December 2018</p> <p>Attended 5 out of 5 Board meetings in 2018/19</p> <p>Attendee of:</p> <ul style="list-style-type: none"> • Quality, Safety and Experience Assurance Committee (attended 2 meetings of 3 in 2018/19) • Finance and Investment Committee (attended 5 meetings of 6 in 2018/19) • Audit Committee (attended 3 meetings of 3 in 2018/19) • Trust Board Remuneration Committee (attended 1 meetings of 1 in 2018/19) • Trust Board Nominations Committee (attended 1 meeting of 1 in 2018/19) <p>Experience</p> <ul style="list-style-type: none"> • Chief Executive – Children’s Health Queensland Hospital and Health Services (2009–2014) • Professor of Medicine, University of Queensland (2009–2014) • Adjunct Professor, School of Public Health, Queensland University of Technology (2003–2008)

	<ul style="list-style-type: none"> • President – McMaster Children’s Hospital, Hamilton, Ontario (2003–2008) • Professor and Chair, Department of Paediatrics, McMaster University, Canada (2003–2008) • Director, Children’s Hospital Group Board, Ireland
<p>Ms Nicola Grinstead</p> <p>Deputy Chief Executive until 7 January 2019.</p> <p>Attended 5 out of 5 Board meetings in 2018/19</p> <p>Attendee of:</p> <ul style="list-style-type: none"> • Quality, Safety and Experience Assurance Committee (attended 3 meetings of 3 in 2018/19) • Finance and Investment Committee (attended 3 meetings of 6 in 2018/19) • Audit Committee (attended 3 meetings of 3 in 2018–19) <p>Experience</p> <ul style="list-style-type: none"> • Director of Operations, Imperial Healthcare NHS Trust (2013–2016) • Deputy Director of Operations, Guy’s and St Thomas’ NHS Foundation Trust (2009–2013) • Chair of the World Board for the World Association of Girl Guides and Girl Scouts until 2017 	<p>Insert image</p>
<p>Insert image</p>	<p>Mr Ali Mohammed Chartered Fellow, CIPD, MSc</p> <p>Director of Human Resources and Organisational Development until 8 August 2018.</p> <p>Attended 1 out of 2 Board meetings in 2018/19</p> <p>Attendee of:</p> <ul style="list-style-type: none"> • Quality, Safety and Experience Assurance Committee (attended 2 meeting of 2 in 2018/19) • Trust Board Remuneration Committee (no meetings held during tenure in 2018/19) • Trust Board Nominations Committee (no meetings held during tenure in 2018/19) <p>Experience:</p>

	<ul style="list-style-type: none"> • Director of Human Resources and Organisational Development (Service Design) for the NHS Commissioning Board (2012–13) • Director of Human Resources and Organisational Development at Barts and The London NHS Trust (2009–12) • Director of Human Resources at Brighton and Sussex University Hospitals NHS Trust (2007–08) • Director of Human Resources at Medway NHS Trust (2001–07)
<p>Ms Polly Hodgson</p> <p>Interim Chief Nurse until 8 April 2018</p> <p>No Board meetings held during tenure in 2018/19</p> <p>Attendee of:</p> <ul style="list-style-type: none"> • Quality, Safety and Experience Assurance Committee (not in post for a meeting in 2018/19) <p>Experience</p> <ul style="list-style-type: none"> • Registered children’s nurse • Led on establishing the Paediatric Intensive Care Unit at St Mary’s Hospital • Lead Nurse for Children’s Services, Evelina (2006 – 2016) • Assistant Chief Nurse for Workforce, GOSH (2016 – 2018) 	<p>Insert image</p>
<p>Insert image</p>	<p>Ms Alison Hall</p> <p>Acting Director of HR and OD (13 August 2018 – 15 March 2019)</p> <p>Attended 2 out of 4 Board meetings in 2018/19</p> <p>Attendee of:</p> <ul style="list-style-type: none"> • Quality, Safety and Experience Assurance Committee (attended 1 meeting of 2 in 2018/19) • Trust Board Remuneration Committee (attended 1 meeting of 1 in 2018/19) • Trust Board Nominations Committee (attended 1 meeting of 1 in 2018/19) <p>Experience</p> <ul style="list-style-type: none"> • Deputy Director of HR and OD, GOSH (2016–2018)

	<ul style="list-style-type: none"> • Acting Associate Director of Workforce for Human Resources Support Services, Guy's and St Thomas' NHS Foundation Trust (2014–2016) • Head of Workforce Relations, Guy's and St Thomas' NHS Foundation Trust (2014)
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Other directors

Ms Cymbeline Moore – Director of Communications

Cymbeline Moore is the Director of Communications for the hospital and the Great Ormond Street Hospital Children's Charity.

Mr Matthew Tulley – Director of Development

Matthew Tulley leads the work to redevelop the Trust's buildings and ensures that it is suitable to support the capacity and quality ambitions of our clinical strategy.

Professor David Goldblatt – Director of Research and Innovation

David Goldblatt leads the strategic development of clinical research and development across the Trust. He is an Honorary Consultant Immunologist.

Register of Interests

The Trust Board has signed up to the revised Trust Board Code of Conduct setting out the requirement for all Board members to declare any interests that may compromise their role. This is also a standing item at the beginning of each Board and assurance committee meeting.

A Register of Directors' Interests is published on the Trust website, gosh.nhs.uk, and can also be obtained by request from the Company Secretary, Great Ormond Street Hospital for Children NHS Foundation Trust, Executive Offices, Paul O'Gorman Building, Great Ormond Street, London WC1N 3JH.

Trust Board meetings

In 2018/19, the Board held a total of six formal meetings. Five meetings included a session held in public and in October 2018 the Board held a strategy session. In addition, the Board held a Board development session in November 2018. The Board did not meet in April 2018, June 2018, January 2019 or March 2019.

Evaluation of Board performance

As part of their routine scheduled inspection programme, the Care Quality Commission conducted an independent well-led inspection of the Trust in January 2018 and during 2018/19 the Board monitored progress with the action plan. Further information can be found on page xx. The Board has signed up to an externally-led Board development programme in 2019. The Trust expects a routine scheduled CQC inspection (including Well-Led) in Q2 2019/20 (see page xx for further information).

Taking into account the number of executive and non-executive director posts that have been subject to change during the year, and to allow a period of stability, the Board has agreed that the next externally led evaluation of Board performance will be planned for 2020, following delivery of the results of the CQC inspection (see above).

Trust Board committees

The Board delegates certain functions to committees that meet regularly. The Board receives any amendments to committee terms of reference, annual reports and committee self-assessments. During the period, one non-executive director sat on both the Audit Committee and Quality, Safety and Experience Assurance Committee to provide a link and ensure that information is effectively passed between them. Members of both assurance committees meet annually to discuss strategic risk and consider how the committees effectively share responsibility for monitoring strategic risk on behalf of the Board. Assurance committee chairs meet to discuss the remit of their committees and avoid duplication.

Audit Committee

The Audit Committee is chaired by a non-executive director and has delegated authority to review the adequacy and effectiveness of our systems of internal control and our arrangements for risk management, control and governance processes to support our objectives. A summary of the work of the committee can be found on page **XX**.

Quality, Safety and Experience Assurance Committee

The Quality, Safety and Experience Assurance Committee is chaired by a non-executive director and has delegated authority from the Board to be assured that we have the correct structure, systems and processes in place to manage quality and safety related matters, and that these are monitored appropriately. A summary of the work of the committee can be found on page **XX**. The committee receives regular internal audit and clinical audit reports.

Finance and Investment Committee

The Finance and Investment Committee is chaired by a non-executive director and has delegated authority from the Board to oversee financial strategy and planning, financial policy, investment and treasury matters and to review and recommend for approval major financial transactions. The committee also maintains an oversight of the Trust's financial position, and relevant activity data and workforce metrics.

Trust Board Remuneration Committee

The Remuneration Committee is chaired by a non-executive director and is responsible for reviewing the terms and conditions of office of the Board's executive directors, including salary, pensions, termination and/or severance payments and allowances. A summary of the work of the committee can be found on page **XX**.

Trust Board Nominations Committee

The Trust Board Nominations Committee is chaired by the Chair of the Board. It has responsibility for reviewing the size, structure and composition of the Board and making recommendations about any changes – giving full consideration to succession planning and evaluating the balance of skills, knowledge and experience in relation to the appointment of both executive and non-executive directors.

During the year the following executive appointments to the Board were made:

- The appointment of Ms Alison Robertson as substantive Chief Nurse on 9 April 2018.
- The appointment of Ms Helen Jameson as substantive Chief Finance Officer on 23 April 2018.
- The appointment of Mrs Alison Hall as Acting Director of HR and OD Officer on 13 August 2018..
- The appointment of Mr Matthew Shaw as substantive Chief Executive on 15 December 2018 following the departure of Mr Peter Steer Chief Executive on 31 December (Mr Shaw covered Dr Steer's annual leave prior to final date of departure).
- The appointment of Mr Andrew Taylor as Acting Chief Operating Officer on 8 January 2019 following the departure of Ms Nicola Grinstead on 7 January 2019.
- The appointment of Dr Sanjiv Sharma as Acting Medical Director from 15 December 2018 following the promotion of Mr Matthew Shaw as Chief Executive.
- The appointment of Mrs Caroline Anderson as substantive Director of HR and OD on 16 March 2019.

GOSH joining the NHS in 1948

Joining the NHS meant that GOSH was no longer a charitable 'Voluntary Hospital' largely funded by private donations and subscriptions, as it had been since its opening as the Hospital for Sick Children in 1852. As a result, the previous Committee of Management was replaced by an NHS Board of Governors.

The Chairman appointed in 1948, T.H. Bischoff, was head of a leading City of London solicitors' practice. Awarded the Military Cross during the First World War, Bischoff had two coincidental earlier links with the hospital: his mother was a relative of *'Alice in Wonderland'* author Lewis Carroll, who had supported GOSH in its early years and had a cot endowed in his memory, and he had attended Rugby School, which owned the land to the east of the hospital, including part of what is now the frontage.

[INSERT PICTURE OF THE first set of Board papers.] Caption: The first page of the first Board papers at GOSH as part of the NHS.

Council of Governors

As a foundation trust we are accountable to our members through our Council of Governors.

The Council of Governors is made up of 27 elected and appointed governors. They support and influence the strategic direction of the Trust by representing the views and interests of our members.

The Council of Governors act as a link to the hospital's patients, their families, staff and the wider community ensuring that their views are heard and reflected in the strategy for the hospital. Although the Council of Governors is not involved in the operational management of the Trust, it is responsible for holding the non-executive directors individually and

collectively to account for the performance of the Trust Board in delivering the Trust’s strategic objectives. More about the responsibilities of the Council of Governors can be found at gosh.nhs.uk/XXX.

Constituencies of the Council of Governors

Governors represent specific constituencies and are elected or appointed to do so for a period of three years, with the option to stand for re–election for a further three years. As a specialist Trust with a UK–wide and international catchment area, we do not have a defined ‘local community’. Therefore, it is important that our geographically diverse patient and carer population is represented in our membership and in the composition of our Council of Governors.

In July 2018, the Council of Governors updated its Constitution. As part of this, it approved a number of recommendations with the aim of strengthening its governance arrangements. The key recommendations were:

- Change the name of the Council from Member’s Council to Council of Governors and the name Councillors to Governors.
- The appointment of two appointed young Governors from the Young People’s Forum, replacing the SelfManagement UK and GOSH School Governors.
- Keeping the minimum age of members at 10 years of age.
- Setting a lifetime maximum tenure for Governors of six years total.

Following these agreed changes, the GOSH Council of Governors continues to be made up of 27 elected and appointed Governors as below:

There were no elections in 2018/19 and there are no planned elections for 2019/20.

Governors’ attendance at meetings

The Council of Governors met five times in 2018/19 (four regular meetings and one extraordinary meeting). Governors attended these meetings as follows:

Name	Constituency	Date role began	Council of Governors’ meeting (out of 5 unless otherwise stated)	Nominations and Remuneration Committee (out of 2 unless otherwise stated)	Membership Engagement Recruitment and Representation Committee (out of 3 unless otherwise stated)
Mariam Ali ¹	Parents and Carers: London Lead Governor 2018/19	February 2015	4	2	Not a member
Stephanie Nash	Parents and Carers: London	February 2018	5	Not a member	Not a member

Tab 6 GOSH Foundation Trust annual financial accounts and annual report 2018/19 including:

Name	Constituency	Date role began	Council of Governors' meeting (out of 5 unless otherwise stated)	Nominations and Remuneration Committee (out of 2 unless otherwise stated)	Membership Engagement Recruitment and Representation Committee (out of 3 unless otherwise stated)
Emily Shaw	Parents and Carers: London	February 2018	3	Not a member	Not a member
Lisa Allera	Parents and Carers: Outside London	February 2018	5	2	Not a member
Claire Cooper-Jones	Parents and Carers: Outside London Deputy Lead Governor from 17 April 2019	February 2018	4	2	Not a member
Faiza Yasin	Patients: Outside London	February 2018	5	Not a member	3
Alice Rath	Patients: Outside London	February 2018	2	Not a member	Not a member
Elena – May Reading	Patients: London	February 2018	2	Not a member	0
Zoe Bacon	Patients: London	February 2018	4	Not a member	2
Fran Stewart ¹	Public: South London and surrounding area**	October 2016	4	Not a member	Not a member
Simon Hawtrey-Woore ¹	Public: North London and surrounding area*	February 2015	4	Not a member	3
Teskeen Gilani ¹	Public: North London and surrounding area*	December 2016	1	Not a member	Not a member
Theo Kayode-Osiyemi	Public: North London and surrounding area*	February 2018	5	Not a member	1

Name	Constituency	Date role began	Council of Governors' meeting (out of 5 unless otherwise stated)	Nominations and Remuneration Committee (out of 2 unless otherwise stated)	Membership Engagement Recruitment and Representation Committee (out of 3 unless otherwise stated)
Yu Tan	Public: North London and surrounding area*	February 2018	3 (4)	Not a member	Not a member
Colin Sincock	Public: Rest of England and Wales	February 2018	5	Not a member	2 (2)
Julian Evans	Public: Rest of England and Wales	February 2018	3	Not a member	Not a member
Sarah Aylett	Staff	February 2018	4	Not a member	1
Michael Glynn ²	Staff	February 2018	2 (2)	Not a member	Not a member
Nigel Mills	Staff	February 2018	5	Not a member	2
Paul Gough	Staff Deputy Lead Governor from 17 April 2019	February 2018	5	Not a member	Not a member
Quen Mok	Staff	February 2018	5	1 (1)	Not a member
Lazzaro Pietragnoli App	London Borough of Camden	February 2018	2	Not a member	Not a member
Lucy Moore ^{1 3} App	Self Management UK	October 2016	0 (4)	Not a member	Not a member
Jugnoo Rahi App	GOS UCL Institute of Child Health	February 2018	3	1	Not a member

¹ Re-elected or reappointed for a second three-year term on 1 February 2018

² Stood down during 2018/19

³ Constituency removed during update of the Constitution July 2018

App: Appointed governors. All other governors are elected.

() Number of meetings it was possible to attend

*The public constituency of North London and surrounding area incorporates the electoral areas of:

- North London: Barking and Dagenham, Barnet, Brent, Camden, City of London, Hackney, Ealing, Enfield, Hammersmith and Fulham, Haringey, Harrow, Havering, Hillingdon, Hounslow, Islington, Kensington and Chelsea, Newham, Redbridge, Tower Hamlets, Waltham Forest, Westminster.
- Bedfordshire: Bedford, Central Bedfordshire, Luton.
- Hertfordshire: Broxbourne, Dacorum, East Hertfordshire, Hertfordshire, Hertsmere, North Hertfordshire, St Albans, Stevenage, Three Rivers, Watford, Welwyn Hatfield.
- Buckinghamshire: Aylesbury Vale, Buckinghamshire, Chiltern, Milton Keynes, South Bucks, Wycombe.
- Essex: Basildon, Braintree, Brentwood, Castle Point, Chelmsford, Colchester, Epping Forest, Essex, Harlow, Maldon, Rochford, Southend on Sea, Tendring, Thurrock, Uttlesford.

**The public constituency of South London and surrounding area incorporates the electoral areas of:

- South London: Bexley, Bromley, Croydon, Greenwich, Royal Borough of Kingston upon Thames, Lambeth, Lewisham, Merton, Richmond upon Thames, Southwark, Sutton, Wandsworth.
- Surrey: Elmbridge, Epsom and Ewell, Guildford, Mole Valley, Reigate and Banstead, Runnymede, Spelthorne, Surrey Heath, Tandridge, Waverley, Woking.
- Kent: Ashford, Canterbury, Dartford, Dover, Gravesham, Maidstone, Medway, Sevenoaks, Shepway, Swale, Thanet, Tonbridge and Malling, Tunbridge Wells.
- Sussex: Brighton and Hove, East Sussex, Eastbourne, Hastings, Lewes, Rother, Wealden, Adur, Arun, Chichester, Crawley, Horsham, Mid Sussex, West Sussex, Worthing.

Elected Governor vacancies

Following elections between 14 November 2017 and 31 January 2018, one elected Governor from the Parents and Carers outside London constituency resigned in February 2018 (before taking office) and a Staff Governor resigned in August 2018. During the year, the Council of Governors agreed to keep the seats vacant in lieu of a review of the Trust Membership Constituencies (see below).

In February 2019 the Council of Governors agreed to invite the next highest polling candidate in each constituency to serve a term of office expiring 31 March 2021. Both candidates accepted and will join the Council from May 2019.

Membership at GOSH

Anyone living in England and Wales over the age of 10 can become a GOSH member, and we strive for our membership to reflect the broad and diverse public communities we serve as well as patients, their families and carers and staff. Automatic membership applies to all employees who hold a GOSH permanent contract or fixed-term contract of 12 months or more. There is more on becoming a member at gosh.nhs.uk/about-us/foundation-trust/foundation-trust-membership.

Future changes to constituencies

As part of the work on the Constitution in July 2018, the Council:

- Reviewed the membership constituencies and agreed changes to ensure that they adequately represent the membership of the Trust.
- Reviewed and agreed phasing of Governor elections so as to appropriately manage consistent Governor turnover.

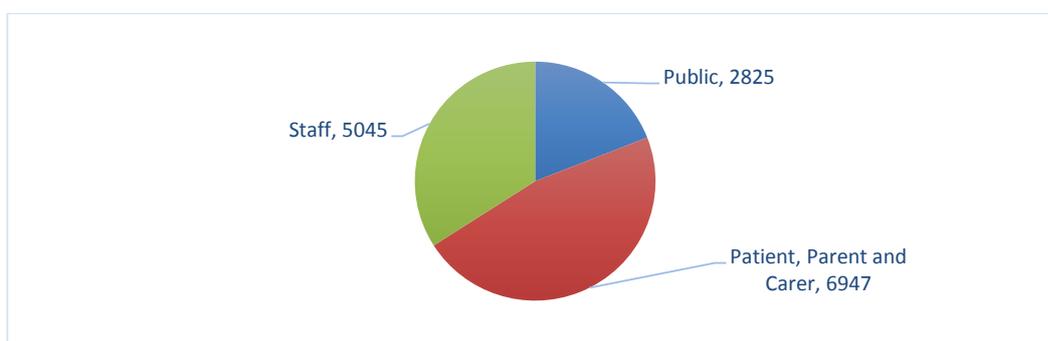
The Council agreed that these changes will be implemented from March 2021. Further information will be made available in 2020 when planning for the Governor elections will begin.

Membership constituencies and membership numbers 2018–19

On 31 March 2019, our membership totalled 14,817.

We managed to increase our public membership by 73 (from 2,752 to 2,825). This was ten members short of our estimated public membership target of 2,835. Although we increased our patient, parent and carer constituency by 30 (from 6,917 to 6,947), this was 178 short of our target of 7,125. Overall, we increased our membership by 103.

Membership Engagement Services (MES) is our membership database provider and holds and manages our public and patient and carer data.



Council of Governors' expenses

Governors can claim reasonable expenses for carrying out their duties. For the year 2018/19, the total amount claimed by five governors was £1,713.00

Register of interests

Governors are asked to sign a code of conduct and declare any interests that are relevant and material. The register of interests for the Council of Governors is published annually and can be found at <https://www.gosh.nhs.uk/about-us/foundation-trust/council-governors/meet-our-governors> and may also be obtained from the Company Secretary, Executive Offices, Paul O’Gorman Building, Great Ormond Street, London WC1N 3JH.

Contacting a governor

Anyone wanting to get in touch with a governor and/or directors can email foundation@gosh.nhs.uk and the message is forwarded on to the relevant person. These details are included within the foundation trust ‘contact us’ section of the Great Ormond Street Hospital for Children NHS Foundation Trust website, gosh.nhs.uk.

Trust Board and Council of Governors working together

The Trust’s Chair is responsible for the leadership of both the Council of Governors and the Trust Board. The Chair is also responsible for effective relationship building between the Trust Board and governors to ensure that governors effectively perform their statutory duties and contribute to the forward planning of the organisation. There has been a continued focus on developing relationships between the Council of Governors and non-executive directors in this reporting period, with the delivery of several programmes of work to facilitate engagement. The key programmes are covered below. Additional examples of how the Council of Governors and Board worked together in 2018/19 included:

- Governors have an open invitation to attend all Trust Board meetings.
- Governors observe at Trust Board assurance committee meetings.
- Governors and Board members worked together on the Constitution Working Group.
- Executive and non-executive directors attend each Council of Governors’ meeting.
- Summaries of the Board assurance committees (Audit Committee, Quality and Safety Assurance Committee and Finance and Investment Committee) are presented by the relevant non-executive director chairs of the committees at each meeting of the Council of Governors.
- Summaries of Council of Governors’ meetings are reported to the Trust Board.

In 2018/19 the Council of Governors has:

- Contributed to the GOSH strategy and its delivery.
- Approved the appointment process and appointed a non-executive director.
- Been involved in stakeholder meetings and approved the appointment of the Chief Executive.
- Contributed to the actions in response to CQC report and recommendations.
- Contributed to the drafting of the Trust Quality Report.
- Received regular updates from the Young People’s Forum.
- Approved role descriptions for the Lead Governor and approved the establishment of a Deputy Lead Governor role.
- Approved the phasing of governor elections.
- Commented on our redevelopment plans including the plans for the Children’s Cancer Centre.

- Worked with Board members to review and update the Trust's Constitution.
- Contributed to the appraisal of the non-executive directors.

Governor induction and development

Governors attended three induction sessions between April 2018 and August 2018. The sessions prepared and supported Governors to discharge their duties and complete mandatory training.

The Governor induction programme concluded in August 2018 and transitioned into a series of Governor development sessions. These sessions were set up in partnership with Governors to provide them with the skills and knowledge needed to deliver their key duties over their tenure.

Governors' and Chair meeting

Prior to each Council of Governors' meeting, the Chair meets with all Governors in a private session. This gives the Governors an opportunity to discuss any issues directly with the Chair.

'Buddying' with non-executive directors

The Trust established a buddying programme between non-executive directors (NEDs) and Governors from September 2018. The buddying programme provides Governors with direct contact with a NED to support their role and share information on matters of interest or concern. A review of the programme will take place in July 2019.

Governors' online library

In February 2019 a small number of Governors trialled access to an online library of resources designed by the Trust's Corporate Affairs team. The trial was successful and will be made available to all Governors in 2019/20. The library will provide Governors with 24/7 access to key documents and information.

Governors' newsletter

From March 2019 Governors have received a monthly newsletter from the Corporate Affairs team containing actions required, key meeting dates, Trust developments and training and development opportunities.

Membership engagement

Members receive updates on hospital news and are invited to get involved throughout the year. Members also have the opportunity to vote in elections and stand for election to the Council of Governors.

The Council fed comments into development of the GOSH operational plan 2019/20 and are being consulted on the revision of the Trust Strategy in April 2019. Further work will be conducted in 2019/20 on enhancing our engagement with members as stakeholders with the publication of the Stakeholder Engagement Strategy.

The Membership and Engagement Representation and Representation Committee, a subcommittee of the Council of Governors, oversees the recruitment and retention of members and seeks to maximise engagement opportunities with members for the benefit of

the Trust. In 2018/19, the committee was chaired by a Patient and Carer Governor. Last year's achievements included a revision of the membership strategy and planning and delivery of a successful annual general meeting and annual members' meeting.

The bi annual magazine Member Matters and monthly Get Involved newsletters offer a variety of opportunities for members to engage with the Trust and its Governors, including:

- The Young People's Forum – a group of current and ex-patients who guide and support the hospital on a range of topics and issues.
- Other forums and committees such as the Young People's Advisory Group.
- Events such as the opening of the new Disney Reef, the Big Youth Forum Meet Up and the Annual General Meeting and Annual Members' Meeting.
- An open invitation to attend Council of Governors' meetings in public throughout the year.
- Governors write personalised articles in Member Matters, Roundabout and the staff newsletter. A letter from the Lead Governor is also included in our updated Welcome Pack for new members.
- An online link to contact a Governor is included on the website and in all membership communications. Members can also contact a Governor via the Trust's new Twitter profile.

[The Membership Strategy 2019 – 2022](#)

The Trust's Membership Strategy was revised for 2018–2021, with the objectives of recruiting, communicating and engaging with our members using a refreshed approach. It aims to strengthen the link between the hospital and its members by maximising involvement and engagement opportunities and focusing on better representing our younger membership community.

[Council of Governors' Nominations and Remuneration Committee](#)

The Council of Governors' Nominations and Remuneration Committee has delegated responsibility for assisting the Council in:

- Reviewing the balance of skills, knowledge, experience and diversity of the non-executive directors.
- Succession planning for the Chair and non-executive directors in the course of its work.
- Identifying and nominating candidates to fill non-executive posts.
- Considering any matter relating to the continuation of any non-executive director.
- Reviewing the results of the performance evaluation process for the Chair and non-executive directors.

The committee is chaired by the Chair of the Trust Board and Council of Governors. Governors nominate themselves each year to sit on the committee.

Membership and attendance of governors at meetings is detailed on page **X**.

Non-executive director appointments

Non-executive directors are appointed for a three-year term and can be reappointed for a further three years (subject to consideration and approval by the Council of Governors).

In 2018/19 the Council of Governors has:

- Approved the appointment of Mr Chris Kennedy as a Non-Executive Director from 1 April 2018.
- Approved the appointment of Ms Kathryn Ludlow as a Non-Executive Director from 6 September 2018.
- Extended the appointment of Professor Rosalind Smyth as a Non-Executive Director for one further year on the basis of a positive appraisal and recommendation from Professor Smyth's appointing body, University College London, due to her role as Director of the UCL GOSH Institute of Child Health and the alignment between the two organisations.

An external search company and open advertising are used for all new non-executive director appointments. The recruitment process includes inviting candidates to attend stakeholder events where they get the chance to meet staff, parents and patients and to take part in a tour of the hospital.

The chair's other significant commitments are disclosed to the council of governors before appointment and when they change. Information about Sir Michael Rake's significant commitments in 2018/18 can be found on in the Board's declarations of interest on the Trust website [\(ADD WEBPAGE\)](#)

The Trust Constitution (revised in July 2018) explains how a Board member may not continue in the role if he/she has been:

- Adjudged bankrupt.
- Made a composition or arrangement with, or granted a trust deed for, creditors and has not been discharged in respect of it.
- In the preceding five years, convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him/her.

Annex 7 of the constitution outlines additional provisions for the removal of the chair and non-executive directors, which requires the approval of three-quarters of the members of the Council of Governors. If any proposal to remove a non-executive director is not approved at a meeting of the Council of Governors no further proposal can be put forward to remove such non-executive director based upon the same reasons within 12 months of the meeting.

Remuneration report

The Trust Board's Remuneration Committee is chaired by a non-executive director. The committee is responsible for reviewing the terms and conditions of office of our most senior managers, including salary, pensions, termination and/or severance payments and allowances. The committee meets twice a year, in November and March. Attendance at meetings held in during 2018/19 can be found on pages **XX-XX**.

Under the terms of reference of the committee and for the report below, voting executive members of the Trust Board are defined as 'senior managers'. Authority for approval of changes to other senior management roles on Trust contracts of employment has been delegated by the Remuneration Committee to the Chief Executive.

Remuneration of non-executive directors is determined by the Council of Governors' Nominations and Remuneration Committee and approved by the Council of Governors. Further information is provided on pages **XX-XX**.

Senior manager remuneration

The committee determines the remuneration of senior managers after taking into account NHS Improvement guidance (see below), any variation in or changes to the responsibilities of the senior managers, market comparisons, job evaluation and weightings and, uplifts recommended for other NHS staff. There is some scope for adjusting remuneration after appointment as senior managers take on the full set of responsibilities in their role.

The only non-cash element of the remuneration package is pension-related benefits accrued during membership of the NHS Pension Scheme. Where appropriate, contributions into the scheme are made by both the employer and employee in accordance with the statutory regulations.

Affordability is also taken into account in determining pay uplifts for senior managers. Where it is appropriate, terms and conditions of service are consistent with NHS pay arrangements, such as Agenda for Change and those for very senior managers.

Performance is closely monitored and discussed through both annual and ongoing appraisal processes. All senior managers' remuneration is subject to performance – they are employed on contracts of employment and are substantive employees of the Trust. Their contracts are open-ended employment contracts, which can be terminated by either party with six months' notice. The committee has started to consider whether an element of performance related pay or earn-back pay will be included within senior manager contracts. This is consistent with NHSI guidance.

The Trust's redundancy policy is consistent with NHS redundancy terms for all staff. All new senior managers are now employed on probationary periods in line with all non-medical staff within the Trust.

Senior Manager Remuneration policy

The structure of pay for senior managers is designed to reflect the long-term nature of our business and the significance of the challenges we face. The remuneration should,

therefore, ensure that it acts as a legitimate and effective method to attract, recruit and retain high-performing individuals to lead the organisation. That said, the financial and economic climate position across the health sector must also be considered.

NHS trusts, including foundation trusts, are free to determine the pay for senior managers in collaboration with the Trust Board’s Remuneration Committee. Historically, reference has been made to benchmarking information available from NHS Improvement on senior manager remuneration, other comparable hospitals, and any recommendations made on pay across the broader NHS, when looking to recommend any potential changes to the remuneration for senior managers. This includes those under the Agenda for Change terms and conditions, and those senior managers in the NHS covered by national pay frameworks.

Our commitment to senior managers’ pay is clear. While consideration is given to all internal and external factors, it is important that GOSH remains competitive so we can achieve our vision of being a leading children’s hospital. The same principles of rating performance and behaviour will be applied to senior managers, in line with the Trust’s appraisal system. This in turn may result in senior managers having potential increases withheld, as is the case with senior managers under the Agenda for Change principles, should performance fall below the required standard.

Senior manager future remuneration policy

The future policy table below highlights the components of directors’ pay, how we determine the level of pay, how change is enacted and how directors’ performance is managed.

How the component supports the strategic objective of the Trust	How the component operates (including provisions for recovery of sums paid and how changes are made)	Maximum potential value of the component	Description of framework used to assess performance
Salary and fees			
Set at an internationally competitive level to attract high-quality directors to a central London base. Benchmarked across other NHS trusts in order to deliver the Trust’s strategic objectives.	Salaries are reviewed annually and any changes are normally effective from 1 April each year. Such changes are proposed and made via the Board’s Remuneration Committee, chaired by a non-executive director. In exceptional circumstances, reviews of salary may be made outside of this cycle, but	Change to basic salary is usually enacted as a percentage increase in line with national Agenda for Change pay arrangements, to ensure parity across the Trust (senior managers are proportionally not treated more	Trust performance and development review (PDR)/annual appraisal to set objectives linked to our strategic objectives. Failure to meet objectives is managed via our performance frameworks.

are made by the Remuneration Committee. favourably than other staff).

Any sums paid in error, malus, recovered due to breach of contract or to be withheld are considered and agreed by the Remuneration Committee and then followed up with the individual.

Taxable benefits

Not applicable

Annual performance–related bonuses

Provides the flexibility and capability to reward high performers adequately for their outcomes. Helps to retain highly specialised senior managers and supports innovation.	The committee reviews application of performance-related pay (PRP) on appointment to a senior manager role where relevant. The decision to apply PRP will be subject to the measurability of the outputs in relation to delivery of the strategy.	The committee will apply PRP as a maximum of 10% of total salary (excluding pension entitlements).	Trust PDR/annual appraisal process.
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Long-term–related bonuses

Not applicable.

Pension–related benefits

Pension benefits (which may be opted out of) are part of the total remuneration of directors to attract high-calibre staff to enable the Trust	Pension is available as a benefit to directors and follows national NHS Pension Scheme contribution rules.	Pension is available as a benefit to directors and follows national NHS Pension Scheme contribution rules. Pension	Not applicable.
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to meet its strategic objectives.

entitlements are determined in accordance with the HMRC method.

Directors with remuneration (total) greater than £150,000

The Committee takes steps to satisfy itself that remuneration is reasonable for those senior managers paid more than £150,000 (and £142,500 pro rata for part-time senior managers), taking account of NHS Improvement's *Guidance on pay for very senior managers in NHS trusts and foundation trusts*.

The Trust balances the market forces factors for recruiting top director talent with social responsibility in relation to executive pay. Remuneration is regularly benchmarked across peer UK NHS organisations.

Service contract obligations

The Trust requires all senior managers to take continuing responsibility for their roles and requires executive directors to provide on-call cover for the hospital on a rostered basis which broadly equates to one week in every six. Details about length of service can be found on page xx.

Policy on payment for loss of office

Senior managers' contracts primarily stipulate a minimum notice period of six months and are determined by the Remuneration Committee.

In the event of loss of office (e.g. through poor performance or misconduct), the Trust will apply the principles and policies set out in this area within its relevant employment policies (disciplinary and performance management policy) and any compensation for loss of office will be in line with the contract of employment. The Trust does have the right to use its discretion about compensation payments for loss of office. Any such payments over and above a contractual entitlement will be in line with appropriate guidance from NHS Improvement.

Notice periods for Senior Managers are determined by the Remuneration Committee.

Payment in lieu of notice, as a lump sum payment, may be made with the approval of the Trust's Remuneration Committee, in line with NHSI guidance.

Remuneration for senior managers in 2018/19

Details of remuneration, including the salaries and pension entitlements of the Board directors, are provided on pages XX-XX.

For the financial year 2018/19 the committee:

- Approved an uplift to the former Chief Executive's remuneration and former Director of HR and OD's remuneration based on data from a benchmarking exercise.*
- Approved remuneration of the incoming Chief Executive, Acting Medical Director and Acting Chief Operating Officer based on data from NHS Improvement.
- Conducted benchmarking exercises on both existing and incoming senior managers' remuneration packages to ensure they are competitive in terms of total remuneration when compared to similar jobs in genuinely comparable NHS organisations. To inform the benchmarking exercise, data was used from NHS Improvement and other publicly available NHS annual reports.
- Agreed uplifts to remaining posts within its remit consistent with the cost of living award made to staff on Agenda for Change contracts.
- Agreed to review application of performance-related pay on appointment to a senior manager role.

* Advice was provided by Harvey Nash (at a cost of £4800) on remuneration for both appointments. Following a request from the Remuneration Committee, the Chair of the Remuneration Committee selected the advisers. The committee was satisfied that the advice provided was objective and independent and took the advice into account when considering remuneration levels for both posts.

Evaluation and remuneration of non-executive directors

The Council of Governors considered and approved the performance evaluation framework for non-executive directors in 2018 and they were appraised throughout the year.

The Council's Nominations and Remuneration Committee is responsible for recommending remuneration levels for non-executive directors to the Council of Governors. In March 2017, following analysis of benchmarking information, the committee recommended that the remuneration levels for both the Chair and the non-executive directors were set at an appropriate level. The Council agreed and approved the policy for benchmarking salaries for the Chair and non-executive directors on a three-yearly basis (i.e. the next review will take place in March 2020) and reviewing the cost of living allowances in line with senior managers' cost of living allowance awards at GOSH on an annual basis.

In March 2019, on the basis of the current financial climate, non-executive directors agreed not to receive cost of living allowances for 2019/20 and this was approved by the Council of Governors.

The salaries for the Chair and non-executive directors for 2019/20 are as follows:

- Chairman's remuneration: 1 April 2019 – 31 March 2020, £55,000pa
- Non-executive directors' remuneration: 1 April 2019 – 31 March 2020, £14,000pa
- Deputy Chair/Chair of Audit Committee and SID's remuneration: 1 April 2019 – 31 March 2020, £19,000pa for each of the two posts

Details of remuneration for the executive and non-executive directors are provided in the tables on pages XX-XX.

Mr Mathew Shaw

Chief Executive

Date: XX May 2019

Great Ormond Street Hospital for Children NHS Foundation Trust															
Finance Department															
Remuneration Report 2018/19															
Salary entitlements of senior managers															
Name	Title	Salary and Fees	Taxable Benefits	2018/19				Total	Salary and Fees	Taxable Benefits	2017/18				Total
				Annual Performance-related Bonuses	Long-term Performance-related Bonuses	Pension-related Benefits	Annual Performance-related Bonuses				Long-term Performance-related Bonuses	Pension-related Benefits			
Non-executive Directors															
Sir Michael Rake	Chairman of Trust Board	50-55	0	0	0	0	50-55	20-25	0	0	0	0	0	20-25	
Lady Amanda Ellingworth	Non-Executive Director	10-15	0	0	0	0	10-15	0-5	0	0	0	0	0	0-5	
Mr James Hatchley	Non-Executive Director	15-20	0	0	0	0	15-20	15-20	0	0	0	0	0	15-20	
Mr Chris Kennedy	Non-Executive Director (from)	15-20	0	0	0	0	15-20	0-5	0	0	0	0	0	0-5	
Miss Kathryn Ludlow	Non-Executive Director (from)	5-10	0	0	0	0	5-10	n/a	n/a	n/a	n/a	n/a	n/a		
Mr Akhter Mateen	Non-Executive Director	15-20	0	0	0	0	15-20	20-25	0	0	0	0	0	20-25	
Professor Stephen Smith	Non-Executive Director (until 31 May 2019)	0-5	0	0	0	0	0-5	10-15	0	0	0	0	0	10-15	
Professor Ros Smyth	Non-Executive Director	10-15	0	0	0	0	10-15	5-10	0	0	0	0	0	5-10	
Executive Directors															
Ms Caroline Anderson	Director of Human Resources and Organisational Development	0-5	0	0	0	0	0-5	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
Ms Nicola Grinstead	Deputy Chief Executive (until 7 January 2019)	180-185	0	0	0	55-60	235-240	140-145	0	0	0	40-42.5	180-185		
Mrs Alison Hall	Acting Director of Human Resources (from 13 August 2018 to 15 March 2019)	100-105	0	0	0	65-70	165-170	n/a	n/a	n/a	n/a	n/a	n/a		
Ms Mary (Polly) Hodgson	Interim Chief Nurse (until 8 April)	50-55	0	0	0	0-5	50-55	80-85	0	0	0	7.5-10	90-95		
Miss Helen Jameson	Chief Finance Officer	140-145	0	0	0	TBC	TBC	10-15	0	0	0	0	10-15		
Mr Niamat (Ali) Mohammed	Director of Human Resources (until 8 August 2018)	130-135	0	0	0	25-30	155-160	125-130	0	0	0	0-2.5	125-130		
Professor Alison Robertson	Chief Nurse (from 9 April 2018)	130-135	0	0	0	0	130-135	n/a	n/a	n/a	n/a	n/a	n/a		
Dr Sanjiv Sharma	Acting Medical Director (from 17 December 2018)	135-140	0	0	0	5-10	140-145	n/a	n/a	n/a	n/a	n/a	n/a		
Mr Matthew Shaw	Medical Director (until 14 December 2018) and Chief Executive (from 15 December 2018)	195-200	0	0	0	0-5	200-205	5-10	0	0	0	0-2.5	5-10		
Dr Peter Steer	Chief Executive (until 31 December 2018)	140-145	0	0	0	0	140-145	235-240	0	0	0	57.5-60	295-300		
Andrew Taylor	Acting Chief Operating Officer (from 17 December 2018)	140-145	0	0	0	0	140-145	n/a	n/a	n/a	n/a	n/a	n/a		

Pension entitlements of senior managers									
Name	Title	Real increase in pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at 31 March 2019 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2019 (bands of £5,000)	Cash equivalent transfer value at 1 April 2018	Real increase/(decrease) in cash equivalent transfer value	Cash equivalent transfer value at 31 March 2019	
		£000	£000	£000	£000	£000	£000	£000	
Ms Nicola Grinstead	Deputy Chief Executive (until 7 January 2019)	2.5-5	0-2.5	35-40	75-80	419	120	539	
Mrs Alison Hall	Acting Director of Human Resources (from 13 August 2018 to 15 March 2019)	5-7.5	15-17.5	20-25	60-65	340	86	426	
Mary (Polly) Hodgson	Interim Chief Nurse (from 1 January 2018)	0-2.5	2.5-5	25-30	85-90	526	91	617	
Miss Helen Jameson	Chief Finance Officer	TBC	TBC	TBC	TBC	TBC	TBC	TBC	
Mr Niamat (Ali) Mohammed	Director of Human Resources (until 8 August 2018)	2.5-5	5-7.5	45-50	130-135	866	168	1,034	
Dr Sanjiv Sharma	Acting Medical Director (from 17 December 2018)	0-2.5	5-7.5	15-20	60-65	340	102	442	
Mr Matthew Shaw	Medical Director (until 14 December 2018) and Chief Executive (from 15 December 2018)	15-17.5	35-37.5	35-40	80-85	281	310	591	
Dr Peter Steer	Chief Executive (until 31 December 2018)	0-2.5	0	10-15	0	124	2	198	

Median pay

The highest paid Director in 2018/19 was the Chief Executive Officer whose remuneration was in the band £195,000–£200,000. This was 5.0 times the median remuneration for all members of the Trust. The calculation is based upon full-time equivalent Trust staff for the year ended 31 March 2019 on an annualised basis.

	2018/19	2017/18
Band of the highest paid director's total remuneration (£000)	195-200	235-240
Median total remuneration	39,244	38,096
Ratio	5.0	6.2

Statement on better payment practice code

The Trust aims to pay its non-NHS trade creditors in accordance with the Prompt Payment Code and government accounting rules. The Trust has registered its commitment to following the Prompt Payment Code.

The Trust maintained its Better Payment Practice Code performance for non-NHS creditor payments and achieved payment within 30 days of 86% of non-NHS invoices measured in terms of number (85% in 2017/18) and 91% by value (83% in 2017/18).

Better payment practice code		2018/19
	Number	£000
Non NHS		
Total bills paid in the year	74,847	299,585
Total bills paid within target	64,000	272,853
Percentage of bills paid within target	86%	91%
NHS		
Total bills paid in the year	3,265	28,229
Total bills paid within target	1,425	22,682
Percentage of bills paid within target	44%	80%

Total		
Total bills paid in the year	78,112	327,814
Total bills paid within target	65,425	295,535
Percentage of bills paid within target	84%	90%

Income from the provision of goods and services

The Trust has met the requirement in section 43(2A) of the *National Health Service Act 2006* (as amended by the *Health and Social Care Act 2012*), which requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes.

Staff report

Fulfilling our potential

We will only achieve delivery of our strategy by ensuring that we attract and retain the right people, working together to create a culture that enables us to learn and thrive.

Equality, diversity and inclusion

In order to provide the highest quality healthcare to children and their families we need to recruit the best possible staff, and for all these staff to be treated with respect and valued. The Trust has developed *Our Always Values*, a set of shared values and behaviours which characterise all our dealings with each other, our patients and families. Recognising, respecting and valuing diversity are important in order to underpin these expectations.

In 2018 we celebrated Black History Month, LGBT History Month and International Women's Day, working with our newly established BAME, LGBT and Women's forums to run a series of events celebrating and recognising the contribution of all our staff. Each of the forums has an executive sponsor working alongside the forum teams.

We were delighted that our LGBT+ staff marched at Pride 2018 for the first time. We are already planning our 2019 participation.

We published our extensive annual staff data report, our Workforce Race Equality Scheme report and action plan as well as our Gender Pay Gap report in March 2019 and will be working with our staff in the coming year to understand the data and implement required actions to ensure GOSH is a welcoming, supportive and inclusive environment for all our service users and staff.

Our staff

In 2018/19, the Trust employed an average of 4,776 full-time equivalent (FTE) staff.

On 31 March 2019, the gender mix of GOSH directors, senior managers and staff was:

	Female	Male
Director	46% (6)	54% (7)
Senior managers	56% (14)	44% (11)
Staff	77% (3870)	23% (1137)

The table below provides analysis of the cost of staff for the year 2018/19.

Employee costs	Year to 31 March 2019				Year to 31 March 2018
	Total	Permanent ly Employed	Other		Total
	£000	£000	£000		£000
Salaries and wages	224,600	213,393	11,207		209,549
Social security costs	22,957	22,957	0		20,933
Apprenticeship levy	1,032	1,032	0		938
Pension cost – defined contribution plans employer's contributions to NHS pensions	25,288	25,288	0		23,063
Pension costs – other	64	64	0		61
Temporary staff – agency/contract staff	3,436	0	3,436		4,819
Termination benefits	471	471	0		0
Total gross staff costs	277,848	263,205	14,643		259,363

Recoveries from DHSC Group bodies in respect of staff cost netted off expenditure	(1,706)	(1,706)	0	(1,844)
Recoveries from other bodies in respect of staff costs netted off expenditure	(804)	(804)	0	(839)
Total staff costs	275,338	260,695	14,643	256,680
Included within:				
Costs capitalised as part of assets	6,881	6,187	694	4,273
Analysed into operating expenditure				
Employee expenses – staff and executive directors	247,115	238,074	9,041	232,851
Research and development	18,000	13,116	4,884	16,254
Education and training	2,871	2,847	24	3,302
Redundancy	0	0	0	0
Total employee benefits excluding capital costs	267,986	254,037	13,949	252,407
Average number of people employed*	Year to 31 March 2019			Year to 31 March 2018
	Total	Permanently Employed**	Other	Total
	Number	Number	Number	Number
Medical and dental	681	654	27	634

Administration and estates	1,335	1,292	43	1,239
Healthcare assistants and other support staff	283	283	0	292
Nursing, midwifery and health visiting staff	1,552	1,548	4	1,526
Scientific, therapeutic and technical staff	920	836	84	780
Other staff	5	5	0	5
Total	4,776	4,618	158	4,476
*Whole Time Equivalent				
** Includes Bank Staff				

Disability

During 2018 our second cohort of eight Project Search interns, formed of young people with learning disabilities, graduated successfully from the scheme successfully and a third intake commenced at the hospital. This scheme provides young people with both valuable work and life experiences in order to prepare them for employment.

We have a Recruitment and Selection Policy and an Equality at Work Policy and which supports the employment, training and development of all our staff including those staff who have disabilities. We now include unconscious bias in both our recruitment and selection and appraisal training for managers.

In 2018 GOSH maintained its Disability Confident Committed status, and in 2019 will work towards Level 2 status. This is a government scheme, replacing the two-tick scheme, to help people with disabilities secure employment.

In the coming year we will prepare for the completion of the Workforce Disability Standard and the launch of the staff disability and long-term health conditions forum.

Staff survey

The NHS staff survey is conducted annually. From 2018 onwards, the results from questions are grouped to give scores in ten indicators. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those.

The response rate to the 2018 survey among trust staff was 50% (2017: 45%). The GOSH response rate of 50% is above the London average (48%). Scores for each indicator

together with that of the survey benchmarking group (Acute Specialist Trusts) are presented below.

	2018/19		2017/18		2016/17	
	Trust	Benchmark Group	Trust	Benchmark Group	Trust	Benchmark Group
Equality diversity and inclusion	8.9	9.3	8.8	9.3	9.2	9.3
Health and wellbeing	5.7	6.3	6.1	6.3	6.4	6.3
Immediate managers	6.7	7.0	6.6	6.9	6.9	6.9
Morale*	5.9	6.3				
Quality of appraisals	5.6	5.7	5.6	5.5	6.0	5.5
Quality of care	7.5	7.8	7.6	7.7	7.8	7.8
Safe environment – bullying and harassment	7.9	8.2	7.9	8.4	8.1	8.3
Safe environment – violence	9.7	9.7	9.6	9.7	9.7	9.7
Safety culture	6.7	6.9	6.6	6.9	6.9	6.9
Staff engagement	7.2	7.4	7.3	7.4	7.5	7.5

*Morale is a new theme for 2018, data for previous years not available

For the first time, in 2018 all staff at GOSH were invited to take part in the survey, and both online and paper surveys were used. This resulted in 2,251 responses being received, representing 50% of the workforce, and is above the national average of 46%. This represents a significantly greater number of responses compared to 2017, when 45% of a sample group completed the survey.

Our results show that 88% of staff respondents would be happy for a friend or relative to be treated at the Trust and 67% would recommend GOSH as a place to work. Our staff engagement score remains above the NHS average.

Our results are broadly similar to previous years across most findings. There were improvements in the percentage of staff experiencing physical violence from colleagues, and staff indicating they feel confident and secure reporting unsafe clinical practice. But there were deteriorations in the percentage of staff feeling unwell due to work related stress and those agreeing that the organisation and management are interested in taking action on staff health and wellbeing.

Future priorities and targets

The key actions associated with addressing the staff survey findings will be incorporated into the development of the Integrated People Strategy, which will comprise four pillars:

- Capacity – strategic workforce planning, resourcing, recruitment and retention
- Infrastructure – policies, processes, systems and structures
- Skills – clinical, technical and generic, including leadership, management and change management
- Culture and Engagement – ensuring all our people are able to be and do their best

Our survey results indicate the need to prioritise the “Culture and Engagement” workstream of the People Strategy. The purpose of this is to ensure our people feel that they are well led and well managed, but also supported and empowered to be and do their best.

Recognising reward and performance

We continue to emphasise the importance of appraisals as an opportunity for line managers to recognise the achievements of individuals. During 2018/19 PDR (appraisal) rates averaged 83%, with an increase to 85% by March 2019. Consultant appraisals in 2018/19 averaged 83%. The 2018 Staff Survey results showed the Trust performance for quality of appraisals had slipped to below the national average for peer trusts. A multidisciplinary working group was established to review the PDR process and identify how to improve compliance and usefulness of the review, as well as embedding the national Agenda for Change amendments.

Our GOSH GEMS awards attract high quality nominations from staff as well as patients and families and during the year we were delighted to receive over 270 nominations for exceptional teams and individuals, with 26 awards being given. In 2019 we will continue to promote GEMS nominations to our colleagues to embed a culture that recognises staff.

In May 2018, staff came together to celebrate the achievements of all those who work at GOSH at the annual award ceremony. The awards, which have been running for 11 years, received almost 500 nominations. They are an opportunity to hear directly from patients and parents about the difference we can make to their lives through outstanding clinical care and living *Our Always Values*.

Engaging and listening to staff

We take engagement with our staff very seriously. We provide frequent opportunities for staff across the hospital to ask questions and share ideas, particularly with senior colleagues. This is important in helping us to live *Our Always Values* of Always One Team and Always Expert:

- Every month, our Chief Executive Matthew Shaw holds “Mat’s Big Briefing” – these are informal briefings, open to all staff and volunteers to give updates and give an opportunity to ask questions on the big things going on at GOSH. Our weekly senior leadership meetings have been extended to include a wider audience of clinical leaders as well as managers.

- We continue to hold regular discussions with formal staff representatives through our Staff Partnership Forum, Local Negotiating Committee and Members Council.
- Formal feedback data is collected via the annual NHS Staff Survey, quarterly Staff Friends and Family Test and exit questionnaires.

With the development of our People Strategy we will enhance the ways we engage and listen to staff.

Raising concerns at GOSH

Implementation of the Trust's Raising Concerns in the Workplace Policy is monitored by the Audit Committee. In the 2018 staff survey, 94% of staff would know how to report a concern about unsafe clinical practice, and 71% would feel secure about raising their concerns. These results are similar to other acute specialist hospitals.

We continue to embed the role of GOSH Freedom to Speak Up (FTSU) Ambassador service for staff to discuss any concerns they may have. This service is provided by a multi-professional group of GOSH staff and led by the FTSU Guardian. It allows representation to be achieved across the Trust as well as accessibility.

Speaking up at the Trust

The Trust believes that every member of staff has a duty to raise concerns and is committed to supporting staff to raise and openly discuss concerns at the earliest reasonable opportunity. A number of ways in which this can be achieved are promoted. Staff can use the incident reporting system or talk to their line manager. They can make safeguarding referrals or speak to the FTSU team. Concerns can also be raised by following the Trust's whistleblowing policy and procedures.

In addition professionally registered staff have duties imposed upon them to raise such concerns by their respective professional regulatory bodies, such as the GMC, NMC and ACCA.

The Trust has also implemented the 'Speaking up' programme to encourage staff to raise their concerns.

GOSH Learning Academy

In 2018/19, an Education and Training Strategy was developed collaboratively with both internal and external stakeholders to deliver the strategic priorities identified in our new Trust Strategy, *Fulfilling Our Potential*.

Our vision is to establish the GOSH Learning Academy. Our ambition is to be the first choice for multi-professional paediatric healthcare education, training, and development for the whole workforce, utilising state-of-the-art technology in contemporary learning environments. A modern operating model and strategic framework was developed during the year underpinning this ambition. The Learning Academy is scheduled to launch in September 2019 with the outline business case to be submitted for approval in 2019/20, securing the resources required to deliver the strategy.

Learning and Development at GOSH

Learning and Development increased its activity over the past year and facilitated a total of 248 courses, which involved 1,761 hours of sessions, where 5,762 delegates attended.

On top of increased activity, the team has expanded many programmes and embarked on new projects. Some main achievements include:

- A large growth in apprenticeships with 110 starters, exceeding the annual public sector target. Newly introduced programmes include Healthcare Scientist, Network Engineer, and Data Analyst.
- The Induction Programme was redesigned integrating EPIC and Speak Up initiatives and engagement activities information.
- New coaching workshops were implemented as part of embedding compassionate leadership at GOSH, where 100 employees attended.
- New documentation was published for staff to support retention – *Developing your career at GOSH*.
- There was greater collaboration with our STPs, streamlining administration of statutory and mandatory training and assessing possible transfer to a new system.
- A Succession Planning and Talent Management workstream programme was created to identify opportunities to build career pathways for high-potential administrative workers, graduates, and apprentices.

Nursing and Non-medical Education

The Nursing and Non-medical Education team sustained growth in overall activity with an 11% increase from the previous year. A successful year saw existing programmes continued and many new and contemporary education and training courses implemented. Some of our main achievements included:

- The team supported 723 multi-professional staff on continued professional development.
- We ran 10 postgraduate academic modules across cardiac, neonates, PICU, renal, and respiratory specialties with a new module validated with partners across the STP.
- The Clinical Simulation Centre delivered 10,308 candidate hours to 2,834 multi-professional learners - a 10% increase from 2017/18.
- We acted as the Lead Trust for Health Education England's (HEE) Nursing Associate pilot, collaborating with five other trusts; 15 Nursing Associates attained Nursing and Midwifery Council registration, and a Nursing Associate Apprenticeship was developed for 2019/20.
- The team facilitated 5,022 Pre-registration Nursing placement weeks across 37 clinical areas, and our partnerships with Higher Education Institutions increased to seven—the largest in GOSH history.
- 155 new nurses commenced the two-year Band 5 Development Programme, and our largest ever intake of 251 new nurses in 2017/18 entered the second year of the programme.
- Numerous new multi-professional development programmes were designed.

Postgraduate Medical Education

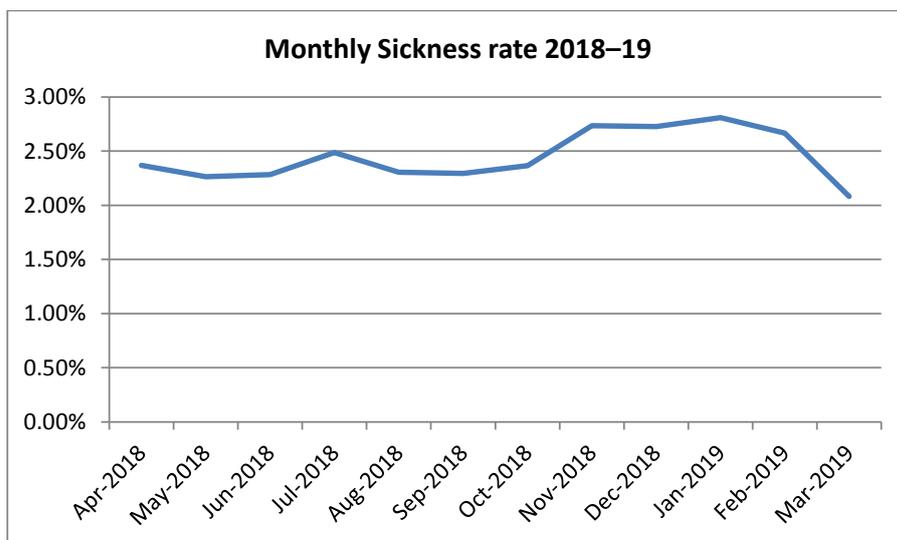
The Postgraduate Medical Education (PGME) department also saw sustained growth in courses over the last year, with an 86% increase in educational events involving 1,379 multi-professional candidates.

A productive and successful year saw some great areas of collaboration in postgraduate education and training development. Some main achievements include:

- The second annual GOSH Conference ‘Continuous Care’ took place in November 2018 with 195 attendees and 150 abstract submissions, showcasing the amazing work taking place across GOSH. All submitted abstracts were published in the *Archives of Disease in Childhood*.
- The PGME and Nursing and Non-Medical Education teams facilitated the first *Children’s Hospitals Education Specialist Symposium (CHES)*, attended by multi-professional education leads from children’s hospitals across the UK. The event was the first of its kind and a great success for the GOSH Learning Academy.
- The team successfully facilitated the formal Royal College of Paediatrics and Child Health Membership exams for a second year with excellent feedback from external examiners. This would not be possible without the help of our wonderful patients and their families.

Health and sickness

The graphs below show our monthly sickness rate over 2018/19. Our sickness rate at March 2019 has increased to 2.5% from 2.4% in March 2018. This is below our target and the NHS average reported rate. The Trust has rolled out a new rostering system in nursing areas in 2018, and will roll out across the other staff groups during 2019. This will allow for improvements to the accuracy of absence reporting.



Staff safety and occupational health

The Trust is committed to effectively minimising risks, controlling hazards and preventing harm to all. This is done through a proactive programme of risk assessment and audit. There are clear processes for incident reporting and we encourage a culture in which staff report incidents. In 2018-19 GOSH employees reported 849 health and safety incidents including 129 patient safety accidents. This has increased from 800 incidents in 2017/2018. This included one serious incident. Five incidents were reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations.

The Trust's governance structure ensures statutory compliance is undertaken within legislative requirements. Assurance via the Health and Safety Committee has been provided on a range of subjects such as violence against staff, sharps compliance, Control of Substances Hazardous to Health and fire safety. Maintaining compliance in a complex and diverse environment can present challenges. We are continuously assessing and auditing to allow us to review and develop our systems to manage risk more effectively.

Trade Union facility time

The Trust has 13 trade union representatives across the organisation. The representatives spent an average of 2% of their work time on union activities (49 hours per month in total).

The total cost of union activities was less than 1% of the total pay bill for the year.

Countering fraud and corruption

We have a countering fraud and corruption strategy. Counter fraud arrangements are reviewed during the year by the Local Counter Fraud Service (LCFS). The LCFS undertakes an ongoing programme of work to raise the profile of counter fraud measures and carry out ad hoc audits and specific investigations of any reported alleged frauds. The LCFS delivers fraud awareness presentations and fraud awareness surveys. The Audit Committee receives and approves the counter fraud annual report, monitors the adequacy of counter fraud arrangements at the Trust and reports on progress to the Board.

Expenditure on consultancy

Consultancy expenditure can be found in note 4 of the annual accounts on page xx.

Exit packages

Information about exit packages can be found on page xx.

Modern Slavery statement for 2019/20

GOSH supports the Government's objectives to eradicate modern slavery and human trafficking, and recognises the significant role the NHS has to play in both combatting it and supporting victims. In particular, we are committed to ensuring our supply chains and business activities are free from ethical and labour standards abuses. Steps taken to date include:

People

The Trust makes appropriate pre-employment checks on all directly employed staff. Only agencies on approved frameworks are used and they are audited to provide assurance that pre-employment clearance has been obtained for all agency staff.

There is a range of policies and procedures designed to protect staff from poor treatment and/or exploitation, which comply with all relevant employment law and the Advisory, Conciliation and Arbitration Service code of practice. These include the provision of fair pay rates based on nationally negotiated terms and conditions of employment. There is also a range of benefits, including health and wellbeing support, and access to training and development opportunities

Where changes to employment, work, organisation and policies and procedures are proposed, there is communication, consultation and negotiation with Trade Unions.

Efforts to engage and involve staff in matters which affect them include regular staff briefings and consultation with a range of staff forums, including BAME and LGBT.

Procurement and our supply chain

Most of our products are purchased from UK or EU based firms, who may also be required to comply with the requirements of the UK Modern Slavery Act (2015) or similar legislation in other EU states.

A significant number of products are purchased through NHS Supply Chain, whose 'Supplier Code of Conduct' includes a provision around forced labour.

Where possible and consistent with the Public Contracts Regulations, the Trust builds long-standing relationships with suppliers.

Training

Advice and training about modern slavery and human trafficking is available to staff through our Safeguarding Children and Adults training, our safeguarding policies and procedures and our Safeguarding team.

Responding

Any concerns about modern slavery are taken seriously and managed sensitively, and support is provided. This includes referring to external agencies, where appropriate.

Approval

This statement has been approved by the Chief Nurse who chairs the Strategic Safeguarding Committee, which will review and update it on an annual basis

Off payroll engagements

Information about off payroll engagements can be found on page **xx**.

Disclosures

Principal activities of the Trust

Information on our principal activities, including performance management, financial management and risk, efficiency, employee information (including consultation and training) and the work of the research and development directorate and International and Private Patients is outlined in the performance report. Page XX summarises GOSH's purpose and activities.

Going Concern

Our going concern disclosure can be found on page X.

Directors' responsibilities

The directors acknowledge their responsibilities for the preparation of the financial statements.

Safeguarding external auditor independence

While recognising that there may be occasions when the external auditor is best placed to undertake other accounting, advisory and consultancy work on our behalf, the Board seeks to ensure that the auditor is, and is seen to be, independent. We have developed a policy for any non-statutory audit work undertaken on our behalf, to ensure compliance with the above objective. The Council has approved this policy, and it is monitored on an annual basis, or as a query arises.

Code of Governance

Great Ormond Street Hospital for Children NHS Foundation Trust has applied the principles of *The NHS foundation trust Code of Governance* on a 'comply or explain' basis. *The NHS foundation trust Code of Governance*, most recently revised in July 2014, is based on the principles of the *UK Corporate Governance Code* issued in 2012.

Throughout our annual report we describe how we meet the Code. A summary of where detail can be found on the issues we are required to disclose is given in the following table.

Code reference	Section of annual report
A.1.1	Accountability Report: <ul style="list-style-type: none"> • Council of Governors (role of Council) • Trust Board (role of Trust Board) • Annual Governance Statement (role of Trust Board)
A.1.2	Accountability Report - Trust Board members 2018-19
A.5.3	Accountability Report - Governors' attendance at meetings

Code reference	Section of annual report
Additional requirement	Accountability Report - Trust Board members 2018-19 Accountability Report - Governors' attendance at meetings
B.1.1	Accountability Report - Trust Board members 2018-19
B.1.4	Accountability Report - Trust Board members 2018-19
Additional requirement	Accountability Report - Trust Board members 2018-19
B.2.10	Accountability Report: Trust Board Nominations Committee Council of Governors' Nominations and Remuneration Committee
Additional requirement	Not applicable
B.3.1	Accountability Report - Trust Board members 2018-19
B.5.6	Accountability Report – Membership Engagement
Additional requirement	Not applicable
B.6.1	Accountability Report – Evaluation of Board performance
B.6.2	Accountability Report – Evaluation of Board performance
C.1.1	Disclosures -Statement of the chief executive's responsibilities as the accounting officer of Great Ormond Street Hospital for Children NHS Foundation Trust
C.2.2	Accountability Report – Audit Committee Report
C.3.5	Not applicable for 2018/19
C.3.9	Accountability Report – Audit Committee Report
D.1.3	Remuneration Report
E.1.4	Accountability Report – Council of Governors

Code reference	Section of annual report
E.1.5	Accountability Report - Trust Board and Council of Governors working together
E.1.6	Accountability Report - Membership constituencies and membership numbers 2018-19 and Membership Engagement
Additional requirement	Accountability Report – Council of Governors
Additional requirement	Accountability Report – Register of Interest (Directors) and Register of Interests (Governors)
B.1.2	<p>The Board is normally comprised of a Chair, Deputy Chair, Senior Independent Director (SID), three additional independent Non-Executive Directors, and six Executive Directors. One of the Non-Executive Directors is appointed by University College London.</p> <p>Mr Chris Kennedy joined the Board as a non--executive director on 1 April 2018 and Ms Kathryn Ludlow joined as a non--executive director from 6 September 2018. From 31 May 2018 until the appointment of Ms Kathryn Ludlow, the Board comprised a chair and five non--executive directors, including one appointed by University College London.</p>
B.2.2	<p>The directors on the Board have all been required to sign a statement declaring that they meet the criteria of a 'fit and proper person'.</p> <p>Governors are asked to make a declaration about their fitness to hold the role of Governor and are subject to a DBS check every three years (and on appointment/ election). Further checks are underway with regards director disqualifications and bankruptcy and on an annual basis.</p>
B.6.5	An evaluation of Council was due in 2018. A decision has been taken to delay this to Q2 2019/20, allowing time for new governors to be inducted and become familiar with their roles.

Transactions with related parties

Transactions with third parties are presented in the accounts on page **xx**. None of the other Board members, the foundation trust's Governors, or parties related to them have undertaken material transactions with the Trust.

Consultations in year

In 2018/19, we have consulted patients, families, members, the public and staff on a variety of issues:

- The Young People's Forum and our staff took part in the Takeover Challenge, a national event launched by the Children's Commissioner for England, which challenges young people to take over prominent job roles within professional organisations.

- In October, young people from Birmingham, Bristol, Derby, Leeds, Manchester, Nottingham, Oxford and other London hospitals joined members of our Young People's Forum for the first ever Big Youth Forum Meet Up (see page xx).
- We consulted with staff about the structure of the clinical operational directorates.
- We consulted with teams and experts from across the Trust including our Young People's Forum, contractors and external stakeholders including the WHO, NHS Improvement and NHS England, the NHS SDU, Royal College of Physicians, Royal College of Paediatrics and Child Health and London Borough of Camden on development of the Clean Air Hospital Framework (see page xx).

Pension funding

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme, which covers all NHS employers. The Trust makes contributions of 14.3% to the scheme. From July 2013, staff who are not eligible for the NHS Pension Scheme have been subject to the auto-enrolment scheme offered by the National Employment Savings Trust. In 2018/19, the Trust contributed 1% for all staff who remain opted in. In addition to the above, the Trust has members of staff who are in defined contribution pension schemes for which it makes contributions.

Accounting policies for pensions and other retirement benefits are set out in note XX to the accounts.

Remuneration of senior managers

Details of senior employees' remuneration can be found in page XX of the remuneration report.

Treasury Policy

Surplus cash balances are lodged on a short-term basis with the National Loan Fund through the Government Banking Service.

Statement of compliance with cost allocation and charging

The Trust has complied, to the extent relevant, with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance.

Trust Board member expenses

Directors can claim reasonable expenses for carrying out their duties. For the year 2018/19, the total amount claimed by five board members was £17,638.70.

Information governance

The implementation of the Information Governance Framework at GOSH is monitored by the Information Governance Steering Group (IGSG). Chaired by the Trust Caldicott Guardian, this group manages risks to data governance security and provides assurance to the Trust's Audit Committee. IGSG meets monthly and reviews areas affecting data quality, records management and information security. Key considerations for its work plan are outlined by

the new Data Security and Protection (DSP) Toolkit. This submission is how the Trust demonstrates it is practising good data security and that personal information is handled correctly. Compliance is required for access to NHS patient data and NHS digital systems but also for many of the Information Sharing Agreements the Trust will enter in.

The implementation of the General Data Protection (GDPR) Legislation in May 2018 drove the information governance work programme over the last year. While a lot of the changes were already requirements for NHS organisations, improvements were still required. This included a focus on reviewing all personal data processing, how individuals access the data GOSH holds on them, and how patients are informed of their options with regards to data sharing.

Over the coming year the Trust will continue to ensure the requirements under GDPR are embedded and that specific areas of improvement identified via the DSP Toolkit have action plans agreed. Training and staff awareness are a key focus to help prevent information breaches. Incidents, near misses and their subsequent lessons learnt are used to inform the training and communication programme, ensuring it remains dynamic and reflects current and meaningful issues to facilitate greater staff engagement and ownership of information governance processes.

With the launch of the new EPIC system and the tools and benefits it brings, GOSH has an opportunity to further develop its commitment to confidentiality. Patients and families will now be able to use the secure online portal, MyGOSH, to access their appointment and medical details. We will have better controls to secure patient records and monitor access to records, combining several different systems ensures one clear, accurate and up-to-date patient record.

Further information can be found in the annual governance statement on page **XX**.

How we govern quality

We place the highest priority on quality, measured through our clinical outcomes, patient safety and patient experience indicators. Our patients, carers and families deserve and expect the highest quality care and patient experience. Despite a range of changing and increasing pressures, we must ensure we manage and deliver services in a way that never compromises our commitment to safe and high-quality care. The key elements of our quality governance arrangements are outlined in the annual governance statement on page **XX**.

Registration with the CQC

GOSH is registered with the CQC as a provider of acute healthcare services. The CQC visited the Trust in January 2018 as part of its rolling schedule of inspections. The report was published in April 2018 and services were rated as 'good' overall and 'outstanding' for being caring and for being effective. The also CQC conducted a well-led inspection and the Trust was rated 'requires improvement' – further information can be found on page **XX**. The Trust has developed an action plan in response to the recommendations. Further information on progress with the plan can be found on page **xx**.

Complaints and how we handle them

The Trust takes all complaints seriously and is committed to being fair, open and transparent when dealing with any complaint. All complaints are acknowledged and the complaints team try to speak with all complainants to understand their complaint and the outcome they are seeking. Complaints are managed promptly, sensitively and timescales are agreed with the complainant while taking into consideration individual circumstances.

A final response is sent from a member of the Executive Team, which aims to provide appropriate and proportionate remedies. If a complainant is dissatisfied with the response to their complaint the Trust aims to work with them to try and resolve their concerns. This includes offering a meeting with the staff members or teams involved where appropriate. If the complainant is not satisfied by the Trust's response, they can request the Parliamentary and Health Service Ombudsman (PHSO) to review their complaint.

As part of complaint investigations, lessons are identified and action plans are devised to improve the service and experience for our patients and families. The Trust uses the Datix system to record, analyse and report on the learning from complaints. Complaint trends and the actions taken in response to these are reported to the Trust Board and a number of committees including the Patient and Family Experience and Engagement Committee.

In 2018/19, the Trust received 98 formal complaints with 95 of these complaints being thoroughly investigated (two were later withdrawn and one could not be investigated in line with the NHS Complaint Regulations due to the significant lapse in time since the events being complained about). During the year, no new complaints were investigated by the PHSO.

Detail of political and charitable donations

The Trust has not made any political or charitable donations during 2018/19.

NHSI's Single Oversight Framework

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

Segmentation

For 2018/19, the Trust continued to be placed in Segment 2 by NHS Improvement. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the trust disclosed above might not be the same as the overall finance score here.

Area	Metric	2018/19 scores			
		Q1	Q2	Q3	Q4
Financial sustainability	Capital service capacity	1	1	1	1
	Liquidity	1	1	1	1
Financial efficiency	I&E margin	1	1	1	1
Financial controls	Distance from financial plan	1	1	1	1
	Agency spend	1	1	1	1
Overall scoring		1	1	1	1

NHSI well-led framework

As part of their routine scheduled inspection programme, the CQC conducted a well-led inspection of the Trust in January 2018. The Trust was rated as 'requires improvement'.

The Trust developed an action plan in response to the negative points raised in the report and the plan was monitored by the Executive Team and reported to the Trust Board and Council of Governors (see page xx).

Working with partner and stakeholder organisations

During 2018/19, we have entered into or continued with formal arrangements with the following organisations, which are essential to the Trust's business.

The UCL Great Ormond Street Institute of Child Health

The Trust has a close and unique partnership with the UCL Great Ormond Street Institute of Child Health (ICH), working together to develop innovative new treatments for children with

rare diseases. Together, we host the National Institute for Health Research (NIHR) Great Ormond Street Biomedical Research Centre (BRC) and represent the largest concentration of paediatric research expertise in Europe, and the largest outside of North America.

Great Ormond Street Hospital Children's Charity

GOSH Children's Charity is a vital partner that offers tremendous support both by raising money directly and through its network of corporate partners. The charity makes it possible for us to redevelop our buildings, buy new equipment, fund paediatric research conducted at the hospital and the ICH, and to make the patient experience as good as it can be. In 2018/19, the charity's total income was just over £83million – another strong year. Further information about the work of the Charity can be found at gosh.org.

Our commissioners

More than 90% of our clinical services are commissioned by NHS England, with the remaining 10% being delivered through arrangements with over 204 clinical commissioning groups. We have a proactive working relationship with NHS England, and hold regular contract meetings with commissioners to discuss service demand, quality indicators and finance. Many of our clinicians are engaging with the clinical reference groups established by NHS England to provide clinical input into the standards and strategic planning of each specialised service.

Other key partners include:

- UCL Partners (see page xx for further information)
- Children's Alliance (see page xx for further information)
- European Children's Hospital Organisation (see page xx for further information)
- Clinical networks and our referrers (see page xx for further information)

Disclosure of information to auditors

The Trust Board directors, of who held office at the date of approval of this annual report and accounts, confirm that, so far as they are each aware, there is no material audit information of which the Trust's auditors are unaware, and each director has taken all the steps that he/she ought to have taken as a director to make himself/herself aware of any relevant audit information and to establish that the Trust's auditors are aware of that information.

The directors consider that this annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for readers to assess the Trust's performance, business model and strategy.

Signed.....

Mr Matthew Shaw

Chief Executive

Date: xx May 2019

Statement of the chief executive's responsibilities as the accounting officer of Great Ormond Street Hospital for Children NHS Foundation Trust

NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Great Ormond Street Hospital for Children NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Great Ormond Street Hospital for Children NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- Observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis.
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements.
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance.
- Confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy.
- Prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above-mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Signed.....

Mr Matthew Shaw

Chief Executive

Date: xx May 2019

Audit Committee report

Introduction from the Chairman of the Audit Committee

I am pleased to present the Audit Committee's report on its activities during the year ending 31 March 2019.

The Audit Committee is a non-executive committee of the Trust Board with delegated authority to review the establishment and maintenance of an effective system of integrated governance, risk management and financial, non-financial internal controls, which support the achievement of the organisation's objectives.

Key responsibilities of the committee include monitoring the integrity of the Trust's annual report and accounts, and the effectiveness, performance and objectivity of the Trust's external and internal auditors. Also, the committee is required to satisfy itself that the Trust has adequate arrangements for counter fraud, managing security and ensuring that there are arrangements by which staff of the Trust may raise concerns.

The Quality, Safety and Experience Assurance Committee consider clinical risks and their associated controls (see page XX).

The table on page XX sets out, in detail, the responsibilities of the Audit Committee and how we have discharged those duties. The report also highlights the key areas considered by the committee in 2018/19, but I would like to draw particular attention to the following items:

The Trust has undertaken a review of the appropriateness of the adoption of the going concern basis for the preparation of the accounts. This effectively reflects the confidence of the Trust that the organisation remains financially viable. In year the Trust successfully responded to NHS England process to secure the ongoing delivery of its services. As a result of this a new three plus two year contract has been signed for 2019/20 onwards, which covers the majority of the Trusts services. A plan to meet the 2019/20 control total has been submitted to NHS Improvement. This aligns contracts agreed with commissioners. We are confident that Trust management has clearly adopted the appropriate accounting basis and recognises that the financial challenges faced by the wider NHS are significant.

The committee worked with the Council of Governors to seek appointment of an external auditor for the Trust from 1 April 2019. Following a formal tender process agreed by the Council, governors and Audit Committee members recommended the re-appointment of Deloitte LLP as the Trust's external audit for a three year period (with an option to extend for a further two years) and this was approved by the Council of Governors in November 2018.

Following a formal tender process conducted by the Audit Committee, the Trust reappointed KPMG LLP as the Internal Auditor and appointed Grant Thornton UK LLP as the Counterfraud specialist (both for a three year contract)

The committee met four times over the financial year, and I am satisfied that it was presented with papers of good quality, in a timely fashion, to allow due consideration of the subjects under review. I am also satisfied that meetings were scheduled to allow sufficient time to enable a full and informed debate. Each meeting is fully minuted, and summaries of

the matters discussed at each meeting are reported to the Trust Board and Council of Governors. Members of the Council of Governors also observed committee meetings throughout the year.

The committee reviewed its effectiveness annually and no material matters of concern were raised in the 2018/19 review.

The Audit committee is composed of three independent non-executive directors. These are listed on page XX. Two of the non-executive members of the committee are qualified accountants and all three members have recent and relevant financial experience.

Mr Akhter Mateen

Chair of the Audit Committee

22 May 2019

Audit Committee responsibilities

The committee's responsibilities and the key areas discussed during 2018/19, whilst fulfilling these responsibilities, are described in the table below:

	Principal responsibilities of the Audit Committee	Key areas formally discussed and reviewed by the committee during 2018/19
<p>Review of the Trust's risk management processes and internal controls</p>	<ul style="list-style-type: none"> • Reviewing the Trust's internal financial controls, its compliance with NHS Improvement's guidance for foundation trusts, including the Code of Governance, and the effectiveness of its internal control and risk management systems. • Reviewing the principal non-clinical risks and uncertainties of the business and associated annual report risk management disclosures. (Clinical risks are reviewed by the Quality and Safety Assurance Committee.) 	<ul style="list-style-type: none"> • The outputs of the Trust's risk management processes including reviews of: • The Board Assurance Framework – the principal risks and uncertainties identified by the Trust's management and movement in the impact and likelihood of these risks in the year. • An annual assessment on the effectiveness of internal control systems taking account of the findings from internal and external audit reports. • An annual report and fraud risk assessment prepared by the Trust's counter fraud officer. • An annual report from the Trust's security manager • Assurance of controls in place for emergency planning and business continuity • Assurance of the investigation, findings and actions taken following <ul style="list-style-type: none"> ○ a power outage in part of the Trust ○ ICT outages in December 2018 ○ a fraud involving the GOSH telephone system • Assurance of plans to manage debt provisioning

	Principal responsibilities of the Audit Committee	Key areas formally discussed and reviewed by the committee during 2018/19
Financial reporting and external audit	<ul style="list-style-type: none"> • Monitoring the integrity of the Trust’s financial statements and annual financial returns; reviewing significant financial reporting judgements contained within them. • Making recommendations to the Board regarding the appointment of the external auditor. • Monitoring and reviewing the external auditor’s independence, objectivity and effectiveness. • Developing and implementing policy on the engagement of the external auditor to supply non–audit services, taking into account relevant ethical guidance. 	<ul style="list-style-type: none"> • A commentary on the annual financial statements • Key accounting policy judgements, including valuations • Impact of changes in financial reporting standards where relevant (IFRS 9 and IFRS 15) • Basis for concluding that the Trust is a going concern • External auditor effectiveness and independence • External auditor reports on planning, a risk assessment, internal control and value for money reviews • External auditor recommendations for improving the financial systems or internal controls • Review of non–audit work conducted by the external auditors • Appointment of the Trust’s External Auditor

	Principal responsibilities of the Audit Committee	Key areas formally discussed and reviewed by the committee during 2018/19
<p>Internal audit</p>	<ul style="list-style-type: none"> • Monitoring and reviewing the effectiveness of the company's internal audit function, including its plans, level of resources and budget. 	<ul style="list-style-type: none"> • Internal audit effectiveness and charter defining its role and responsibilities • Internal audit programme of reviews of the Trust's processes and controls to be undertaken, and an assurance map showing the coverage of audit work over three years against the risks • Status reports on audit recommendations and any trends and themes emerging • The internal audit reports discussed by the committee included: <ul style="list-style-type: none"> - key financial controls (significant assurance with minor improvement potential) - contract management (partial assurance with improvements required) - facilities management (significant assurance with minor improvement potential) - risk management (significant assurance with minor improvement potential) - budget reporting (significant assurance with minor improvement potential) • Appointment of the Trust's Internal Auditor

	Principal responsibilities of the Audit Committee	Key areas formally discussed and reviewed by the committee during 2018/19
Other	<ul style="list-style-type: none"> • Reviewing the committee’s terms of reference and monitoring its execution. • Considering compliance with legal requirements, accounting standards. • Reviewing the Trust’s whistle–blowing policy and operation. 	<ul style="list-style-type: none"> • Review of SFIs and Scheme of Delegation • Review of Audit Committee’s terms of reference and workplan • The impact of new regulations • Updates on compliance with GDPR preparation and implementation and data quality • Assurance of the delivery of the Trust cyber security strategy • Updates on staff raising concerns policy (Whistleblowing) and issues raised with Freedom to Speak Up Ambassadors • Monitoring of the process for and approval of procurement waivers • Reporting to the Board and Council of Governors where actions are required and outlining recommendations • Assurance of compliance with the Bribery Act 2011 • Appointment of a new counterfraud specialist

Effectiveness of the committee

The committee reviews its effectiveness and impact annually, using criteria from the NHS Audit Committee Handbook and other best practice guidance, and ensures that any matters arising from this review are addressed.

The information from the committee self–assessment survey 2018/19 was used to review and update the committee’s terms of reference in May 2019 with no major changes being made.

The committee also reviews the performance of its internal and external auditor’s service against best practice criteria as detailed in the NHS Audit Committee Handbook.

External audit

Their audit and non-audit fees are set, monitored and reviewed throughout the year and are included in note XX of the accounts.

Internal audit and counter-fraud services

Internal audit services were provided by KPMG LLP during 2018/19 covering both financial and non-financial audits according to a risk-based plan agreed with the Audit Committee.

The Trust's counter-fraud service was provided by TIAA Ltd during 2018/19, who provided fraud awareness training, carry out reviews of areas at risk of fraud and investigate any reported frauds.

Key areas of focus for the Audit Committee in the past year

Data quality reviews

During the year, the committee was assured that progress had continued to be made to improve data quality across the Trust and that plans were in progress within the EPR project build to ensure safeguards are in place to minimise data quality risks in the future. The committee received assurance that a new data quality action plan would be developed, including a review of the data quality kite marking framework and update to the Data Quality Policy.

Board Assurance Framework (BAF)

The Audit Committee reviewed the BAF in detail this year. The Risk Assurance and Compliance Group reviewed each strategic risk on the BAF along with the related mitigation controls and assurances.

For each risk, the Audit Committee reviewed the risk assessment (including risk definition, risk appetite, and likelihood and impact scores), the robustness of the controls and the evidence available that the controls were operating. The Committee received presentations on strategic risks at each committee meeting based upon focused questions posed to risk owners by Audit Committee members prior to each meeting.

Preparing for GDPR

The Audit Committee received updates on progress against the introduction of GDPR and were assured of the actions taken and plans in place across the Trust.

Preparing for implementation of the EPR

The Audit Committee received updates on progress with implementation of the EPR including a focused review of the criteria used to measure progress and ultimately confirm readiness for Go Live, covering staff training, Trust technical readiness, Epic technical readiness, data migration completeness, clinical safety and Trust operational readiness.

Productivity and efficiency

The Finance and Investment Committee monitored the identification, planning, monitoring, delivery and post-implementation review of Trust's savings schemes. The Quality, Safety and Experience Assurance Committee received assurances from the Quality Impact Assessment Group that those schemes do not adversely or unacceptably affect the quality of services delivered. The Audit Committee sought independent assurance that the systems and processes supporting those assurances were operating effectively. The Audit Committee linked closely with the Finance and Investment Committee and received the minutes of that Trust Board committee and the Quality, Safety and Experience Assurance Committee.

IPP debtors

The Audit Committee monitored and reviewed the IPP debt levels for each major customer and discussed with management strategies to minimise the level of exposure. Although the debt exposure for the organisation has increased over the year, the committee has confirmed it is happy that management are actively working to reduce this and will continue to monitor this key risk.

Internal controls

We focused in particular on controls relating to cyber-security, information governance, contract management and delays in debt collection. Action plans were put in place to address issues in operating processes.

The audit plan of the internal auditors is risk-based, and the Executive Team works with the auditors to identify key risks to inform the audit plan. The Audit Committee considers the links between the audit plan and the BAF. The Audit Committee approves the internal audit plan and monitors the resources required for delivery. During the year, the committee considers any proposed changes to the audit plan and monitors delivery against the plan approved at the start of the financial year.

Fraud detection processes and whistle-blowing arrangements

We reviewed the levels of fraud and theft reported and detected, and the arrangements in place to prevent, minimise and detect fraud and bribery.

Financial reporting

We reviewed the Trust's financial statements and determined how to position these within the annual report. We considered reports from management and the internal and external auditors in our review of:

- The quality and acceptability of accounting policies, including their compliance with accounting standards.
- Judgements made in preparation of the financial statements
- Compliance with legal and regulatory requirements
- The clarity of disclosures and their compliance with relevant reporting requirements

- Whether the annual report as a whole is fair, balanced and understandable and provides the information necessary to assess the Trust's performance and strategy.

Going concern

Our management team has carefully considered the appropriateness of reporting on the 'going concern' basis.

In 2018/19, the Trust reported a small operating surplus prior to capital donations and impairments, which includes £12.8m funding via the NHS sustainability and transformation fund. The Trust delivered efficiency savings to support this position.

In 2019/20 the Trust will enter a new three year contract with NHS England Specialised Commissioning. This contract aligns to the plan submitted to NHS Improvement, and the agreed business plans to meet demand and deliver access targets. It demonstrates the organisation will deliver breakeven control total, which is in part achieved through £20m efficiency savings.

In 2018/19 IPP turnover continued to increase (8.6%), with the majority of demand originating from the Middle East (79% of total IPP clinical income came from government agency sponsored activity within the Middle East). It is recognised this is a risk to the organisation so the Trust continues to seek other markets to diversify income sources and reduce its exposure.

As at the 31 March 2019 the Trust held £48.6m in cash reserves and it remains able to meet all commitments as and when they fall due, demonstrating strong liquidity. The Trust continues to carefully manage any investment in capital assets and ensure that the support provided by the Charity is appropriately reflected in the accounts.

Funding within the NHS remains constrained and it is recognised that the organisation is operating in a difficult financial climate. However, the directors have a reasonable expectation that the Trust has adequate resources to continue to operate for the foreseeable future. For this reason, and following reasonable enquiries, the directors continue to adopt the going concern basis for the preparation of the accounts within this report.

Significant financial judgements and reporting for 2018/19

We considered a number of areas where significant financial judgements were taken, which have influenced the financial statements.

We identified through discussion with both management and the external auditor the key risks of misstatement within the Trust's financial statements. We discussed these risks with management during the year, and with the auditor at the time we reviewed and agreed the external auditors' audit plan during the year and also at the conclusion of the audit. We set out in the table below how we satisfied ourselves that these risks of misstatement had been appropriately addressed.

Level of debt provisions

The financial statements include provisions in relation to uncertainty. Judgements in this area are largely related to the timing of recognition of these provisions, the quantum recognised and the amount which has been utilised in previous years. We reviewed and discussed the level of debt and debt provisions with management. This included consideration of new provisions and any release and utilisation of existing provisions. Management confirmed to us that they have applied a consistent approach to the recognition and release of provisions. We also considered the views of the external auditors in respect of the provisions and associated disclosures in the accounts. We concluded that we were satisfied with the level of provisions carried and the disclosure in respect of those provisions.

Valuation of assets

The Trust has historically revalued its properties each year, which combines properties held under freehold with those held under finance and operating leases. Judgements relate to the future life of these buildings, which can change the appropriate accounting treatment and affect the carrying value on the balance sheet. We reviewed reports from management which explained the basis of valuation for the most significant buildings, including the future life and rationale for any impairments associated with structural refurbishment expenditure. We also considered the auditors' views on the accounting treatment for these buildings. We are satisfied that the valuation of these properties within the financial statements is consistent with management intention, and is in line with accepted accounting standards.

Due to the value of the intangible asset under construction related to the Electronic Patient Record and Digital Research Platform systems, the Trust engaged a third party to undertake a valuation in line with the requirements of International Accounting Standard 36 (IAS 36) and the DH Group Accounting Manual to determine whether the assets carrying value exceed the service potential value. We reviewed reports from management which explained the basis of valuation of these assets including the future life and rationale for any impairment. We also considered the auditors' views on the accounting treatment for these assets. We are satisfied that the valuation of these intangible assets under construction within the financial statements is consistent with management intention and is in line with accepted accounting standards.

Other areas where an inappropriate decision could lead to significant error include:

- the recognition of commercial revenue on new contracts
- the treatment of expenditure related to capital contracts

We consider that the Trust's existing financial control systems should ensure that such items are properly treated in the financial statements. We have discussed the external auditors' findings in these areas. There were no issues of concern reported to us in these areas and consequently, we are satisfied that the systems are working as intended.

Conclusion

The committee has reviewed the content of the annual report and accounts and advised the Board that, in its view, taken as a whole:

- It is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Trust's performance, business model and strategy.
- It is consistent with the annual governance statement, head of internal audit opinion and feedback received from the external auditors, and there are no matters that the committee is aware of at this time that have not been disclosed appropriately.
- It is appropriate to prepare accounts on a going concern basis.

Mr Akhter Mateen

Chair of the Audit Committee

xx May 2019

Quality, Safety and Experience Assurance Committee report

Introduction from the Chair of the Quality, Safety and Experience Assurance Committee

I am pleased to present the Quality, Safety and Experience Assurance Committee's report on its activities during the year ended 31 March 2019. In January 2019, following a self-assessment effectiveness review of the committee (see below), it was agreed that the committee name should be amended to reflect its role in seeking assurance of parent, parent and carer experiences at GOSH. The name of the committee was changed to the Quality, Safety and Experience Assurance Committee (QSEAC) and will be referred to as this throughout this report.

The Quality, Safety and Experience Assurance Committee is a subcommittee of the Trust Board, with delegated authority to ensure that the correct structure, systems and processes are in place within the Trust to appropriately manage and monitor clinical governance and quality related strategic and operational risks.

As Chair of the committee, I am satisfied that during the year, the committee was presented with the appropriate level of information and in a timely fashion. Each meeting is fully minuted and summaries of the matters discussed at each meeting are reported to the Trust Board and Council of Governors.

The members of the Quality, Safety and Experience Assurance Committee are listed on pages **XX-XX**, including information about their attendance at meetings. Governors from the Council are invited and attend the committee as observers during the year.

I have been Chair of the committee since June 2018 taking on this responsibility from Stephen Smith, Non-Executive Director.

Review of effectiveness of the committee

In late 2018, the committee conducted a self-assessment effectiveness review. On the basis of the findings, the committee agreed that its remit had been reviewed, including how it can more effectively be supported to receive assurance on key and relevant clinical and quality risks and issues in a timely way. Following this review, the committee agreed the following key changes from April 2019:

- Committee members should be provided with assurance of the safety of care and quality of the patient and family experience of services at GOSH through consideration of benchmarked quality metrics, external quality reporting results (audits, reviews, learning from reports at other trusts, GOSH inspection reports), patient and staff survey results etc.
- Different formats of reporting will be encouraged at the committee, including inviting external speakers, patients and staff to report to the committee on quality focused matters, providing a more direct form of assurance to members.

- More deliberate reporting will be given to the committee from the Risk Assurance and Compliance Group and the Bioethics Committee.
- The committee’s name will be changed (see above) and updated terms of reference and workplan reflecting the above changes.
- A proposal will be given to the Board to consider the establishment of a new assurance committee to provide a dedicated focus on the controls and assurances in place to mitigate new risks on the BAF – culture, service innovation and workforce (see page XX for further information).

Quality, Safety and Experience Assurance Committee responsibilities

The principal purpose of the Quality, Safety and Experience Assurance Committee is to assure the Board that the necessary structures and processes are in place to deliver safe, high-quality, patient-centred care and an excellent patient experience. The committee also works in partnership with the Audit Committee to ensure that implications for clinical care of non-clinical risks and incidents are identified and adequately controlled.

The committee requests assurance on scheduled matters as well as quality and safety issues arising during the year. Where weaknesses are identified the committee agrees and tracks the strengthening actions. The committee’s responsibilities and the key areas discussed during 2018/19 are outlined below.

Principal responsibilities of the committee	Key areas formally reviewed during 2018/19
<p>Review and seek assurance on any issues identified by the Trust Board (as requiring more detailed review that falls within the remit of the committee) including on any quality, safety or patient experience matters or shortcomings arising from the Trust’s operational and quality and safety performance.</p>	<ul style="list-style-type: none"> • Review of the annual Quality Report • Monitoring of actions arising from patient stories • Updates on quality issues: <ul style="list-style-type: none"> ○ Progress with the transition programme at GOSH ○ The extent of bullying and harassment at GOSH and actions taken to mitigate this ○ Mandatory training with specific focus on honorary contract holders ○ Compliance with food hygiene standards ○ Consultant attendance at wards rounds ○ Compliance with cleaning standards
<p>Review when an issue occurs which threatens the Trust’s ability to enable excellent clinical care to flourish, that this is managed and escalated appropriately and actions are taken and followed through.</p>	<ul style="list-style-type: none"> • Assurance of maintenance of the compliance register • Quarterly reports from the FTSU Guardian • A range of specific, emergent issues and their ameliorations were considered in 2018/19 including: <ul style="list-style-type: none"> ○ A review of the number of cardiac arrests on wards ○ Software for irradiating blood

	<ul style="list-style-type: none"> ○ Compliance with clinical waste collections following national incident
<p>Assure the Trust Board that the controls to mitigate risk within the areas of responsibility of the committee are in place and working within a regulatory and legislative framework.</p>	<ul style="list-style-type: none"> ● Review of all clinical strategic risks and their mitigations at least annually ● Compliance with the risk management strategy ● Assurance of quality and safety flows under the new clinical operations structure ● Assurance of the impact of the reduction in the specialist bank rate on quality of services ● Review of clinical outcomes development programme ● Reports received on specific and/or high risk areas: <ul style="list-style-type: none"> ○ Health and safety ○ Safeguarding ○ Raising concerns (whistleblowing and FTSU) – quality related cases ○ Research governance ○ Update on learning from deaths ○ Integrated Quality Report including update on incidents, complaints and patient experience feedback
<p>Review of findings and recommendations from internal audit, clinical audit and learning from external investigations and reports</p>	<ul style="list-style-type: none"> ● The internal audit annual plan and strategy was presented to the committee in April 2018 with an update on progress with the plan covered at subsequent meetings ● Findings and recommendations of clinical focused internal audit reports are presented to every committee meeting. The following audits were discussed this year: <ul style="list-style-type: none"> ○ Cancelled operations (significant assurance with minor improvements) ○ Nursing recruitment and retention (partial assurance with improvements required) ○ Safeguarding (Significant assurance with minor improvements) ○ Risk Management (significant assurance with minor improvements) ○ Infection control (significant assurance with minor improvements) ○ Theatres (significant assurance with minor improvements) ● Regular reports from the Trust’s clinical audit manager and annual plan for 2018/19

Quality impact of the productivity and efficiency programme

The committee has received assurance of the Quality Impact Assessment (QIA) processes in place for Better Value schemes in 2018/19. The committee also reviewed high level indicators used to provide early warning of impacts (both positive and negative) that may be attributable to the programme.

CQC compliance

The committee reviewed the actions taken to implement the recommendations arising from the CQC report of April 2018. The committee was also kept apprised of plans in place to prepare for future inspections.

Patient stories

The Trust Board receives patient stories at every public Board meeting. Matters that arise from these stories are documented and acted upon. The committee reviews progress on these matters at every meeting.

Conclusion

As Chair of the Quality, Safety and Experience Assurance Committee, I am satisfied that the committee adequately discharged its duties in accordance with its terms of reference throughout 2018/19.

Lady Amanda Ellingworth

Chair of the Quality, Safety and Experience Assurance Committee

XX May 2019

Finance and Investment Committee report

Introduction from the Chair of the Finance and Investment Committee

I am pleased to present the Finance and Investment Committee's report on its activities during the financial year ending 31 March 2019.

The Finance and Investment Committee is chaired by a non-executive director and has delegated authority from the Board to oversee financial strategy and planning, financial policy, investment and treasury matters and to review and recommend for approval major financial transactions. The committee also maintains an oversight of the Trust's financial position and relevant activity data and workforce metrics.

The Finance and Investment Committee's membership is three independent non-executive directors, the Chief Executive, Chief Operating Officer and the Chief Finance Officer. These are listed on page XX. Two of the non-executive members of the committee are qualified accountants and all three members have recent and relevant financial experience.

Key responsibilities of the Committee

Key responsibilities include:

- reviewing the annual and long term financial plans
- review progress against key financial and operational targets, financial performance ratings, trends in workforce numbers and costs, capacity utilisation, productivity and efficiency measures
- overseeing the Trust's Treasury management strategy and borrowings arrangements
- reviewing changes in the Trust's corporate structures, investments or acquisitions including significant transactions
- Retain oversight on the financial implications of all major investments and business developments
- Advise the Board on all proposals/business cases for expenditure over £2.5 million, including the Estates and IT strategies.
- Review of the Trust's Procurement policies, processes and performance.

Key areas of work

The list below sets out the key areas considered by the committee in 2018/19 that I would particularly like to draw attention to.

Review and approval of Long Term Financial Plan	The Committee reviewed and approved the budgeting approach for 2018/19 and reviewed the Trust's Long term Financial Model and the variables within the model.
Finance report	The Committee received a finance report at every meeting and discussed performance against the NHS Improvement control total and Trust income targets.

	The format of the report was redeveloped over the course of the year to improve Committee focus on the most pertinent areas of Trust finances.
Productivity and Efficiency (Better Value) Monthly Update	The Committee received a report at every meeting covering both department and Trust-wide efficiency schemes and challenged Executives to consider a variety of approaches to identify additional schemes.
Integrated Performance Report and local activity trackers	The Committee received the integrated performance report at every meeting and challenged Executives where necessary on performance. The Committee received local activity trackers as a standing item which showed activity levels, by speciality, required to achieve contracted performance levels.
IPP and Commercial	The Committee received regular updates on International and Private Patient directorate business activity with a focus on: expediting debt recovery and the development of new business markets.
Improved working practices with the GOSH Children's Charity	The 'Charitable Funding Alignment Group' which includes members of the Committee was set up with the Charity to align and scrutinise joint projects. The Committee members attended a joint Charity trustee and Trust Non-Executive Director meeting on the Children's Cancer Centre. The Committee reviewed the approvals processes between the GOSH Children's Charity and the Trust to ensure they remained robust.
Directorate reviews	The Committee undertook reviews of the Trust's Directorates throughout the year.
Electronic Patient Record	The Committee received regular reports on the Trust's preparations for implementation of the EPIC EPR. The Committee probed the robustness of action plans to address risk and issues and proactively sought assurance that all reasonably practicable considerations had been made to ensure smooth delivery of the system.
Review of Hospital Estate Projects	The Committee reviewed and challenged a range of ongoing projects related to the continuing redevelopment of hospital estate in line with its the long term strategy
Post project reviews	At each meeting, the Committee reviewed a completed major Estates Project to identify lessons learned that could be applied to future projects. A revised template for the post implementation review was developed over the course of the year. The following projects were reviewed by the Committee: <ul style="list-style-type: none"> • Woodpecker ward • Hedgehog ward • Premier Inn Clinical Building • Theatre 10 • Cheetah outpatient rooms

	<ul style="list-style-type: none"> • Chillers
Procurement services	The Committee received a report from its new procurement provider and noted that the move had been positive for the Trust and that future work looked promising in terms of finding efficiencies in the system.
Sustainability at GOSH	The Committee reviewed the Trust's plans for sustainability and environmental management.
2017/18 review of effectiveness	<p>Following the Committees review of effectiveness a number of actions were implemented:</p> <ol style="list-style-type: none"> 1. The Committee reviewed a case study from a Foundation Trust that had been placed into special measures. The Committee was assured of the controls at Great Ormond Street Hospital NHS Foundation Trust. 2. After each meeting, Committee members evaluate the papers received for appropriateness, quality and quantity and make recommendations to Executives where necessary.

The committee met eight times over the financial year and I am satisfied that it was presented with papers of good quality and in a timely fashion to allow due consideration of the subjects under review. I am also satisfied that meetings were scheduled to allow sufficient time to enable a full and informed debate. Each meeting was fully minuted and summaries of the matters discussed at each meeting reported to the Trust Board, Council of Governors' and Audit Committee. Members of the Council of Governors' also observed committee meetings throughout the year.

The committee reviewed its effectiveness at the beginning of 2018/19 and no material matters of concern were raised. A second review at the end of the year showed an improvement in the Committee's performance compared to the previous review as a result of recommendations implemented throughout the year.

Mr James Hatchley

Chair of the Finance and Investment Committee

xx May 2019

Head of Internal Audit opinion

Basis of opinion for the period 1 April 2018 to 31 March 2019

Our internal audit service has been performed in accordance with KPMG's internal audit methodology which conforms to

Public Sector Internal Audit Standards (PSIAS). As a result, our work and deliverables are not designed or intended to comply with the International Auditing and Assurance Standards Board (IAASB), International Framework for Assurance

Engagements (IFAE) or International Standard on Assurance Engagements (ISAE) 3000. PSIAS require that we comply with applicable ethical requirements, including independence requirements, and that we plan and perform our work to obtain sufficient, appropriate evidence on which to base our conclusion.

Roles and responsibilities

The Board is collectively accountable for maintaining a sound system of internal control and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system. The Annual Governance

Statement (AGS) is an annual statement by the Accountable Officer, on behalf of the Board, setting out:

- how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
- the purpose of the system of internal control as evidenced by a description of the risk management and review processes, including the Assurance Framework process; and the conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures together with assurances that actions are or will be taken where appropriate to address issues arising.

The Assurance Framework should bring together all of the evidence required to support the AGS.

The Head of Internal Audit (HoIA) is required to provide an annual opinion in accordance with PSIAS, based upon and limited to the work performed, on the overall adequacy and effectiveness of the Trust's risk management, control and governance processes (i.e. the system of internal control). This is achieved through a risk-based programme of work, agreed with Management and approved by the Audit and Risk Committee, which can provide assurance, subject to the inherent limitations described below.

The purpose of our HoIA Opinion is to contribute to the assurances available to the Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the system of internal control. This Opinion will in turn assist the Board in

the completion of its AGS, and may also be taken into account by other regulators to inform their own conclusions.

The opinion does not imply that the HoIA has covered all risks and assurances relating to the Trust. The opinion is derived from the conduct of risk-based plans generated from a robust and Management-led Assurance Framework. As such it is one component that the Board takes into account in making its AGS.

Opinion

Our opinion is set out as follows:

- Basis for the opinion;
- Overall opinion; and
- Commentary.

Basis for the opinion

The basis for forming our opinion is as follows:

- An assessment of the design and operation of the underpinning aspects of the risk and assurance framework and supporting processes; and
- An assessment of the range of individual assurances arising from our risk-based internal audit assignments that have been reported throughout the period. This assessment has taken account of the relative materiality of these areas.

Our overall opinion for the period 1 April 2018 to 31 March 2019 is that 'significant assurance with minor improvements required' can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

Commentary

The commentary below provides the context for our opinion and together with the opinion should be read in its entirety.

Our opinion covers the period 1 April 2018 to 31 March 2019 inclusive, and is based on the nine audits that we completed in this period.

The design and operation of the Assurance Framework and associated processes

The Trust's Assurance Framework does reflect the Trust's key objectives and risks and is regularly reviewed by the Board. The Executive reviews the Assurance Framework on a quarterly basis and the Audit Committee reviews whether the Trust's risk management procedures are operating effectively.

The range of individual opinions arising from risk-based audit assignments, contained within our risk-based plan that have been reported throughout the year

We issued one partial assurance reports and no no assurance reports in respect of our 2018/19 assignments. Our partial assurance report related to contract management. We identified that limited progress had been made in implementing the recommendations from our 2015-16 contract management review. A plan has been developed for transitioning to another contract register to support improving the management of the Trust's contracts but was not yet in place at 31 March 2019.

We have not raised any new high priority recommendations during 2018-19, however as part of our contract management review from 2015-16 we determined that two high priority recommendations from the previous review had not yet been implemented. These related to the oversight of the contracts that the Trust has entered into and assignment of contract managers. We are satisfied that this is isolated and that there are appropriate plans in place to resolve the outstanding recommendations from the review and therefore did not consider that this was sufficient to prevent us from being able to issue a significant assurance with minor improvements opinion.

There are no further outstanding high priority recommendations.

KPMG LLP

Chartered Accountants

London 23 May 2018

Annual Governance Statement

1. Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, while safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives. It can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Great Ormond Street Hospital for Children NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Great Ormond Street Hospital for Children NHS Foundation Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

As Chief Executive, I have overall responsibility for ensuring there is an effective risk management system in place within the Trust for meeting all relevant statutory requirements, and for ensuring adherence to guidance issued by regulators which include NHS Improvement and the CQC. Further accountability and responsibility for elements of risk management are set out in the Trust's risk management strategy. The strategy has been subject to review and will be considered by the Board in May 2019.

Trust Board and assurance committees

The Board has a formal schedule of matters reserved for its decision, and delegates certain matters to committees as set out below. Matters reserved for the Board include:

- Determining the overall strategy.
- Creation, acquisition or disposal of material assets.
- Matters of public interest that could affect the Trust's reputation.
- Ratifying the Trust's policies and procedures for the management of risk.
- Determining the risk capacity of the Trust in relation to strategic risks.
- Reviewing and monitoring operating plans and key performance indicators.
- Prosecution, defence or settlement of material incidents and claims.

The Board has a work programme, which includes all matters the Board is required to consider by statutory, regulatory and other forms of guidance. It also has a range of strategic

and operational performance information, which enables it to scrutinise the effectiveness of the Trust's operations, and deliver focused strategic leadership through its decisions and actions. The Board maintains its commitment that discussion of patient safety will always be high on its agenda.

In 2018/19 there were two Board assurance committees being the Audit Committee and the Quality, Safety and Experience Assurance Committee. These committees assess the assurance available to the Board in relation to risk management, review the Trust's non-clinical and clinical and quality risk management processes and raise issues that require the attention of the Board. In addition to the two assurance committees, the Finance and Investment Committee considers financial performance, productivity and use of resources. The chairs of these committees report to the Board following every committee meeting. Each committee is charged with reviewing its effectiveness annually.

In February 2019 the Board agreed to establish (for one year, in the first instance, from July 2019), a new assurance subcommittee of the Board, being the People and Education Assurance Committee. The remit of the committee is to provide assurance to the Board and that the necessary structures and processes are in place to deliver the Trust's vision for a supported and innovative workforce, an excellent learning environment for clinical and non-clinical staff and a culture that aligns with the Trust's strategy and *Our Always Values*. The committee was established to scrutinise the new strategic risks on the BAF on culture, service innovation and provide additional scrutiny to the risk around recruitment and retention of staff.

Risk Assurance and Compliance Group

The Risk Assurance and Compliance Group (RACG) comprises executives, quality, safety and compliance leads. The Group reports to the Audit Committee, the Quality, Safety and Experience Assurance Committee and the People and Education Assurance Committee (from July 2019). The RACG monitors the effectiveness of risk management systems and the control and assurance processes and monitors the BAF.

Operational Board

The Operational Board comprises senior managers from the directorates and corporate departments and has oversight and delivery of Trust-wide operational performance. It holds responsibility for reviewing high rated risks and Trust-wide risks (risks that have been identified as affecting more than one directorate).

Standing committees

Standing committees are responsible for managing the cross-Trust issues relevant to their area of expertise and as such have delegated authority within their terms of reference for a specific remit. This includes assessing the effectiveness of the control systems in place to reduce the risks relevant to their areas of expertise. Standing committees with responsibility for risk management include, but are not limited to:

- Patient Safety and Outcomes Committee
- Patient, Family Experience and Engagement Committee
- Health and Safety Committee
- Education and Workforce Committee

Risk Action Groups

Local Risk Action Groups (RAGs) are multidisciplinary meetings which discuss the principal risks to patient safety and service delivery within a division or department. The RAGs review low, medium and high risks, approve scores, monitor actions to mitigate the risks and accept low and medium risks where appropriate. The RAGs receive information on a monthly basis on their clinical and non-clinical incidents (reported through the central reporting system) to consider actions to control risks and identify key themes. These are the key management forums for consideration of risks. The RAGs report into the Directorate Boards and equivalent in corporate areas.

Risk Management Team and staff training

The Trust has a central Risk Management team that administers the risk management processes. Following the restructure of the clinical operations team in 2018, each clinical operational directorate has appointed a Deputy Chief of Service, who is responsible for championing safety and is supported by an individual within the Risk Management team. The Risk Management team also meet regularly with their peers at other trusts to share learning.

All staff receive relevant training to enable them to manage risk in their directorate, specialty or department. At a Trust level, we emphasise the importance of preparing risk assessments where required, and the importance of reporting, investigating and learning from incidents. Support is available to staff from various corporate areas of the Trust to discuss and document risks including the Quality and Safety team, Health and Safety team, Emergency Planning Officer and Information Governance team.

Learning from good practice

The following frameworks are in place to support learning from auditing of current practice and best practice:

- Clinical audit: Clinical audit is undertaken at GOSH to ensure that the quality of care and services are reviewed against best practice standards, and improvement actions taken where those standards are not met.
- Clinical outcomes: The GOSH Clinical Outcomes Programme was established in 2010 and seeks to achieve the following aims:
 - Robust clinical outcome measures identified in each specialty
 - Consistent and accurate data collection against these measures
 - Robust analysis of outcomes data
 - Publication of outcomes to the Trust website for public visibility
 - Benchmarking of outcomes, nationally and internationally, with other paediatric centres of excellence

Cascading risk and embedding learning

There are a range of ways in which information on risk is embedded across the Trust. Lessons are learnt from specific incidents, complaints and other reported issues. These include:

- Quality impact assessments for example, of the Better Value schemes
- Equality impact assessments of our policies and strategies

- Risk management training
- Incident reporting
- Reports to and cascade from risk action groups, directorate boards and the Operations Board (Trust meeting of senior managers) where high risks and Trust-wide risks are discussed
- Cascading from key risk meetings such as the Patient and Safety Outcomes Committee
- Articles within internal newsletters
- Learning from events

4. The risk and control framework

The risk management strategy and process

The Trust's risk management strategy which has recently been updated and is subject to approval at Trust Board, sets out how risk is systematically managed. This extends across the organisation, from the front-line service through to the Board, to promote the reduction of clinical and non-clinical risks associated with healthcare and research, and to ensure the business continuity of the Trust.

The strategy identifies the organisational risk management structure, the roles and responsibilities of committees and groups that have some responsibility for risk, and the duties and authority of key individuals and managers with regard to risk management activities. It describes the process to provide assurance for the Trust Board review of the strategic organisational risks, and the local structures to manage risk in support of this policy.

The strategy is integrated into the management, performance monitoring and assurance systems of the Trust, to ensure that safety and improvement are embedded in all elements of the Trust's work, partnerships and collaborations and existing service developments. This enables early identification of factors, whether internally or externally driven, which may prevent the Trust from achieving its strategic objectives.

In 2018, the internal auditors conducted an audit into the management of risk at GOSH and this indicated significant assurance, with minor improvement potential.

Risk appetite

The Trust defines its risk appetite as the amount of risk it is prepared to accept, tolerate, or be exposed to at any particular time, in the context of the highly specialised services the Trust offers. The Board is committed to doing everything possible to reduce risk for children and to deliver high-quality, efficient and effective care. The Board recently reviewed and approved its revised risk appetite statement.

The Board recognises that the Trust delivers clinical services and research activity within a high-risk environment. The delivery of GOSH's strategic objectives and its relationships with its patients, the public, its funders and other strategic partners determines the Trust's long-term sustainability. As such, the Board has agreed that the Trust has an overall low appetite for risks relating to its clinical service and research delivery. The lowest risk appetite applies to all safety and compliance objectives, including preventable patient harm, public and

employee health and safety. The Trust has a marginally higher risk appetite for the pursuit of innovation and its operations and commercial objectives. This means that the risks originating from clinical and research processes as well as meeting legal and other regulatory obligations will take priority over other business objectives.

Identification, evaluation and control of risk

The Trust's Assurance and Escalation Framework presents a single, comprehensive overview of the governance and assurance structures and systems through which the Trust Board and other stakeholders receive assurance. The Trust routinely reviews and reports this assurance through the following key governance processes and frameworks including:

- Performance Management: The Trust has a range of frameworks and policies in place that outline how the Trust's performance objectives and standards will be met, reviewed and managed. The Performance Management Framework is the most significant.
- The Trust's risk management strategy (see above) sets out how the organisation identifies, monitors, escalates and manages risks in a timely fashion and at an appropriate level. Further detail on the identification and evaluation of strategic and local risks is provided below.
- The Trust has in place a comprehensive and integrated Compliance Framework that seeks to ensure ongoing compliance with statutory and regulatory requirements through integrated, rigorous and proactive structures, policies and practices. It ensures appropriate controls are in place to maintain compliance with statutory and regulatory requirements and that external guidance and alerts are considered in a fulsome and responsive way.
- Policy Framework: This provides for clear and accessible policies, procedures and guidelines which support staff in undertaking their duties in a safe and effective way that takes account of all relevant legislation, regulation and guidance. The Trust's policy framework is administered by the Policy Approval Group (PAG).
- Committee structure: The Trust's committee structure, developed from the Trust Board down, is currently under review to ensure each committee or group has a clear purpose, scope and authority. Some committees have statutory functions, others have authority to make decisions and direct actions, and others provide advice, support and oversee specific functions.

Identification and monitoring of strategic risks

The Trust's BAF is used to provide the Board with the assurance that there is a sound system of internal control in place to manage the risks of the Trust not achieving its strategic objectives. The BAF is used to provide information about the controls in place to manage the key risks, and details the evidence provided to the Board indicating that the control is operating. The BAF includes cross-references to assurance obtained from internal and external audits and self-assessments of compliance with other regulatory standards. It has been monitored and updated throughout the year.

In February 2019 the Board approved an updated BAF including six new strategic risks covering medicines management, Brexit, service innovation, culture, data protection and consistent delivery of services.

Each strategic (BAF) risk on the assurance framework, including the related mitigation controls and assurance available as to the effectiveness of the controls, is reviewed by the Risk Assurance and Compliance Group. The Quality, Safety and Experience Assurance Committee and the Audit Committee scrutinise the BAF risks relevant to their remits on a rotational basis and at least annually. The assurance committees look for evidence that the controls are appropriate to manage the risk and independent assurance that the controls are effective. The assurance committees monitor progress with actions to reduce or remove control or assurance gaps.

In addition, the Trust Board recognises the need to 'scan the horizon' for emerging risks and review low-probability/high impact risks to ensure that contingency plans are in place. The Board has included such matters in Board discussions of risks as well as holding an annual risk management meeting and inviting external speakers on future risk matters relevant to paediatric and wider healthcare.

Identification and monitoring of local risks

Each directorate and department is required to identify, manage and control local risks whether clinical, non-clinical or financial, in order to provide a safe environment for patients and staff and to reduce unnecessary expenditure. This ensures the early identification of risks and the devolution of responsibility for management of risks to staff at all levels of the organisation. In practice, this is achieved through the involvement of staff in risk action groups, risk training and occasional surveys.

Risks are identified through diverse sources of information such as:

- Formal risk assessments
- Audit data
- Clinical and non-clinical incident reporting
- Complaints
- Claims
- Patient/user feedback
- Information from external sources in relation to issues which have adversely affected other organisations
- Operational reviews
- Use of self-assessment tools

Further risks are also identified through specific consideration of external factors, progress with strategic objectives, and other internal and external requirements affecting the Trust. Risks are evaluated using a '5x5' scoring system that enables the Trust to assess the impact and likelihood of the risk occurring and prioritise accordingly. Assessments are made as to whether the prioritised risks are acceptable or not.

Control measures aimed at both prevention and detection are identified for accepted risks, to either reduce the impact or the likelihood of the risk. An assessment is then made of the effectiveness of the control on reducing the risk score, and what assurance is available to the Board that the control is both in place and operating effectively to reduce risk. A designated person becomes responsible for monitoring, reviewing and reporting on the effectiveness of the control in place. Risks and controls are evaluated periodically and also when new or changed risks are identified, or if the degree of acceptable risk changes.

Principal risks in 2018/19

The principal risks for the Trust during the year and in the immediate future are:

- Financial sustainability (being able to meet the control total target set by NHS Improvement, in an environment where core services are underfunded, money available to NHS organisations is reduced, and the cost of delivering specialised services is high. The need to rely on IPP to support financial viability).
- Implementation of the new Trust-wide EPR system.
- Management and monitoring of medicines.
- Impact of Brexit on effective patient care
- Management of personal and sensitive personal data
- Recruitment and retention of staff

These risks are broken down into a number of component parts covering their different drivers, and appropriate mitigating actions for each component identified.

A summary of these six risks to our operational and/or strategic plans in 2018/19 and the mitigations in place to manage them are outlined below:

Risk	Explanation	Mitigating actions implemented and underway
Financial sustainability	A reduction in funding and/or increasing costs will lead to a need to reduce activity, which could potentially impact on our ability to deliver our vision, despite efforts to ensure excellent patient experience and outcomes.	<ul style="list-style-type: none"> • Robust financial planning including downside contingency planning and regular performance reviews and • Programme management office in place to support the Trust in identifying and delivering productivity and efficiency schemes. • Development of commercial strategies. • Monthly monitoring of capital expenditure. • Working with commissioners to support the Trust's service and growth strategy. • Continued involvement in forums influencing paediatric tariff discussions. • Ongoing cost benchmarking. • Escalation processes in place to minimise IPP debt and aging debt.
Electronic Patient Record	The risk that the EPR programme will not be delivered on time or within budget.	<ul style="list-style-type: none"> • Robust programme governance led by the EPR Programme Board, including engagement with clinical experts, patients and families, Finance, IT, research and operational management. • Clinical and research leadership in place. • Communication strategy in place, including specific strategies to ensure thorough engagement with clinicians and to ensure all staff and stakeholders are aware of programme and impacts of changes.

Risk	Explanation	Mitigating actions implemented and underway
		<ul style="list-style-type: none"> • Project closely integrated with Quality Improvement and Operations teams to ensure the EPR is delivered as a change programme. • Engaged external expert advisors for legal, commercial and procurement processes. • EPR delivered on time on 19 April 2019
Medicines management	Medicines are not managed in line with statutory and regulatory guidance and that processes are not appropriately documented or monitored.	<ul style="list-style-type: none"> • Drugs and Therapeutics Committee (DTC) in place • Medicines are dispensed by competent pharmacy staff • Work programmes in place to enhance the EPIC prescribing system • Quality assurance process in place to scrutinise manufacturing of medicines • Controlled Drugs are securely stored and auditable paperwork • Review of policies and pharmacy facilities underway
Brexit	Brexit will have an adverse impact on the ability of the Trust to ensure continuity of effective patient care.	<ul style="list-style-type: none"> • Short-life Brexit Steering Working Group established, chaired by the Acting Chief Operating Officer • Business continuity plans in place • The trust is connected at various levels with national and local NHS networks and with local borough networks to scope and share information on the impacts of Brexit. • The supply of medicines (and ingredients for medicines) to the NHS is being monitored and risk-assessed nationally by the Department of Health and Social Care (DHSC). Engagement with specialty groups on plans for managing medicines, devices and re-agents including consideration of storage requirements • Processes in place to support EU nationals working at GOSH including support with obtaining settled status • Contingency plans in place for clinical trials that are GOSH-sponsored to mitigate potential impacts on supply of drugs, devices and reagents.
Management of personal and sensitive personal data	Personal and sensitive personal data is not effectively collected, stored, appropriately	<ul style="list-style-type: none"> • The Trust's list of all systems/information assets holding or sharing personal information is under review to ensure that

Risk	Explanation	Mitigating actions implemented and underway
	shared or made accessible in line with statutory and regulatory requirements.	it is up to date and collects the required information. <ul style="list-style-type: none"> • Data Protection Privacy Impact Assessments (DPIA) undertaken for new projects and policies. • A patient and carer notice and research notice is published on the website outlining how the Trust gathers, uses, discloses and manages patient data. • All I new systems require an appropriate security review by ICT with a focus with any data held offsite • Mandatory training on Information Governance and reminding staff of their requirements with regards to confidentiality and the processing of personal data • Collection of evidence for the Data Security and Protection Toolkit and establishment of actions plans to close identified gaps.
Recruitment and retention of staff	The organisation will be unable to recruit and retain sufficient highly skilled staff.	<ul style="list-style-type: none"> • Specific action plans are in place for key service areas and professions including: <ul style="list-style-type: none"> ○ GOSH Learning Academy Strategic Plan accepted by Trust Board in July 2018 will focus on the provision of education, training and development for the whole workforce A Trust-wide nursing and medical recruitment and retention programme. ○ Membership of the NHSI Retention programme to learn from other trusts and collaborate ○ Enhanced processes to establish GOSH as an attractive employer. ○ Tactical use of temporary staff to fill vacancies ○ Education commissioning plans to increase numbers of potential staff.

Involvement of stakeholders in risk management

The Trust recognises the importance of the involvement of stakeholders in ensuring that accidents are minimised, and that patients, visitors, employees, contractors and other members of the public are not exposed to any unnecessary risks or hazards.

Risks are assessed and managed to ensure that the Trust's systems reflect consideration of all these stakeholder interests. Stakeholders are also involved in the Trust's risk management process where appropriate. For example:

- Patient views on issues are obtained through the Patient Advice and Liaison Service (PALS).
- Patient representatives are involved in Patient-led Assessments of the Care Environment (PLACE) inspections.
- There are regular discussions of service issues and other pertinent risks with commissioners.
- Staff are also involved in strategic planning groups with commissioners and other healthcare providers.
- The Board receives patient stories at every Board meeting and tracks learning and actions agreed from these stories via the Quality, safety and Experience Assurance Committee.

Internal audit function

The Trust contracts with KPMG LLP for its internal audit function. Internal audit reports to the Audit Committee and the Quality, Safety and Experience Assurance Committee. Further information about the work of internal audit can be found on page xx.

Workforce safeguards

The Trust has an organisation strategy built around its vision of 'Helping Children with Complex Health Needs Fulfil Their Potential'. Within that strategy are four pillars, and the people pillar is an aspiration to attract and retain the right people through creating a culture that enables us to thrive and learn. Workforce strategies and plans have been built around the 'people pillar' and in particular around the themes of culture, leadership, talent and education.

Assurance against our workforce strategies is provided by the following groups and committees:

- Education and Workforce Development Board
- Recruitment and Retention Group
- Nursing Workforce Board
- Modernising Medical Workforce Board

The Trust has recently established a People and Education Assurance Committee (see above).

Our workforce plan has been derived from the business planning process and is aligned to operational activity and finance, together with local, national and international drivers.

The Medical Director and Chief Nurse are engaged throughout the workforce planning process and all plans, including those for new roles such as physicians' assistants and nursing associates. Any savings schemes, business cases and service changes undergo a thorough quality impact assessment via a properly constituted quality impact assessment panel.

Ward establishments are reviewed on an annual basis as per National Quality Board Guidance and reported on by the Chief Nurse to the Nursing Board and Executive Management Team, and then presented to the Trust Board. Removing or making changes to any nursing posts has to be signed off by the Chief Nurse.

The Trust Board regularly receives workforce analysis and key performance indicators, benchmarked metrics including staffing profile, voluntary and non-voluntary turnover, sickness, agency usage (as a percentage of the paybill) and vacancies. Monthly directorate performance reviews are executive-led and consider this workforce data at a drill-down level in conjunction with finance, activity and quality data in order to identify themes or impact on service delivery. In addition, other quality metrics such as staff survey results are reported to the Board, Executive Management Team and at directorate performance meetings to provide an overall picture of workforce issues within each directorate, including cultural and leadership issues. Nurse recruitment and retention workstreams are overseen by the Nursing Workforce Advisory Board which reports to the Executive Management Team and the Trust is currently participating in the NHSI retention work with a retention plan for nursing going to Board April 2019.

Our workforce plans are included in the Trust operational plan, which is signed off by the Board and monitored by the Workforce and Education Committee. As part of the workforce planning processes and safe staffing assessments, the Trust uses the paediatric acuity and nurse dependency assessment tool (PANDA), which the Trust co-designed, as an acuity tool for inpatient paediatric services. We have now implemented the SafeCare system which will integrate the existing PANDA acuity information with information from the rostering system. The Trust uses Allocate E Rostering system for all staff (currently in roll out for non-clinical staff) and Doctors Job Planning.

Assurance of safe staffing is provided via workforce numbers, data and metrics including:

- statutory and mandatory training compliance
- appraisal rates
- temporary staffing spend
- annual staff survey results
- other quality metrics such as patient feedback, serious incidents etc.

This is reported to the Trust Board and, from July 2019, the People and Education Assurance Committee.

Other means of assurance include:

- Nurse Safe staffing – Care Hours Per Patient Day (CHPPD) information is reported at every formal Board meeting and the Guardian of Safe Working also reports to every Board meeting.
- Progress against recruitment and retention plans is monitored at the Recruitment and Retention Group.
- The Modernising Medical Workforce Board reviews current and future workforce challenges while the Nursing Workforce Advisory Board ensures that there is a bottom up approach which supports the development of our trust-wide plans for nursing.
- A bed management meeting is held twice a day where all matrons attend to present the bed and staffing status. Any issues of safety relating to staffing are notified to the Executive Management Team via the weekly safety report.

Key elements of the Trust's quality governance arrangements

The Trust places a high priority on quality, measured through its clinical outcomes, patient safety and patient experience indicators. The Board is committed to placing quality and safety at the top of its own agenda, to encourage continuous improvement in safety and quality indicators, and to establish mechanisms for recording and benchmarking clinical outcomes.

The key elements of the Trust's quality governance arrangements are:

- There is clear accountability at Board level for safety and clinical quality objectives and structured reporting of performance against these objectives.
- Under the executive directorship of the Medical Director, quality improvement at the Trust is part of the broad remit of the Quality and Safety team which incorporates clinical audit, patient safety, clinical outcomes and complaints. This team of quality improvement specialists work together to ensure an organisational approach to maintaining and improving our quality governance processes.
- Executive oversight of patient experience and engagement is through the Chief Nurse who, with the Medical Director, ensures an organisation-wide approach to the integrated delivery of the quality governance agenda. They are supported in this work by a number of senior managers including the Deputy Chief Nurse, the Head of Quality and Safety and the Associate Medical Director for Quality, Safety and Patient Experience. Patient and parent feedback is received through: the Friends and Family Test (FFT), a more detailed survey carried out at least once a year, the work programme of the Patient and Family Experience and Engagement Committee and through a range of other patient/parent engagement activities.
- Each specialty and clinical directorate has an internal monitoring structure so teams regularly review their progress and identify areas where improvements may be required.
- Each specialty must measure and report a minimum of two clinical outcomes.
- Each directorate's performance is considered at monthly performance review meetings.
- Working with the directorate management teams, the aim is to develop a culture of continual identification of learning from events and making changes that are effective, sustainable and improve the quality of the service and experience of our children, young people and their families.
- The Quality and Safety team work collaboratively with the Trust's Project Management Office to ensure the right resources are available to the right workstreams at the right time. This will reduce duplication of effort and support the transition of projects to 'business as usual' while providing effective support to sustain changes and monitor outcomes.
- Each of the priority quality improvement projects have an allocated executive director, operational lead and allocated specialist from the Quality and Safety team, who, along with other key specialists, form a steering group to oversee and support delivery.
- Each improvement project has a steering group that reports to relevant Trust committees such as the Quality Improvement Committee, the Patient Safety and Outcomes Committee, the Education and Workforce Committee or the Patient Family

Experience and Engagement Committee. These committees provide assurance to the Trust Board on the quality and safety programme.

- Using the Institute for Health Improvement model for improvement, the Quality and Safety Team use data to encourage improvement activity and to demonstrate and evidence the impact of the improvement programme.
- Key performance indicators are presented on a monthly basis to the Trust Board. The report, which has recently been refreshed and integrates quality and performance data, includes progress against external targets, internal safety measures, operational efficiency/process measures, well-led and other clinical quality measures such as complaints, incidents and reports from specific quality functions within the Trust, such as the Patient Advice and Liaison Service. It also includes the external indicators assessed and reported monthly by the CQC. The report is aligned to the CQC key lines of enquiry: Safe, Effective, Caring, Responsive and Well Led. It asks the question: are our patients receiving high-quality care?
- Risks to quality are managed through the Trust risk management process, which includes a process for escalating issues. There is a clear structure for following up and investigating incidents and complaints and disseminating learning from the results of investigations.

Never events

No never events were reported by the Trust in 2018/19.

Data quality and security

All data on the quality of care in each specialty and service is considered as part of our internal and external management and assurance process. A data quality dashboard has previously been developed which provides visibility of potential data quality issues across the organisation. This 'kite mark report' is subject to review following the redesign of the Trust's quality and performance dashboard and will be relaunched in July 2019.

Risks to data security are managed in the same way as other Trust risks but are subject to separate evaluation and scrutiny by the Information Governance Steering Group. This group uses the Data Security and Protection Toolkit (DSPT) to inform its review. The Audit Committee seeks assurance of progress with implementation of GDPR and the Trust's Cyber Security strategy including the management of risks to delivering the strategy and operational risks and incidents.

The Cyber Security strategy includes a number of elements designed to increase the protection of the organisation. A number of these were technological and others were policy related or procedural, including development/updating of procedures for server hardening, cloud storage, learning lessons from incidents, removing data from local devices to the network and unencrypted data.

Compliance with CQC registration

The foundation trust is fully compliant with the registration requirements of the Care Quality Commission.

The Trust has identified an executive director and a manager who are respectively accountable and responsible for ensuring compliance with each element of the CQC

registration standards. It is the responsibility of these staff to collate evidence of compliance with the standards. The evidence is reviewed periodically by compliance staff.

In January 2018, the CQC conducted a scheduled unannounced inspection of two services (surgery and outpatients) and an announced inspection against the well-led criteria. The report was published in April 2018. The Trust was rated 'Good' overall and 'Requires Improvement' for well-led.

The Trust developed an action plan in response to the inspection and actively monitors progress with this at operational level and provides assurance to the Board and the Council of Governors.

The Trust has commenced a programme of work in order to ensure CQC readiness and to maintain compliance for the Trust. This work has been rolled out with a view to ensuring that compliance and governance are interlinked with quality, safety and experience and embedded in day-to-day working within the Trust. The work being undertaken includes:

- Weekly Steering Groups with Deputy Chiefs of Service
- Mock inspection framework (CQC Quality Rounds) in clinical directorates
- Reviews of potential areas/sources of learning e.g. review of themes from other CQC reports, evaluation of insight reports

The Trust was advised that a CQC routine scheduled inspection would take place in late Q1 2019. A request was made by the Trust to delay the inspection as it would have taken place in the weeks directly after the implementation of the EPR, when staff will be focusing on ensuring patients are not affected by the programme of work. The CQC agreed and the Trust expects a routine scheduled CQC inspection (including well-led) in Q2 2019/20.

[NHS Improvement Well led framework](#)

While the CQC made no formal recommendations to the Trust in relation to the findings in its separate well led assessment published in April 2018, the Trust took it upon itself to review any negative commentary in the report and ensure that relevant actions were taken to mitigate the issues raised. The Executive Management Team have reviewed evidence against the well led key lines of enquiries (KLOEs) and developed an action plan in preparation for the next CQC well-led assessment.

Themes arising from an assessment of the evidence and identified gaps mapped to the KLOEs include:

- Ensuring that strategies and associated plans are developed, consulted on, communicated across the Trust, monitored and implemented.
- Ensuring that governance frameworks, procedures and policies are in place and up-to-date.
- Ensuring staff (all groups) and director appraisals and mandatory training targets are met.
- Reviewing how strategy, decisions, changes to practice, and learning from risks are communicated across the Trust to all staff groups.
- Ensuring that directors and senior managers are visible to staff.
- Being deliberate about documentation

- Progress with strategic and local partnerships.
- Responding to external benchmarked data such as the staff survey results etc.
- Progress with actions against internal and external reviews of GOSH services.

Compliance with the foundation trust licence conditions

The Trust has reviewed its compliance with the NHS foundation trust license conditions, and, in relation to condition four, it has concluded that it fully complies with the requirements and that there are processes in place to identify and mitigate risks to compliance. No significant risks have been identified. Mitigations include:

- governance structures including clarity of role of directors as outlined below and under the Accountability Report;
- reporting lines and accountabilities - the clinical operations structure was consulted on in 2018, reviewed and revised. The Trust's assurance and escalation framework details the governance and assurance structures and systems through which the Trust Board and other stakeholders receive assurance. It includes the range of forums and processes available to staff, patients, families and other stakeholders to raise and escalate concerns or risks;
- submission of timely and accurate information to assess risks to compliance with the trust's licence;
- the board's oversight of the trust's performance- as outlined below.

Governance structure, responsibilities and reporting

The Trust's committee structure has been developed from the Trust Board down, to ensure each committee or group has a clear purpose, scope and authority. Some committees have statutory functions (for example the Trust Board, Health and Safety Committee, Infection Prevention and Control Committee), others have authority to make decisions and direct actions (for example Executive Management Team and Operational Board) and others provide advice, support and oversee specific functions.

The Trust has terms of reference and work plans in place for the Board, Council and relevant committees. The Board committees conduct annual effectiveness reviews (surveys) on the delivery of their terms of reference and running of the committees. Findings are reviewed and where appropriate, changes to the terms of reference and workplans of the committees are made.

The Trust's assurance and escalation framework details how the Trust presents a single, comprehensive picture of the governance and assurance structures and systems through which the Trust Board and other stakeholders receive assurance (currently subject to review and update).

The clinical operations structure was consulted on in 2018, reviewed and revised. There are now eight directorates, each with a Chief of Service, Deputy Chief of Service, Head of Nursing and General Manager. The Senior Leadership Team meets weekly (around 100 senior managers from across the clinical and corporate areas of the Trust). An Operational Board has been established which meets fortnightly. The purpose of the Board is to bring together clinical and corporate senior leadership members to ensure the robust, effective and efficient operational management of the Trust.

The Trust's risk management strategy identifies the organisational risk management structure, the roles and responsibilities of committees and groups that have some responsibility for risk, and the duties and authority of key individuals and managers with regard to risk management activities.

Oversight of performance by the Board

The Board receives an integrated performance and quality report at every meeting (recently refreshed – see above).

Further information on how the Board retains oversight can be reviewed under the section on a *review of economy, efficiency and effectiveness of the use of resources* (below).

Declarations of Interest

The foundation trust has published an up-to-date register of interests for decision-making staff within the past 12 months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

NHS Pension Scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Equality and diversity

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

Carbon reduction

The foundation trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

5. Review of economy, efficiency and effectiveness of the use of resources

The Board has agreed standing orders and standing financial instructions, which provide the framework for ensuring appropriate authorisation of expenditure commitments in the Trust. The Board's processes for managing its resources include approval of annual budgets for both revenue and capital, reviewing financial performance against these budgets, and assessing the results of the Trust's cost improvement programme on a monthly basis. Also the Trust has a prescribed process for the development of business cases for both capital and revenue expenditure and, where significant, these are reviewed by the Trust Board.

The Trust's performance management framework is aligned to the directorate management structure. The Finance and Investment Committee reviews the operational, productivity and financial performance and use of resources both at Trust and directorate level (see page

XX). More details of the Trust's performance and some specific Trust projects aimed at increasing efficiency are included in the performance report.

The Trust's external auditors are required to consider whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. They report the results of their work to the Audit Committee. Their report is on page XX.

6. Information governance

The Trust is in the process of finalising its first submission against the relaunched Information Governance Toolkit, the Data Security and Protection Toolkit (DSPT), helping to demonstrate its position against the General Data Protection Regulations (GDPR) 2018. While it is compliant with the majority of mandatory requirements some areas of improvement have been identified, for which action plans have been produced. These include updating and embedding the process for accessing the privacy risks of proposed new uses of personal information (Data Protection Impact Assessments). The action plans also ensure the Trust has an accurate and up-to-date list of all personal information it holds and, reviews arrangements and checks for sharing personal information with external suppliers.

This year there have been three serious incidents in information governance (classified at a reportable level using the Incident Reporting Tool within the DSPT) involving sensitive information.

Details are as follows:

- An issue in which redactions were not correctly applied to a record released and thus other patient details were accessible to a member of the public.
- The accidental release of sensitive HR information to an unintended recipient.
- A case in which Trust information from 2011 was found in a public area.

Each of these cases have been reported to the Information Commissioner's Office and NHS England as Serious Reportable Incidents with an internal root cause analysis completed and shared. The learning from these has been implemented back into Trust practice to ensure similar incidents do not occur.

Risks to data security are managed in the same way as other Trust risks, but are subject to separate evaluation and scrutiny by the Information Governance Steering Group, which provides assurance to the Trust's Audit Committee.

7. Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

There are a number of controls in place to ensure that the Quality Report presents a balanced view of the Trust's quality agenda. Many of the measures in the Quality Report are monitored throughout the year, either at the Board or the Patient and Safety Outcomes Committee, which reports into the Quality, Safety and Experience Assurance Committee. The Trust has a wide range of specific clinical policies in place to ensure the quality of care. These address all aspects of safety and quality. Policies are used to set required standards and ensure consistency of care. They are reviewed and approved by the Policy Approval Group and accessible via the Trust intranet pages to all staff.

A data quality dashboard has been developed which provides visibility of potential data quality issues across the organisation. This 'kite-mark report' is reported at every Board meeting.

The Trust's annual corporate objectives include targets for quality and safety measures, and performance relative to these targets is monitored by the Trust Board. Measures specific to clinical directorates are monitored at the regular performance review meetings.

The Audit Committee is responsible for monitoring progress on data quality. Objectives for data quality are defined, and data quality priorities are monitored. Particular focus has been directed at key measures of quality and safety, which are relied upon by the Board and are collected from locally maintained systems. These measures are reported regularly through the Trust's quality performance management processes and reviews of deterioration in any such measure are fully investigated.

External assurance statements on the Quality Report are provided by our local commissioners and our Local Involvement Networks (LINKs) as required by quality account regulations.

The Trust has been on a considerable journey over the last few years to improve the quality and accuracy of its elective waiting time data, encompassing the referral to treatment, cancer and diagnostic standards which are reported nationally and patient pathways who are monitored at a local level to ensure that all patients are tracked and managed according to their clinical requirements. Following the challenges the Trust had in 2015, it has put in place a dedicated Data Assurance team whose role is to provide support across the organisation to provide support to staff, rather than focus on data validation. The team support staff to 'get it right first time' through a programme of training, mentoring and development of standard operation procedures to support work.

In April 2019, the Trust is moving to a new EPR and this has changed the majority of the key electronic systems across the organisation, while it will ultimately lead to a far more integrated system, with the aim to drive improved quality and accuracy to the data that we hold on our patients. A considerable amount of work has been completed to develop a new data quality dashboard, together with a large number of indicators to track potential data quality challenges and improve accuracy by highlighting potential challenges.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical

leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report attached to this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and Quality Safety and Experience Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

My review is also informed by:

- Reviews of the strategic risks facing the Trust by the Board assurance committees. This includes deep dives into each BAF risk on a rotational basis every year, with committee members scrutinising the effectiveness of controls and seeking assurances that any gaps in controls will be closed in a timely manner.
- Internal audit reports providing evidence that the controls are in place and effective in mitigating the risk.
- The Trust clinical audit programme.
- Reviews of compliance with CQC standards and other regulatory bodies (see above for explanation of the work programme in place).
- Consideration of performance against national targets (see above on waiting list data as an example).
- The assessment against the Data Security and Protection Toolkit (see above for further information).
- Health and safety reviews.
- Results from the PLACE assessment.
- Relevant reviews by external bodies.
- Results of the assessment of compliance with the NHS Improvement Code of Governance for NHS foundation trusts (which are set out in the annual report on page xx).

The instances where the assurance was not sufficient or controls were not adequate when subject to routine audits during the 2018/19 year were:

- Contract management (partial assurance with improvements required): Limited progress had been made in implementing the recommendations from a previous internal audit. A plan has been developed for transitioning to another contract register to support improving the management of the Trust's contracts by 31 December 2019. This will provide:
 - the means to produce regular contract management reports.
 - provide oversight of contracts and their status.
 - ensure a consistent process for assigning and managing responsibilities of contract managers.

[Assurance of core systems and controls](#)

The governance section within the annual report explains how the Trust is governed and provides details of its Board committee structure, the frequency of meetings of the Board

and its committees, attendance records at these meetings and the coverage of the work carried out by committees.

In all cases, action plans have been put in place to remedy any controls or assurance gaps, and the remedial action is being monitored by the assurance committees of the Board.

In addition, the Board and its assurance committees have reviewed the risks and assurance available in relation to the following key operational risks:

- Implementation of an EPR: the Audit Committee and Trust Board have received regular reports on the mitigations in place to manage the risk of implementing the EPR. Assurances at Audit Committee have been sought via external gateway reports on the Governance, Implementation Readiness (including technical, clinical and data approach readiness), Design Readiness (including data, configuration and training strategies), Configuration and Testing, Training and Go–Live (including clinical readiness/safety assessments, training plans, data migration trial loads and achievement of go–live criteria) and Intensive Support. Both assurances and gaps have been reported to the Board.
- Brexit – the executives established a Brexit Steering Group attended by key senior managers from across the Trust representing emergency planning, pharmacy, research, procurement, and workforce. The Board has received updates on mitigations in place to manage the risk of leaving the EU without a deal.
- Data Protection, Data Quality and Cyber Security – the Audit Committee has scrutinised these areas of risk throughout the year, reporting assurances and gaps to the Board (see above on data quality).
- Redevelopment of the site – during the year, the Board and the Finance and Investment Committee have actively considered and balanced the risks involved in redeveloping the frontage buildings of the hospital into a Children’s Cancer Centre. Discussions continue informed by monitoring of future expected activity and the availability of alternative funding streams.
- Level of international and private practice debt – throughout the year the Audit Committee has scrutinised the mitigations in place to secure payment from authorities for outstanding debt.

The Board is committed to continuous improvement and ensures there are regular reviews of the Trust’s performance in relation to its key objectives, and that processes for managing risks are continually developed and strengthened.

- During the year the escalation processes for risk reporting were aligned with the refreshed directorate structure and this informed the review of the Risk Management Strategy.
- Work began on refreshing the Trust Duty of Candour Policy, and the Acceptable Behaviour Policy was agreed and rolled out across the Trust.
- The Trust Constitution was reviewed and updated in line with current best practice.

8. Conclusion

With the exception of the gaps in internal controls and matters where assurances can be improved, as set out above, my review confirms that GOSH has a generally sound system of

internal controls that supports the achievement of its policies, aims and objectives, and I am confident that all minor gaps are being actively addressed. In the area where there was a significant control issue identified during the period, actions have now been implemented to address the issue.

Signed.....

Mr Matthew Shaw

Chief Executive

Date: XX May 2019

Independent auditor's report

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS AND BOARD OF DIRECTORS OF THE GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST

Accounts

See agenda

Quality Report 2018/19

See Agenda

Glossary

ACAS	Advisory, Conciliation and Arbitration Service
BAF	Board Assurance Framework
BAME	Black Asian and Minority Ethnic
BRC	Biomedical Research Centre
CAHF	Clean Air Hospital Framework
CHESS	Children’s Hospital Education Specialist Symposium
CHP	Combined Heat and Power
CRF	Clinical Research Facility
CQC	Care Quality Commission
DRIVE	Digital Research Informatics & Virtual Environment
DSP	Data Security and Protection
DSPT	Data Security and Protection Toolkit
ECHO	European Children’s Hospital Organisation
EEA	European Economic Area
EMT	Executive Management Team
EPIC	The service provider of the EPR
EpiCARE	The European Reference Network for rare and complex epilepsies
EPR	Electronic Patient Record
ERN	European Research Networks
EU	European Union
FTE	Full-time equivalent
FTSU	Freedom to Speak Up
GDPR	General Data Protection Regulations
GEMS	GOSH Exceptional Member of Staff
GOSH	Great Ormond Street Hospital
HEE	Health Education England

ICH	UCL Great Ormond Street Institute of Child Health
I&E	Income and Expenditure
IGSG	Information Governance Steering Group
IP	Intellectual Property
LCFS	Local Counter Fraud Service
LITT	Laser interstitial thermal therapy
MES	Membership Engagement Services
NED	Non-Executive Directors
NHS	National Health Service
NHSI	NHS Improvement (Monitor)
NIHR	National Institute for Health Research
NIHR BRC	National Institute for Health Research Great Ormond Street Biomedical Research Centre
PALS	Patient Advice and Liaison Service
PDR	Performance and development review
PHSO	Parliamentary and Health Service Ombudsman
PICB	Premier Inn Clinical Building
PLACE	Patient-led Assessments of the Care Environment
QIA	Quality impact assessment
QSEAC	Quality, Safety and Experience Assurance Committee
RACG	Risk Assurance and Compliance Group
SDMP	Sustainable Development Management Plan
SID	Senior independent director
STP	Sustainability and Transformation Partnerships
UCL	University College London
UCLH	University College London Hospitals
UCLP	UCL Partners
WHO	World Health Organisation
YPF	Young People's Forum

Great Ormond Street Hospital for Children NHS Foundation Trust - Annual Accounts 2018/19

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
3.1 Other operating income		
Other operating income recognised in accordance with IFRS 15		
Research and development (IFRS 15)	13,235	24,227
Education and training	9,226	9,643
Non-patient care services to other bodies	2,003	889
Provider sustainability fund	12,763	9,067
Clinical tests	5,817	5,644
Clinical excellence awards	2,431	2,832
Catering	1,434	1,375
Creche services	424	472
Staff accommodation rentals	60	91
Other revenue	2,152	2,866
	<u>49,545</u>	<u>57,106</u>
Other operating income recognised in accordance with other standards		
Research and development (non IFRS 15)	14,567	0
Education and training - notional income from apprenticeship fund	238	48
Charitable contributions in respect of capital expenditure	32,780	24,653
Charitable contributions to expenditure	7,504	6,179
	<u>55,089</u>	<u>30,880</u>
Total other operating income	<u>104,634</u>	<u>87,986</u>
of which		
Related to continuing operations	104,634	87,986

The Trust received £12,763k of Provider Sustainability Funding. This was made up of: £7,571k core, £116k Incentive Scheme (Finance), £1,614k Incentive Scheme (Bonus) and £3,462k General Distribution.

3.2 Additional information on revenue from contracts with customers recognised in the period

	Year ended 31 March 2019 £000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	0
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	0

Note 5.2 Transaction price allocated to remaining performance obligations

	Year ended 31 March 2019 £000
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	
within one year	0
after one year, not later than five years	0
after five years	0
Total revenue allocated to remaining performance obligations	0

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

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NHS Foundation Trust

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Deloitte LLP
3 Victoria Square
Victoria Street
St. Albans
AL1 3TF

23 May 2019

Our Ref: CAW/RLG/2019

Dear Sirs

This representation letter is provided in connection with your audit of the annual financial statements and consolidation schedules (together "the financial statements") of Great Ormond Street Hospital for Children NHS Foundation Trust for the year ended 31 March 2019 for the purpose of expressing an opinion as to whether the financial statements give a true and fair view of the financial position of Great Ormond Street Hospital for Children NHS Foundation Trust as of 31 March 2019 and of the results of its operations, other recognised gains and losses and its cash flows for the year then ended in accordance with the directions given by NHS Improvement - Independent Regulator of NHS Foundation Trusts in accordance with paragraph 25 of Schedule 7 of the National Health Service Act 2006. It is also provided in connection with your limited assurance report on the quality report for the year ended 31 March 2019.

As Accounting Officer and on behalf of the board of directors, I confirm, to the best of my knowledge and belief, the following representations:

Financial statements

1. We understand and have fulfilled my responsibilities for the preparation of the financial statements in accordance with the directions given by NHS Improvement – Independent Regulator of NHS Foundation Trusts in accordance with paragraph 25 of Schedule 7 of the National Health Service Act 2006 which give a true and fair view, as set out in the terms of the engagement letter.
2. Significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable.
3. Related party relationships and transactions have been appropriately accounted for and disclosed in accordance with the requirements of IAS24 "Related party disclosures".

With regard to the transactions and balances listed in the notes to the financial statements, we confirm that to the best of our knowledge and belief these transactions are not significant to the related party or to the Trust such that they would influence decisions made by a user of the financial statements.

4. All events subsequent to the date of the financial statements and for which the applicable financial reporting framework requires adjustment of or disclosure have been adjusted or disclosed.
5. The effects of uncorrected misstatements and disclosure deficiencies are immaterial, both individually and in aggregate, to the financial statements as a whole. A list of the disclosure deficiencies is detailed in the appendix to this letter.
6. We confirm that the financial statements have been prepared on the going concern basis and disclose in accordance with IAS 1 all matters of which we are aware that are relevant to the Trusts' ability to continue as a going concern, including principal conditions or events and our plans. We do not intend to liquidate the Trust or cease trading as we consider we have realistic alternatives to doing so. We are not aware of any material uncertainties related to events or conditions that may cast significant doubt upon the Trust's ability to continue as a going concern. We confirm the completeness of the information provided regarding events and conditions relating to going concern at the date of approval of the financial statements, including our plans for future actions. We are satisfied as to the status of negotiations with commissioners being in support of this.

Information provided

7. We have provided you with all relevant information and access as agreed in the terms of the audit engagement letter and required by the National Health Service Act 2006.
8. All transactions have been recorded and are reflected in the financial statements and the underlying accounting records.
9. We acknowledge our responsibilities for the design, implementation and maintenance of internal control to prevent and detect fraud and error.
10. We have disclosed to you the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.
11. We have disclosed to you all information in relation to fraud or suspected fraud that we are aware of and that affects the entity or group and involves:
 - (i) management;
 - (ii) employees who have significant roles in internal control; or

- (iii) others where the fraud could have a material effect on the financial statements.

- 12. We have disclosed to you all information in relation to allegations of fraud, or suspected fraud, affecting the entity's financial statements communicated by employees, former employees, analysts, regulators or others.

- 13. We have disclosed to you all known instances of non-compliance, or suspected non-compliance, with laws, regulations and contractual agreements whose effects should be considered when preparing financial statements.

- 14. We have disclosed to you the identity of the Trust's related parties and all the related party relationships and transactions of which we are aware.

- 15. All minutes of board and management meetings during the year and since the financial year have been made available to you.

- 16. All known actual or possible litigation and claims whose effects should be considered when preparing the financial statements have been disclosed to you and accounted for and disclosed in accordance with the applicable financial reporting framework. On the basis of legal advice we have set them out in the attachment with our estimates of their potential effect. No other claims in connection with litigation have been or are expected to be received.

- 17. We have no plans or intentions that may materially affect the carrying value or classification of assets and liabilities reflected in the financial statements.

- 18. We have reconsidered the estimated remaining useful lives of the fixed assets and confirm that the present rates of depreciation are appropriate to amortise the revalued amount less residual value over the remaining useful lives.

- 19. We confirm that no significant fixed assets have been sold or scrapped during the financial year other than those listed in the fixed asset register.

- 20. We have recorded or disclosed, as appropriate, all liabilities, both actual and contingent.

- 21. Except as disclosed in Note 12 to the financial statements, as at 31 March 2019 there were no significant capital commitments contracted by the Trust.

- 22. We acknowledge our responsibility for ensuring the Trust has put in place arrangements for securing economy, efficiency and effectiveness in its use of resources.

- 23. We are not aware of any deficiencies in the Trust's arrangements to secure economy, efficiency and effectiveness in its use of resources.

24. All grants or donations, the receipt of which is subject to specific restrictions, terms or conditions, have been notified to you. We have evaluated whether the restrictions, terms or conditions on grants or donations have been fulfilled with and deferred income to the extent that they have not.
25. Based on discussions with other NHS bodies, we consider that the resolution of disputed balances and accrued over performance will not result in a material adverse effect on the reported financial position.
26. We do not currently have the power to govern, nor do we have control over any of the charities involved with Great Ormond Street Hospital for Children NHS Foundation Trust and as a result have not consolidated any of these charities in our financial statements.
27. We have considered the valuation of the Trust's Property with respect to the revaluation of the property in accordance with the Group Accounting Manual:
 - a) the measurement processes used are appropriate and have been applied consistently, including related assumptions and models;
 - b) the assumptions appropriately reflect our intent and ability to carry out specific courses of action on behalf of the entity where relevant to the accounting estimates and disclosures;
 - c) the disclosures are complete and appropriate.
 - d) there have been no subsequent events that require adjustment to the valuations and disclosures included in the financial statements.
28. We confirm that we consider that depreciated historic cost is an appropriate proxy for the fair value of non-property assets, and are not aware of any circumstances that would indicate that these assets require revaluation.
29. The effects of uncorrected misstatements and disclosure deficiencies are immaterial, both individually and in aggregate, to the quality report as a whole. A list of the uncorrected misstatements and disclosure deficiencies is detailed in the appendix to this letter.
30. We acknowledge our responsibilities for the design, implementation and maintenance of internal control to prevent and detect fraud and error when preparing the quality report.

Quality report

31. We understand and have fulfilled our responsibilities for the preparation of the quality report in accordance with the NHS Foundation Trust Annual Reporting Manual.

32. We have made available to you all records, correspondence, information and explanations necessary for you to perform your work. All the records have been made available to you for the purpose of your work and all the data collected by the Foundation Trust has been properly reflected and recorded.
33. Significant assumptions that have been made by us in determining the indicators are reasonable.
34. As such we confirm the disclosures in relation to the number of cases and the approach to testing are appropriate.
35. All events subsequent to the date of the quality report and for which the NHS Foundation Trust Annual Reporting Manual requires adjustment of or disclosure have been adjusted or disclosed.
36. The effects of uncorrected misstatements and disclosure deficiencies are immaterial, both individually and in aggregate, to the quality report as a whole. A list of the uncorrected misstatements and disclosure deficiencies is detailed in the appendix to this letter.
37. We acknowledge our responsibilities for the design, implementation and maintenance of internal control to prevent and detect fraud and error when preparing the quality report.
38. We are not aware of any instances of non-compliance, or suspected non-compliance, with laws and regulations whose effects should be considered when preparing the quality report.
39. We have disclosed to you all deficiencies in internal control over the collection and reporting of the measures of performance included in the quality report of which we are aware, including in respect of 18 week Referral to Treatment waiting times.

We confirm that the above representations are made on the basis of adequate enquiries of management and staff (and where appropriate, inspection of evidence) sufficient to satisfy ourselves that we can properly make each of the above representations to you.

Yours faithfully

Dr. Matthew Shaw, Chief Executive Officer
Signed as Accounting Officer, and on behalf of the Board of Directors

Appendix 1

Schedule of Uncorrected Misstatements

Description	Assets	Liabilities	Equity	Income Statement
	DR / (CR) £	DR / (CR) £	DR / (CR) £	DR / (CR) £
NONE NOTED				

Appendix 2

Disclosure deficiencies

#	Disclosure title	Description of the deficiency and explanation of why not adjusted	Amount (if applicable)
1	None noted		

Trust Board 22 May 2019	
Compliance with the Code of Governance 2018/19 Submitted by: Anna Ferrant, Company Secretary	Paper No: Attachment S
<p><i>Aims / summary</i></p> <p>Monitor, the Independent Regulator of NHS Foundation Trusts, has drawn on the practice developed in the private sector, and, based on the Combined Code for Corporate Governance, produced the NHS Foundation Trust Code of Governance. This code consists of a set of Principles and Provisions. The Code was revised and republished in July 2014.</p> <p>Foundation trusts are required to report against Monitor’s (now referred to as NHS Improvement) Code of Governance each year in their Annual Report, on the basis of either compliance with the Code provisions, or, an explanation where they do not.</p> <p>A review has been conducted against all the Code’s provisions and an outline of the evidence to support compliance against each of the criteria is attached at Appendix 1 for information. The text in red highlights those criteria against which the Trust is required to explain any areas of non-compliance.</p> <p>The review has found that the Board has applied the principles and met the requirements of Code of Governance during 2018/19 with the exception of three provisions where alternative arrangements/ plans are explained. It is proposed that the text provided below is published in the annual report 2018/19 explaining the Trust’s compliance with the Code.</p> <ul style="list-style-type: none"> • The first section (highlighted in yellow) outlines where in the annual report reference to the provisions of the Code that must be explained are located. • The second section (highlighted in blue) provides an explanation against those provisions where there is a “comply or explain” requirement. These disclose where the Trust has departed from the Code and the plans/ alternative arrangements in place to reflect the principles of the Code. <p><i>Code of Governance</i></p> <p><i>Great Ormond Street Hospital for Children NHS Foundation Trust has applied the principles of The NHS foundation trust Code of Governance on a ‘comply or explain’ basis. The NHS foundation trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.</i></p> <p><i>Throughout our annual report we describe how we meet the Code. A summary of where detail can be found on the issues we are required to disclose is given in the following table.</i></p>	

Attachment S

Code reference	Section of annual report
A.1.1	Accountability Report: <ul style="list-style-type: none"> • Council of Governors (role of Council) • Trust Board (role of Trust Board) • Annual Governance Statement (role of Trust Board)
A.1.2	Accountability Report - Trust Board members 2018-19
A.5.3	Accountability Report - Governors' attendance at meetings
Additional requirement	Accountability Report - Trust Board members 2018-19 Accountability Report - Governors' attendance at meetings
B.1.1	Accountability Report - Trust Board members 2018-19
B.1.4	Accountability Report - Trust Board members 2018-19
Additional requirement	Accountability Report - Trust Board members 2018-19
B.2.10	Accountability Report: Trust Board Nominations Committee Council of Governors' Nominations and Remuneration Committee
Additional requirement	Not applicable
B.3.1	Accountability Report - Trust Board members 2018-19
B.5.6	Accountability Report – Membership Engagement
Additional requirement	Not applicable
B.6.1	Accountability Report – Evaluation of Board performance
B.6.2	Accountability Report – Evaluation of Board performance
C.1.1	Disclosures -Statement of the chief executive's responsibilities as the accounting officer of Great Ormond Street Hospital for Children NHS Foundation Trust
C.2.2	Accountability Report – Audit Committee Report
C.3.5	Not applicable for 2018/19
C.3.9	Accountability Report – Audit Committee Report
D.1.3	Remuneration Report
E.1.4	Accountability Report – Council of Governors
E.1.5	Accountability Report - Trust Board and Council of Governors working together

Attachment S

E.1.6	<i>Accountability Report - Membership constituencies and membership numbers 2018-19 and Membership Engagement</i>
Additional requirement	<i>Accountability Report – Council of Governors</i>
Additional requirement	<i>Accountability Report – Register of Interest (Directors) and Register of Interests (Governors)</i>
B.1.2	<i>The Board is normally comprised of a Chair, Deputy Chair, Senior Independent Director (SID), three additional independent Non-Executive Directors, and six Executive Directors. One of the Non-Executive Directors is appointed by University College London. Mr Chris Kennedy joined the Board as a non–executive director on 1 April 2018 and Ms Kathryn Ludlow joined as a non–executive director from 6 September 2018. From 31 May 2018 until the appointment of Ms Kathryn Ludlow, the Board comprised a chair and five non–executive directors, including one appointed by University College London.</i>
B.2.2	<i>The directors on the Board have all been required to sign a statement declaring that they meet the criteria of a ‘fit and proper person’. Governors are asked to make a declaration about their fitness to hold the role of Governor and are subject to a DBS check every three years (and on appointment/ election). Further checks are underway with regards director disqualifications and bankruptcy and on an annual basis.</i>
B.6.5	<i>An evaluation of the Council was due in 2018. A decision has been taken to delay this to Q2 2019/20, allowing time for new governors to be inducted and become familiar with their roles.</i>
Action required from the meeting	
To note the review and approve the statement to be included in the annual report.	
Contribution to the delivery of NHS Foundation Trust strategies and plans	
Good corporate governance	
Financial implications	
None	
Legal issues	
Compliance with the Code is required in order to retain authorisation as a Foundation Trust	
Who needs to be / has been consulted about the proposals in the paper (staff, councillors, commissioners, children and families) and what consultation is planned/has taken place?	
N/A	
Who needs to be told about any decision?	
N/A	
Who is responsible for implementing the proposals / project and anticipated timescales?	
Company Secretary	
Who is accountable for the implementation of the proposal / project?	
Chair of Board and Council	

Compliance with the Code of Governance 2018-2019		
Key		
	Fully compliant with the requirement	
	Partially compliant with the requirement	
Red text	Criteria against which Monitor expects the Trust to explain any areas of non-compliance.	
Para	Code of Governance Requirement	Disclosure
A.1.1	The board of directors should meet sufficiently regularly to discharge its duties effectively. There should be a schedule of matters specifically reserved for its decision. The schedule of matters reserved for the board of directors should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the board of directors. These arrangements should be kept under review at least annually.	<ul style="list-style-type: none"> A schedule of matters is in place and subject to review in 2019 (added to Board Calendar) The Constitution was revised in July 2018 in consultation with the Board and Council. It includes: <ul style="list-style-type: none"> A statement about resolving disagreements is detailed in the Constitution. The annual report includes a statement about how the Board and Council operate and the types of decision taken by the Board and the Council.
A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors.	The annual report identifies these individuals and outlines the number of meetings attended by Board members.
A.1.3	The board of directors should make available a statement of the objectives of the NHS foundation trust showing how it intends to balance the interests of patients, the local community and other stakeholders, and use this as the basis for its decision-making and forward planning.	This statement is incorporated in the Trust's Annual Plan.
A.1.4	The board of directors should ensure that adequate systems and processes are maintained to measure and monitor the NHS foundation trust's effectiveness, efficiency and economy as well as the quality of its health care delivery. The board should regularly review the performance of the NHS foundation trust in these areas against regulatory and contractual obligations, and approved plans and objectives.	<p>The Board receives regular reports on quality, safety, patient experience and workforce and these are presented in a refreshed integrated report. A separate report is presented on finance and activity. These reports monitor the Trust's plans and strategies. Corporate risks are reviewed at the Risk, Assurance and Compliance Group (an executive led group chaired by the CEO) and the actions shared with the Audit Committee and Quality, Safety and Experience Assurance Committee (QSEAC). Assurance of the robustness of the controls in place to mitigate these risks is sought by the Audit Committee and QSEAC. The annual report provides a summary of the adequacy of these systems.</p> <p>External sources of assurance are sought on high risk/ complex areas .</p>
A.1.5	The board of directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and delivery of performance. Where appropriate and, in particular, in high risk or complex areas, independent advice, for example, from the internal audit function, should be commissioned by the board of directors to provide an adequate and reliable level of assurance.	<p>The Board receives regular reports on quality, safety, finance, patient experience and workforce. These include relevant metrics, milestones and measures.</p> <p>The assurance committees seek assurance of the robustness of the controls in place to mitigate risk and direct the internal audit function to provide assurance that these controls are robust. The assurance committees approve the internal audit and clinical audit plan every year.</p>
A.1.6	The board of directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in accordance with guidance set out by the DH, NHS England, the CQC and Monitor. The board should record where, within the structure of the organisation, consideration of clinical governance matters occurs.	<p>The Board receives an integrated quality and performance report at each Board meeting.</p> <p>The Quality, Safety and Experience Assurance Committee, a committee of the Board, seeks assurance of the adequacy of controls in place to manage quality risks and provides a summary report of matters considered at its last meeting to the next available Board meeting.</p> <p>The Patient, Safety and Outcomes Committee monitors the development and implementation of clinical risk management processes and evidence based standards and ensures that learning is disseminated and embedded across the Trust.</p> <p>The Quality Report is published with the annual report. Progress with the Quality Strategy is reviewed by the CGC on an annual basis.</p> <p>Compliance with CQC standards and other regulatory and statutory requirements are monitored by the Risk Assurance and Compliance Group. An Assurance and Escalation Framework has been developed (subject to review) including enhanced monitoring of risk and compliance requirements.</p>
A.1.7	The chief executive as the accounting officer should follow the procedure set out by Monitor for advising the board of directors and the council of governors and for recording and submitting objections to decisions considered or taken by the board of directors in matters of propriety or regularity, and on issues relating to the wider responsibilities of the accounting officer for economy, efficiency and effectiveness.	The Chief Executive is aware of his role and responsibility as accounting officer for the Trust and signs the statement in the annual report.
A.1.8	The board of directors should establish the constitution and standards of conduct for the NHS foundation trust and its staff in accordance with NHS values and accepted standards of behaviour in public life, which includes the principles of selflessness, integrity, objectivity, accountability, openness, honesty and leadership (The Nolan Principles).	<p>Standards of conduct are included in staff job descriptions.</p> <p>The Board of Directors' Code of Conduct has been refreshed in 2018/19 and reflects these values (including the Trust's Always Values) and accepted standards of behaviour in public life and all directors have signed this code which includes reference to the fit and proper person test. The Governors' Code of Conduct was also refreshed, covering the same values and standards and governors are required to sign this.</p>
A.1.9	The board of directors should operate a code of conduct that builds on the values of the NHS foundation trust and reflect high standards of probity and responsibility. The board of directors should follow a policy of openness and transparency in its proceedings and decision-making unless this is in conflict with a need to protect the wider interests of the public or the NHS foundation trust (including commercial-in-confidence matters) and make clear how potential conflicts of interest are dealt with.	<p>See above on the Code of Conduct for directors and governors.</p> <p>The directors and governors are asked to submit an annual declaration of interests and are prompted to declare any interests at the start of every Board meeting. The register of interests for directors and governors is published on the GOSH website.</p>

Para	Code of Governance Requirement	Disclosure
A.1.10	The NHS foundation trust should arrange appropriate insurance to cover the risk of legal action against its directors. Assuming the governors have acted in good faith and in accordance with their duties, and proper process has been followed, the potential for liability for the council should be negligible. Governors may have the benefit of an indemnity and/or insurance from the trust. While there is no legal requirement for trusts to provide an indemnity or insurance for governors to cover their service on the council of governors, where an indemnity or insurance policy is given, this can be detailed in the trust's constitution.	This cover is provided under the LTPS (NHSLA). The Trust has also arranged top up insurance to provide additional indemnity for risks not covered by the NHSLA e.g.: • Claims made against the Entity itself • Past Directors, Governors, Employees A review of insurance cover across the Trust will be conducted in 2018/19
A.2.1	The division of responsibilities between the chairperson and chief executive should be clearly established, set out in writing and agreed by the board of directors.	The responsibilities of the Chair and Chief Executive are set out in writing in their Job Descriptions. A summary of these responsibilities are also documented as an appendix to the schedule of matters.
A.2.2	The roles of chairperson and chief executive must not be undertaken by the same individual.	The Chair and Chief Executive roles are undertaken by two separate individuals.
A.3.1	The chairperson should, on appointment by the council, meet the independence criteria set out in B.1.1. A chief executive should not go on to be the chairperson of the same NHS foundation trust.	The Chair meets the independence criteria and has not been chief executive of the Trust.
A.4.1	In consultation with the council of governors, the board should appoint one of the independent non-executive directors to be the senior independent director to provide a sounding board for the chairperson and to serve as an intermediary for the other directors when necessary. The senior independent director should be available to governors if they have concerns that contact through the normal channels of chairperson, chief executive, finance director or trust secretary has failed to resolve, or for which such contact is inappropriate. The senior independent director could be the deputy chairperson.	The senior independent director is Mr James Hatchley appointed by the Board in consultation with the Council in April 2017. The deputy chair is Akhter Mateen, appointed in April 2017. The SID attends Council meetings, is available to speak with governors individually and invites comments from governors on the appraisal of the Chair during the period.
A.4.2	The chairperson should hold meetings with the non-executive directors without the executives present. Led by the senior independent director, the non-executive directors should meet without the chairperson present, at least annually, to appraise the chairperson's performance, and on other such occasions as are deemed appropriate.	The Chair held meetings with the NEDs during the year without the executives present. The Senior Independent Director (SID) lead the performance evaluation of the Chair and consulted with the other NEDs and the governors on his performance.
A.4.3	Where directors have concerns that cannot be resolved about the running of the NHS foundation trust or a proposed action, they should ensure that their concerns are recorded in the board minutes. On resignation, a director should provide a written statement to the chairperson for circulation to the board, if they have any such concerns.	Any matters raised are recorded in the minutes of the meetings and the minutes reviewed and approved at the next relevant Board meeting. No concerns have been submitted to the Chair outwith this process during the period.
A.5.1	The council of governors should meet sufficiently regularly to discharge its duties. Typically the council of governors would be expected to meet as a full council at least four times a year. Governors should, where practicable, make every effort to attend the meetings of the council of governors. The NHS foundation trust should take appropriate steps to facilitate attendance.	The Council of Governors now meets 4 times a year as a minimum (excluding extraordinary meetings). Governor attendance at meetings is recorded in the annual report. Governors are provided with regular reminders about meetings (including opportunities to observe Board and assurance committees) via the monthly Governor bulletin.
A.5.2	The council of governors should not be so large as to be unwieldy. The council of governors should be of sufficient size for the requirements of its duties. The roles, structure, composition, and procedures of the council of governors should be reviewed regularly as described in provision B.6.5.	The Council is made up of 27 governors. When revising the Constitution in July 2018, the Board and Council agreed that this was of a sufficient, representative size. The Council of Governors has a terms of reference which will be subject to review in 2019 and reflect the revisions to the Trust Constitution.
A.5.3	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor. A record should be kept of the number of meetings of the council and the attendance of individual governors and it should be made available to members on request.	This information is recorded in the annual report which is published on the website. The Constitution includes an expectation of the number of meetings that governors should attend. A record of attendance for governors is maintained and is available on request throughout the year.
A.5.4	The roles and responsibilities of the council of governors should be set out in a written document. This statement should include a clear explanation of the responsibilities of the council of governors towards members and other stakeholders and how governors will seek their views and keep them informed.	The annual report outlines the role and responsibilities of the Council, highlighting the responsibilities of the Council towards members and stakeholders. This is also included on the GOSH website and in other promotional material. The schedule of matters highlights the Council's responsibilities.
A.5.5	The chairperson is responsible for leadership of both the board of directors and the council of governors (see A.3) but the governors also have a responsibility to make the arrangements work and should take the lead in inviting the chief executive to their meetings and inviting attendance by other executives and non-executives, as appropriate. In these meetings other members of the council of governors may raise questions of the chairperson or his/her deputy, or any other relevant director present at the meeting about the affairs of the NHS foundation trust.	The chief executive gives a written report at each Council meeting. Non-executive directors attend the Council meeting on a regular basis and answer questions from governors which is recorded in the Council meeting minutes. Executive Directors are invited to present on relevant reports. Governors receive feedback from the non-executive chairs of the Board assurance committees. Governors are invited to attend to observe the Board and assurance committee meetings. Governors have contact details of their 'Buddy' NED to ask questions inbetween meetings.
A.5.6	The council of governors should establish a policy for engagement with the board of directors for those circumstances when they have concerns about the performance of the board of directors, compliance with the new provider licence or other matters related to the overall wellbeing of the NHS foundation trust. The council of governors should input into the board's appointment of a senior independent director (see A.4.1).	The Constitution details how such issues will be managed. The SID is available to discuss concerns about the performance of the board of directors and/or compliance with licence requirements. All of the Non-Executive directors attend each Council meeting and are available to answer questions about performance matters. The Chair holds a private meeting with Governors prior to each Council meeting and provides the opportunity to ask any question and receive updates on key matters.
A.5.7	The council of governors should ensure its interaction and relationship with the board of directors is appropriate and effective. In particular, by agreeing the availability and timely communication of relevant information, discussion and the setting in advance of meeting agendas and, where possible, using clear, unambiguous language.	Governors are invited to attend the Board and the assurance committees as observers. A bulletin is sent regularly to governors, updating them on development opportunities, requests for information, media news stories and dates for diaries. The Trust seeks to spell out all acronyms in Council papers. A glossary of terms has also been circulated to governors

Para	Code of Governance Requirement	Disclosure
A.5.8	The council of governors should only exercise its power to remove the chairperson or any non-executive directors after exhausting all means of engagement with the board of directors. The council should raise any issues with the chairperson with the senior independent director in the first instance.	The Council will seek to engage with the Board of Directors should this situation arise, through the lead governor and SID.
A.5.9	The council of governors should receive and consider other appropriate information required to enable it to discharge its duties, for example clinical statistical data and operational data.	<p>At every meeting, the Council receives a report from the Chief Executive which includes information on targets and quality indicators (covering safety and patient experience), workforce and a financial update.</p> <p>Governors receive feedback from the non-executive chairs of the Board assurance committees. Governors are invited to attend to observe these assurance committee meetings.</p> <p>Emails are sent to governors on significant performance matters between meetings.</p> <p>A bulletin is sent out regularly to governors, updating them on development opportunities, requests for information, media news stories and dates for diaries.</p>
A.5.10	The council of governors has a statutory duty to hold the non-executive directors individually and collectively to account for the performance of the board of directors.	<p>The Council is aware of this duty and carry it out in a number of ways:</p> <ul style="list-style-type: none"> - raising matters with non-executive directors in Council meetings (NEDs attend every Council meeting) - Attending assurance committees chaired by NEDs and observing how they hold the executive team to account; - Holding a private meeting with the Chair prior to each Council meeting -Attending public Board meetings; - Attending the AGM.
A.5.11	The 2006 Act, as amended, gives the council of governors a statutory requirement to receive the following documents. These documents should be provided in the annual report as per the <i>NHS Foundation Trust Annual Reporting Manual</i> : (a) the annual accounts; (b) any report of the auditor on them; and (c) the annual report.	These documents are presented to the Council at the Annual Member's meeting in September.
A.5.12	The directors must provide governors with an agenda prior to any meeting of the board, and a copy of the approved minutes as soon as is practicable afterwards. There is no legal basis on which the minutes of private sessions of board meetings should be exempted from being shared with the governors. In practice, it may be necessary to redact some information, for example, for data protection or commercial reasons. Governors should respect the confidentiality of these documents.	<p>The agenda and minutes of confidential meetings of the Board are being uploaded to the Governor Portal where Governors have access to these documents at all times and can be easily found in one place.</p> <p>The public agenda and papers are available on the Trust website and governors are invited to attend Board public meetings.</p>
A.5.13	The council of governors may require one or more of the directors to attend a meeting to obtain information about performance of the trust's functions or the directors' performance of their duties, and to help the council of governors to decide whether to propose a vote on the trust's or directors' performance.	The executive (when appropriate) and non-executive directors attend most Council meetings and provide information about performance of the Trust. This includes updates from those non-executive directors who chair Board assurance committees (Audit Committee, Quality, Safety and Experience Assurance Committee and the Finance and Investment Committee).
A.5.14	Governors have the right to refer a question to the independent panel for advising governors. More than 50% of governors who vote must approve this referral. The council should ensure dialogue with the board of directors takes place before considering such a referral, as it may be possible to resolve questions in this way.	Governors are provided with a copy of the Code of Governance and are aware of this right through their induction
A.5.15	Governors should use their new rights and voting powers from the 2012 Act to represent the interests of members and the public on major decisions taken by the board of directors. These new voting powers require: • More than half of the members of the board of directors who vote and more than half of the members of the council of governors who vote to approve a change to the constitution of the NHS foundation trust. • More than half of governors who vote to approve a significant transaction. • More than half of all governors to approve an application by a trust for a merger, acquisition, separation or dissolution. • More than half of governors who vote, to approve any proposal to increase the proportion of the trust's income earned from non-NHS work by 5% a year or more. For example, governors will be required to vote where an NHS foundation trust plans to increase its non-NHS income from 2% to 7% or more of the trust's total income. • Governors to determine together whether the trust's non-NHS work will significantly interfere with the trust's principal purpose, which is to provide goods and services for the health service in England, or its ability to perform its other functions. NHS foundation trusts are permitted to decide themselves what constitutes a "significant transaction" and may choose to set out the definition(s) in the trust's constitution. Alternatively, with the agreement of the governors, trusts may choose not to give a definition, but this would need to be stated in the constitution.	The Constitution covers all of these rights and voting powers. The Council approved a revision to the Constitution in 2018/19.
B.1.1	<p>The board of directors should identify in the annual report each non-executive director it considers to be independent. The board should determine whether the director is independent in character and judgement and whether there are relationships or circumstances which are likely to affect, or could appear to affect, the director's judgement. The board of directors should state its reasons if it determines that a director is independent despite the existence of relationships or circumstances which may appear relevant to its determination, including if the director:</p> <ul style="list-style-type: none"> • has been an employee of the NHS foundation trust within the last five years; • has, or has had within the last three years, a material business relationship with the NHS foundation trust either directly, or as a partner, shareholder, director or senior employee of a body that has such a relationship with the NHS foundation trust; • has received or receives additional remuneration from the NHS foundation trust apart from a director's fee, participates in the NHS foundation trust's performance-related pay scheme, or is a member of the NHS foundation trust's pension scheme; • has close family ties with any of the NHS foundation trust's advisers, directors or senior employees; • holds cross-directorships or has significant links with other directors through involvement in other companies or bodies; • has served on the board of the NHS foundation trust for more than six years from the date of their first appointment; or • is an appointed representative of the NHS foundation trust's university medical or dental school. 	<p>The annual report details the independence of all of the non-executive directors. It notes that one NED is appointed by UCL Great Ormond Street Institute of Child Health (ICH).</p> <p>All directors are asked to annually declare any interests, including the matters outlined under B.1.1. Directors are also prompted to declare any interests at the start of every Board meeting</p>

Para	Code of Governance Requirement	Disclosure
B.1.2	At least half the board, excluding the chairperson, should comprise non-executive directors determined by the board to be independent.	The Board is normally comprised of a Chair, Deputy Chair, Senior Independent Director (SID), three additional independent Non-Executive Directors, and six Executive Directors. One of the Non-Executive Directors is appointed by University College London. Mr Chris Kennedy joined the Board as a non-executive director on 1 April 2018 and Ms Kathryn Ludlow joined as a non-executive director from 6 September 2018. From 31 May 2018 until the appointment of Ms Kathryn Ludlow, the Board comprised a chair and five non-executive directors, including one appointed by University College London.
B.1.3	No individual should hold, at the same time, positions of director and governor of any NHS foundation trust.	None of the directors on the GOSH Board are governors on the GOSH Members' Council nor a governor on another Trust's Council of Governors.
B.1.4	The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust. Both statements should also be available on the NHS foundation trust's website.	This information is included in the annual report and on the Trust website.
B.2.1	The nominations committee or committees, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors. The nominations committee should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the NHS foundation trust and the skills and expertise required within the board of directors to meet them.	There are two nomination committees: one for the appointment of the Chair and NEDs and one for the appointment of executive directors. Both have approved terms of reference and are responsible for taking into account succession planning. In 2018/19 the Council of Governors considered and approved the updated Board skills and experience survey, in preparation for informing the appointment of a new Non-Executive Director.
B.2.2	Directors on the board of directors and governors on the council of governors should meet the "fit and proper" persons test described in the provider licence. For the purpose of the licence and application criteria, "fit and proper" persons are defined as those without certain recent criminal convictions and director disqualifications, and those who are not bankrupt (undischarged). Trusts should also abide by the updated guidance from the CQC regarding appointments to senior positions in organisations subject to CQC regulations	The directors on the Board have all been required to sign a statement declaring that they meet the criteria of a 'fit and proper person'. Governors are asked to make a declaration about their fitness to hold the role of Governor and are subject to a DBS check every three years (and on appointment/ election). Further checks are underway with regards director disqualifications and bankruptcy and on an annual basis.
B.2.3	There may be one or two nominations committees. If there are two committees, one will be responsible for considering nominations for executive directors and the other for non-executive directors (including the chairperson). The nominations committee(s) should regularly review the structure, size and composition of the board of directors and make recommendations for changes where appropriate. In particular, the nominations committee(s) should evaluate, at least annually, the balance of skills, knowledge and experience on the board of directors and, in the light of this evaluation, prepare a description of the role and capabilities required for appointment of both executive and non-executive directors, including the chairperson.	There are two nominations committees - the Board of Directors' Nominations Committee and the Council Nominations and Remuneration Committee. A Board skills analysis is undertaken every 18 months - 2 years to enable the Board and Council to review the structure and composition of the Board.
B.2.4	The chairperson or an independent non-executive director should chair the nominations committee(s). At the discretion of the committee, a governor can chair the committee in the case of appointments of non-executive directors or the chairman.	The Council Nominations and Remuneration Committee is chaired by the chair of the Board and Council. The terms of reference state that when the chair is being appointed or reappointed, the deputy chair shall take his or her place, unless he or she is standing for appointment, in which case another non-executive director shall be identified and agreed prior to the meeting to take his or her place. A majority of the committee is made up of governors (at meetings and at NED appointment panels). The Board of Directors' Nominations Committee is chaired by Sir Michael Rake, Chairman
B.2.5	The governors should agree with the nominations committee a clear process for the nomination of a new chairperson and non-executive directors. Once suitable candidates have been identified the nominations committee should make recommendations to the council of governors.	The Council of Governors approved the appointment process for two NEDs in 2018/19. The Nominations and Remuneration Committee followed the agreed process and made recommendations to the Council.
B.2.6	Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should consist of a majority of governors. If only one nominations committee exists, when nominations for non-executives, including the appointment of a chairperson or a deputy chairperson, are being discussed, there should be a majority of governors on the committee and also a majority governor representation on the interview panel.	The Council of Governors nominations and remuneration committee comprises the chair of the Trust, the deputy chair, lead governor, two governors from the public constituency and/or the patient and carer constituency, one staff governor and one governor from any constituency (patient and carer, public, staff or appointed). A majority of the committee is made up of governors (at meetings and on appointment panels).
B.2.7	When considering the appointment of non-executive directors, the council of governors should take into account the views of the board of directors and the nominations committee on the qualifications, skills and experience required for each position.	The Council took into account the views of the board of directors and the nominations committee on the qualifications, skills and experience required for the two NED positions in 2018/19.
B.2.8	The annual report should describe the process followed by the council in relation to appointments of the chairperson and non-executive directors.	The annual report includes an overview of the process followed for appointment of two new NEDs in 2018/19
B.2.9	An independent external adviser should not be a member of or have a vote on the nominations committee(s).	An independent external adviser is not a member of the nominations committees and does not have a vote. Independent external advisers were invited to attend the interview panel for the appointment of the Chief Executive and Director of HR and OD but in both cases did not have a vote.
B.2.10	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments. The main role and responsibilities of the nominations committee should be set out in publicly available, written terms of reference.	This information is presented in the annual report. The Board of Directors' Nominations Committee and the Council of Governors' Nominations and remuneration Committee Terms of Reference are published on the Trust website.
B.2.11	It is a requirement of the 2006 Act that the chairperson, the other non-executive directors and – except in the case of the appointment of a chief executive – the chief executive, are responsible for deciding the appointment of executive directors. The nominations committee with responsibility for executive director nominations should identify suitable candidates to fill executive director vacancies as they arise and make recommendations to the chairperson, the other non-executives directors and, except in the case of the appointment of a chief executive, the chief executive.	The Nominations Committee terms of reference details these requirements.
B.2.12	It is for the non-executive directors to appoint and remove the chief executive. The appointment of a chief executive requires the approval of the council of governors.	The Nominations Committee terms of reference details these requirements. The Council approved the appointment of the current Chief Executive in November 2018.
B.2.13	The governors are responsible at a general meeting for the appointment, re-appointment and removal of the chairperson and the other non-executive directors.	This process is documented in the Trust Constitution.
B.3.1	For the appointment of a chairperson, the nominations committee should prepare a job specification defining the role and capabilities required including an assessment of the time commitment expected, recognising the need for availability in the event of emergencies. A chairperson's other significant commitments should be disclosed to the council of governors before appointment and included in the annual report. Changes to such commitments should be reported to the council of governors as they arise, and included in the next annual report. No individual, simultaneously whilst being a chairperson of an NHS foundation trust, should be the substantive chairperson of another NHS foundation trust.	The Chair JD and terms and conditions define the role and capabilities required including an assessment of the time commitment expected. The Chair's significant commitments are documented in the annual report and declared in the register of interests. The Chair is not a chairperson of another NHS Foundation Trust.

Para	Code of Governance Requirement	Disclosure
B.3.2	The terms and conditions of appointment of non-executive directors should be made available to the council of governors. The letter of appointment should set out the expected time commitment. Non-executive directors should undertake that they will have sufficient time to meet what is expected of them. Their other significant commitments should be disclosed to the council of governors before appointment, with a broad indication of the time involved and the council of governors should be informed of subsequent changes.	The terms and conditions of the NEDs were revised and approved by the Council in April 2018, including reference to the Fit and Proper Persons Test. The non-executive directors' significant commitments are reported in the Trust annual report.
B.3.3	The board should not agree to a full-time executive director taking on more than one non-executive directorship of an NHS foundation trust or another organisation of comparable size and complexity, nor the chairperson of such an organisation.	None of the executives or the Chair have taken on a non-executive directorship of an NHS foundation trust or another organisation of comparable size and complexity.
B.4.1	The chairperson should ensure that new directors and governors receive a full and tailored induction on joining the board or the council of governors. As part of this, directors should seek out opportunities to engage with stakeholders, including patients, clinicians and other staff. Directors should also have access, at the NHS foundation trust's expense, to training courses and/or materials that are consistent with their individual and collective development programme.	New directors and governors receive information as part of their induction and are required to attend a tailored Trust corporate induction programme. The Governor induction process has been refreshed including external speakers attending and training on roles and responsibilities. Governors receive information on an on-going basis via presentations to meetings and separate seminar sessions. Directors have access to development programmes organised and run by NHS Providers, the Kings Fund, Deloitte etc.
B.4.2	The chairperson should regularly review and agree with each director their training and development needs as they relate to their role on the board.	The Chair held meetings with the NEDs during the year. The appraisal of Chair and NEDs was conducted in December 2018 and March 2019 and the results reported to the next Council meeting.
B.4.3	The board has a duty to take steps to ensure that governors are equipped with the skills and knowledge they need to discharge their duties appropriately.	New directors and governors receive information as part of their induction and are required to attend a tailored Trust corporate induction programme. The Governor induction process has been refreshed including external speakers attending and training on roles and responsibilities. Governors receive information on an on-going basis via presentations to meetings and separate seminar sessions. Governors have been consulted on agreeing their development programme. Governors attend meetings with other governors run by external organisations such as Deloitte and NHS Providers and report back to meetings.
B.5.1	The board of directors and the council of governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make. The board of directors and the council of governors should agree their respective information needs with the executive directors through the chairperson. The information for the boards should be concise, objective, accurate and timely, and it should be accompanied by clear explanations of complex issues. The board of directors should have complete access to any information about the NHS foundation trust that it deems necessary to discharge its duties, including access to senior management and other employees.	The Board agenda and information contained within the reports is under constant scrutiny to ensure that the appropriate level of information is available to directors. The Board receives an integrated quality and performance report at every public meeting (this has recently been refreshed). The communication team regularly send around press updates to the Board and the Council. The Board work calendar has been updated to mirror reporting around the refreshed Trust strategy. Any significant matters are communicated to the Board as soon as possible by email, rather than wait for the next board meeting. The executive directors and the Company Secretary regularly email governors between meetings on significant matters to ensure that information is shared in a timely way, rather than wait for the next Council of governors meeting. The Council of governors receive a regular ebulletin updating them on important matters, highlighting access to training events and other events where they can meet members.
B.5.2	The board of directors and in particular non-executive directors, may reasonably wish to challenge assurances received from the executive management. They need not seek to appoint a relevant adviser for each and every subject area that comes before the board of directors, although they should, wherever possible, ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis. When complex or high-risk issues arise, the first course of action should normally be to encourage further and deeper analysis to be carried out in a timely manner, within the NHS foundation trust. On occasion, non-executives may reasonably decide that external assurance is appropriate.	The non-executive directors do request deeper analysis of high risk areas during board and assurance Committee meetings. Access to external assurance/ advice is made available on request, for example legal advice around agreements regarding large scale development contracts or information governance matters.
B.5.3	The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the NHS foundation trust's expense, where they judge it necessary to discharge their responsibilities as directors. Decisions to appoint an external adviser should be the collective decision of the majority of non-executive directors. The availability of independent external sources of advice should be made clear at the time of appointment.	Where requested, external advice is sought, for example legal advice or HR advice.
B.5.4	Committees should be provided with sufficient resources to undertake their duties. The board of directors should also ensure that the council of governors is provided with sufficient resources to undertake its duties with such arrangements agreed in advance.	The Company Secretary, Deputy Company Secretary and Trust Board Administrator supports the duties of the Board and Council committees.
B.5.5	Non-executive directors should consider whether they are receiving the necessary information in a timely manner and feel able to raise appropriate challenge of recommendations of the board, in particular making full use of their skills and experience gained both as a director of the trust and also in other leadership roles. They should expect and apply similar standards of care and quality in their role as a non-executive director of an NHS foundation trust as they would in other similar roles.	Non-executive directors provide feedback on information received at Board meetings. As a result and where necessary, additional information is provided/ professional and legal advice is sought.
B.5.6	Governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	The Council fed comments into development of the GOSH operational plan 2019/20 and are being consulted on the revision of the Trust Strategy in April 2019. Further work will be conducted in 2019/20 on engagement with stakeholders such as members with the publication of the Stakeholder Engagement Strategy
B.5.7	Where appropriate, the board of directors should take account of the views of the council of governors on the forward plan in a timely manner and communicate to the council of governors where their views have been incorporated in the NHS foundation trust's plans, and, if not, the reasons for this.	The Council fed comments into development of the GOSH operational plan 2019/20 and are being consulted on the revision of the Trust Strategy in April 2019.
B.5.8	The board of directors must have regard for the views of the council of governors on the NHS foundation trust's forward plan.	The board of directors took account of the views of the Council of Governors on the NHS foundation trust's forward plan.

Para	Code of Governance Requirement	Disclosure
B.6.1	The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted, bearing in mind the desirability for independent assessment, and the reason why the NHS foundation trust adopted a particular method of performance evaluation.	As part of their routine scheduled inspection programme, the CQC conducted an independent well-led inspection of the Trust in January 2018 and during 2018/19 the Board monitored progress with the action plan. The Board has signed up to an externally-led Board development programme in 2019. The Trust expects a routine scheduled CQC inspection (including Well Led) in Q2 2019/20. Taking into account the number of executive and NED posts that have been subject to change during the year and to allow a period of stability, the Board has agreed that the next externally led evaluation of Board performance will be planned for 2020, following delivery of the results of the CQC inspection (see above).
B.6.2	Evaluation of the boards of NHS foundations trusts should be externally facilitated at least every three years. The evaluation needs to be carried out against the board leadership and governance framework set out by Monitor. The external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the trust.	See above.
B.6.3	The senior independent director should lead the performance evaluation of the chairperson, within a framework agreed by the council of governors and taking into account the views of directors and governors.	The SID leads the performance evaluation of the Chair and discusses the Chair's performance with the executive directors, NEDs and governors (via the Lead Governor).
B.6.4	The chairperson, with assistance of the board secretary, if applicable, should use the performance evaluations as the basis for determining individual and collective professional development programmes for non-executive directors relevant to their duties as board members.	All directors are subject to performance evaluation, identifying any personal professional development requirements. Non-executive directors individually attend professional development events held by the Kings Fund, the NHS Providers, auditor companies etc.
B.6.5	Led by the chairperson, the council of governors should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities, including their impact and effectiveness on: • holding the non-executive directors individually and collectively to account for the performance of the board of directors. • communicating with their member constituencies and the public and transmitting their views to the board of directors; and • contributing to the development of forward plans of NHS foundation trusts. The council of governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice.	Members can communicate with governors via the foundation trust GOSH email address (emails are sent on to the relevant governor) This information is also presented in the annual report. Governors have been involved in drafting the letters accompanying the Member Matters publication. An evaluation of the Council was due in 2018. A decision has been taken to delay this to Q2 2019/20, allowing time for new governors to be inducted and become familiar with their roles.
B.6.6	There should be a clear policy and a fair process, agreed and adopted by the council of governors, for the removal from the council of any governor who consistently and unjustifiably fails to attend the meetings of the council of governors or has an actual or potential conflict of interest which prevents the proper exercise of their duties. This should be shared with governors. In addition, it may be appropriate for the process to provide for removal from the council of governors where behaviours or actions of a governor or group of governors may be incompatible with the values and behaviours of the NHS foundation trust. Where there is any disagreement as to whether the proposal for removal is justified, an independent assessor agreeable to both parties should be requested to consider the evidence and determine whether the proposed removal is reasonable or otherwise.	The revised Constitution (July 2018) details the process for removal of a councillor, including the requirements to attend a certain number of council meetings and management of potential conflicts of interest.
B.7.1	In the case of re-appointment of non-executive directors, the chairperson should confirm to the governors that following formal performance evaluation, the performance of the individual proposed for re-appointment continues to be effective and to demonstrate commitment to the role. Any term beyond six years (e.g., two three-year terms) for a non-executive director should be subject to particularly rigorous review, and should take into account the need for progressive refreshing of the board. Non-executive directors may, in exceptional circumstances, serve longer than six years (e.g., two three-year terms following authorisation of the NHS foundation trust) but this should be subject to annual re-appointment. Serving more than six years could be relevant to the determination of a non-executive's independence.	Following the performance evaluation and at the time of reappointment, the chair confirms to the governors the performance of the individual proposed for re-appointment continues to be effective and demonstrates commitment to the role. The Council of Governors extended the appointment of Professor Rosalind Smyth as a Non-Executive Director for one further year on the Board on the basis of a positive appraisal and recommendation from Professor Smyth's appointing body, University College London highlighting her role as Director of the UCL GOSH Institute of Child Health and the alignment between the two organisations. It was not felt that the reappointment affected Professor Smyth's independence on the Board.
B.7.2	Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The names of governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to take an informed decision on their election. This should include prior performance information.	The Foundation Trust conducted its last election in January 2018. The information presented to members for the elected governors who wished to be re-appointed included information about the prior performance attendance at meetings and involvement in committees and other activities.
B.7.3	Approval by the council of governors of the appointment of a chief executive should be a subject of the first general meeting after the appointment by a committee of the chairperson and non-executive directors. All other executive directors should be appointed by a committee of the chief executive, the chairperson and non-executive directors.	The Trust is compliant with this requirement. The Board of Directors' Nominations Committee Terms of Reference details the appointment process for executive directors.
B.7.4	Non-executive directors, including the chairperson should be appointed by the council of governors for the specified terms subject to re-appointment thereafter at intervals of no more than three years and subject to the 2006 Act provisions relating to removal of a director.	The Trust is compliant with this requirement.
B.7.5	Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years.	The Trust complies with this requirement. Elections are administered by the Electoral Reform Services on behalf of the Trust. The last Trust election was conducted in January 2018. The next election will be held in 2021 and seats will be staggered to prevent the turnover of the entire Council at the end of a 2x 3 year tenure.
B.8.1	The remuneration committee should not agree to an executive member of the board leaving the employment of an NHS foundation trust, except in accordance with the terms of their contract of employment, including but not limited to service of their full notice period and/or material reductions in their time commitment to the role, without the board first having completed and approved a full risk assessment.	The Board is aware of this requirement and has carefully planned where executive directors have stepped down from their post during the year (Chief Executive, Director of HR and OD and Deputy Chief Executive). The Chief Executive position was appointed to prior to the
C.1.1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. There should be a statement by the external auditor about their reporting responsibilities. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report).	These statements are presented in the annual report.
C.1.2	The directors should report that the NHS foundation trust is a going concern with supporting assumptions or qualifications as necessary.	This statement is presented in the annual report and states that the Trust is a going concern.

Para	Code of Governance Requirement	Disclosure
C.1.3	<p>At least annually and in a timely manner, the board should set out clearly its financial, quality and operating objectives for the NHS foundation trust and disclose sufficient information, both quantitative and qualitative, of the NHS foundation trust's business and operation, including clinical outcome data, to allow members and governors to evaluate its performance.</p>	<p>The Trust publishes an annual report, including a quality report, outlining financial, quality and operating objectives for the NHS foundation trust.</p> <p>The Council of Governors receives performance and financial information at each meeting and all directors attend Council meetings to answer any questions where required.</p> <p>The annual plan is consulted on with the Council.</p> <p>Public Board meetings and Council of Governors meetings are advertised and the papers are available on the GOSH website.</p>
C.1.4	<p>The board of directors must notify Monitor and the council of governors without delay and should consider whether it is in the public's interest to bring to the public attention, any major new developments in the NHS foundation trust's sphere of activity which are not public knowledge, which it is able to disclose and which may lead by virtue of their effect on its assets and liabilities, or financial position or on the general course of its business, to a substantial change to the financial wellbeing, health care delivery performance or reputation and standing of the NHS foundation trust.</p> <p>The board of directors must notify Monitor and the council of governors without delay and should consider whether it is in the public interest to bring to public attention all relevant information which is not public knowledge concerning a material change in:</p> <ul style="list-style-type: none"> • the NHS foundation trust's financial condition; • the performance of its business; and/or • the NHS foundation trust's expectations as to its performance which, if made public, would be likely to lead to a substantial change to the financial wellbeing, health care delivery performance or reputation and standing of the NHS foundation trust. 	<p>The directors maintain an open dialogue with the regulators (both NHS Improvement and CQC), reporting any significant matters and ensuring that these are also flagged with the Council</p>
C.2.1	<p>The board of directors should maintain continuous oversight of the effectiveness of the NHS foundation trust's risk management and internal control systems and should report to members and governors that they have done so in the annual report. A regular review should cover all material controls, including financial, operational and compliance controls.</p>	<p>The Trust is compliant with preparing and reviewing the assurance framework and the annual governance statement. The internal auditors conducted an audit into the systems in place for managing risk and awarded 'significant assurance with potential for minor improvements' for 2018-19.</p> <p>The Non-executive directors meet once a year to focus on risk management, including how the Trust scans for emerging risks, risk appetite, escalation of risk and the relationship between incident reporting and risk management.</p> <p>The Risk Management Strategy has been revised and is subject to approval at the May 2019 Trust Board meeting.</p>
C.2.2	<p>A trust should disclose in the annual report:</p> <p>(a) if it has an internal audit function, how the function is structured and what role it performs; or</p> <p>(b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.</p>	<p>The annual report presents this information.</p>
C.3.1	<p>The board of directors should establish an audit committee composed of at least three members who are all independent non-executive directors. The board should satisfy itself that the membership of the audit committee has sufficient skills to discharge its responsibilities effectively, including ensuring that at least one member of the audit committee has recent and relevant financial experience. The chairperson of the trust should not chair or be a member of the audit committee. He can, however, attend meetings by invitation as appropriate.</p>	<p>The Trust is compliant with this requirement.</p>
C.3.2	<p>The main role and responsibilities of the audit committee should be set out in publicly available, written terms of reference. The council of governors should be consulted on the terms of reference, which should be reviewed and refreshed regularly. It should include details of how it will:</p> <ul style="list-style-type: none"> • Monitor the integrity of the financial statements of the NHS foundation trust, and any formal announcements relating to the trust's financial performance, reviewing significant financial reporting judgements contained in them; • Review the NHS foundation trust's internal financial controls and, unless expressly addressed by a separate board risk committee composed of independent directors, or by the board itself, review the trust's internal control and risk management systems; • Monitor and review the effectiveness of the NHS foundation trust's internal audit function, taking into consideration relevant UK professional and regulatory requirements; • Review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements; • Develop and implement policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance regarding the provision of non-audit services by the external audit firm; and • Report to the council of governors, identifying any matters in respect of which it considers that action or improvement is needed and making recommendations as to the steps to be taken. 	<p>The Audit Committee's terms of reference outline its role and responsibilities and are published on the GOSH website. The terms of reference were subject to review and approved by the Audit Committee in May 2018. They will be reviewed by the Audit Committee in May 2019.</p>
C.3.3	<p>The council of governors should take the lead in agreeing with the audit committee the criteria for appointing, re-appointing and removing external auditors. The council of governors will need to work hard to ensure they have the skills and knowledge to choose the right external auditor and monitor their performance. However, they should be supported in this task by the audit committee, which provides information to the governors on the external auditor's performance as well as overseeing the NHS foundation trust's internal financial reporting and internal auditing.</p>	<p>The Council was involved in the appointment of Deloitte LLP for a 3 year term from 2018/19.</p>
C.3.4	<p>The audit committee should make a report to the council of governors in relation to the performance of the external auditor, including details such as the quality and value of the work and the timeliness of reporting and fees, to enable to council of governors to consider whether or not to re-appoint them. The audit committee should also make recommendation to the council of governors about the appointment, re-appointment and removal of the external auditor and approve the remuneration and terms of engagement of the external auditor.</p>	<p>The Council receives an annual report on the performance of the external auditors. Both the Audit Committee and the Council were satisfied with their independence and objectivity and the effectiveness of the audit process.</p> <p>The external auditors were appointed by the Council in 2018 (for 2019/20) via an open tender process and a working group including governors and Audit Committee members</p>

Para	Code of Governance Requirement	Disclosure
C.3.5	If the council of governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position.	This statement is not applicable for 2018/19.
C.3.6	The NHS foundation trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans of the NHS foundation trust. The current best practice is for a three- to five-year period of appointment.	Deloitte LLP have been appointed for a three year term from 2018/19, following a competitive tender process.
C.3.7	When the council ends an external auditor's appointment in disputed circumstances, the chairperson should write to Monitor informing it of the reasons behind the decision.	The Trust will be compliant with this requirement, should the situation arise. Deloitte were re-appointed as the Trust's external auditors following a competitive tender process.
C.3.8	The audit committee should review arrangements that allow staff of the NHS foundation trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. The audit committee's objective should be to ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action. This should include ensuring safeguards for those who raise concerns are in place and operating effectively. Such processes should enable individuals or groups to draw formal attention to practices that are unethical or violate internal or external policies, rules or regulations and to ensure that valid concerns are promptly addressed. These processes should also reassure individuals raising concerns that they will be protected from potential negative repercussions.	This matter is the responsibility of the Audit Committee and documented in its terms of reference. The Committee receives a quarterly report on an whistle blowing and Freedom to Speak up cases and actions taken to address issues raised. The QSEAC considers any reports that are related to the quality of care.
C.3.9	A separate section of the annual report should describe the work of the committee in discharging its responsibilities. The report should include: <ul style="list-style-type: none"> • the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; • an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and • if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded. 	The annual report includes an Audit Committee report and covers the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed and the effectiveness of the external audit process. The Audit Committee considers application of the non audit services policy and reports this to the Council of Governors.
D.1.1	Any performance-related elements of the remuneration of executive directors should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels. In designing schemes of performance-related remuneration, the remuneration committee should consider the following provisions: i) The remuneration committee should consider whether the directors should be eligible for annual bonuses in line with local procedures. If so, performance conditions should be relevant, stretching and designed to match the long-term interests of the public and patients. ii) Payouts or grants under all incentive schemes should be subject to challenging performance criteria reflecting the objectives of the NHS foundation trust. Consideration should be given to criteria which reflect the performance of the NHS foundation trust relative to a group of comparator trusts in some key indicators, and the taking of independent and expert advice where appropriate. iii) Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed. iv) The remuneration committee should consider the pension consequences and associated costs to the NHS foundation trust of basic salary increases and any other changes in pensionable remuneration, especially for directors close to retirement.	Executive directors are not awarded annual bonuses. The Remuneration Committee has started to consider whether an element of performance related pay or earn-back pay will be included within senior manager contracts. This is consistent with NHSI guidance.
D.1.2	Levels of remuneration for the chairperson and other non-executive directors should reflect the time commitment and responsibilities of their roles.	The terms and conditions of service of the Chairman and the NEDs were considered in January and April 2017 including the time commitment for both roles. The Council of Governors' Nominations and Remuneration Committee is responsible for recommending remuneration levels for non-executive directors to the Council of Governors. In 2017, the Council agreed and approved the proposed policy for benchmarking salaries and reviewing cost of living allowances for the Chairman and NEDs on a three yearly basis (next review 2020).
D.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	No executive director has been released on this basis during the period.
D.1.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate claw-back provisions should be considered in case of a director returning to the NHS within the period of any putative notice.	All executive director contracts require 6 months' notice period. Chief Executive and executive director terms and conditions of employment are set by the Board Remuneration Committee (except for pension entitlements which are managed in accordance with the provisions of the NHS Pension Scheme). Contracts issued to directors allow the Trust to terminate employment in accordance with employment legislation (for instance, for unsatisfactory performance, capability, ill health). On termination due to poor performance, directors would receive their right to notice of dismissal (except in cases of gross misconduct where dismissal without payment of notice can occur) and any other relevant contractual entitlement (such as payment of outstanding annual leave). Non-contractual payments on dismissal cannot occur without the authorisation of the Remuneration Committee and taking into account guidance from external bodies NHSI and the Treasury; the Committee, therefore, can ensure Directors are not financially rewarded (beyond their contractual entitlements) if their employment is terminated on the grounds of poor performance.
D.2.1	The board of directors should establish a remuneration committee composed of non-executive directors which should include at least three independent non-executive directors. The remuneration committee should make available its terms of reference, explaining its role and the authority delegated to it by the board of directors. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the NHS foundation trust.	The Board of Directors have established a Remuneration Committee, chaired by a NED and including all non- executive directors as members (therefore complying with the requirement for at least three independent NEDs). Terms of reference are in place. A remuneration consultant was employed during the period and did not have any connection with the Foundation Trust.
D.2.2	The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management. The definition of senior management for this purpose should be determined by the board, but should normally include the first layer of management below board level.	The terms of reference of the Board of Directors Remuneration Committee cover these areas. The Chief Executive determines the remuneration for non Board senior managers (first layer below Board) and reports this to the Remuneration Committee.

Para	Code of Governance Requirement	Disclosure
D.2.3	The council should consult external professional advisers to market-test the remuneration levels of the chairperson and other non-executives at least once every three years and when they intend to make a material change to the remuneration of a non-executive.	The Council of Governors' Nominations and Remuneration committee is responsible for recommending remuneration levels for non-executive directors to the Council. The Council agreed and approved the policy for benchmarking salaries and reviewing cost of living allowances for the Chairman and NEDs on a three yearly basis. In 2020, NED remuneration levels will be market tested.
D.2.4	The council of governors is responsible for setting the remuneration of non-executive directors and the chairperson.	This is the case. NEDs remuneration is evaluated by the Council every three years (next evaluation 2020)
E.1.1	The board of directors should make available a public document that sets out its policy on the involvement of members, patients and the local community at large, including a description of the kind of issues it will consult on.	The Patient and Family Experience and Engagement Committee is responsible for overseeing involvement of members, patients and the local community at large. Information from the committee is reported to the Board (via the integrated quality and performance report) and the Council.
E.1.2	The board of directors should clarify in writing how the public interests of patients and the local community will be represented, including its approach for addressing the overlap and interface between governors and any local consultative forums (e.g. Local Healthwatch, the Overview and Scrutiny Committee, the local League of Friends, and staff groups)	A summary of patient and local community engagement activity is included in the annual report.
E.1.3	The chairperson should ensure that the views of governors and members are communicated to the board as a whole. The chairperson should discuss the affairs of the NHS foundation trust with governors. Non-executive directors should be offered the opportunity to attend meetings with governors and should expect to attend them if requested by governors. The senior independent director should attend sufficient meetings with governors to listen to their views in order to help develop a balanced understanding of the issues and concerns of governors.	<p>The Chair presents a summary report of the previous Council meeting to the Trust Board.</p> <p>The Chair holds a private meeting with governors prior to every Council meeting. NEDs (and executive directors) regularly attend Council meetings (including the SID).</p> <p>The SID has met with individual governors during the year. The NEDs provided opportunities for governors to meet with them via the buddying system throughout the year (outwith the normal general meetings)</p> <p>Emails from governors raising any concerns are shared with the executive and non-executive directors.</p> <p>All governors have gosh emails.</p>
E.1.4	The board of directors should ensure that the NHS foundation trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the annual report.	<p>All governors are promoted on the Trust website and members can communicate with them via the foundation trust GOSH email address. This information is also presented in the annual report.</p> <p>Governors have been involved in drafting the letters accompanying the Member Matters publication.</p> <p>See B.5.6 for information about consultation held during the year with members.</p>
E.1.5	The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	All NEDs attend Council of Governors meetings and executives attend where required. The Council of Governors and the Board have reviewed how they work together and made recommendations for enhanced communication including establishing NED buddying groups and circulating a monthly news bulletin to governors. Consultation and survey results are shared with the Board and the Council. Governors attend the Board assurance committees and the public Board as observers. The annual report outlines how the Board and the Council of Governors have worked together during the year.
E.1.6	The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report. This information should be used to review the trust's membership strategy, taking into account any emerging best practice from the sector.	The Membership Engagement, Recruitment and Representation Committee (MERRC) routinely reviews the representation of the membership and report this to the Council. This information is also presented in the annual report and in the annual membership report. The Trust Membership Strategy was reviewed and approved in 2018/19.
E.1.7.	The board of directors must make board meetings and the annual meeting open to the public. The trust's constitution may provide for members of the public to be excluded from a meeting for special reasons.	The Constitution details that there will be Board meetings held in public and provides for the exclusion of members of the public for special purposes. The annual meeting is also held in public.
E.1.8	The trust must hold annual members' meetings. At least one of the directors must present the trust's annual report and accounts, and any report of the auditor on the accounts, to members at this meeting.	The annual members' meeting is held every year (October 2018 and being planned for October 2019) and the directors present the annual report and accounts and the report from the auditors. All governors, FT members and members of the public are invited.
E.2.1	The board of directors should be clear as to the specific third party bodies in relation to which the NHS foundation trust has a duty to co-operate. The board of directors should be clear of the form and scope of the co-operation required with each of these third party bodies in order to discharge their statutory duties.	A schedule of third parties is in place and maintained.
E.2.2	The board of directors should ensure that effective mechanisms are in place to co-operate with relevant third party bodies and that collaborative and productive relationships are maintained with relevant stakeholders at appropriate levels of seniority in each. The board of directors should review the effectiveness of these processes and relationships annually and, where necessary, take proactive steps to improve them.	The Board and its committees and the executive team review the mechanisms in place for cooperating with third parties on a regular basis, including referrers, NHSI, CQC, commissioners, external auditors, the Charity etc. The Chief Executive and other directors regularly discuss attendance at key stakeholder meetings at the EMT. A Stakeholder Engagement Strategy is under development in response to recommendations from the last CQC Well Led Assessment in 2018.

Attachment O

Trust Board 22 May 2019	
Compliance with the NHS provider licence – self assessment	Paper No: Attachment O
Submitted by: Anna Ferrant, Company Secretary	
<p>Aim To present the annual self assessment of compliance with NHS Improvement (“NHSI”) license conditions for providers of NHS services.</p> <p>Summary The NHS provider licence is NHSI’s main tool for regulating providers of NHS services. The licence sets out important conditions that providers must meet to help ensure that the health system works for the benefit of NHS patients. These conditions gives the regulator the power to:</p> <ul style="list-style-type: none"> • set prices for NHS funded care in partnership with the NHS England and require information from providers to help them in this process; • enable integrated care across the NHS system; • safeguard choice and prevent anti-competitive behaviour which is against the interests of patients; • support commissioners to protect essential health services for patients if a provider gets into financial difficulties; and • oversee the way that NHS foundation trusts are governed. <p>An FT Board is required by NHSI to annually declare compliance or otherwise with a small number of FT licence conditions and a requirement under the Health and Social Care Act as follows:</p>	
Licence condition	Deadline and comment
Condition G6(3): Providers must certify that their board has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution.	The deadline for this declaration is 31 May 2019 . The G6 self-certification also needs to be published within one month of sign off by the Board.
Condition CoS7(3): Providers providing commissioner requested services (CRS) must certify that they have a reasonable expectation that the required resources will be available to deliver the designated service.	The deadline for this declaration is 31 May 2019 .
Condition FT4(8): Providers must certify compliance with required governance standards and objectives	The deadline for this declaration is 30 June 2019 . Board is required to identify risks to achieving the governance standards and any mitigating actions taken to avoid those risks.
NHS Improvement require the Board to state whether it is satisfied that during the financial year most recently ended the Trust has provided the necessary training to Governors, as required in s.151(5) of the Health and Social Care Act to ensure that they are equipped with the skills and knowledge they need to undertake their role.	The deadline for this declaration is 30 June 2019 .

Attachment O

NHSI require that an FT Board must take into account the views of governors when considering whether the Trust confirms compliance with the above declarations. **Appendix 1** documents evidence against the four conditions stating the executive directors' recommendations for each condition.

The Council of Governors were asked for their views on the attached conditions and evidence cited and made the following comments:

Governors agreed with the recommendations proposed by the GOSH executive team for the following conditions:

- G6 – Systems for compliance with licence conditions and related obligations
- FT4- NHS foundation trust governance arrangements
- s.151(5) of the Health and Social Care Act (not a licence condition)

Under condition CoS7 (Availability of resources), Governors requested further information at the meeting about the recommendation to confirm the required resources are in place for the next 12 months to meet the requirements of the Licence (statement a). |On the basis of the current and expected financial position of the Trust (2019/20) Governors queried whether the rust could confirm sufficient resources for the year. The Chief Executive gave assurances of the mitigating actions being taken by the executive team and Board to highlight and reduce the impact of the tariff changes and other NHS financial decisions on the Trust forecast, including collaborating with other trusts via the Children's Alliance and implementing a robust savings plan. Mr Akhter Mateen, Deputy Chair informed the Governors that the statement given by the Trust was a going concern statement, one that was also made in the annual report. He stated that the proposal was to report the trust as a going concern and that this was appropriate even where a trust was looking at a potential deficit. The Chair assured the Governors that these views would be shared with the Board when considering the position the Trust would take and statement to be published.

In the past, providers have been required to complete and return an annual self-certification for the above. This year, NHS Improvement does not require a submission. Instead, the regulator will contact a select number of NHS trusts and foundation trusts to ask for evidence that they have self-certified using completed templates provided by NHSI, or relevant board minutes and papers recording sign-off.

Action required from the meeting

The Board is asked to **consider and agree** the Trust's response to the four conditions (confirm/ not confirm), taking into account the views of the governors. In all cases, the Board is required to document the reasons for their declaration.

Contribution to the delivery of NHS / Trust strategies and plans

Providers are required to complete an annual self-certification that confirms their continued eligibility to hold an NHS provider licence.

Financial implications

None

Legal issues

None

Who is responsible for monitoring the license conditions?

Company Secretary and Chief Finance Officer

Who is accountable for the implementation of the proposal / project

The Board is responsible for ensuring continued eligibility to hold an NHS provider licence.

Appendix 1: FT Licence self-certification – four requirements that must be signed off by the Board

The board must sign off on self-certification for the following licence conditions and H&SCA requirement, taking into account the views of governors.

Licence condition	Description	Confirmation: Confirmed or Not Confirmed	Assurance
G6 – Systems for compliance with licence conditions and related obligations (scope = past financial year 2018/19)	<p>The Licensee shall take all reasonable precautions against the risk of failure to comply with the Conditions of this Licence, any requirements imposed on it under the NHS Acts, and the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.</p> <p>The steps that the Licensee must takeshall include: (a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and (b) regular review of whether those processes and systems have been implemented and of their effectiveness.</p> <p>A statement shall be provided for Monitor to certify compliance with this condition no later than 2 months from the end of the financial year.</p>	<p>The Executive Team have considered the evidence cited and recommend 'Confirmed'.</p> <p>Response to be considered by the Board in light of assurance provided here and taking into account the views of the governors</p>	<p>The Trust has systems and processes to monitor risks of failure through lack of compliance or adverse variances in performance:</p> <ul style="list-style-type: none"> • There is clear accountability at Board level for safety and clinical quality objectives and structured reporting of performance against these objectives. (see Annual Governance Statement in annual report) • The Trust's Assurance and Escalation framework sets out how the organisation identifies, monitors, escalates and manages concerns and risks in a timely fashion and at an appropriate level (under review for completion by June 2019). This covers the following areas: <ul style="list-style-type: none"> ○ Performance Management framework ○ Risk Management framework ○ Policy framework ○ Compliance framework ○ Accountability framework ○ Escalation framework ○ Assurance framework • Other key frameworks and policies in place include: <ul style="list-style-type: none"> ○ Information Governance framework ○ Safeguarding policy ○ Health and Safety Policy ○ Infection Control Assurance Framework • The Trust's risk management strategy, which sets out how risk is systematically managed, extends across the organisation from the front-line service through to the Board, to promote the reduction of clinical and non-clinical risks associated with healthcare and research,

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Licence condition	Description	Confirmation: Confirmed or Not Confirmed	Assurance
			<p>and to ensure the business continuity of the Trust. The strategy identifies the organisational risk management structure, the roles and responsibilities of committees and groups that have some responsibility for risk, and the duties and authority of key individuals and managers with regard to risk management activities. It describes the process to provide assurance for the Trust Board review of the strategic organisational risks, and the local structures to manage risk in support of this policy. The strategy has recently been refreshed in light changes to the clinical operations structure and will be presented at the April Trust Board.</p> <ul style="list-style-type: none"> • The Trust’s Board Assurance Framework is used to provide the Board with assurance that there is a sound system of internal control in place to manage the key risks to the Trust of not achieving its strategic objectives. The BAF records the controls in place to manage the key risks, and highlights how the control is operating. The BAF includes cross-references to assurance obtained from internal and external audits, and self-assessments of compliance with other regulatory standards. It has been monitored by the assurance committees and updated throughout the year. In February 2019 a revised BAF was approved by the Trust Board incorporating 6 new strategic risks. The Risk Assurance and Compliance Group monitors progress with the BAF. This includes a ‘stress test’ of an individual BAF risk at every meeting to check (using key performance indicators and external assurance information) whether the controls and assurances cited are working and appropriate. The internal auditors conducted a Risk Management audit looking at the processes in place for the recording and management of operational risks.. The report allocated a rating of ‘Significant assurance with four minor improvement opportunities (AMBER-GREEN)’. • Directorate performance reviews take place on a monthly basis,

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Licence condition	Description	Confirmation: Confirmed or Not Confirmed	Assurance
			<p>attended by directorate management and Trust executives. These reviews are designed to facilitate a triangulated and risk-focused discussion across a number of key domains: Caring, Safe, Responsive, Well-led (people, management and culture), Effective, Finance, Productivity. The review packs contain an integrated dashboard which provides a one page summary of key metrics across the domains, allowing rapid identification of linked risks and issues. The packs also contain more in-depth dashboards for each domain. An integrated performance report is then scrutinised at each Board meeting. This provides a summary of the key issues in each domain and actions planned to resolve, as well as an integrated dashboard – this provides trust level data using the same format as the divisional integrated dashboard reviewed in the monthly performance reviews.</p> <ul style="list-style-type: none"> • The Trust has identified an executive director and a manager who are respectively accountable and responsible for ensuring compliance with each element of the CQC registration standards and for monitoring compliance against other requirements across the Trust. The Trust has developed an action plan in response to the recent CQC inspection and actively monitors progress with this at operational level and provides assurance to the Board. All remaining outstanding actions from the Well led Review in October 2016 and any negative commentary from the CQC inspection I 2018 have been closed or consolidated with the Well Led action plan 2019 (reported at Board and Council in February 2019). • The Trust has commenced a programme of work in order to ensure CQC readiness and to maintain compliance for the Trust. This work has been rolled out with a view to ensuring that compliance and governance are interlinked with quality, safety and experience and embedded in day to day working within the Trust. The work being undertaken includes:

Licence condition	Description	Confirmation: Confirmed or Not Confirmed	Assurance
			<ul style="list-style-type: none"> • Weekly Steering Groups with Deputy Chiefs of Service <ul style="list-style-type: none"> ○ Mock inspection framework (CQC Quality Rounds) in clinical directorates ○ Gap analysis of information for RPIR undertaken ○ Reviews of potential areas/sources of learning e.g. review of themes from other CQC reports, evaluation of insight reports • The Trust has systems and processes in place to support staff and patients in escalating concerns in provision of care or management of systems. These include the complaints process, PALS, Freedom to Speak Up Guardian, Guardian of Safe Working, Raising Concerns Policy, Counterfraud service etc. The Trust is one of the first UK hospitals to partner with the Cognitive Institute in their Safety and Reliability Improvement Programme. Signing up to this partnership recognises our commitment to achieving zero preventable harm and delivering the best possible outcomes through providing the safest, most effective and efficient care. Safety Champions from across the hospital have been appointed and a pilot is in the process of being run in one of the directorates. • The Trust assesses compliance with the FT licence annually.
<p>CoS7 – Availability of resources (scope = next financial year 2019/20)</p>	<p>The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources.</p> <p>The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available</p>	<p>The Executive Team have considered the evidence cited and recommend 'Confirmed' for statement a: <i>"After making enquiries the</i></p>	<p>The Trust sets its budget on an annual basis and actively manages and monitors its financial position and resource levels on a regular basis throughout the year through routine performance reporting to the Board and its Committees. The Executive Team actively monitors the finance position at every meeting to ensure that the mitigations in place are effective and appropriate. Both External and Internal Audit services provide assurance that reporting is accurate and there is no material mis-statement.</p> <p>No material agreements which might create a material risk have been entered</p>

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Licence condition	Description	Confirmation: Confirmed or Not Confirmed	Assurance
	<p>to the Licensee.</p> <p>The Licensee, not later than two months from the end of each Financial Year, shall submit to Monitor a certificate as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate, in one of the following forms:</p> <p>(a) "After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate."</p> <p>OR</p> <p>(b) "After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any</p>	<p><i>Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate."</i></p> <p>Response to be considered by the board in light of assurance provided here and taking into account the views of the governors</p>	<p>into.</p> <p>The Trust Audit Committee and Board will review for approval the 2018/19 annual report and accounts (22 May 2012), on a going concern basis, confirming that the Directors have a reasonable expectation that the organisation has the required resources available for the next 12 month licence (a).</p> <p>The Trust is implementing a robust savings plan for 2019/20. The Trust is holding discussions with other NHS trusts on managing implications of tariff changes.</p>

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Licence condition	Description	Confirmation: Confirmed or Not Confirmed	Assurance
	<p>distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services”.</p> <p>OR</p> <p>(c) “In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate”.</p>		
<p>FT4- NHS foundation trust governance arrangements (scope = next financial year 2019/20)</p> <p>PLEASE NOTE – all four parts need to be confirmed for an overall ‘confirmation’</p>	<p>The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.</p>	<p>The Executive Team have considered the evidence cited and recommend ‘Confirmed’.</p> <p>Response to be considered by the Board in light of assurance provided here and taking into account the views of the governors</p>	<p>The Trust has a range of governance and assurance structures and systems in place including a Trust wide strategy, scheme of delegation, risk management framework, accountability framework, compliance framework, escalation framework, policy framework and assurance framework and a financial management framework.</p> <p>Directors and governors are asked to sign a code of conduct (both documents were refreshed in 2018) and declare any interest for publication on a Register of Interests.</p> <p>Directors complete a self-assessment for the Fit and Proper Person Test (and are reviewed against the criteria annually) and are required to declare any interests annually.</p> <p>Governors sign an eligibility form which includes reference to the Fit and</p>

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Licence condition	Description	Confirmation: Confirmed or Not Confirmed	Assurance
			<p>Proper Person’s Process.</p> <p>A self-assessment is prepared annually against the Monitor code of Governance and will be reported to the Board in May 2019. The Trust Board considers that from 1 April 2018 to 31 March 2019 it was compliant with the provisions of The NHS foundation trust Code of Governance and proposes to explain its compliance (on a comply or explain basis) for the following criteria in the annual report – to be approved by the Board in May 2019:</p> <ul style="list-style-type: none"> • To be determined following review <p>Further information about corporate governance systems and standards at GOSH is detailed below.</p>
	<p>The Licensee shall:</p> <p>(a) have regard to such guidance on good corporate governance as may be issued by Monitor from time to time;</p> <p>(b) comply with the following paragraphs of this Condition.</p>	<p>Same as above - confirmed</p>	<p>The Trust has regard to guidance on good corporate governance as issued by NHS Improvement.</p>
	<p>The Licensee shall establish and implement:</p> <p>(a) effective board and committee structures;</p> <p>(b) clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and</p> <p>(c) clear reporting lines and accountabilities throughout its organisation.</p>	<p>Same as above - confirmed</p>	<p>The Board has a formal schedule of matters reserved for its decision, and delegates certain matters to committees.</p> <p>The Board has a work programme, which includes all matters the Board is required to consider by statutory, regulatory and other forms of guidance. It also has a range of strategic and operational performance information, which enables it to scrutinise the effectiveness of the Trust’s operations, and deliver focused strategic leadership through its decisions and actions. The Board maintains its commitment that discussion of patient safety will always be high on its agenda.</p>

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Licence condition	Description	Confirmation: Confirmed or Not Confirmed	Assurance
			<p>There are two Board assurance committees - the Audit Committee and the Quality, Safety and Experience Assurance Committee. These committees assess the assurance available to the Board in relation to risk management, review the Trust’s non-clinical and clinical and quality risk management processes and raise issues that require the attention of the Board.</p> <p>In addition to the two assurance committees, the Finance and Investment Committee considers financial performance, productivity and use of resources. The chairs of these committees report to the Board following every committee meeting. Each committee is charged with reviewing its effectiveness annually.</p> <p>In February 2019 the Board agreed to establish (for one year in the first instance from June 2019), a new assurance subcommittee of the Board – the People and Education Assurance Committee. The remit of the committee is to provide assurance to the Board and that the necessary structures and processes are in place to deliver the Trust’s vision for a supported and innovative workforce, an excellent learning environment for clinical and non-clinical staff and a culture that aligns with the Trust’s strategy and always values. The committee was established to scrutinise the new strategic risks on the Board Assurance Framework on culture, service innovation and provide additional scrutiny to the risk around recruitment and retention of staff.</p> <p>The Trust has terms of reference and work plans in place for the Board, Council and relevant committees. The Board committees conduct annual effectiveness reviews (surveys) on the delivery of their terms of reference and running of the committees. Findings are reviewed and where appropriate, changes to the terms of reference and workplans of the committees are made.</p>

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Licence condition	Description	Confirmation: Confirmed or Not Confirmed	Assurance
			<p>The assurance committees receive minutes from other assurance committees to prevent matters from falling between the governance framework. Summaries of assurance committee meetings are reported at the Board and the Council. At the Council, the chairs of the assurance committees present the summary reports and are held directly to account by the governors at the Council meeting. Governors are also invited to attend assurance committees and Board meetings throughout the year.</p> <p>The Board and Council receive regular updates on findings from CQC Well led reviews and progress with the Well Led action plan.</p> <p>The Trust’s Assurance and Escalation Framework presents a single, comprehensive picture of the governance and assurance structures and systems through which the Trust Board and other stakeholders receive assurance. The Trust routinely reviews and reports this assurance through the following key governance processes and frameworks including:</p> <ul style="list-style-type: none"> • Performance Management: The Trust has a range of frameworks and policies in place that outline how the Trust’s performance objectives and standards will be met, reviewed and managed; most significantly, the Performance Management Framework. • The Trust’s Risk Management Strategy (see above) sets out how the organisation identifies, monitors, escalates and manages risks in a timely fashion and at an appropriate level. Further detail on the identification and evaluation of strategic and local risks is provided below. • The Trust has in place a comprehensive and integrated Compliance Framework that seeks to ensure on-going compliance with statutory and regulatory requirements through integrated, rigorous and proactive structures, policies and practices. It ensures appropriate controls are in place to maintain compliance with statutory and

Attachment G

Licence condition	Description	Confirmation: Confirmed or Not Confirmed	Assurance
			<p>regulatory requirements and that external guidance and alerts are considered in a fulsome and responsive way.</p> <ul style="list-style-type: none"> • Policy Framework: This provides for clear and accessible policies, procedures and guidelines which support staff in undertaking their duties in a safe and effective way that takes account of all relevant legislation, regulation and guidance. The Trust’s policy framework, which is administered by the Policy Approval Group (PAG) • Committee structure: The Trust’s committee structure, developed from the Trust Board down, is currently under review to ensure each committee or group has a clear purpose, scope and authority. Some committees have statutory functions, others have authority to make decisions and direct actions, and others provide advice, support and oversee specific functions. <p>The clinical operations structure was consulted on in 2018, reviewed and revised. There are no eight directorates, each with a Chief of Service, Deputy Chief of Service, Head of Nursing and General Manager. The Senior Leadership Team meets weekly (around 100 senior managers from across the clinical and corporate areas of the Trust). An Operations Board has been established which meets fortnightly. The purpose of the Board is to bring together clinical and corporate senior leadership members to ensure the robust, effective and efficient operational management of the Trust.</p> <p>The Trust’s risk management strategy sets out how risk is systematically managed. This extends across the organisation, from the front-line service through to the Board, to promote the reduction of clinical and non-clinical risks associated with healthcare and research, and to ensure the business continuity of the Trust.</p>

Attachment G

Licence condition	Description	Confirmation: Confirmed or Not Confirmed	Assurance
	<p>The Licensee shall establish and effectively implement systems and/or processes:</p> <p>(a) to ensure compliance with the Licensee’s duty to operate efficiently, economically and effectively;</p> <p>(b) for timely and effective scrutiny and oversight by the Board of the Licensee’s operations;</p> <p>(c) to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;</p>	<p>Same as above - confirmed</p>	<p>The Board has agreed standing orders and standing financial instructions, which provide the framework for ensuring appropriate authorisation of expenditure commitments in the Trust. The Board’s processes for managing its resources include approval of annual budgets for both revenue and capital, reviewing financial performance against these budgets, and assessing the results of the Trust’s cost improvement programme on a monthly basis. In addition, the Trust has a prescribed process for the development of business cases for both capital and revenue expenditure and, where significant, these are reviewed by the Trust Board.</p> <p>The Trust’s performance management framework is aligned to the revised directorate management structure. Each specialty and clinical directorate has an internal monitoring structure so teams regularly review their progress and identify areas where improvements may be required. Each directorate’s performance is considered at monthly performance review meetings.</p> <p>The Finance and Investment committee reviews the operational, productivity and financial performance and use of resources both at Trust and divisional level.</p> <p>The Board has a work programme (aligned with the Well Led Assessment Key Lines of Enquiry), which includes all matters the Board is required to consider by statutory, regulatory and other forms of guidance. It also has a range of strategic and operational performance information, which enables it to scrutinise the effectiveness of the Trust’s operations, and deliver focused strategic leadership through its decisions and actions. The Board maintains its commitment that discussion of patient safety will always be high on its agenda.</p> <p>The Board assurance committees scrutinise the strategic risks facing the trust</p>

Attachment G

Licence condition	Description	Confirmation: Confirmed or Not Confirmed	Assurance
			<p>on a rotational basis every year, with committee members reviewing the effectiveness of controls and seeking assurances that any gaps in controls will be closed in a timely manner.</p> <p>Key performance indicators are presented on a monthly basis to the Trust Board. The report, which has recently been refreshed and integrates quality and performance data includes progress against external targets, internal safety measures, operational efficiency/process measures, well-led and other clinical quality measures such as complaints, incidents and reports from specific quality functions within the Trust such as the Patient Advice and Liaison Service (PALS). It also includes the external indicators assessed and reported monthly by the CQC. The report is aligned to the CQC key lines of enquiry: Safe, Effective, Caring, Responsive and Well Led. It asks the question: are our patients receiving high quality care?</p> <p>The external auditors envisage issuing an XXXXX audit opinion for 2018/19 TBC</p> <p>In January 2018, the Trust was inspected by the CQC and achieved an overall rating of GOOD. An action plan was developed and rolled out across the Trust. The Trust has developed an action plan in response to the recent CQC inspection and actively monitors progress with this at operational level and provides assurance to the Board. All remaining outstanding actions from the Well led Review in October 2016 and any negative commentary from the CQC inspection in 2018 have been either closed or consolidated with the Well Led action plan 2019 (progress reported at Board and Council in February 2019). The Trust has commenced a programme of work in order to ensure CQC readiness and to maintain compliance for the Trust. This work will be rolled out with a view to ensuring that compliance and governance are interlinked with quality, safety and experience and embedded in day to</p>

Attachment G

Licence condition	Description	Confirmation: Confirmed or Not Confirmed	Assurance
			<p>day working within the Trust. The initial work being undertaken will include:</p> <ul style="list-style-type: none"> • Weekly Steering Groups with Deputy Chiefs of Service • Mock inspection framework (CQC Quality Rounds) being drafted and implemented • Service line meetings with Directorates and Medical Director established and on-going • Communication plan being drafted • CQC action plan routinely monitored and scrutinised • Work to review potential areas/sources of learning being undertaken e.g. review of themes from other CQC reports, evaluation of insight reports. <p>Whilst the CQC made no formal recommendations to the Trust in relation to the findings in its Well Led Assessment published in April 2018, the Trust took it upon itself to review any negative commentary in the report and ensure that relevant actions were taken to mitigate the issues raised. The executive team have reviewed evidence against the Well Led Key Lines of Enquires and developed an action plan in preparation for the next CQC Well Led assessment.</p> <p>Themes arising from an assessment of the evidence and identified gaps mapped to the KLOEs include:</p> <ul style="list-style-type: none"> • Ensuring that strategies and associated plans are developed, consulted on, communicated across the Trust, monitored and implemented. • Ensuring that governance frameworks, procedures and policies are in place and up to date. • Ensuring staff (all groups) and director appraisals and mandatory training targets are met. • Reviewing how strategy, decisions, changes to practice, learning

Attachment G

Licence condition	Description	Confirmation: Confirmed or Not Confirmed	Assurance
			<p>from risks are communicated across the Trust to all staff groups.</p> <ul style="list-style-type: none"> • Ensuring that directors and senior managers are visible to staff. • Being deliberate about documenting: • Progress with strategic and local partnerships. • Responding to external benchmarked data such as the staff survey results etc. • Progress with actions against internal and external reviews of GOSH services.

<p>s.151(5) of the Health and Social Care Act (not a licence condition) (scope = past financial year 2018/19)</p>	<p>NHS Improvement require the Board to state whether it is satisfied that during the financial year most recently ended the Trust has provided the necessary training to Governors, to ensure that they are equipped with the skills and knowledge they need to undertake their role.</p>	<p>The Executive Team have considered the evidence cited and recommend 'Confirmed'.</p> <p>Response to be considered by the board in light of assurance provided here and taking into account the views of the governors</p>	<p>Governor Induction and training and development: During 2018/19, governors received mandatory Trust training and were provided with access to the Trust's internal on line training portal (GOLD) to update their training during their tenure. This is actively monitored by the Deputy Company Secretary and governors reminded and supported to complete the training during the year.</p> <p>Governors attended three induction sessions between April and August 2018. The sessions prepared and supported Governors to discharge their duties and complete the mandatory training.</p> <p>Prior to each Council of Governors' meeting, the Chair meets with all governors in a private session. This gives the Governors an opportunity to discuss any issues directly with the Chair and to gather information about the Trust and its activities and processes.</p> <p>The Trust established a buddying programme between Non-Executive Directors (NEDs) and governors from September 2018. The buddying programme provides governors with direct contact with a NED to support their role and share information on matters of interest or concern. The programme will be evaluated after 12 months.</p> <p>The Governor Induction programme concluded in August 2018 and transitioned into a series of Governor Development sessions. These sessions were developed in partnership with Governors to provide them with the skills and knowledge needed to deliver their key duties over their tenure.</p> <p>Representative Governors attended NHS Providers events.</p> <p>Information was provided to governors appointed to the Constitution Working Group from an external legal/governance provider.</p> <p>In April 2019 Governors will have access to an online library of resources. This will provide governors with 24/7 access to key documents and information.</p> <p>Since February 2019, governors receive a monthly newsletter from the Corporate Affairs team containing key dates, developments and training and development opportunities.</p>
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Trust Board 22 May 2019	
Quality Report 2018/19	Paper No: Attachment P
Submitted by: Dr Sanjiv Sharma, Medical Director	
<p>Aims / summary The Quality Report is an annual report produced for the public by NHS healthcare providers about the quality of services they deliver. Its aim is to enhance accountability and engage leaders of NHS organisations in their quality improvement agendas. The Quality Report is a mandated document, which is laid before Parliament before being made available to patients, their families, and the public on the NHS Choices website.</p> <p>The production of the document is in line with Department of Health and NHS Improvement published requirements. One document has been produced, which meets the requirements of both.</p> <p>This report has been subject to external audit. Any final comments from the auditors after this version will be shared at the Board meeting.</p>	
Action required from the meeting Sign off of Quality Report	
Contribution to the delivery of NHS Foundation Trust strategies and plans This document describes quality improvement work that has taken place in line with Trust strategic aims of 'Fulfilling Our Potential' and in line with quality as defined in the Next Stage Review. The document also outlines some of the Trust's quality improvement work for 2019/20.	
Financial implications None	
Who needs to be told about any decision? Deloitte	
Who is responsible for implementing the proposals / project and anticipated timescales? The delivery of the report is the responsibility of the Clinical Outcomes Development Lead. The deliveries of the projects therein are the responsibility of the individual project teams.	
Who is accountable for the implementation of the proposal / project? Dr Sanjiv Sharma, Medical Director	



Great Ormond Street
Hospital for Children
NHS Foundation Trust



Quality Report 2018/19

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Cover: **Eleanor**, is four years old. While she's at GOSH she loves tie dying and crafting, and visits the GOSH school with other patients on Squirrel ward.

What is the *Quality Report*?

The *Quality Report* is an annual report produced for the public by NHS healthcare providers about the quality of services they deliver. Its aim is to enhance accountability and engage leaders of NHS organisations in their quality improvement agendas. The *Quality Report* is a mandated document, which is laid before Parliament before being made available to patients, their families, and the public on the NHS Choices website.

What does it include?

The content of the *Quality Report* includes:

- Local quality improvement information, which allows trusts to:
 - demonstrate their service improvement work
 - declare their quality priorities for the coming year and how they intend to address them
- Mandatory statements and quality indicators, which allow comparison between trusts
- Stakeholder and external assurance statements

Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH) has a long-standing reputation as one of the finest paediatric hospitals in the world. We are keen to share information publicly about the quality of our services and about our continuous improvement work.

Understanding the *Quality Report*

We recognise that some of the information provided may not be easily understood by people who do not work in healthcare. So, for clarity, we have provided explanation boxes alongside the text.

This is a 'what is' box

It explains or describes a term or abbreviation found in the report.

"Quotes from staff, patients and their families can be found in speech bubbles."

What is NHS Choices?

NHS Choices is the UK's biggest health website. It provides a comprehensive health information service to patients and the public.

What is a Foundation Trust?

A Foundation Trust is a type of NHS trust in England that has been created to devolve decision-making from central government control to local organisations and communities. NHS Foundation Trusts provide and develop healthcare according to core NHS principles – free care, based on need and not on ability to pay. NHS Foundation Trusts have members drawn from patients, the public, and staff, and are governed by a board of governors comprising people elected from and by the membership base.

Faridat is six years old. She comes to Safari outpatients at GOSH with her mum and grandma to have treatment. While she's at the hospital, she enjoys playing with the toy kitchen and doing arts and crafts with the playroom.



Our hospital

GOSH has
62
nationally recognised
specialties

GOSH has
19
highly specialised services for
rare and complex conditions,
the largest number of any
NHS Trust in the UK

97%
of inpatients would
recommend the hospital

GOSH employs
5,014
hospital staff including doctors,
nurses, allied health professionals
and administrative staff

Over
1,300
research studies
active in 2018/19

100%
of our clinical specialties
collect data on outcomes
of treatment

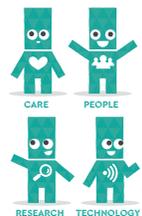
GOSH had
43,218
inpatients and
237,908
outpatient appointments
in 2018/19

Fulfilling our potential.

Our mission is to put the child first and always – this describes why GOSH exists.

Our vision has been updated to better describe what lies at the heart of the work we do at GOSH – to help the sickest children with complex health needs to fulfil their potential.

To turn our vision into goals we have defined four areas of focus around care, people, research, and technology.



To deliver our work we need to have the right capabilities, resources, and programmes of work.



Our Always Values are the guiding principles for everything we do and will help us deliver our ambition.



Our strategy – fulfilling our potential

Following a refresh and launch of Fulfilling Our Potential in 2017, our activities in 2018 continued to focus on creating a structure and engaging staff to embed our strategy as a plan for the Trust.

Alongside celebration of the work at GOSH to help children and young people with the most complex needs to fulfil their potential, this year's Open House event launched a new structure for clinical operations teams. The new organisational structure is designed to improve clarity on leadership and reduce the gap between Trust leaders and frontline services.

In December, staff came together for business planning events. Groups cut across departments and discussed how teams throughout the Trust can support one another to deliver Fulfilling Our Potential.

Other key achievements include delivery of the national Referral to Treatment target throughout the year, saving £12.3m through the Trust's 'Better Value' programme, and progress on the redevelopment programme to create inspiring spaces to deliver care and learning. In 2019/20, we plan to deliver savings of £20m.

Implementation of the Electronic Patient Record system is to harness technology to transform care, and we are also working to improve recruitment and retention at GOSH, to ensure we have the right people in place to fulfil our potential.

We actively engage in a range of national and international collaborations to learn together and to share good practice across paediatric healthcare settings. Our collaborations include the UK Children's Alliance, and the European Children's Hospitals Organisation, for which we co-chair the Quality, Safety, Outcomes and Value working group. Read more about our collaborations in our 2018/19 Annual Report.

A number of our clinical projects from the past year are showcased in section 2A of this report.



Staff showcasing the GOSH Arts BloodQuest app, which aims to reduce anxieties before children and young people have blood tests



A special visit from Hoover to promote our wonderful GOSH Therapy Dog Programme

See the GOSH Annual Report 2018/19 for more on Fulfilling Our Potential, and the programmes that are delivering key elements.

FUTURE PROOF

ELECTRONIC
PATIENT RECORDS

Electronic Patient Record programme

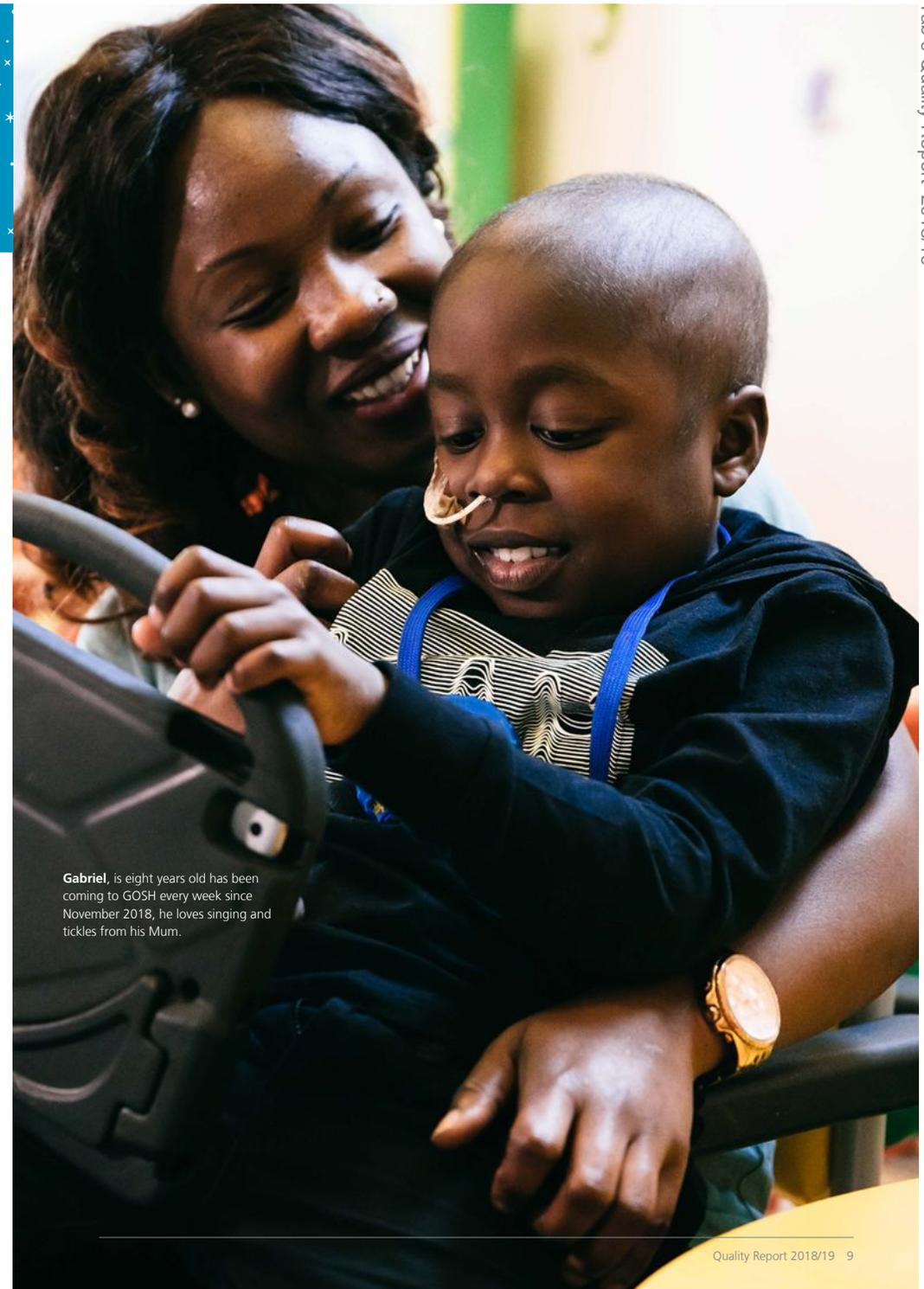
GOSH went live successfully with the Epic electronic patient record (EPR) system over the Easter weekend 2019, and this will be reported on in the 2019/20 Quality Report.

Our EPR vision is that every member of the team caring for a child can always access the information they need – rapidly, confidently and from a single source. Patients, parents and carers, as well as care providers in other hospitals and care settings will also be able to see relevant records and contribute information between visits to GOSH.

2018/19 has seen an iterative process of building, testing and reviewing the system, with hundreds of staff from every corner of the organisation involved in rigorously testing workflows. There were 127 Usability Sessions in 27 locations around the Trust, with almost 400 staff taking part. Our build of the Epic EPR system has been presented specialty wide, culminating in more than 13,000 hours of training to equip our staff for go-live.

Testing of hardware and software has taken place, with full 'technical dress rehearsals' across all wards, including every device that will be used with Epic. Devices for use in the event of downtime have been deployed in all clinical areas, alongside other new pieces of equipment such as workstations on wheels, barcode scanners and label printers.

After go-live, a period of stabilisation follows where the hospital gets used to the new ways of working. Then a phase of optimisation will allow for additional builds to the system to further utilise the capabilities of our EPR for patient care and reporting.



Gabriel, is eight years old has been coming to GOSH every week since November 2018, he loves singing and tickles from his Mum.



Digital Research, Informatics, and Virtual Environment (DRIVE)

October 2018 marked the official launch of GOSH's new digital research and informatics unit, DRIVE, with the vision to become a world-leading clinical informatics unit focused on data analysis and the acceleration of research. Investment in infrastructure and a Digital Research Environment (DRE) mean that DRIVE is uniquely placed to focus on early phase evaluation of digital technologies.



GOSH's new Electronic Patient Record System, Epic, is now live and collecting the complex clinical data associated with GOSH patients. The DRE provides us with the platform we need to apply machine learning and artificial intelligence tools to our rich patient data and to be able to improve patient care and hospital efficiency through:

- prediction of outcomes/complications
- improving scheduling
- reducing variation in care
- improving patient experience using technology

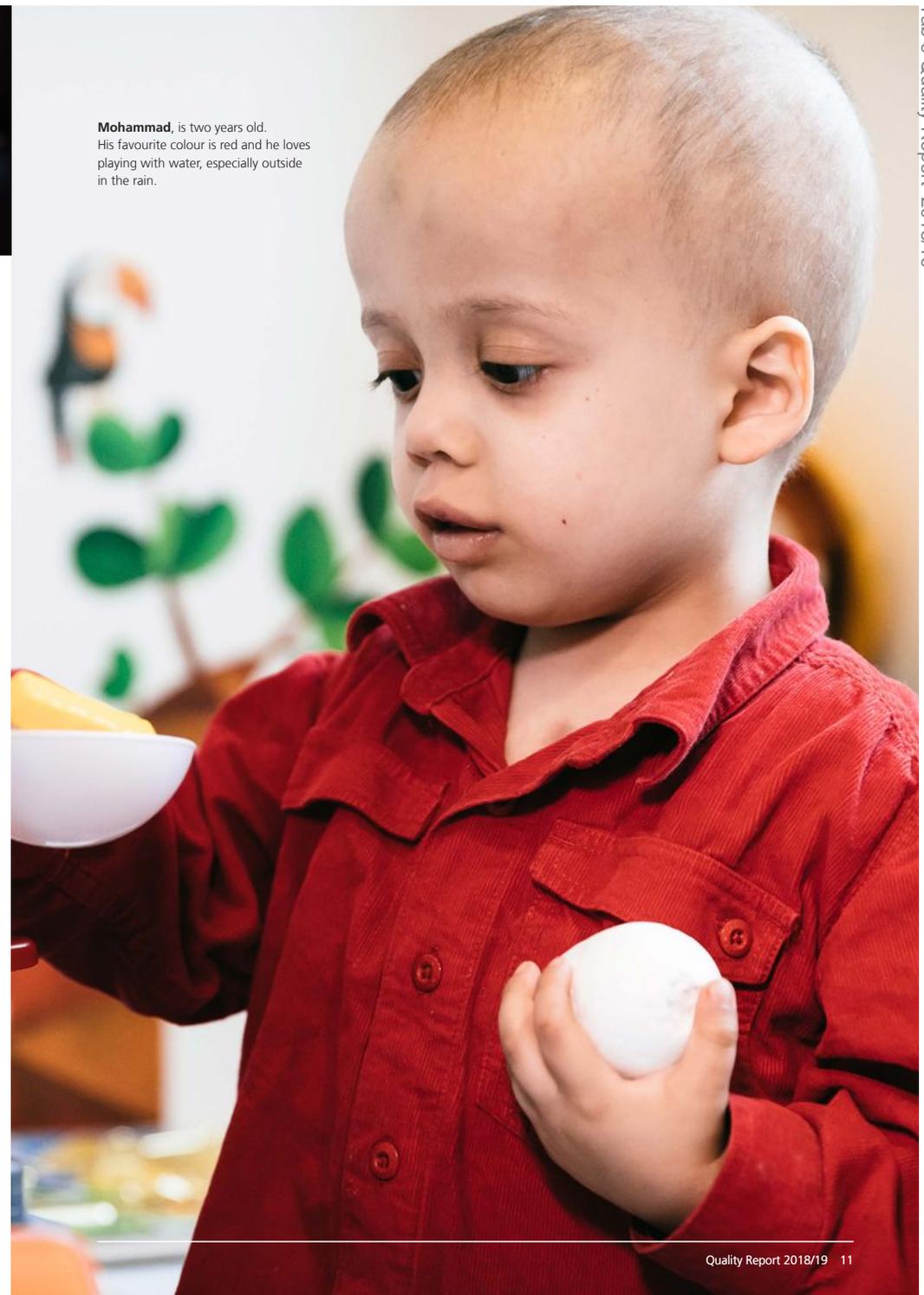
We are developing a programme of engagement with patients, families and staff and will make the most of game-changing technologies, such as artificial intelligence, sensor technology and robotics to address the daily challenges they face. Examples of such technologies include:

- better monitoring of patients both in hospital and at home for earlier detection of complications through sensors and wearables
- use of robots and chatbots for improved patient experience
- development of remote consultation technology to prevent patients travelling to GOSH unnecessarily
- improved patient safety through computer vision and machine learning

DRIVE has established an important partnership with NHS Digital, who has provided significant funding to support the collaboration, alongside partnerships with a selection of global technology giants. DRIVE continues to work with the Industry Exchange Network (IXN) at University College London and their computer science students, who bring an impressive array of novel ideas to DRIVE.

DRIVE also aspires to grow a culture of entrepreneurship across the organisation and, together with Barclays' Digital Eagles programme, will be running a course for staff with the aim of fostering good ideas and encouraging digital innovation in line with NHS and DH priorities.

Mohammad, is two years old. His favourite colour is red and he loves playing with water, especially outside in the rain.





Making inclusivity a reality at GOSH

We know from research evidence that people perform better at work when they are valued, treated fairly, and feel comfortable to be themselves. We also know that discriminatory attitudes and behaviours, whether conscious or unconscious, perpetuate inequalities that prevent us from maximising the skills, talents and experience of our rich and diverse workforce¹.

In response to the 2017 NHS Staff Survey results, which indicated that GOSH had some work to do to ensure all our staff feel valued, we created staff inclusion forums. These forums are staff-led initiatives, supported by the Human Resources and Organisational Development department. Each forum has a sponsor who is a member of the Trust's executive team.

Black, Asian and Minority Ethnic (BAME) Forum

The BAME Staff Forum launched in October 2018, with the purpose of empowering BAME staff to achieve their potential by creating a positive change and cultural shift in the Trust. Based on feedback from members, the Forum's Executive Team has defined three main focuses for 2019:

- Career development
- Leadership
- Social and networking opportunities

In addition to four main events throughout the year (based around major cultural and/or religious celebrations), there is a schedule of events including interview skills workshops and joint events with like-minded organisations. To date, two successful events have been held including the Forum Launch and a Welcome Breakfast, which boosted current membership to 150 staff.



Top left: The BAME Forum Executive Team

Top right: GOSH staff enjoying the crowds and sunshine at the Pride in London parade

LGBT+ and Allies Forum

GOSH launched its LGBT+ and Allies Forum in October 2018, which aims to ensure the Trust recognises and involves staff and volunteers who identify as lesbian, gay, bisexual, trans and non-binary (LGBT+), relationship diverse or as an LGBT+ ally. Its forum executive team has surveyed staff and identified forum priorities, which include: visibility and support of LGBT+ staff and families; policy input; training and education; mentoring; social and other events; and working closely with the other forums to recognise intersectionality, and to provide cross-forum support.

In 2018/19, the LGBT+ and Allies Forum:

- saw the first GOSH presence at the Pride in London parade
- celebrated LGBT+ History Month with events and activities, including the first raising of a rainbow flag at GOSH
- hosted forum breakfasts and evening events
- produced a regular newsletter for members and supporters
- prepared for the launch of its rainbow badge initiative in April 2019

Plans for 2019/20 include the roll out of the 'GOSH We're Proud' badge at GOSH, which gives staff a way to show that GOSH offers an open, non-judgemental and inclusive environment for patients and their families, staff and volunteers who identify as LGBT+.

Women's Forum

To coincide with International Women's Day, the GOSH Women's Forum was launched on 8th March 2019. The Forum is currently setting their agenda of what they want to achieve, including working with colleagues across the organisation to explore a range of events and work streams to benefit women working at GOSH. The plans for 19/20 include developing and promoting the forum across the Trust and engaging with staff to shape the agenda. Work streams will focus on how to support women working at GOSH. Initial suggestions have included menopause support, returning to work after having a baby, and career progression.

Disability and Long-Term Health Conditions Forum

Launching later this year, this forum aims to create a safe, inclusive and diverse working environment that encourages and supports engagement from those members of our staff who are disabled or who are affected by a long-term health condition. Members will have the opportunity to actively influence relevant GOSH policies, strategies and work streams and engage with the Trust to promote awareness around specific issues affecting the membership. We hope that members will help shape our health and wellbeing plans as well as supporting us as we progress through the Disability Confident Employer Scheme. The forum will also support the Trust to develop positive work experiences at GOSH.



Top left: Making history: The rainbow flag flies for the first time at GOSH

Top right: Women's Forum launch

¹ West MA and Dawson JF (2012) Employee engagement and NHS performance. London : Kings Fund

Part 1:

A statement on quality from the Chief Executive

It is widely accepted that research-based organisations have a culture of learning and that learning organisations tend to have better patient outcomes and patient experience.

Great Ormond Street Hospital is a standalone specialist children's hospital with a very strong academic partner, University College London. We are, therefore, very fortunate to be a research hospital where an emphasis is put on learning. That is, learning from when things go well and when they don't and fostering a culture where we continually seek to improve all we do.

This Quality Report is one way we can provide information on how we are improving our services and meeting a range of standards and expectations. While some standards are set externally, many of our quality improvement projects are informed by feedback from our patients, their carers and families, our commissioners and other stakeholders. Input from our staff is also vital as we identify and implement actions to improve the quality of the GOSH experience.

This report is divided into sections. In part two of this report we provide detail of a number of improvement projects aligned to our three quality priorities. In this same section we also provide a range of information that serves as reassurance from the Board as to the Quality of our services and information on how we are doing against core quality indicators. The final section includes our performance against key national targets.

Our improvement work should always link to our quality priorities. These are:

Safety - we are committed to reducing avoidable harm and improving patient safety as rapidly as possible. Our safety initiatives aim to ensure that each patient receives the correct treatment or action the first time, every time.

Clinical effectiveness - we seek to provide patient care that is amongst the best in the world and work with our patients to improve the effectiveness of our care through research and innovation.

Experience - we wish our patients and their families to have the best possible experience of our treatment and care. Measurement is important and we seek feedback from our patients, their families, and the wider public to improve the services we offer.

In the area of safety, this report highlights the very good work to improve the safety and experience of patients when venous access is needed. The introduction of a Vessel Health Preservation Framework (VHP) is important. Having a needle introduced to a vein can be an extremely distressing experience for our young patients, but prior to this work no framework existed for children and young people. The framework was carefully developed and tested with staff and children and young people, and the results are impressive: there has been a reduction in the number of unsuccessful cannulation attempts and a sustained reduction in the number of extravasation injuries.

The introduction and further development of the electronic Paediatric Early Warning System (PEWS) was a focus for our efforts to further improve clinical effectiveness. This tool, designed to recognise and respond to children and young people at risk of deterioration, is generated by combining scores from a selection of routine observations. This year we included sepsis risk triggers and alerts to the system and adapted the software for better adherence to full observation sets. Feedback from staff has been overwhelmingly positive and the percentage of completed observations has increased. The number of cardiac arrests outside ICU wards has also decreased and we are monitoring this sustained improvement to see if there is a direct correlation with the use of PEWS. I am also very pleased we are now working with other hospitals and NHS England to develop a national PEWS tool.

In the area of patient experience this year we have done further work to improve our transition support. As a specialist children's hospital we are very mindful of the need to prepare our young people for a transition into general adult or specialist adolescent or adult services, while recognising that the age and type of transition varies. To support our young people to be aware and develop the skills needed to engage with other centres, this year we rolled out the Growing Up Gaining Independence (GUGI) Tool. Feedback from young people and their parents about their experiences has been very good and over the next year we hope to further embed the framework as well as working with other children's hospitals to seek consistency of approach.

Looking forward to the next year, and following inputs from a wide range of stakeholders, including our Young People's Forum, three of the quality priorities we have set ourselves are: the introduction of a Trust wide programme that empowers staff to speak up for safety in the moment; an initiative to reduce the rejected samples for laboratory testing; and to further implement and develop a system that enables our families to give feedback in real time.

Audits are an important way we are able to gain assurance of the quality of our services. During this year we had a number of national audits and clinical outcome reviews, the results of which are found in the body of this report. GOSH staff also carried out a large number of local clinical audits. In order to underline the importance of this work and celebrate the teams that trailblaze in this area, and this year we introduced a clinical audit prize, won by three exceptional teams.

The quality of our services is also assured by our regulator, the Care Quality Commission. At the beginning of this year, we published the report on our latest inspection which rated our services as good overall. However, we recognise that there are also many areas of improvement. So, during this year we have developed a post-inspection action plan that includes the introduction of a rolling schedule of peer-to-peer mock inspections. These inspections aim to create a cycle of continuous monitoring, learning and improvements as part of the day-to-day culture across the Trust.

The healthcare targets that are set nationally are an important way we can assess whether we are delivering timely and effective care. I am very pleased that after a huge piece of work to improve our systems and process for recording patient data, we were able to consistently meet the national standard of treating 92 per cent of our patients within 18 weeks of referral.

Feedback from our staff, our patients and their families is also essential to monitor and improve the quality of our services. One of the principal ways our staff give feedback is through the national NHS Staff Survey. This year the confidence our staff had in the quality of our services - measured through the percentage likely to recommend the hospital for their family and friends - improved and remained far above the national average. However, the feedback we had from staff about their experience at work was not as positive, with a higher than average proportion of staff saying they had experienced at least one incident of bullying, harassment or abuse at work. Understanding why this is the case and taking concrete steps to address this is a priority for the next year and one which will be addressed in our new People Strategy.

One of the richest sources of feedback comes from our patients and their families. One mechanism to capture this is the Friends and Family Test (FFT). In previous years we had struggled to achieve sufficient response rates. This year I am very pleased that the rate substantially increased, meeting our target in the last quarter, and that the percentage of families recommending the hospital remained very high. The improvements are a result of substantial efforts by our staff from across the Trust. I would also like to thank all the children, young people and their families who take time to give feedback and by doing so become partners in care - you are not only helping us to ensure the quality of care for your family but for all the families that use our services.

At GOSH we also strive to harness the latest technology to transform the care and experience we offer. Throughout this year, we have worked to prepare for the implementation of our Electronic Patient Record (EPR) known as Epic. This was launched successfully in April 2019 and offers enormous potential for further driving up quality. Throughout this report you will see references to how the Epic system is set to augment and improve how we deliver care. I look forward to sharing the impact this system has had in next year's Quality Report.

Of final note, the information provided in this report relies on good quality data. To this end, we have sought to take all reasonable steps and exercise appropriate due diligence to ensure the accuracy of the data reported.



Matthew Shaw
Chief Executive

Part 2a: Priorities for improvement

This part of the report sets out how we have performed against our 2018/19 quality priorities. These are made up of a combination of national priorities as well as local priorities identified by staff, patients and their families, and wider stakeholders such as referrers and commissioners. The quality priorities fall into three categories: safety, clinical effectiveness and experience. These categories were defined by Lord Ara Darzi in his 2008 NHS review for the Department of Health, in which he emphasised that quality should be a central principle in healthcare.



Safety

We are committed to reducing avoidable harm and improving patient safety as rapidly as possible. Our safety initiatives aim to ensure that each patient receives the correct treatment or action the first time, every time.

Clinical effectiveness

At GOSH, we seek to provide patient care that is amongst the best in the world. As a major academic centre, we work with our patients to improve the effectiveness of our care through research and innovation. We use national and international benchmarks to measure our effectiveness whenever possible, and we publish this outcomes data on our website and in renowned academic journals. To measure our effectiveness from the patient's perspective, we use Patient-Reported Outcome Measures (PROMS).

Experience

We wish our patients and their families to have the best possible experience of our treatment and care. Therefore, we measure patient experience across the hospital and seek feedback from our patients, their families, and the wider public to improve the services we offer. We do this via:

- Membership, patient and member surveys
- Focus groups and events
- Social media
- Asking patients and families about their experience within 48 hours of discharge

Reporting our quality priorities for 2018/19

The six quality priorities reported for 2018/19 were:

Safety

- Improving the safety and experience of our patients when venous access is needed for their care
- Reducing the rate of rejected samples for laboratory testing

Clinical effectiveness

- Improving the early recognition of the deteriorating child and young person, through the introduction of the electronic Paediatric Early Warning System
- Improving the process for ordering and delivery of chemotherapy

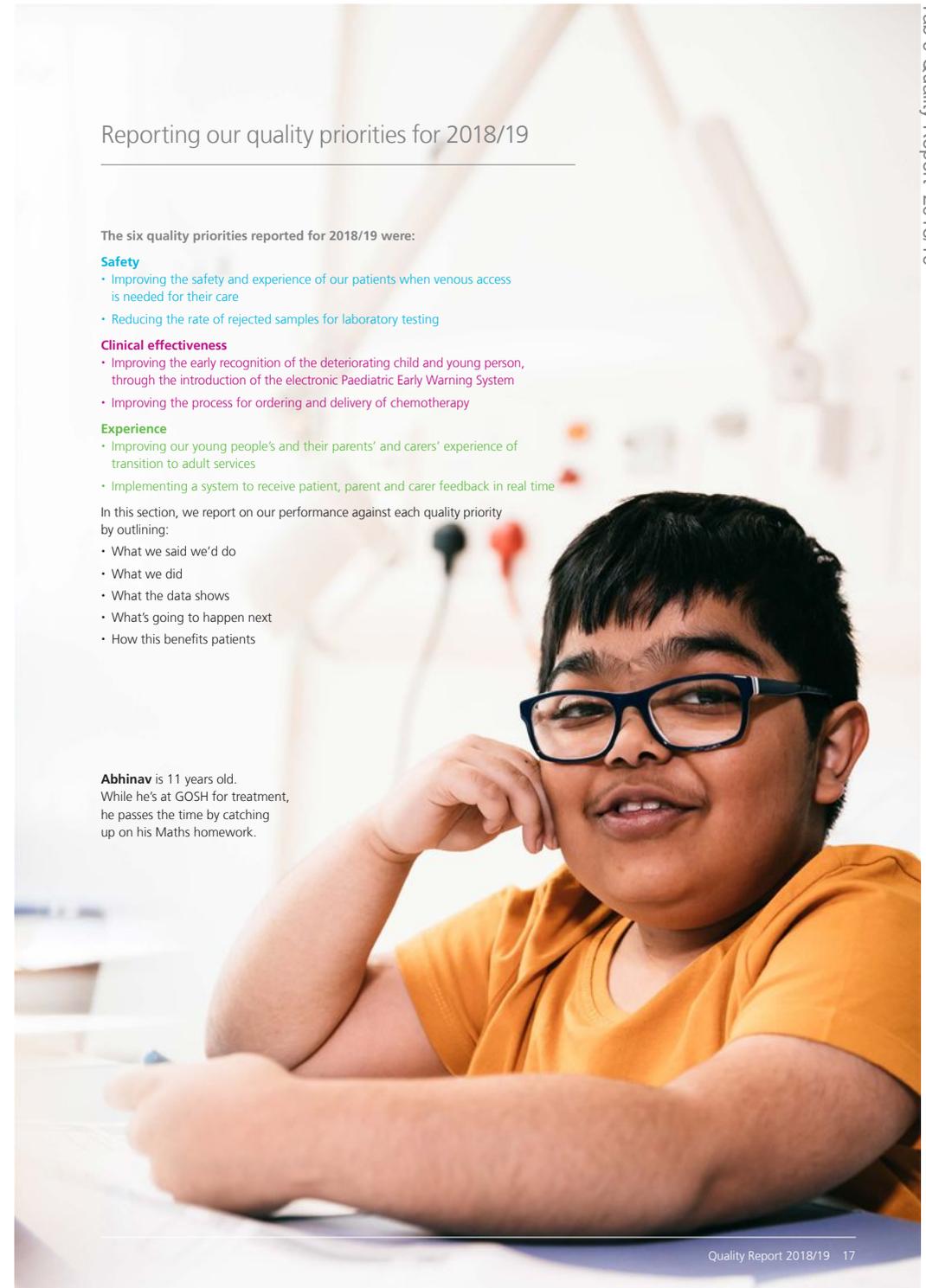
Experience

- Improving our young people's and their parents' and carers' experience of transition to adult services
- Implementing a system to receive patient, parent and carer feedback in real time

In this section, we report on our performance against each quality priority by outlining:

- What we said we'd do
- What we did
- What the data shows
- What's going to happen next
- How this benefits patients

Abhinav is 11 years old. While he's at GOSH for treatment, he passes the time by catching up on his Maths homework.



Safety

Improving the safety and experience of our patients when venous access is needed for their care

For many of the children who come to GOSH, a daunting experience of their stay is when a needle needs to be introduced into a vein to draw blood or give medication. This anxiety can lead to behavioural distress that further intensifies pain and can interfere with the procedure, and any future procedures required. If ongoing venous access such as a peripheral cannula is required, there is also a risk of extravasation.

What we said we'd do

We said we would introduce a Vessel Health Preservation (VHP) framework that supports staff to:

- choose the right device
- make sure the right procedure is considered based on the child's individual needs
- help prepare the child and family for the procedure
- make sure the staff member with the right skills is performing the task

What we did

Trusts across the UK use a VHP framework in adult care, where they grade the quality of veins before attempting venous access. However, such a framework did not exist in paediatric healthcare. We decided that to make progress with vessel health, we needed to develop a similar framework for children and young people.

We established a GOSH steering group, consisting of clinical and non-clinical leads including the Chief Nurse, anaesthetists, speciality leads, clinical site practitioners, infection control staff and quality improvement (QI) staff. We also regularly consulted with patients and families to understand their experiences of cannulation. Over a number of months, the group carefully developed a paediatric VHP framework, testing the framework on pilot wards to ensure it was fit for purpose for both staff and patients.

Once we had refined the framework, we held the 'Vessel Health Roadshow', an education and engagement event to raise awareness of the new framework across the hospital. This included teaching by members of the Play Team to promote how preparation of the child and family, positioning, and distraction techniques can help ease anxieties and lead to a more successful procedure.

To ensure early identification of patients where venous access may be more difficult to achieve due to vein condition, we added a section to our electronic Patient Status at a Glance (ePSAG) boards to document vein grade. This helps to highlight these patients to the whole ward team to ensure appropriate treatment plans are put in place at the outset. We have also worked with the team who are implementing Epic, our new electronic patient record system, to ensure that vein grading is supported in the new system.

We also reviewed and updated our education programme to ensure children and young people are cannulated by appropriately skilled clinicians. We developed a teaching and engagement video to ensure all existing and new staff are aware of the new framework, and share good practice in paediatric cannulation to reduce avoidable pain and distress. This is now embedded in the cannulation and venepuncture study day. We have also tested opportunities for junior doctors to gain additional skills and experience in paediatric cannulation through shadowing experts such as anaesthetists and vascular access facilitators, and are working to embed this into the junior doctors' education pathway.

What is extravasation?

Extravasation is the inadvertent leakage of a medicine or fluid from its intended vein into the surrounding tissue. Extravasation has the potential to cause blisters, severe tissue injury or necrosis.

What is venepuncture?

Venepuncture is a common procedure that involves the insertion of a needle into the vein, to draw a blood sample or administer medication.

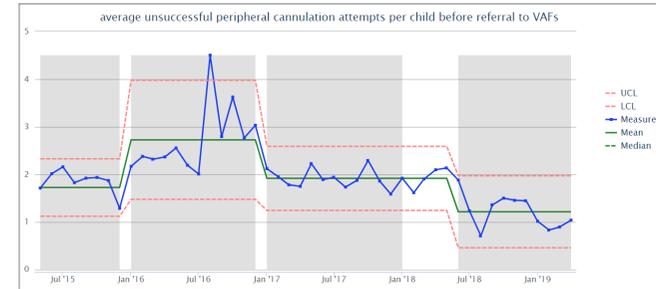
What is cannulation?

Sometimes when intravenous treatment is required over a longer period of time, an intravenous cannula is inserted. This is a small, flexible tube inserted into a vein and secured. A syringe or infusion line can then be attached to the cannula to administer medication or fluids directly into the bloodstream.

What the data shows

1. The average number of unsuccessful cannulation attempts before a patient is referred to the Venous Access Team

We have seen a reduction from an average of 1.9 attempts per child to 1.2 attempts prior to referral, indicating improvement in timely escalation of children whose vein condition requires additional expertise to achieve venous access.



2. The number of extravasation injuries referred to the Plastics Team

We have achieved and sustained a reduction in the number of extravasation injuries referred to the Plastics Team, decreasing from an average of 12 a month before the project commenced, to 5 a month.



What's going to happen next?

We are updating our policy and guidelines to ensure the new framework is embedded as standard across the Trust. We are also developing an e-learning package incorporating the training video for all doctors to complete on induction.

The Trust is considering establishing a larger peripheral venous access team to improve out-of-hours access to expert practitioners in venepuncture and cannulation.

How this benefits patients

The VHP framework benefits patients by ensuring:

- The most suitable type of venous access is consistently determined for the patient depending on the reason for access and the length of time it is required for
- Venous access is attempted by a practitioner with the right level of skill. This reduces the likelihood of failure, improving patient safety and reducing distress



Expert



CARE

What is a Statistical Process Control chart?

Statistical Process Control (SPC) charts are used to measure variation and improvement over time. Importantly, SPC takes into account natural variation of data, which, if acted upon without analysis, is an inefficient approach to improvement work. Upper control limits (UCL) and lower control limits (LCL) are calculated to help with data analysis. SPC methodology enables us to focus on 'special cause' variation, which identifies areas that require further investigation and action.

What is a baseline period?

A baseline is the period of measurement to establish 'how things are' before changes are made to a process, to enable comparison 'before' and 'after'. An average (mean) of the data from the baseline period would be used for that comparison.

"It helps prevent distress in children from excessive attempts at venepuncture." Staff nurse, Bear

"It helps guide your management of a patient and tries to minimise the harm in those circumstances where there is known difficult access." Staff nurse, Koala

Reducing the rate of rejected samples for laboratory testing

Approximately 70%² of clinical decisions are based on information derived from laboratory test results. In 2017, GOSH's laboratories received more than 400,000 samples and performed more than 1 million tests.

An audit in 2017 identified that approximately 4900 samples were rejected due to pre-analytical reasons over the year. When a sample is rejected, it usually means that the test needs to be repeated. We know that a delay in receiving a result can contribute to delays in diagnosis, treatment and discharge, as well as having a significant impact on patient experience.

What we said we'd do

Early in 2018, the rejection of nasopharyngeal aspirate (NPA) samples due to container leaks was considered as an area for improvement. Issuing guidance for staff to send all of these samples through porters rather than via the pneumatic tube system ('chute') reduced the rejection rate.

After this 'quick win', we decided to explore other opportunities for improvement in sample collection practice and to implement solutions, with the overall aim of significantly reducing the number of sample rejections by the end of 2019. We said that we would investigate the reasons for sample rejection to understand the causes and identify ways to avoid them.

We identified four key work streams that were integral to achieving a quality sample:

Sample Collection Resources – focusing on the equipment and resources we use to collect patient samples to certify that they are adequate, compatible and do not hinder a quality sample being obtained.

Sample Transport – looking at the different routes, methods and timings for patient samples to get to the laboratory.

Training and Education – assessing the current availability and content of education and training opportunities related to sample collection and comparing it with best practice.

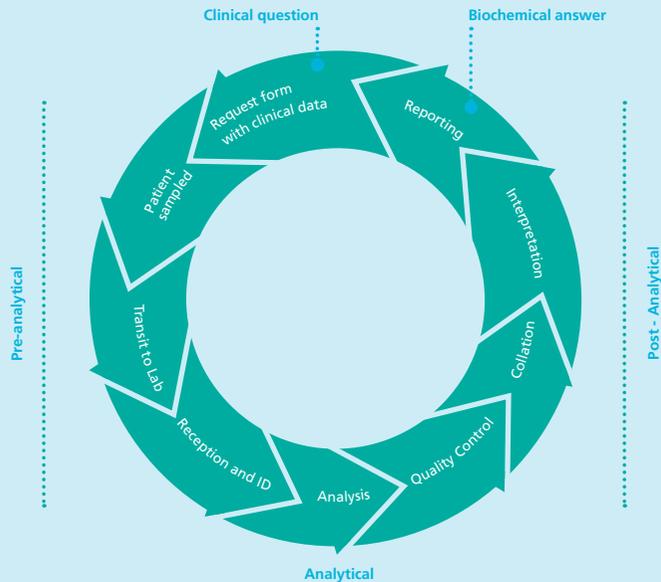
Policy and Guidelines – reviewing our policies and guidelines to ensure they are evidence based and support staff to obtain adequate samples.

What is the pre-analytical phase?

The pre-analytical phase starts at the point of sample collection and test requesting by the medical team and ends when the sample arrives in the laboratory and is evaluated for errors before processing.

What are blood cultures?

Blood cultures are blood samples performed to detect infections in the blood. If a blood culture test is positive, the bacteria causing the infection will be identified and testing will be done to find out which antibiotics will effectively treat the infection.



² Datta P (2004) *Resolving discordant specimens in clinical laboratory practice*. Medical Laboratory Observer. November. Accessed 19/02/2019.

What we did

We set up a project team of clinical and non-clinical stakeholders from across the Trust, led by the Quality Leads for the laboratories. To understand the main reasons for rejection and where the greatest areas for improvement were, we developed a real-time report on the intranet using data from the laboratory information system. Data can be viewed at Trust and ward level and is accessible by all staff. From the data we were able to identify the most common reasons for rejection:

- Clotted coagulation test samples
- Insufficient/underfilled samples
- Labelling errors

The causes were identified as: incorrect technique when taking the sample (such as insufficient mixing or vigorous shaking), issues with the equipment (such as loss of vacuum, expired tubes or incompatible resources), or delays in transporting samples to the laboratory.

Delayed transport of blood cultures was identified as a frequent issue. It is important that blood cultures are sent to the laboratory as soon as possible so that any bacteria that might be present in the sample can grow, be detected and be treated. We developed visual guides to remind staff to send these samples via the chute for speed of delivery.

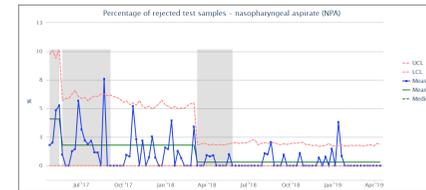
Blood must be drawn in a specific order to avoid cross-contamination between blood tubes. We found the collection sequence used at GOSH was different to the order recommended by the suppliers of the bottles, laboratory standards and the World Health Organisation. We have now changed our guideline, created new resources to reflect this, and shared the rationale with staff.

Epic, our new electronic patient record system, will change how tests are requested. When blood tests are requested on Epic, the clinician will be prompted to print a patient label for the tube and will also be reminded of the new sequence in which to take their samples. We therefore anticipate that labelling errors will decrease further from April 2019.

What the data shows

1. Percentage of rejected nasopharyngeal aspirate samples

The weekly percentage of NPA samples rejected due to leakage has reduced from a mean of 1.79% to a mean of 0.3%. This improvement has been sustained since March 2018.



3. Weekly rate of rejected samples

Though we have not yet seen an improvement in the mean rejected samples for these laboratories, our project continues to strive for a decrease. We expect the implementation of Epic to aid this by the end of 2019, when the project is scheduled to end.



2. Average blood culture transport time

The weekly average transport time mean has reduced from 239 minutes (June 2017 to October 2018) to 169 minutes (November 2018 to February 2019). In March 2019 it reduced further to 146 minutes.



What's going to happen next?

We're going to continue to develop and implement interventions to reduce the rate of rejection. We plan to develop a training strategy and practical best practice guide with quick tips for decreasing the likelihood of a sample being rejected.

We're going to continue to evaluate the products we use including trialling an alternative needle and an alternative coagulation tube for neonates with a reduced minimum volume requirement.

How this benefits patients

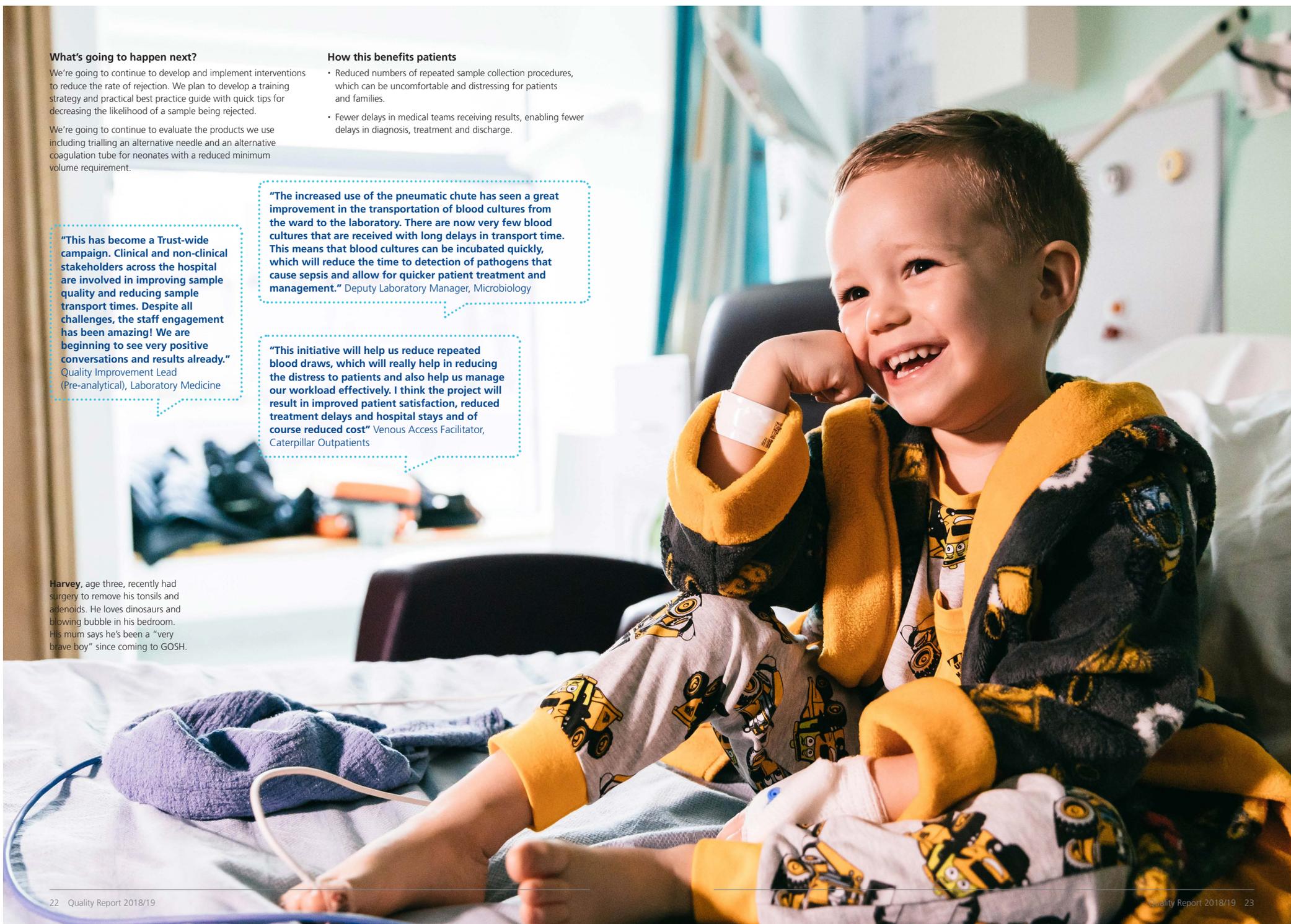
- Reduced numbers of repeated sample collection procedures, which can be uncomfortable and distressing for patients and families.
- Fewer delays in medical teams receiving results, enabling fewer delays in diagnosis, treatment and discharge.

"This has become a Trust-wide campaign. Clinical and non-clinical stakeholders across the hospital are involved in improving sample quality and reducing sample transport times. Despite all challenges, the staff engagement has been amazing! We are beginning to see very positive conversations and results already."
 Quality Improvement Lead (Pre-analytical), Laboratory Medicine

"The increased use of the pneumatic chute has seen a great improvement in the transportation of blood cultures from the ward to the laboratory. There are now very few blood cultures that are received with long delays in transport time. This means that blood cultures can be incubated quickly, which will reduce the time to detection of pathogens that cause sepsis and allow for quicker patient treatment and management." Deputy Laboratory Manager, Microbiology

"This initiative will help us reduce repeated blood draws, which will really help in reducing the distress to patients and also help us manage our workload effectively. I think the project will result in improved patient satisfaction, reduced treatment delays and hospital stays and of course reduced cost" Venous Access Facilitator, Caterpillar Outpatients

Harvey, age three, recently had surgery to remove his tonsils and adenoids. He loves dinosaurs and blowing bubble in his bedroom. His mum says he's been a "very brave boy" since coming to GOSH.



Clinical effectiveness

Improving the early recognition of the deteriorating child and young person, through the introduction of the electronic Paediatric Early Warning System

Early warning scores are designed to alert health professionals to the signs of clinical deterioration. They support staff by strengthening team communication and helping to deliver the best possible care to stabilise the child or young person.

What we said we'd do

In the Quality Report 2017/18, we made a commitment to improve the early recognition of the deteriorating child and young person at GOSH, through the introduction of the electronic Paediatric Early Warning System (PEWS).

What we did

The decision to replace our Children's Early Warning Score (CEWS) with PEWS was made after extensive national research and data modelling of over 1.5 million clinical observations showing PEWS to be a more sensitive tool in identifying paediatric patients at risk of deterioration.

A Quality Improvement project was initiated with the aim of implementing PEWS across GOSH by April 2018 and supporting wards to embed use of the new scoring system.

Process Approach

In addition to the implementation of PEWS, Sepsis risk factors, prompts and alerts were built into the electronic system. This provided clinical staff with the additional markers to improve the early recognition of clinical deterioration when completing their observations.

The recording of incomplete observations is possible within Epic. However, dashboards have been built to monitor this at ward level, so that any issues with observations completion can be addressed promptly.

What is PEWS?

The Paediatric Early Warning System is a tool to recognise and respond to children and young people at risk of deterioration. It is generated by combining the scores from a selection of routine observations of patients including respiratory rate, heart rate, systolic blood pressure, and oxygen saturation.

What is sepsis?

Sepsis is a life threatening condition that arises when the body's response to an infection injures its own tissues and organs. Sepsis leads to shock, multiple organ failure and death, especially if not recognised early and treated promptly. UK Sepsis Trust.

What is a Clinical Site Practitioner?

A Clinical Site Practitioner (CSP) is a senior nurse in charge of the day-to-day operational management of the hospital.

Training and Education

A comprehensive training package was created by the clinical education team, and rolled out using a 'Train-the-Trainer' approach. Key features included:

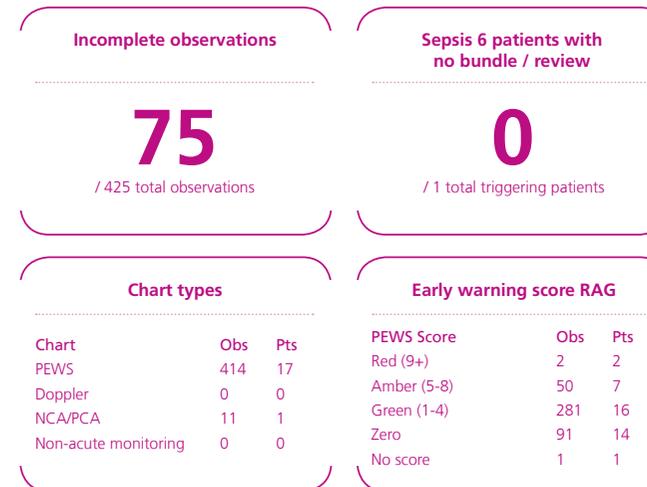
- Differences in the scoring between CEWS and PEWS
- A 'Back to Basics' campaign designed to improve the quality of observation taking
- Staff roles and responsibilities in response to PEWS e.g. agreed timeframes for staff to respond to a high PEWS alert

Project Approach and Implementation

The PEWS was successfully launched at GOSH in March 2018, and an eight week post implementation review was completed in May 2018.

The main recurring theme in the initial period was alert fatigue. It became apparent that escalation alerts had been set at a level that caused a significant increase in the number of unnecessary alerts that nursing staff were required to action. We therefore worked to align the scores with more appropriate escalation triggers, ensuring appropriate reviews were undertaken by the right clinical staff member and at the right time.

Early Warning Dashboard example



The Quality Improvement data analysts built the Early Warning Dashboard, which combines specific PEWS and Sepsis measures in a user-friendly way, including the ability to view data at a hospital, ward and patient level.

The data provides assurance that the correct chart types are being used, patient observations are fully completed, and that when Sepsis flags are triggered, decisions are made within agreed timeframes.

What is cardiac arrest?

Cardiac arrest is a term used to describe sudden loss of heart function. It can occur due to an electrical disturbance in the heart, but can also be caused by structural heart abnormalities that disrupt the heart's normal pumping action.

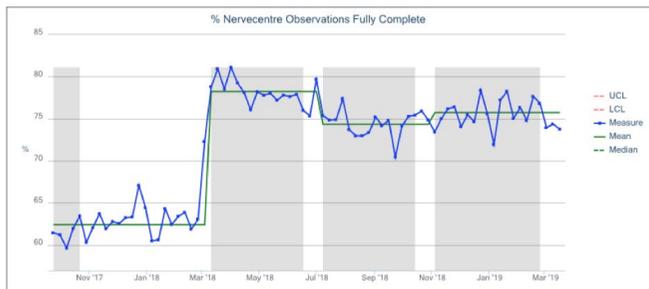
What is 'Train the Trainer'?

'Train-the-Trainer' is a cascading training model. PEWS subject matter experts intensively trained a number of staff on how to use PEWS appropriately. Those staff then trained others, and so on. This approach is often used within healthcare when a large number of staff must be trained but cannot all attend training at the same time, and peer learning is appropriate.

What the data shows

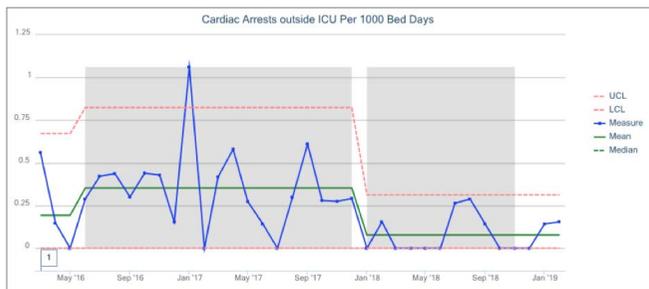
1. The percentage of observations where all parameters are completed (required to produce an Early Warning Score)

CEWS prior to 07/03/2018, PEWS after this date. Since the launch of PEWS, the percentage of completed observations has increased from 62% to 75%.



2. Cardiac arrests outside ICU wards/ theatres, per 1000 bed days

Cardiac arrests per 1000 bed days have decreased from a mean of 0.35 to 0.08 from January 2018, and the reduction has been sustained. Though we cannot claim a direct causal link between the PEWS project and the reduction in cardiac arrests, the timings co-occur and we continue to monitor this improvement.



What's going to happen next?

PEWS has been integrated within our EPR system, Epic, with no changes to the scoring or escalation algorithm.

Led by NHS England, GOSH is also working with other hospitals to develop a national PEWS tool. The initiative is designed to standardise the approach to managing deterioration in children and young people across the UK.

How this benefits patients

- A safer environment
- Better outcomes for patients



“I’m a huge advocate of PEWS, especially when I’m the nurse in charge on the ward, as the system will automatically prompt me whenever one of our patients has a high PEWS score. I can then go and check in with the nurse and patient to see how they’re getting on and put a plan in place if needed.” Staff Nurse

“Since PEWS started we’ve noticed staff feel more confident in escalating concerns to the CSP team, even if their patient doesn’t have a high PEWS score. For me this shows staff are using the system correctly, by using PEWS to support their clinical judgement, rather than replace it.” Clinical Site Practitioner (CSP)



Improving the process for ordering and delivery of chemotherapy

The chemotherapy unit prepares 80-100 doses per day of bespoke chemotherapy for a range of patients in the hospital. Both inpatients and outpatients receive complex regimens of chemotherapy for the treatment of cancer. Specialised pharmacists oversee the process from prescribing, clinical verification, manufacture and administration of these high-risk drugs with numerous safety checks built into the process to prevent harm.

What we said we’d do

Tracking preparation of these medicines had always been through a manual paper process that relied on access to a single sheet of paper per day, which would need to be kept up-to-date as changes occurred. Inevitably, the chemotherapy unit would receive numerous phone calls to receive updates about particular patients or from ward areas to enquire about the status of a patient’s chemotherapy. These interruptions along with the labour intensive process of keeping the ‘day planner’ up-to-date led to inefficiencies and required specialist pharmacists to oversee this workflow. There was no visibility at ward level as to the status of chemotherapy, so the chemotherapy unit had limited ability to manage workload.

We decided to explore options for the development of an electronic solution to bring visibility of this information to both pharmacy and ward.

What we did

We approached the Quality Improvement Team with a proposal to create a fully electronic tracking system for chemotherapy prescriptions from prescribing to collection. By identifying the process from start to finish, we provided a comprehensive plan to ensure that the system would bring visibility about chemo status at ward level and pharmacy, with safety mechanisms to ensure chemotherapy can be prioritised. After initial development, the system was tested and refined with the wider team, with additional features developed e.g. clinical trial flags to help highlight trial medicines. After running the system in parallel to the old system to validate it, Chemotracker was launched in February 2018.

The system:

- Allows ward-based pharmacists to update Chemotracker at ward level, without the need to call the chemotherapy unit
- Helps track preparation of chemotherapy through each stage of preparation providing real-time information from Pharmacy to ward areas
- Allows the technicians to prioritise workload based on when patients are due and provide better visibility on expected workload and tasks that need to be completed for the day, all of which help reduce any delays in preparation of chemotherapy

A significant benefit of introducing the system has been that due to the simplified processes in the chemotherapy unit, it has allowed the release of specialist pharmacist time away from the chemotherapy unit and into patient facing areas, making best use of our resources. This has allowed us to maintain specialist pharmacists in all haematology/oncology ward areas, providing a continued benefit in the quality of prescribing.

Prior to the launch of the tracker, ward nurses would call the chemotherapy unit with queries about chemotherapy or communications about patient investigation results. They now are directed to Chemotracker, which answers the majority of their queries. Where additional queries or communications are required they can now talk to their ward-based pharmacist, who knows the patient best and is more readily available on the ward due to the time saved by Chemotracker.

What the data shows

We did a baseline audit in October 2018 of our paper-based system:

After full implementation of Chemotracker:

October 2018



40-60 calls per day
to the chemotherapy unit

March 2019 onwards



0 calls per day
to the chemotherapy unit

The chemotherapy unit phone now has a voicemail message to direct any, now occasional, callers to speak directly to their ward-based pharmacists as the authoritative and now routinely on-site source of information. Ward-based pharmacists communicate with the chemotherapy unit now using Chemotracker, and urgent messages can be called through to the chemotherapy unit manager.

What's going to happen next?

Chemotracker will be used in conjunction with Epic after go-live in April 2019, providing an ideal model to eventually develop in Epic itself.

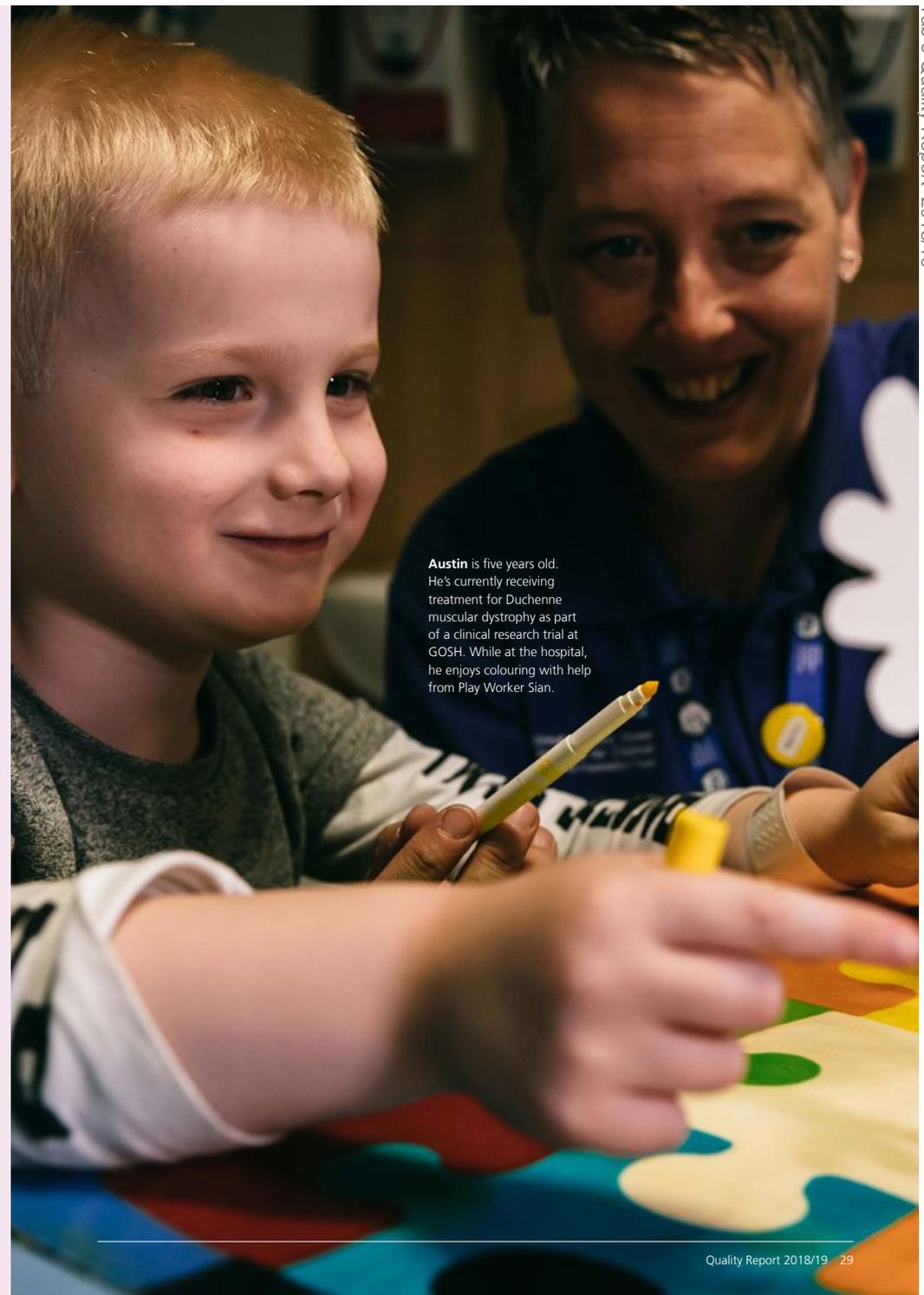
How this benefits patients

- Reduced errors
- Reduced delays
- Nurses and doctors have access to specialist pharmacists on the ward at all times where they are best placed to help optimise patient care and support in the delivery of complex chemotherapy

"Chemotracker has allowed us to concentrate on the tasks we need to do. It's a big improvement from the old system which was difficult to use and interpret. By reducing the number of phone calls, we can provide an environment free from interruptions to ensure the safe preparation of chemotherapy."
Chemotherapy unit manager

"It allows us as nurses to concentrate on the patients rather than needing to chase up where chemo is. We don't need to spend time calling to find out if chemo is ready and it is instantly visible to us. The pharmacist can update the tracker on the ward. Having the pharmacist around more on the ward means we can optimise patients' treatment better and resolve any queries much quicker."
Senior Staff Nurse Safari Day Care

"It allows us as ward-based pharmacists to concentrate on being visible in ward areas, reducing the amount of time taken tracking prescriptions. It allows us to fully manage our patients' chemotherapy orders and reduce delays." Specialist Haematology/Oncology Pharmacist



Austin is five years old. He's currently receiving treatment for Duchenne muscular dystrophy as part of a clinical research trial at GOSH. While at the hospital, he enjoys colouring with help from Play Worker Sian.

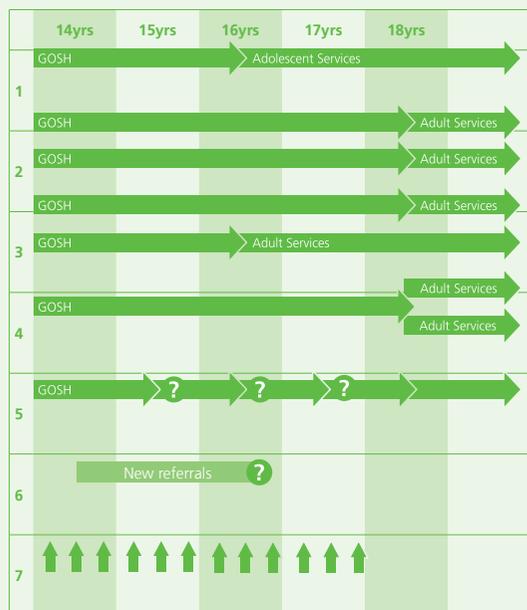
Experience section

Improving our young people's and their parents' and carers' experience of transition to adult services

The way young people and their families are prepared for the move from paediatric to adult health services has come under increasing scrutiny in recent years. NICE published the guidelines, *Transition from Children's to Adults' Services for Young People Using Health or Social Care Services* in 2016. One of the underlying principles in the guidelines is that young people should start to be prepared for adult health services (termed 'transition') by the age of 14 at the latest.

As a stand-alone paediatric hospital providing highly specialised care, this principle presents a challenge for GOSH. It is not always clear at this age whether transfer to specialist adult health services, and therefore transition, will be necessary. In addition, some young people move to dedicated adolescent services located in other Trusts. They encounter similar challenges as those who move to adult services (including different environments, procedures and personnel) and consequently have similar preparation needs. This is a situation unique to GOSH and is not addressed in the NICE Guidance.

Working jointly with young people and parents we developed the Growing Up, Gaining Independence (GUGI) framework at GOSH to enable us to both find solutions to the unique challenges our young people and their families face, and to comply with the NICE guidelines as closely as possible.



Variety of transition types and timings

What is transition?

Transition is 'the purposeful, planned process of preparing young people under paediatric care and their families or carers for, and moving them to, adolescent- or adult-oriented healthcare'. GOSH, 2017, adapted from Blum et al, 1993³

What is Pals?

The Patient Advice and Liaison Service (Pals) offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and carers, and are available in all NHS hospitals.

The Growing Up Gaining Independence (GUGI) programme has been developed to:

- Make all young people and their parents/carers aware of the skills and knowledge they need to engage with adult health care services
- Support the young person to develop these skills
- Prepare those who need to continue onto specialist adolescent or adult healthcare services

³ Blum RW, Garell D, Hadgman CH et al. Transition from child-centred to adult health-care systems for adolescents with chronic conditions. A position paper of the Society for Adolescent Medicine. *J Adol Health* 1993; 14, 570-6.

What we said we'd do

In last year's Quality Report, we said that in 2018/19, we would:

- Roll out the two part GUGI programme across the Trust and embed it as standard practice
- Start those older than 16 on GUGI Part Two, which is specifically designed to support those who will soon transfer into specialist adolescent or adult care from GOSH

What we did

GUGI information folders are now available in all the clinic rooms in the Trust and on the Trust's internet. The information is also freely available on the external GOSH website⁴ and on display outside the Patient Advice and Liaison (Pals) office. Information is available in a variety of formats including Easyread[®] for young people and parents with a learning disability.

Templates for GUGI part 2 information booklets are available, which teams can adapt as necessary. We are developing further supporting information in a variety of formats (written, audio and video). An additional project is underway with the GOSH Arts programme to produce a resource to help young people with the emotional impact of moving on from GOSH.

What the data shows

A total of 21,899 (29%) of our patients were in the 12-19 age bracket in 2018/19. Not all of these patients will need to transition to specialist adult care but we recognise that the majority will need to engage with health services as adults. The numbers by each age are shown in the table below:

1. Number of patients	
Age	Number of patients
12	3,991
13	4,162
14	4,051
15	3,860
16	2,989
17	1,915
18	669
19	262
Total	21,899

Another indication of volume is outpatient appointments. The table below shows the total number of appointments by age for people aged 12 -19 years in 2018/19.

2. Number of appointments	
Age	Number of patients
12	12,228
13	12,696
14	12,129
15	11,790
16	8,942
17	5,561
18	1,519
19	550
Total	65,415

Anecdotal evidence so far suggests GUGI is making a positive difference by prompting young people and families to consider their independence preparation needs and making them aware of legal changes that occur at their 16th birthday. The launch of Epic is necessary for quantitative measures, such as number of transition plans in place two years prior to expected age of transfer.

What's going to happen next?

The Clinical Nurse Specialist for Adolescent Health will continue the improvement programme and further develop and embed the GUGI framework, support teams to adapt resources, and ensure transition is an integral and early aspect of the care we provide to our young people.

We will undertake research and audit in 2019 to assess the impact of the GUGI framework on young people's preparation for the move to specialist adult care.

We have joined with other children's hospitals, including Alder Hey, Royal Manchester, Birmingham, Leeds, and Sheffield in a nurse-led National Transition Improvement Group to share challenges and good practice, make recommendations, and seek consistency of approach nationally where possible.

GOSH is also an active member of the National Transition Collaborative. Launching in May 2019, this joint NHS Improvement and NHS England initiative was established to help organisations develop their transition practices.

How this benefits patients

- Helps promote young people's independence and helps them prepare for adulthood and for adult health services
- Provides practical advice for young people on how to prepare for clinic appointments and how to get the most out of them
- Makes families aware of health-related legal changes after the 16th birthday

"Transition was always something that really scared me. I feel very fortunate that I have been able to help in the development of *Growing Up, Gaining Independence*. I really think this will give people a much smoother transition, make them better prepared and help to alleviate some of the fear." Emma, 18

"This has really opened my eyes – I simply hadn't thought about making sure my son knew how to make an appointment for himself. And I certainly didn't know he would be signing his own consent form once he is 16!" Parent of 15 year old

"Me and mum started talking about it on the train. Next appointment I want to go in and see the Dr on my own for a bit. And we're going to look at all my clinic letters when we get home. I didn't know you got sent a letter." Ben, 13



⁴ gosh.nhs.uk/your-hospital-visit/growing-gaining-independence

Implementing a system to receive patient, parent and carer feedback in real time

At GOSH, we think it is vital to use the feedback we get from children, young people and families to continually improve our services.

What we said we'd do

We said that we would introduce new computer software to replace the Friends and Family Test (FFT) database that we developed in-house to initially implement the FFT here at GOSH. This would enable patients and families to enter feedback online, including via tablet or phone.

We wanted the new software to:

- expand the options for our patients and families in how they can enter feedback about their experiences
- enable us to act on feedback as quickly as possible, and ideally in 'real time'
- ensure tracking of any actions needed from feedback to ensure they are achieved in a timely manner
- enable central storage of all data received from the FFT (including paper cards)
- achieve streamlined reporting
- work alongside Epic
- reduce manual data input of feedback

We also wanted the software to be interactive to encourage children and young people to give feedback. None of the suppliers we reviewed met each of these requirements but one supplier was willing to work in partnership with GOSH to develop an interactive module for children and young people.

What we did

We looked at companies that produce feedback software in the UK, North America and Canada. We also asked colleagues in North America and Canada for advice in integrating feedback software with Epic. After extensive evaluation, we selected a supplier at the end of 2017 that could deliver a reliable software solution and had the willingness and capability to work with us to develop new functionality. Work commenced on configuring the software to meet our needs in January 2018. The system was launched ahead of schedule on 5 June 2018.

What the data shows

15,000

the number of feedback comments received since we went live with the new software

271%

increase in the amount of feedback received online January to February 2019

11

the average number of days to respond to and resolve a negative comment received via a feedback card

2

the average number of days to respond to and resolve a negative comment received through the online system

What is the Friends and Family Test?

The Friends and Family Test (FFT) is a national patient feedback mechanism that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. FFT asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary questions, the FFT provides a mechanism to highlight both good and poor patient experience, to inform improvement.

What's going to happen next?

Having implemented and rigorously tested the standard feedback software, we are now working with the software company and the GOSH Young People's Forum to develop an interactive surveying module. Our aim is to encourage more children and young people to tell us about their experiences at GOSH by providing an engaging and fun feedback module. This will initially be for children under eight years old, and will extend to other age groups in time.

We want our Heads of Nursing to manage the feedback for their areas of responsibility. The software allows customised dashboards for various job roles, which will give an overall impression of the feedback being received, but will also provide the facility to look deeper into specific issues. After this development, we will extend the dashboards to meet the needs of matrons and managers at all levels.

We will continue to promote the online feedback tool to give patients and families a range of feedback options. In addition to promotional materials, we are also aiming to send a link to the feedback page via a text message both in the reminder before an appointment and also afterwards.

How this benefits patients

- Families can give us their feedback at any time that suits them
- Queries submitted online can be investigated and resolved quickly
- All feedback that requires action can be easily tracked and remains 'open' until resolution
- By analysing actions taken, themes for broader improvement can be identified and prioritised more effectively
- All feedback methods (cards and online) give respondents the option to record their disability, ethnicity and gender so that additional analysis can show whether experience varies as a result of these characteristics

What is the Young People's Forum?

The Young People's Forum (YPF) is a group of young people aged 11 – 25 who are or have been patients, or siblings of patients, at GOSH. The mission of the YPF is to improve the experience of teenage patients at GOSH. The group meet formally six times a year, as well as participating in Trust projects and consultations, and meeting with the executive team and other key decision-makers.

We monitor the feedback and nominate members of staff for a GOSH Exceptional Member of Staff (GEMS) award. In March 2019, a Healthcare Assistant within our International Private Patients directorate has received a GEMS award as a result of the feedback received about her.

A family were having problems contacting GOSH regarding their daughter's appointment. Action was taken by the Dermatology team and the child had an appointment booked the same day.

"Thank you for your help. Although we were unhappy that we had to chase, we are very pleased with the outcome and quick response."
Parent of dermatology patient

A parent wanted to pass on her thanks to the Learning Disability team:

"From contacting the hospital to arrange support for our appointment to arriving on the day, I cannot praise [staff name] (who organised support) and [staff name] (who assisted on the day) enough. This service is a life saver to ourselves as parents and our son. To have someone by our side who understands and empathises with his needs is like a dream come true. We cannot thank you enough for this fabulous service."



Helpful



TECHNOLOGY

Quality priorities for 2019/20

The following table provides details of three of the quality improvement projects that the Trust will undertake in 2019/20. These priorities were determined with input from staff, patients and their families, and commissioners. This input was sought through a range of mechanisms including a survey, consultation, and use of established meetings such as our Council of Governors, Young People's Forum, and Patient and Family Engagement and Experience Committee. The new quality improvement projects are in line with our strategic priority to provide the safest, most effective and efficient care, with the best possible outcomes.

Safety

To eliminate avoidable harm.

Improvement initiative	What does this mean and why is it important?	How will progress be monitored, measured and reported?
<p>Implementing the Speak Up Programme</p>  <p>Expert</p>  <p>CARE</p>	<p>GOSH is undertaking a transformational multi-year programme of work to build and sustain an outstanding culture of safety, reliability and openness.</p> <p>The Speak Up Programme includes work undertaken with the Cognitive Institute and the Medical Protection Society UK, and involves us supporting our staff to take responsibility and be held accountable for behaviours and attitudes that create and build culture.</p> <p>The programme includes 'Speaking Up for Safety'™ and also encompasses NHS-wide work streams such as the Freedom to Speak Up Guardian and Ambassadors.</p> <p>This is a Trust-wide programme focused on developing and sustaining a healthcare culture that enhances safety, reduces risk and promotes openness.</p>	<ol style="list-style-type: none"> 1. Rate of incident reporting per 1000 bed days 2. Number of Serious Incidents reported 3. Percentage of staff who have witnessed errors, near misses or incidents that could hurt patients in the last month 4. Percentage of staff who reported the last error/near miss/incident seen that could hurt staff or patients 5. Number of staff who feel able to appropriately challenge where hand hygiene should have been performed 6. Number of grades 2, 3 and 4 pressure ulcers acquired in our hospital <p>Progress is monitored at monthly programme board. Reports are provided quarterly to Trust Board.</p>

Clinical effectiveness

To consistently deliver excellent clinical outcomes, to help children with complex health needs fulfil their potential.

Improvement initiative	What does this mean and why is it important?	How will progress be monitored, measured and reported?
<p>Reducing the number of rejected samples for laboratory testing</p>  <p>One Team</p>  <p>INFORMATION</p>	<p>70% of clinical decisions rely on laboratory test results. At GOSH, a high proportion of samples were rejected due to 'pre-analytical' reasons - from sample collection methods and labelling through to transportation to the laboratory.</p> <p>If a sample must be rejected, re-taking of the sample will often be needed. Consequences may include delay in diagnosis, treatment, and discharge, negative patient experience, and increased cost to the Trust.</p> <p>This project is supported Trust-wide by stakeholders across the hospital. A real-time QI dashboard of measures displays sample rejection data as well as a table of reasons for rejections, so that the team can identify key aspects for improvement quickly.</p>	<ol style="list-style-type: none"> 1. The number of rejected lab samples due to pre-analytical reasons 2. Percentage of blood cultures transported within 120 mins 3. Percentage of clotted anticoagulant tubes 4. Number of under-filled / insufficient samples 5. Percentage of rejected stool samples <p>Project progress is reported to and monitored at the Quality Improvement Committee.</p>

Experience

To deliver kind and compassionate care, and communicate clearly to build confidence and ease.

Improvement initiative	What does this mean and why is it important?	How will progress be monitored, measured and reported?
<p>Implementing a system to receive patient, parent and carer feedback in real time</p>  <p>Helpful</p>  <p>TECHNOLOGY</p>	<p>Patients and their families told us that they would like to have choice in how they provide feedback to the Trust.</p> <p>The online system allows families to give feedback at a time that suits them. In addition, this enables the Patient Experience Team to investigate and resolve any issues very quickly. By analysing the comments, themes for improvement can be identified and prioritised.</p> <p>Children and young people have told us that they would be encouraged to feed back if the software was more interactive.</p> <p>We will work with the system supplier and our Young People's Forum to develop the feedback software to encourage a higher percentage of online feedback from our patients.</p>	<ol style="list-style-type: none"> 1. Number of feedback items received online and in paper form 2. Ongoing monitoring of the resolution time of negative comments 3. Number of feedback items we receive from our children and young people <p>Project progress will be reported and monitored at the Patient and Family Experience and Engagement Committee and the Quality, Safety and Experience Assurance Committee.</p>

Part 2b: Statements of assurance from the Board

This section comprises the following statements:

- Review of our services
- Clinical audit
- Learning from deaths
- Participation in clinical research
- CQC registration
- Use of the CQUIN payment framework
- Data quality
- Priority clinical standards for seven-day hospital services
- Promoting safety by giving voice to concerns
- Reducing rota gaps for NHS doctors and dentists in training

Review of our services

During 2018/19, GOSH provided and/or sub-contracted 62 relevant health services. The income generated by these services reviewed in 2018/19 represents 100 per cent of the total income generated from the provision of relevant services by GOSH for 2018/19. GOSH has reviewed all the data available to us on the quality of care in our 62 services.

In order to ensure that we maintain excellent service provision, we have internal processes to check that we meet our own internal quality standards and those set nationally. These processes include scrutiny by committee. One example is our Quality, Safety and Experience Assurance Committee, where there is a focus on improvements in quality, safety and patient experience. Assurance is provided through reports on compliance, risk, audit, safeguarding, clinical ethics, and performance. Patient stories are often presented to this forum and to the Trust Board.

As a matter of routine, key measures relating to the Trust's core business are presented to the Trust Board. These include measures of quality and safety, patient and referrer experience, and patient access to services.

The Trust's performance framework enables clinical divisions to regularly review their progress, to identify improvements, and to provide the Trust Board with appropriate assurance. Our structure can respond to our improvement needs. For example, our recent NHS Staff Survey results have prompted the development of a comprehensive People Strategy and a new committee, the People and Education Assurance Committee.

James, is eleven months old and was diagnosed with Leukaemia on New Years day. He was rushed to GOSH when he was seven months old, here he is visiting Elephant Ward with Mum Faye.



Clinical Audit

Participation in national clinical audit

During 2018/19, 13 national clinical audits and clinical outcome review programmes covered the NHS services that GOSH provides. The Trust has participated in them all and data submissions are outlined below.

Name of national audit / clinical outcome review programme	Cases submitted, as a percentage of the number of registered cases required
Cardiac arrhythmia (NICOR: National Institute for Cardiovascular Outcomes Research)	162/162 (100%)
Congenital heart disease including paediatric cardiac surgery (NICOR: National Institute for Cardiovascular Outcomes Research)	610/610 (100%) for surgical procedures 515/515 (100%) for catheters 18/18 (100%) for support procedures
Diabetes (Paediatric) (National Paediatric Diabetes Association)	49/49 (100%)
Inflammatory Bowel Disease (IBD) Registry (British Society of Gastroenterology, The Royal College of Physicians, and Crohn's and Colitis UK via IBD Registry Ltd)	The IBD has 120 GOSH patients in the registry, and this is all eligible patients
Learning Disability Mortality Review Programme (LeDeR)	6/6 (100%)
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK)	17/17 (100%)
National Cardiac Arrest Audit (ICNARC: Intensive Care National Audit and Research Centre)	11/11 (100%)
Use of Fresh Frozen Plasma and Cryoprecipitate in Neonates and Children (National Comparative Audit of Blood Transfusion Programme)	21/21 (100%)
National Neurosurgical Audit Programme	Data is collected from mandatory national Hospital Episode Statistics
Seven Day Hospital Services Self-Assessment Survey (NHS England)	10/10 (100%)
Paediatric Intensive Care Audit Network (PICANet)	1896/1896 (100%)
Serious Hazards of Transfusion (SHOT) (UK National Haemovigilance Scheme)	21/21 (100%)
UK Cystic Fibrosis Registry (Cystic Fibrosis Trust)	191/191 (100%)

What is clinical audit?

'Clinical audit is a way to find out if healthcare is being provided in line with standards, and lets care providers and patients know where their service is doing well and where there could be improvements. The aim is to allow quality improvement to take place where it will be most helpful and will improve outcomes for patients.⁵

National clinical audit reports

The following national clinical audit reports with relevance to GOSH practice were published in 2018/19 from mandatory national audits:

Name of national audit/clinical outcome review programme	Relevance to GOSH practice
Congenital heart disease including paediatric cardiac surgery (NICOR: National Institute for Cardiovascular Outcomes Research)	The 30-day survival rate for paediatric cardiac surgery is a nationally accepted benchmark that is used to judge outcomes. In the three years 2014 to 2017, there were 1885 cardiac operations performed at GOSH, of which 99.2% of patients survived to 30 days. The GOSH risk-adjusted survival rates for paediatric cardiac surgery are defined as 'much higher than predicted'. More information about this can be found on the Cardiothoracic clinical outcomes page ⁶ on the Great Ormond Street Hospital website.
Diabetes (Paediatric) (National Paediatric Diabetes Association)	The 2017/2018 report focuses on measuring care for type 1 diabetes patients. GOSH does not have sufficient numbers of typical type 1 diabetes patients to allow comparison of performance. 18.7% of GOSH cases included in the audit have complex forms of Type 1 diabetes in comparison to 98.1% of standard Type 1 and Type 2 diabetes in other centres. 81.3% of GOSH cases included are rare forms of diabetes.
Inflammatory Bowel Disease Registry	No paediatric data has been published by the IBD Registry at the time of writing. GOSH's Gastroenterology service participates in <i>Improve Care Now</i> , an international collaboration between paediatric gastroenterology centres. The collaboration benchmarks improvement in quality and monitors clinical outcomes for children with inflammatory bowel disease. As part of the <i>Improve Care Now</i> initiative, GOSH has routinely collected data since 2011 and monitors specific IBD outcome measures including disease remission rates, nutrition and growth for the children we treat. More information about this can be found on the Gastroenterology clinical outcomes page ⁷ on the Great Ormond Street Hospital website.
National Cardiac Arrest Audit (NCAA) (ICNARC (Intensive Care National Audit & Research Centre).	The NCAA 2017/18 audit report was published in 2018/19 and reports the incidence and outcome of in-hospital cardiac arrest in order to inform practice and policy. The annual audit report has been reviewed by Resuscitation Services. The number of paediatric cardiac arrests nationally is approximately 250-300 per year. The interpretation of the data for GOSH is: <ul style="list-style-type: none"> • There were 24 in-hospital cardiac arrests in 2017/18. • GOSH has a higher incidence of cardiac arrests per 1000 hospital admissions (0.6 per 1000) than the four other standalone paediatric centres who participate in NCAA. This data is not risk-adjusted, so it does not take into account the severity of illness. • Overall data from NCAA since 2011 indicate that GOSH has an excellent rate of survival to discharge for patients who have had a cardiac arrest. The actions that have been completed in the last year to support best practice in management of cardiac arrests were: <ul style="list-style-type: none"> • Continued Clinical Emergency Team Simulation Training • Re-organisation of the Clinical Emergency Team to improve efficiency and further embed quality cardiopulmonary resuscitation • Increased numbers of resuscitation training places for all staff

⁵ www.england.nhs.uk/ourwork/qual-clin-lead/clinaudit/

⁶ www.gosh.nhs.uk/health-professionals/clinical-outcomes/cardiothoracic-clinical-outcomes

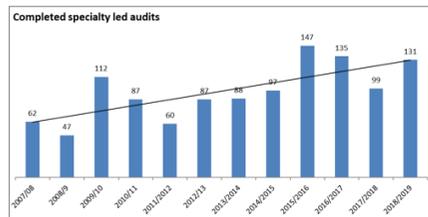
⁷ www.gosh.nhs.uk/health-professionals/clinical-outcomes/gastroenterology-clinical-outcomes

Name of national audit/clinical outcome review programme	Relevance to GOSH practice
Paediatric Intensive Care Audit Network (PICANet)	<p>The primary outcome measure used in Intensive Care Units (ICU) is the survival rate for patients, measured at the time when they are discharged. Raw survival/mortality rates may be challenging to interpret as patients that are admitted in a sicker condition are at greater risk, and therefore the outcomes need to be 'adjusted' to consider the level of severity of the patients in respect of case mix.</p> <p>The most recent PICANET report compares Trusts' Standardised Mortality Ratio⁸ for the calendar years of 2015-17. The data in this report shows GOSH mortality as well within the expected range, factoring case mix.</p> <p>More information about this can be found on the Intensive Care Unit clinical outcomes page⁹ on the Great Ormond Street Hospital website.</p>
Cancer in Children, Teens and Young Adults: On the Right Course?	<p>The Cancer in Children, Teens and Young Adults report identifies areas for improvement nationally in the care of children and young people who receive chemotherapy. A GOSH consultant is the national clinical lead for this study.</p>
Child Health Clinical Outcome Review Programme (NCEPOD)	<p>The recommendations in the report apply across care settings and care pathways. A GOSH Haematology/Oncology consultant is involved in the implementation of actions to achieve the recommendations with NHS England.</p>
UK Cystic Fibrosis Registry (Cystic Fibrosis Trust)	<p>The 2017 Cystic Fibrosis report was published in 2018/19 and includes data about individual cystic fibrosis centres, to help the centres benchmark themselves against their peers.</p> <p>The data shows that GOSH results for key clinical outcomes are within the expected range. More information about this can be found on the Cystic Fibrosis clinical outcomes page¹⁰ on the Great Ormond Street Hospital website.</p>

Specialty-led clinical audit

131 clinical audits led by clinical staff were completed at GOSH during 2018/19. To promote the sharing of information, a summary of completed projects is published on the Trust's intranet and monthly reports of clinical audit activity are shared with the Patient Safety and Outcomes Committee.

Our long term data suggests we are encouraging a culture of sharing our specialty-led clinical audit activity.



A full list of clinical audits completed in 2018/19, and their impact on quality and safety at GOSH, can be obtained on request by contacting the Clinical Audit Manager on 0207 405 9200 ext 5892 or at clinical.audit@gosh.nhs.uk.

⁸ Standardised Mortality Ratio (SMR)
 The SMR is the ratio of observed deaths in the ICU compared to the expected number of deaths based upon the PIM2r score: the SMR is calculated periodically and is used as a method of benchmarking the outcomes between ICUs nationally via PICANet.
⁹ www.gosh.nhs.uk/health-professionals/clinical-outcomes/intensive-care-unit-clinical-outcomes
¹⁰ www.gosh.nhs.uk/health-professionals/clinical-outcomes/cystic-fibrosis-clinical-outcomes

Clinical audit prize

The Clinical Audit team developed a clinical audit prize in 2018/19 to promote, value, and incentivise clinical audit in the Trust.

1	1	1
Dental and Maxillofacial Alveolar bone grafting in patients with a cleft lip and palate	Kangaroo and Leopard Ward Ventilator prescriptions	Urology Referral pathway for urodynamic requests
<p>Audit highlighted excellent clinical outcomes.</p> <p><i>"This audit has demonstrated excellent treatment outcomes as well as effective and efficient patient care. As a department, we have learnt greatly from the audit results and will continue to persevere with maintaining and improving our current standards."</i></p>	<p>Actions were taken to learn from incidents and to reduce risk. This is a nurse-led audit that resulted in clear improvements.</p> <p><i>"This has led to there being no clinical incidents surrounding ventilator prescriptions with inpatients. Nurses feel more empowered to be able to ask for a ventilator prescription if it is not present due to it being on the safety checklist. It is acknowledged amongst the medical team that every child on a ventilator must have a ventilator prescription and they have been more engaged in completing these as needed."</i></p>	<p>Clear improvements were made to benefit patient experience and safety, and this audit 'closed the loop'.</p> <p><i>"We have achieved better resource utilisation and added multiple check-points, thus improving patient service and safety."</i></p>

"This idea of acknowledging audit work throughout the Trust is brilliant and am sure will encourage more good work."
 Urology Specialist Registrar



Learning from deaths

Death in childhood is a rare event. Whenever a child dies, it is important to reflect and to learn if anything could be done differently in the future.

Background

In March 2017, the National Quality Board published *National Guidance on Learning from Deaths*, with the aim to initiate a standard approach to reviewing and learning from deaths.

The GOSH Mortality Review Group (MRG) is a multidisciplinary group of senior clinicians that conducts routine, independent structured case record reviews of all deaths that occur at GOSH. The MRG has been in place since 2012.

The purpose of the MRG is to provide a Trust-level overview of all deaths to identify themes and risks, and take action as appropriate, to shape quality improvement activities in the Trust. This process is linked with local case reviews undertaken by specialty teams and provides an additional oversight of deaths in the Trust. The MRG reviews the patient care pathway to identify whether there are modifiable factors, and identify any learning for the Trust.

Deaths in 2018 and case record reviews

2018	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Total
Number of deaths	17	20	20	29	86
Modifiable factors	1	0	3	1	5

Between 1 January 2018 and 31 December 2018, 86 children died at GOSH. All of these deaths have been subject to a case record review as part of the investigative process of the MRG.

Five (5.8%) of the reviewed patient deaths had modifiable factors at GOSH that may have contributed to vulnerability, ill health or death.

No deaths in 2018 had modifiable factors at GOSH that provided a complete and sufficient explanation for death.

- Between 1 January 2018 and 31 December 2018, 86 children died at GOSH. All of these deaths have been subject to a case record review by the MRG.
- Five (5.8%) of the reviewed patient deaths had modifiable factors at GOSH that may have contributed to vulnerability, ill health or death.
- No deaths in 2018 had modifiable factors at GOSH that provided a complete and sufficient explanation for death.

Learning from clinical case reviews

The learning points from case record reviews are shared at the Trust Patient Safety and Outcomes Committee, and at Trust Board. Modifiable factors identified outside of GOSH are shared with the Child Death Overview Panel.

Where modifiable factors or other issues are identified about GOSH care, these are fed back in an appropriate manner to the relevant clinical team and/or directorate management team for action. The feedback mechanism will be determined based on the nature of the information to be shared, but could include a specialty case review meeting, email, and/or directorate management meeting.

Some key themes have been identified, including the importance of clear communication between clinical teams, accurate documentation, and identification of the deteriorating patient in a timely manner.

These learning points have been reflected back to the clinical directorate via the Patient Safety and Outcomes Committee.

In recognition of the Trust's commitment to promoting learning lessons from child deaths, a plan to enhance and embed the organisational learning culture has been agreed as a Trust Quality Priority for 2019/20. This includes the introduction of a forum that aggregates learning from a range of sources, including Child Death Overview Panels. The forum will support timely operational action to:

- Address any immediate process/infrastructure problems
- Triage education and communication on lessons learned into the most appropriate pathways

It is anticipated that the introduction of the Epic EPR system in 2019/20 will help to improve the quality of the medical record and communication between clinicians.

A working group has been established to implement the Child Death Review Statutory Guidance, which aims to help strengthen links with referring hospitals and the Child Death Overview Panels to identify modifiable factors to help prevent future deaths.

What are modifiable factors?

Modifiable factors are defined as those factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

An influence score offers an interpretation of the extent to which a factor may have contributed to the death of the patient: 0 – Information not available 1 - No factors, or unlikely to have contributed to death 2 - Factors may have contributed to vulnerability, ill health or death 3 - Factors provide a complete and sufficient explanation for death.

What is the Child Death Overview Panel (CDOP)?

The CDOPs are statutory bodies that review the deaths of all children who die in the UK. The death is reviewed by the CDOP where the child is resident, so GOSH liaises with multiple CDOPs.



Expert



INFORMATION

Participation in clinical research

As one of the leading children's research hospitals, children are referred to GOSH from all over the world. They are often in need of treatment for the most complex and life threatening diseases. Working in partnership with the UCL Great Ormond Street Institute of Child Health, the hospital is the largest paediatric research and training centre in the UK and one of a very small number of internationally recognised centres of excellence in the field of child health.

The vision of GOSH as a research hospital is one where:

- Research is an integral part of the working lives of our staff and the patients and families we treat and see
- Research is fully integrated into every aspect of the hospital, to improve the treatment and outcomes for our patients
- We learn from every patient we see, using the knowledge gained to improve our patients' health and the health of future patients
- Staff, patients and families understand the opportunity and importance of research (research is seen to benefit and not compromise NHS clinical activity)
- We support, value and train all those involved in research, and research is considered as a core component when recruiting to leadership positions across the organisation
- We lead the way in involving patients and families in research design, delivery and strategy and continue to develop creative ways to ensure equitable involvement
- All clinical directorates and services develop and own their research agenda and are supported to do this.

Research activity

During 2018/19, we have run 1,349 research projects at GOSH/ICH. Of these, 365 were adopted onto the National Institute for Health Research Clinical Research Network¹¹ (NIHR CRN) Portfolio, a prestigious network that facilitates research delivery across the NHS. Our already extensive research activity has grown with an ever increasing focus on high intensity, experimental research since our most recent NIHR Clinical Research Facility (CRF) and Biomedical Research Centre (BRC) awards began in April 2017. These studies account for over 40% of those supported by the CRF but for 65% of the total patient hours. The intensity of care in delivering these studies in paediatrics translates into increased clinical time to deliver each study, often requiring regular overnight visits.

¹¹www.nihr.ac.uk/research-and-impact/nihr-clinical-research-network-portfolio/

Lacey is 13 years old, but she's been coming to GOSH since she was a baby. Because she was born without intestines, she's had to have many procedures to help her absorb nutrients.

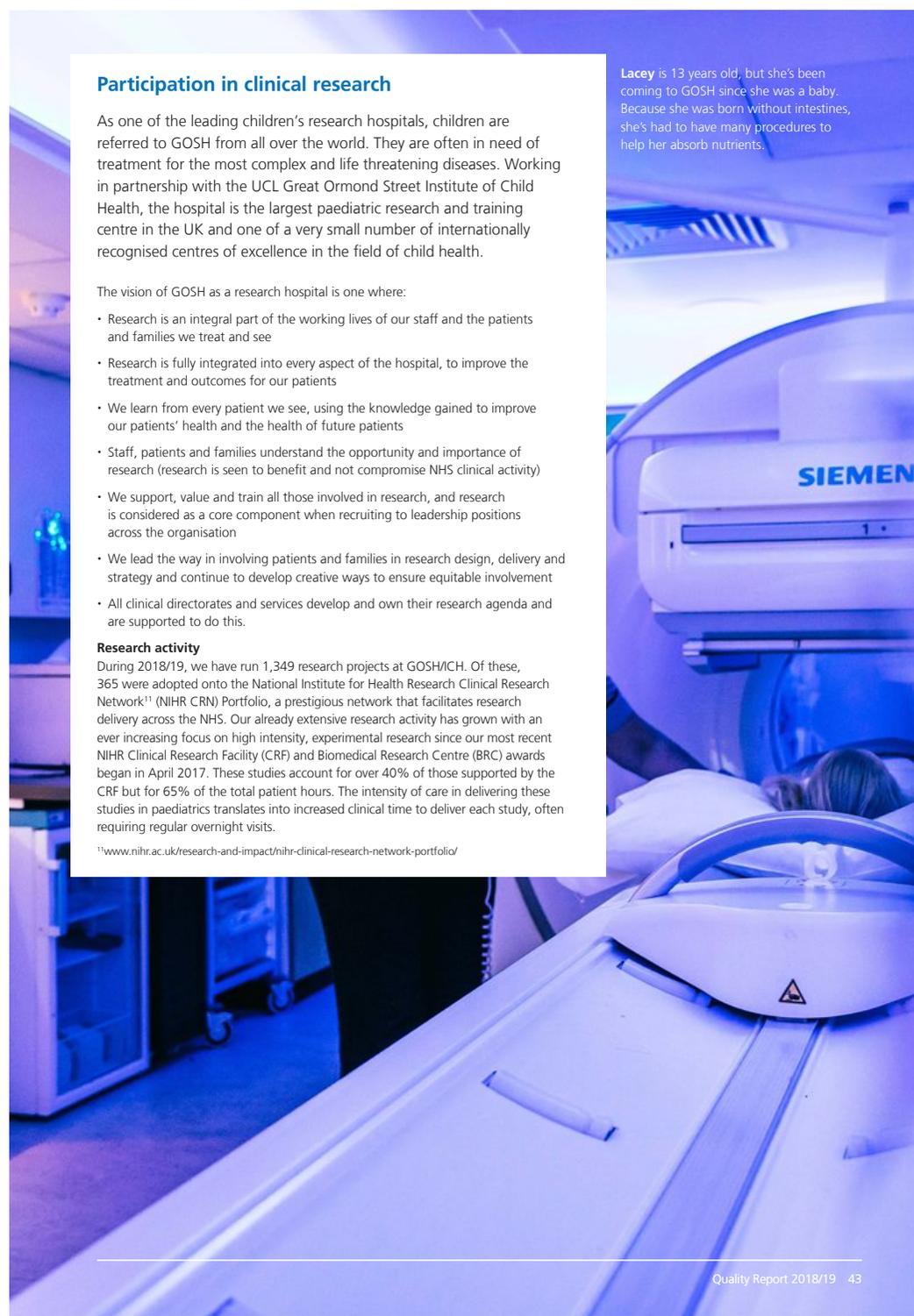
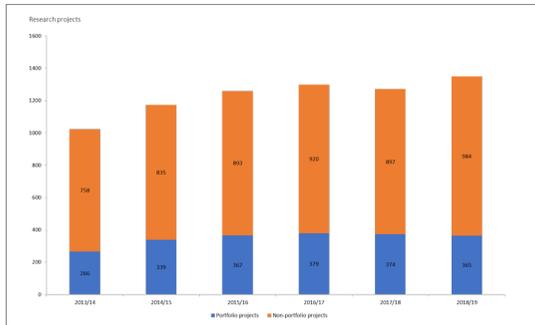
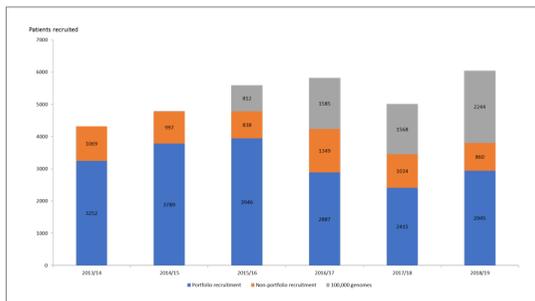


Figure 1. Number of research projects taking place at GOSH/ICH, highlighting the high quality NIHR CRN Portfolio projects



In 2018/19, over 3,800 patients and family members took part in research at GOSH, approved by the Health Research Authority, including Research Ethics Committee and Medicines and Healthcare Products Regulatory Agency approval as appropriate. In addition, GOSH leads the North Thames Genomic Medicine Centre¹² (GMC), one of 13 regional centres that are responsible for coordinating the return of results for patients that were recruited to the 100,000 Genomes Project. This pioneering project aims to better understand and treat rare conditions and cancers and this year completed its recruitment phase. Over 23,000 genomes have been collected by the North Thames GMC (23% of all genomes collected nationally) including 5,674 rare disease and 296 cancer genomes collected at GOSH (2,244 in 2018/19). Across the North Thames GMC, we have completed the scientific analysis of over 1,200 reports for patients with rare disease (and their families) and over 500 reports for patients with cancer.

Figure 2. Number of research participants recruited at GOSH/ICH, highlighting the high quality NIHR CRN Portfolio projects and those recruited to the 100,000 genomes project



The Trust is making considerable progress against its objective to obtain generic consent from patients, allowing us to use clinical data and excess tissue for research. The pilot completed its initial outpatient phase in September 2017, moving to the next phase (inpatients) in July 2018, with further areas beginning to consent in 2019. The pilot phase indicated that the principle for generic consent was generally accepted by patients and families but indicated the need for face-to-face discussion about the scheme. To assist our teams with this communication, the Trust has commissioned a short animation to explain to patients what happens to their samples, with input from both our Young Person's Advisory Group and Parent/Carer Research Advisory Group.

¹² www.ntgmc.nhs.uk/

What is a genome?

A genome is the complete set of genetic material present in a cell or organism. The study of genomes is called genomics.

Funding

This year we saw an overall 25% growth in our research income to £25 million, which supports research infrastructure and projects across the Trust. This has been in part due to a higher than anticipated growth in commercial income of 13%, through attracting an increased number and value of commercial studies to the Trust as well as extensive work to improve the effectiveness of commercial income recovery. 2018/19 was the second (out of five) year of our third funding term of the NIHR GOSH Biomedical Research Centre (BRC) and of our new NIHR Clinical Research Facility.

Innovation

The Trust has established a GOSH Innovation Hub and an intellectual property (IP) oversight group to review our IP portfolio and make strategic recommendations to the Research and Innovation (R&I) Board for support of innovation with commercial potential. The Trust has a robust IP policy that supports the Trust's objective to encourage the creation and successful commercialisation of innovation by GOSH employees, ensuring that GOSH effectively manages its IP and that revenue share arrangements to incentivise employees are transparent and well-managed. The Trust works with third party organisations with appropriate expertise, for example technology transfer offices to support its innovation activities, including commercialisation of IP.

A dedicated Business Development Manager based within the Division of R&I enables regular on-site access to our university partner and facilitates shared learning in the translational research space.

The Trust launched the Digital Research Informatics & Virtual Environment¹³ (DRIVE) in October 2018; a partnership with University College London (UCL) and leading industry experts in technology, artificial intelligence and digital innovation. The unit aims to revolutionise clinical practice and transform patient experience with new approaches to research and tailored care. This will be enhanced following the implementation of Epic, which has a specific research work stream with input from across R&I. This will allow much greater alignment across research and clinical practice, with clinical data extracted into the Trust's Digital Research Environment, linked to a high-performance analytical platform in collaboration with Aridhia.

Journal Publications

With our academic partner, we publish over 1,000 papers a year, 700 from 1 April to 31 December 2018. In the five year period between 2012 and 2016, GOSH and ICH research papers together had the second highest citation impact of comparable international paediatric organisations.

Research Highlights

1 A new, targeted treatment for a rare genetic form of rickets called X-Linked Hypophosphataemia (XLH) became available to NHS patients in January 2019, just three and a half years after the clinical trial first started. The new drug, known as burosumab, is the first to specifically target the root cause of the condition. In the trial, which recruited several GOSH patients, children experienced less pain and showed improved growth rates.

2 GOSH and ICH researchers developed a sophisticated rapid genome sequencing technique that has helped quickly diagnose GOSH patients in intensive care. Results can be returned within four days. This enables doctors to make quicker decisions about treatment pathways and provide families with a diagnosis. It also reduces the time children have to spend in hospital and delivers savings by reducing the length of stays in our intensive care units.

3 Following the success of the cell therapy research programme at GOSH and ICH, GOSH recently became one of only three UK hospitals commissioned to offer a cutting edge CAR-T cell therapy to NHS patients with acute lymphoblastic leukaemia. The first NHS patient was treated with the therapy, known as Kymriah, in January 2019.

4 GOSH researchers grew the world's first oesophagus engineered from stem cells and successfully transplanted them into mice. Within a week the engineered tissue developed its own blood supply. It is hoped this research could pave the way for clinical trials of lab-grown food pipes for children with congenital and acquired gut conditions such as oesophageal atresia.

In the five year period 2012-2016, GOSH and ICH research papers together had the second highest citation impact¹⁴ of comparable international paediatric organisations.



¹³ www.gosh.nhs.uk/news/latest-press-releases/new-unit-opening-great-ormond-street-hospital-set-revolutionise-how-technology-used-hospitals

¹⁴ GOSH citation impact = 1.997. The average citation impact is calculated from the number of citations for reviews and original papers normalised for research field and year of publication

Supporting nurses and allied health professionals in research activity

GOSH also hosts one of the few centres dedicated to supporting nurses and allied health professionals in research activity: The Centre for Outcomes and Experiences Research in Children's Health, Illness and Disability (ORCHID). Professor Faith Gibson, Director of Research – Nursing and Allied Health, leads this centre, who along with Dr Kate Oulton, Dr Debbie Sell and Associate Professor Jo Wray, provides leadership to the Research and Clinical Academic Faculties within ORCHID.

This year has been another successful year with increased research and engagement activity, awards and capacity building as our team goes from strength to strength. Two of our allied health professionals (AHPs) were awarded prestigious Clinical Doctoral Fellowships from the National Institute for Health Research (NIHR). Speech and Language Therapist Alex Stewart and Physiotherapist Emma Shkurka will start their PhD studies in the summer, bringing our total number of NIHR funded Fellowships to seven, one of the highest of any NHS Trust in the country. One of our senior team members, Dr Kate Oulton, was awarded a place on the NIHR 70@70 Research Leadership Programme, for senior nurse/midwife clinical leaders with a record of developing existing practice and contributing to a research-rich environment. Furthermore, in conjunction with the Parent Support Group (the Cleft Lip and Palate Association, Ireland) the PLAT project, co-led by Dr Debbie Sell, which empowers parents to improve their child's speech at home, received the Social Entrepreneurs Award, Ireland.

Our research collaborations are far-reaching. In conjunction with the GOSH Biomedical Research Centre, we held a Clinical Academic Careers training weekend for 35 nurses/AHPs from 10 organisations across London and are in the process of establishing a Pan-London support network. The Heart of the Matter (insidetheheart.org), a Wellcome Trust funded public engagement project, co-led by Associate Professor Jo Wray, culminated in an exhibition visited by more than 20,000 people across the country. Professor Faith Gibson leads a workstream within the NIHR funded study BRIGHTLIGHT¹³. Part of this work involved working with young people and a theatre company to co-produce a piece of performance art, 'There is a Light', performed to approximately 1600 people, with national and international coverage.

CQC registration

GOSH is required to register with the CQC and is currently registered, without conditions, as a provider of acute healthcare services. GOSH has not participated in any special reviews or investigations by the CQC in 2018/19.

In January 2018, the Trust obtained a CQC rating of 'Good' overall following an unannounced inspection of two (surgery and outpatients) out of the eight core services provided at GOSH. An additional unannounced inspection for the Well Led aspect was also conducted in the same period. The report was published in April 2018.

An action plan has been developed for 2019/20 that focuses on areas that received ratings of 'Requires Improvement'. Oversight of progress against the actions is monitored through the directorates, and assurance is provided to the Board and Council of Governors. Executive directors and operational managers have been identified to respectively hold accountability and responsibility for achieving compliance with each element of the CQC registration standards. The Trust has commenced a programme of work to ensure overall compliance that is interlinked with quality, safety and experience as part of day-to-day culture across the Trust. This will be delivered through established programmes including:

- Weekly steering groups with Deputy Chiefs of Service
- Deep-dive mock inspections (CQC Quality Rounds) in clinical directorates
- Directorate led self-assessments
- An assurance framework to provide sight of compliance performance from ward to board
- Gap analysis of information undertaken for the Routine Provider Information Return
- Reviews of potential areas/sources of learning e.g. review of themes from CQC inspection and insight reports

Read more about our work on the Well Led work in our 2018/19 Annual Report.

¹³ www.brightlightstudy.com/

What is CQC?

The Care Quality Commission (CQC) is the independent healthcare regulator for England and is responsible for inspecting services to ensure they meet fundamental standards of quality and safety.

Use of the CQUIN payment framework

A variety of CQUINs have been undertaken by the Trust in 2018/19. Some of these are national indicators, which may also be undertaken by other trusts across the country, and some were locally defined in order to improve our individual performance. Due to the specialist nature of our care, some of the national CQUINs needed to be adapted to fit with the services we provide for our patients.

CQUIN Reporting 2018/19	
CQUIN title	Overview
Anti-Microbial Resistance/Sepsis	The aim of the project is to improve the timeliness of both identification and treatment of sepsis, as well as reducing inappropriate antibiotic usage within the Trust.
Child and Adolescent Mental Health Services – Long-Term Conditions	The aim is to establish screening and provision of mental health services for specialised paediatric inpatients with a chronic and severely disabling medical condition.
Cardiac Devices	This scheme seeks to ensure that device selection for patients remains consistent with the commissioning policy, service specification, and relevant NICE guidance. It also aims to ensure that contractual requirements are in place for providers while new national procurement and supply chain arrangements are embedded.
Critical Care - Paediatric Networked Care	This scheme aligns with the national Paediatric Intensive Care Service Review. It aims to gather information that allows the demand across the whole paediatric critical care pathway to be considered.
Haemtrack	This scheme intends to improve adherence, timeliness, and accuracy of patient data submissions to the Haemtrack patient reporting system.
Medicines Optimisation	This CQUIN scheme aims to support the procedural and cultural changes required to optimise use of medicines commissioned by specialised services. A number of priority areas for implementation have been identified nationally by clinical leaders, commissioners, Trusts, the Carter Review and the National Audit Office.
Neuroscience Network	The scheme aims to support the development of the North Thames Neurosciences Paediatric Network.
Enhanced Supportive Care	This scheme aims to better integrate the work of the disease-specific Clinical Nurse Specialists and Advanced Nurse Practitioners with the Paediatric Oncology Outreach Nurses in the Palliative Care Team. The aim is to review the cancer clinical pathways and identify where it would be expected for Palliative Care to be involved.
Severe Asthma	The Severe Asthma scheme aims to ensure that assessment and investigation of children with difficult-to-control asthma is completed within twelve weeks of referral. This is so that all eligible children have appropriate and timely intervention in order to improve asthma control, reduce hospital admissions and avoid inappropriate escalation of therapy including the initiation of expensive monoclonal antibodies.
Transition Planning	The aim is to increase the number of transition plans for young people aged 13 years and above that will be used across the Trust.
Univentricular Home Monitoring	This scheme involves implementation of home monitoring programmes for children following palliative cardiac surgery for patients with a primary diagnosis of: hypoplastic left heart syndrome, functionally univentricular heart or pulmonary atresia with intact ventricular septum. Collectively, these conditions are referred to as univentricular hearts or univentricular circulations.

In 18/19 (as in 17/18), the total financial allocation for CQUINs was set at 2% of GOSH's NHS income (activity only). This equates to £4.9m for the 18/19 financial year. However, this value includes the Clinical Utilisation Review CQUIN, which the Trust declined to participate in (total value of £1.07m). The value of the individual CQUINs for the Trust ranged from £750,000 for Medicines Optimisation to £175,000 for Complex Device Optimisation. During Q1 to Q3 of the financial year, we reported high compliance against all our CQUIN indicator milestones. We expect to report approximately 98% compliance at year end. In 2017/18, our final monetary total for the CQUIN payment was £4 million.

Data quality

Good quality data is crucial to the delivery of effective and safe patient care. Data is vital to enable us to run our services efficiently as well as to identify any care quality issues and predict trends in order to take early action.

In March 2018, the Data Quality Review group signed off an updated data quality action plan, which focused on the improvement work needed during progression towards going live with the Epic system in April 2019. A monthly EPR Existing Systems, Data and Reporting Readiness Group supports data quality improvement work and planning across the programme to ensure the Trust's position is robust in moving forward with Epic.

Highlights of the work completed in 2018/19 include:

Information Services

- Information Services reporting tools to support returns and internal monitoring dashboards
- Completion of the data warehouse audit
- Data warehouse standards have been defined
- Clear implementation of soft and hard stops for incomplete data and data entered outside of expected values where poor data quality affects reporting
- Establishment of multi-dimensional and comprehensive live data quality dashboard within the EPR system to flag data quality errors that drill down to patient level across the patient journey - referral, pathways, waiting list, outpatient and inpatient activities and patient demographics

Data assurance

- All members of the Data Assurance Team are trained as EPR super users within the key modules to support the EPR go-live period
- Links to training content and standard operating procedures (SOPs) are embedded within the EPR learning home dashboard and on the intranet
- Weekly and monthly targeted data quality training for front line users based on information from the data quality dashboard
- Establishment of data assurance audit methodology signed off by the Data Quality Review Group in September 2018
- Full validation of clock start information for all tertiary referrals received by the Trust means we now report less than 3% unknown clock starts as part of our referral-to-treatment pathway (RTT) data submissions
- Re-launch of RTT training in April 2018 and delivery of data quality principles as part of the course contents. We have now trained 97% of our core users
- Data Quality Review Group commissioned patient demographics training across the Trust in August 2018 to support data migration. We have trained 156 staff (September 2018 to January 2019). Patient demographics training content is now incorporated into EPR training materials and SOPs.

We have made good progress to improve our data quality to date, and work continues within the EPR project build to ensure safeguards are in place to minimise data quality risks.

The focus for 2019/20 is to continue to support front line staff on data quality in Epic and to ensure our clinical operational teams have access to timely and reliable information that will support business processes and decision making.

What is data quality?

Data quality refers to the tools and processes that result in the creation of accurate, complete and valid data that is required to support sound decision making.

What is an NHS Number?

Everyone registered with the NHS in England and Wales has their own NHS number, a unique 10-digit number that helps healthcare staff to find a patient's health records. The NHS number increasingly helps to identify the same patient between organisations and different areas of the country.

What is the Secondary Uses Service?

Everyone registered with the NHS in England and Wales has their own NHS number, a unique 10-digit number that helps healthcare staff to find a patient's health records. The NHS number increasingly helps to identify the same patient between organisations and different areas of the country.

What is NHS Digital?

NHS Digital is the national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care.



Secondary Uses Service

As required by NHS Digital, GOSH submitted records during 2018/19 to the Secondary Uses Service (SUS) for inclusion in the national Hospital Episode Statistics. These are included in the latest published data.

The table below shows key data quality performance indicators within the records submitted to SUS.

Indicator	Patient group	Trust score	Average national score
Inclusion of patient's valid NHS number	Inpatients	92.7%	99.4%
	Outpatients	93.8%	99.5%
Inclusion of patient's valid General Practitioner Registration Code	Inpatients	99.5%	99.9%
	Outpatients	99.8%	99.8%

Notes:

- The table reflects data from January 2019 at month 10 SUS inclusion date.
- Nationally published figures include our international private patients, who are not assigned an NHS number. Therefore the published figures are consequently lower at 92.7% for inpatients and 93.8% for outpatients.
- Figures for accident and emergency care are not applicable as the Trust does not provide this service.

Information governance

The Trust is in the process of finalising its first submission against the re-launched Information Governance Toolkit, the Data Security and Protection Toolkit (DSPT). This new system will allow us to demonstrate our position against the General Data Protection Regulations (GDPR) 2018 and outline the key requirements to maintain status as a 'Trusted Organisation' with regards to sharing NHS data.

While compliant with the mandatory requirements, some areas of improvement have been identified and an action plan is underway. Actions include:

- updating and embedding the process for accessing the privacy risks of proposed new uses of personal information (Data Protection Impact Assessments)
- ensuring the Trust has an accurate and up-to-date list of all personal information it holds and a review of the arrangements and checks for sharing personal information with external suppliers

Clinical coding

GOSH has a dedicated and highly skilled clinical coding team, which continues to maintain high standards of inpatient coding. The depth of coding continues to sit above the national average due to the complexity of our patients.

GOSH carries out quarterly internal specialty audits to ensure that accuracy and quality are maintained, that national standards are adhered to, and any training needs are identified.

The recent 2018/19 audit for the Data Security & Protection Toolkit (DSPT) showed results of over 98% accuracy for primary diagnostic coding, and 95% for primary procedure coding.

GOSH was not subject to a national Payment by Results clinical coding audit during the 2018/19 reporting period.

Priority clinical standards for seven-day hospital services

The seven-day services programme is designed to ensure patients that are admitted as an emergency receive high quality consistent care, whatever day they enter hospital.

GOSH does not have an accident and emergency department and therefore our 'emergency' workload relates to non-elective patients admitted directly from other hospitals into our critical care units.

For these unplanned critical care admissions, we participate in the NHS England seven-day service audit and self-assessment framework. The audit measures whether patients admitted as an emergency are seen by a consultant within 14 hours of arrival, and whether patients are subsequently seen twice daily by a consultant. Our audit data for 2018/19 shows that we meet all required clinical standards.



Vinnie, who's two and a half, had surgery at GOSH earlier this year to remove a tumour from his brain. Since his operation, the physio team have been working with Vinnie to help him regain his balance and walk again. He loves playing with Lego and getting involved in music sessions in the playground.

Promoting safety by giving voice to concerns

Speak Up Programme

One of GOSH's key priorities is to eliminate avoidable harm to patients in our hospital. In the coming year, we are launching two new initiatives to support our work on harm-free care.

1. Speaking Up for Safety™ workshop

A focused workshop is being delivered across the organisation to equip, empower and support every one of our staff to 'Speak Up for Safety'. The objective of the workshop is to develop staff insight and skills to respectfully raise issues with colleagues when concerned about a patient's safety. In conjunction with the Medical Protection Society, we have trained and accredited 22 internal Safety Champions to support the programme and deliver the workshops to all staff across the Trust. Once complete, the workshop content will become part of Trust induction for all new staff, so the knowledge in our workforce is embedded and sustained in a culture of safety.

2. Promoting Professional Accountability™

At all times, we aim to provide a considerate and respectful environment for our staff and patients. To assist us in doing this, we will be introducing the Promoting Professional Accountability programme. Promoting Professional Accountability works hand-in-hand with the Speaking Up for Safety message. It provides a platform for staff to give feedback on colleagues who have either championed or undermined our Trust values, to ensure that great team working is recognised and difficult behaviours are discouraged.

Supporting staff to speak up

Being able to speak up about a concern in the workplace is an essential part of providing safe care for children and young people at GOSH. In line with other hospitals across the country, we have established a Guardian for the Freedom to Speak Up. This role is in conjunction with Freedom to Speak up Ambassadors, who work with the Guardian to provide support to any staff member across the hospital who wishes to raise a concern.

Support may be needed where a staff member wants to raise a concern about safety but doesn't know how, or doesn't feel comfortable to do so, or where a concern has been raised locally but the staff member feels it has not been taken seriously. The Freedom to Speak Up roles provide this additional layer of support to ensure that concerns are heard, explored, and any actions identified and acted upon.

Whistleblowing protection

Most issues raised by employees are easily resolved. However, there are times when concerns are of a more serious nature. The Trust has a policy that has recently been updated in line with national guidance, which provides a clear and easily accessible route for raising these types of concerns known as qualifying disclosures (also known as whistleblowing concerns). The policy also outlines a range of people who employees can raise concerns with even if they don't fall under the definition of a whistleblowing concern, including the Freedom to Speak Up Guardians and Speaking Up for Safety™. The overarching aim of the policy is to demonstrate the Trust's commitment to openness and accountability through:

- The provision of a safe environment to raise concerns at work
- Reassurance of employees that it's safe and acceptable to speak up
- Reassurance of employees that they can raise a concern at an early stage and with clarity about the process

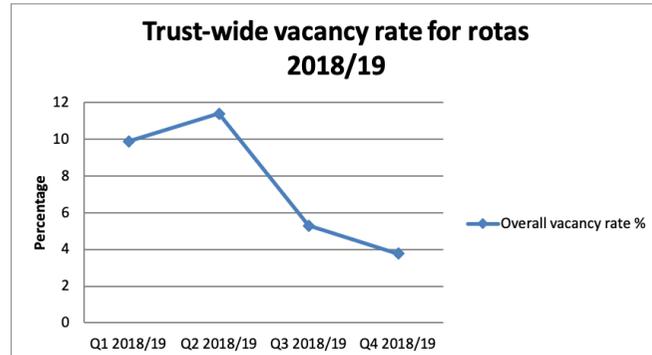


Reducing rota gaps for NHS doctors and dentists in training

Vacancy rates and rota gaps are a constant area of change within the organisation. They reflect the end point of multiple workforce issues, including short term unplanned absence, delays in recruitment process and rotational pathways, alongside a national reduction in the medical paediatric workforce.

Rota gaps have been highlighted as an organisational pressure and measures are being taken to mitigate the situation at GOSH. The Modernising Medical Workforce Group has been established through the Medical Director's Office in direct response to the issues impacting the medical workforce at local and national level. The group is designed to assist the Board and Executive Team in the recruitment, support and retention of doctors, with a focus on the sustainability of the medical workforce. The goal of the group is to problem-solve and think innovatively about the Trust-wide challenges facing the medical workforce. Rota gap pressures for our junior doctors is a particular focus.

We have become aware of the requirement for centralised 'real time' continuous data collection regarding vacancy rates that reflect rota gaps. Therefore we are currently developing a mechanism to capture this data to ensure that there is consideration to both the immediate and medium term impact of rota gaps across the organisation. In parallel to this, we are creating a clear plan for the escalation process to support doctors on rotas that have short-and medium-term vacancies. Below are 2018/19 vacancy rates, by end-of-quarter census across the organisation.



It is our experience that the impact of rota gaps is specific to each department and is dependent upon multiple factors including the number of doctors available in day-time hours, the use of advanced clinical practice roles and the overall rota establishment. Although the average organisational vacancy rate percentage is a useful metric, we currently anticipate and consider the direct impact of rota gaps upon each department, with a review of medical work flow and work schedules when necessary.



Maxwell, is three years old. He has a Berlin Heart and has been on the transplant list since 2018. He loves football (like his dad!) and playing with the little kitchen in the GOSH playroom.

Part 2c: Reporting against core indicators

Performance against Department of Health and Social Care quality indicators

NHS trusts are subject to national indicators that enable the Department of Health and Social Care and other institutions to compare and benchmark trusts. Trusts are required to report against the indicators that are relevant to them. The table below shows the indicators that GOSH reports against on a quarterly basis to our Trust Board and also externally. Where national data is available for comparison, it is included in the table.

What is the Department of Health and Social Care?

The Department of Health and Social Care (DHSC) is a department of the UK government with responsibility for government policy for England alone on health, social care and the NHS.

Indicator	From local trust data			From national sources				GOSH considers that this data is as described for the following reasons:	GOSH intends to take the following actions to improve this score, and so the quality of its services, by:
	2018	2017	2016	Most recent results for Trust	Best results nationally	Worst results nationally	National average		
Source: NHS Staff Survey Time period: 2018 calendar year									
The percentage of staff who would be happy with the standard of care provided by the organisation if a friend or relative needed treatment.	88.2%	86.1%	90.4%	88.2%	94.8%	77.5%	89.7%	The survey is carried out under the auspices of the DH, using their analytical processes. GOSH is compared with other acute specialist trusts in England.	The key actions associated with addressing staff survey findings will be incorporated into the Integrated People Strategy – with its four pillars, Capacity, Infrastructure, Skills and Culture & Engagement. The survey results indicate the need to prioritise the Culture & Engagement pillar. This workstream's purpose is to ensure all our people feel well led and managed, but also supported and empowered to do and be their best. The key components of this pillar are: Visible Leadership, Corporate Strategy & Narrative, Creating an Employee Voice, Living Our Values, Creating Transparency & Promoting Dialogue, and Integrating Support Services & Networks. These are underpinned by Training & Development and Internal Communications.
Percentage of staff who agreed that care of patients is the organisation's top priority	84.2%	82%	88%	84.2%	92.7%	76.9%	75.5%		
Percentage of staff saying they experienced at least one incident of bullying, harassment or abuse at work from managers in last 12 months	17.2%	17.1%	14.6%	17.2%	3.3%	27.2%	13.1%		
Percentage of staff saying they experienced at least one incident of bullying, harassment or abuse at work from other colleagues in last 12 months	22.1%	20.8%	18.6%	22.1%	10.3%	28.4%	18.7%		
Percentage of staff who consider the organisation acts fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age	78.8%	81.3%	84.6%	78.8%	94.3%	60.8%	83.4%		

Indicator	From local trust data			From national sources				GOSH considers that this data is as described for the following reasons:	GOSH intends to take the following actions to improve this score, and so the quality of its services, by:
	2018/19	2017/18	2016/17	Most recent results for Trust	Best results nationally	Worst results nationally	National average		
Friends and Family Test (FFT) - % of responses (inpatient)	18.9%	24.6%	23.8%	18.9%	37.3%	12.4%	24.5% (mean)	The rates are from NHS England Time period: 2018/19 financial year	We are promoting FFT at ward level, so every family is aware they can provide feedback and how. We advertise the online feedback on our weekly Feedback Friday slot on the @GreatOrmondSt Twitter feed, along with the feedback page link. Interactive feedback functions are being developed to encourage our children and young people to complete the FFT.
FFT - % of respondents who recommend the Trust (inpatient)	96.7%	97.1%	98%	96.7%	98%	93%	96.5% (mean)	Comparing: paediatric trusts*	
*Children's hospitals: Alder Hey; Birmingham; Bristol Royal; Evelina; GOSH; Leeds; Nottingham; The Alex; Royal Manchester; Southampton; The Great North									
Number of clostridium difficile (C.difficile) in patients aged two and over	6	11	1	11	1	11	4.7 (mean)	The rates are from Public Health England. Time period: 2017/18 financial year	Continuing to test stool samples for the presence of C.difficile, investigate all positive cases, implement isolation precautions and monitor appropriateness of antimicrobial use across the organisation.
Rate of C. difficile in patients aged 2 and over (number of hospital acquired infections/ 100,000 bed days)	10.3	18.8	1.79	12.6*	1.4	12.6	6.3 (mean)	Comparing: Stand-alone paediatric trusts ¹	Note: C. difficile colonisation is common in children and, while severe disease may occur at any age, it is rare. At GOSH, we test for C. difficile toxin in all diarrhoeal stool that "conforms to the shape of the pot" (minimal national standard), as well as other stool where diarrhoea, fever or blood in stool was reported; where a request is made for enteric viruses; and as part of the surveillance programme in children with congenital immunodeficiency and undergoing bone marrow transplants. On agreement with our commissioners, we investigate all positive detections and report to Public Health England those aged 2 and above with diarrhoea (or a history of diarrhoea) where no other cause is present or, if another possible cause is present, clinical opinion led to treatment as a possible case. We report on the Healthcare Acquired Infection database according to a locally agreed paediatric modification of the national definition, to enable year-on-year comparison in our specialist trust. Our approach means we find more positive samples compared with the number of cases that we report. ¹ National report used estimated bed days at time of reporting. ¹ www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data.

Indicator	From local trust data			GOSH considers that this data is as described for the following reasons:	GOSH intends to take the following actions to improve this score, and so the quality of its services, by:
	2018/19	2017/18	2016/17		
Patient safety incidents reported to the National Reporting and Learning System (NRLS):					
Number of patient safety incidents	6,751	6,345	5,429	GOSH uses electronic incident reporting to promote robust reporting and analysis of incidents. It is expected that organisations with a good safety culture will see higher rates of incident reporting year-on-year, with the severity of incidents decreasing.	Initiatives such as: Risk Action Groups, local training in root cause analysis, and "Learning from..." events and posters, improve the sharing of learning to reduce the risk of higher-graded incident recurrence. Initiatives are reported and monitored by the Patient Safety and Outcomes Committee.
Rate of patient safety incidents (number/100 admissions)	14.9	14.2	12.4		
Number and percentage of patient safety incidents resulting in severe harm or death	6 (0.1%)	12 (0.2%)	8 (0.1%)		

Explanatory note on patient safety incidents resulting in severe harm or death

It is mandatory for NHS trusts in England to report all serious patient safety incidents to the CQC as part of the CQC registration process. GOSH also reports its patient safety incidents to the NRLS, which runs a national database designed to promote learning.

There is no nationally established and regulated approach to reporting and categorising patient safety incidents. Different trusts may choose to apply different approaches and guidance to reporting, categorisation and validation of patient safety incidents. The approach taken to determine the classification of each incident, such as those 'resulting in severe harm or death', will often rely on clinical judgement. This judgement may, acceptably, differ between professionals. In addition, the classification of the impact of an incident may be subject to a lengthy investigation, which could result in the classification being changed. This complexity makes it difficult to do a formal comparison.

What is a mean?

The mean is the average of a set of numbers. It is calculated by adding up all the values and then dividing the answer by the total number.

Part 3: Other information

NHS Improvement uses a limited set of national mandated performance measures, described in its *Single Oversight Framework*, to assess the quality of governance at NHS foundation trusts.

Performance is measured on an aggregate (rather than specialty) basis and Trusts are required to meet the appropriate threshold each month. Consequently, any failure in one month is considered to be a quarterly failure. The table below sets out the relevant national performance measures used to assess the Trust's quality governance rating.

Performance against key healthcare targets 2018/19

Domain	Indicator	National threshold	GOSH performance for 2018/19 by quarter				2018/19 mean	Indicator met?
			Q1	Q2	Q3	Q4		
Effectiveness	All cancers: 31-day wait from decision to treat to first treatment**	96%	97.87%	100%	100%	100%	99.45%	Yes
Effectiveness	All cancers: 31-day wait for second or subsequent treatment, comprising:*** · surgery	94%	100%	93.33%	90.91%	100%	Indicative position: 95.65%	Yes for Q1&4. No for Q2&3
	· anti-cancer drug treatments	98%	100%	100%	100%	100%	100%	Yes
Experience	Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway***	92%	Apr: 93.62% May: 93.64% June: 92.59%	Jul: 92.76% Aug: 92.85% Sep: 92.24%	Oct: 92.19% Nov: 92.15% Dec: 92.09%	Jan: 92.59% Feb: 92.18% Mar: 92.24%	N/A**	Yes
Experience	Maximum 6-week wait for diagnostic procedures***	99%	Apr: 97.87% May: 97.45% June: 98.43%	Jul: 97.43% Aug: 94.44% Sep: 94.53%	Oct: 94.07% Nov: 96.98% Dec: 93.14%	Jan: 95.19% Feb: 97.54% Mar: 97.48%	N/A**	No
Experience	Certification against compliance with requirements regarding access to healthcare for people with a learning disability	Compliance against requirements*	Achieved	Achieved	Achieved	Achieved	Achieved	Achieved

**Target based on meeting the needs of people with a learning disability, from recommendations set out in Healthcare for All (Department of Health, 2008)
***These monthly figures are snapshots so a mean is not applicable. ***Source: NHS Digital

Additional indicators – performance against local improvement aims

In addition to the national mandated measures identified in the above tables, the Trust has implemented a range of local improvement programmes that focus on the quality priorities as described in Part 2a. The table below sets out the range of quality and safety measures that are reviewed at each Trust Board meeting. Statistical Process Control (SPC) charts are used to measure improvements in projects over time and to identify areas that require further investigation (see definition on page 19). All measures remain within expected statistical tolerance.

Domain	Indicator	GOSH performance for 2018/19 by quarter				2018/19 mean
		Q1	Q2	Q3	Q4	
Safety	Central Venous Line (CVL) related bloodstream infections (per 1,000 line days)	1.7	1.2	1.3	2.6	1.7 [†]
Effectiveness	Inpatient mortality rate (per 1,000 discharges) ^{†††}	4.74	5.00	7.62	8.95	6.49
Effectiveness	PICU discharges delayed by 8–24 hours	19	13	16	17	16
Effectiveness	PICU discharges delayed by more than 24 hours	36	25	57	56	43
Experience	Discharge summary completion time (within 24 hours)	89.24%	87.18%	80.75%	77.32%	83.30%
Effectiveness	Last minute* non-clinical hospital cancelled operations* and breaches of 28-day standard: · cancellations	112	135	155	150	137
	· breaches	13	17	21	13	16
Experience	Formal complaints investigated in line with the NHS complaints regulations**	18	30	27	20	95 (total)
Effectiveness	% of patients aged 0–15 readmitted to hospital within 28 days of discharge ^{††}	1.63%	2.72%	2.24%	1.58%	2.04%
Effectiveness	% of patients aged 16+ readmitted to hospital within 28 days of discharge ^{††}	0	0	1.53%	0	0.38%

What is NHS Improvement?

NHS Improvement is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care.

Performance against key healthcare targets 2017/18

Domain	Indicator	National threshold	GOSH performance for 2017/18 by quarter				2017/18 mean	Indicator met?
			Q1	Q2	Q3	Q4		
Effectiveness	All cancers: 31-day wait from decision to treat to first treatment**	96%	100%	100%	100%	100%	100%	Yes
Effectiveness	All cancers: 31-day wait for second or subsequent treatment, comprising:*** · surgery	94%	100%	100%	100%	100%	100%	Yes
	· anti-cancer drug treatments	98%	100%	100%	100%	100%	100%	Yes
Experience	Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway***	92%	Apr: 90.31% May: 90.36% June: 89.26%	Jul: 97.77% Aug: 90.07% Sep: 89.67%	Oct: 98.69% Nov: 90.72% Dec: 90.75%	Jan: 92.96% Feb: 93.53% Mar: 92.91%	90.91%	Yes, for Q4 but not for Q1-3. Improvement work continues.
Experience	Maximum 6-week wait for diagnostic procedures***	99%	Apr: 97.44% May: 97.49% June: 97.73%	Jul: 97.77% Aug: 97.49% Sep: 98.09%	Oct: 98.69% Nov: 99.02% Dec: 98.93%	Jan: 99.51% Feb: 98.60% Mar: 98.98%	N/A**	No
Experience	Certification against compliance with requirements regarding access to healthcare for people with a learning disability	Compliance against requirements*	Achieved	Achieved	Achieved	Achieved	Achieved	Achieved

*Target based on meeting the needs of people with a learning disability, from recommendations set out in Healthcare for All (Department of Health, 2008)

Additional indicators – performance against local improvement aims

Domain	Indicator	GOSH performance for 2017/18 by quarter				2017/18 mean
		Q1	Q2	Q3	Q4	
Safety	CVL related bloodstream infections (per 1,000 line days)	1.57	1.47	1.31	1.54	1.47
Effectiveness	Inpatient mortality rate (per 1,000 discharges) ^{†††}	8.8	5.7	6.7	4.2	6.3
Effectiveness	PICU discharges delayed by 8–24 hours	11	11	32	19	25
Effectiveness	PICU discharges delayed by more than 24 hours	11	11	43	54	48
Experience	Discharge summary completion time (within 24 hours)	87.8%	87.1%	88.1%	88.1%	87.7%
Effectiveness	Last minute* non-clinical hospital cancelled operations*** and breaches of 28 day standard: · cancellations	137	119	176	105	537 (total)
	· breaches	14	7	27	24	72 (total)
Experience	Formal complaints investigated in line with the NHS complaints regulations***	29	21	14	22	86 (total)
Effectiveness	% of patients aged 0–15 readmitted to hospital within 28 days of discharge ^{††}	1.93%	1.99%	2.23%	1.23%	1.83%
Effectiveness	% of patients aged 16+ readmitted to hospital within 28 days of discharge ^{††}	0%	0%	0.81%	1.55%	0.54%

[†] Does not include day cases ^{††} Reported to Board from October 2017 ^{†††} Source: NHS Digital ^{††††} Source: Hospital Episode Statistics

Last minute is defined as: on the day the patient was due to arrive, after the patient has arrived in hospital, or on the day of the operation or surgery.

[†]Thirteen episodes come from one child with a serious gastrointestinal issue who had recurrent bacteraemias likely to have arisen from the gut but seeded the line. Removing these unavoidable 13 episodes (and the line days) gives an annual rate of 1.4.

^{††††} Throughout the last year, the Trust continued work to improve the quality and robustness of our waiting list data, building on the work that had been completed over previous years. The principal focus for 2018/19 was maintaining compliance against the RTT standard as an organisation and focusing on specialty-level compliance. In addition, a significant focus has been placed on the build of the Epic system to ensure we are able to robustly track and manage patients who are awaiting treatment, both within Epic and by utilising Qlikview reporting to provide a patient targeting list (PTL) and booking reports for the operational teams. Throughout 2018/19, the Trust successfully delivered the 92% incomplete standard every month. This was a testament to the work completed by the clinical and operational teams. Following the completion of our audit of the Quality accounts for 2018/19, a number of data quality issues were identified related to the small sample undertaken, although the number of errors have reduced since last year's audit. While disappointing, the majority of the errors related to documentation management and late receipt / processing of referral information and thus were not material to the Trust's reported RTT position. As such it is the opinion of the Trust that this is not reflective of the quality of data used to manage elective care or that used to report against the national RTT standards. This year's audit was completed using a cross section of waits on the PTL rather than focusing on those waiting 17-18 weeks. So, the review highlighted a reduced quality of data across those pathways under 18 weeks, compared to those who have waited over 18 weeks as all of these pathways are validated as part of our RTT reporting processes which is in line with processes completed. Those pathways under 18 weeks are randomly sample audited as part of our waiting times and data assurance processes on a weekly basis. Our previous patient administration system was not capable of tracking patients against an RTT pathway, so this had to be constructed and calculated outside of the system in a data warehouse environment. While much work has been completed to compensate for this, it allowed the user to enter pathway data and an outcome code regardless of the status of the pathway. The functionality provided by Epic will go some way to mitigate this, having a positive impact on the quality of our RTT pathways. Finally, although the number of errors was higher than the organisation expected, GOSH notes the context of other Foundation Trusts and their performance against this indicator. It is clear this is a significant challenge to the wider NHS.

Annex 1:

Statements from external stakeholders

Statement from NHS England (London), Specialised Commissioning Team

NHS England would like to thank Great Ormond Street Hospital NHS Foundation Trust (GOSH) for the opportunity to review and provide a response to the 2018/19 Quality Account.

We continue to work together to address improvements in the quality of care and accessibility of services for those children whose healthcare needs are managed by GOSH.

NHS England reviews feedback from: patients and families, clinical quality review meetings and other external sources including the Care Quality Commission, Health Education England (North Central and East London), and Public Health England to inform decisions about where improvements are required. This year, the Trust itself has also undertaken to benchmark performance against some of its peers to identify opportunities for learning and improvement and we welcome this proactive reflection. Notable improvements include:

- A new system to replace the Friends and Family Test which has significantly improved the volume of responses received from service users
- Implementation of the PANDA system - designed to objectively assess the nursing dependencies and calculate safe nurse ratios for each ward area
- Improved recognition of deteriorating patients through implementation of Paediatric Early Warning System (PEWS)
- Better identification and management of children at risk of developing sepsis
- Improvements in the experience of patients requiring venous access
- The Growing Up Gaining Independence Programme, which addresses transition to adult services
- Reducing sample rejection rates in laboratories

The CQC report published in April 2018 identified two areas which require improvement; outpatients, and diagnostic imaging and surgery. NHS England will work with the Trust over the coming year to ensure that the action plans to address these priority areas are delivered. Whilst the Trust has made progress against the CQC Well-Led domain, this has been an area of significant discussion with NHS England and, it will remain as such so that the organisational changes that aim to improve the annual staff survey results are implemented.

The Trust has a busy year ahead; in addition to those mentioned above, priority areas include - assuring the stability of services following implementation of Epic, the electronic patient record which went live in April 2019; addressing any further improvements that may be identified following a scheduled review of surgery by the CQRG and, aligning processes with the new Child Death Overview Panel guidance.

Great Ormond Street Hospital is host to the newly established North Thames Paediatric Network and through the new leadership team, we are confident that this will enable stronger collaboration across Providers to improve the care of children and young people in the region.

Statement from Camden Health and Adult Social Care Scrutiny Committee

Disclaimer: The Health and Adult Social Care (HASC) Scrutiny Committee did not sit between the receipt of the draft quality report and the due date for comments. They could not therefore provide comments on the named quality report. The following statement was provided solely by the Chair of the HASC Scrutiny Committee, Cllr Alison Kelly, and they should not be understood as a response on behalf of the Committee.

Thank you for sending us your 2018/19 quality report for comment. The report is comprehensive.

The Trust is to be congratulated on the progress made in 2018/19 and for the dedication of so many GOSH colleagues who ensured that this happened.

Other Trusts have a specific section on key achievements and exciting developments during the year. Perhaps the Trust should, succinctly, celebrate its achievements a bit more loudly early on in its report.

The report has not been the easiest to comment on as it is an early draft without a contents page, without a statement of quality from the chief executive, and without the priorities and actions for 2019/20, for example.

The following observations were made in accordance with a set of core governance principles which guide the scrutiny of health and social care in Camden.

1) Putting patients at the centre of all you do

The report makes clear that 'fulfilling our potential' is the strategic focus of the Trust. 'The child first and foremost' is the pinnacle. This is excellent.

2) Focussing on a common purpose, setting objectives, planning

Pages 6-13 under the heading 'Our strategy' cover a range of important topics but it is not always immediately clear how the individual topics on these pages link to the Trust's strategic focus.

The Trust may want to consider how it initially describes its strategy to make clear that helping children and young people with the most complex needs to fulfil their potential is the absolute priority of the Trust.

The report contains six clear, patient focused priorities which were taken forward during 2018/19. The priorities are narrower and less strategic than in some other Trusts.

Action taken and progress made is detailed. As are the next steps, which is very helpful. However the Trust should give further consideration to the audience of the report as too much detail can get in the way of understanding.

Ideally the national audit and clinical outcomes review programme should be linked to priorities.

It is unclear what the priorities are for 2019/20. They may be included but are difficult to locate without a context page.

3) Working collaboratively

The Trust demonstrates that it takes seriously working with, listening to and learning from patients, their families and carers. The progress made is positive. The Trust may want to consider a more holistic approach, which encompasses cultural change, in future.

Following the disappointing 2018 staff survey result it is positive to see the steps the Trust is taking to improve clarity of leadership and reduce the gap between leaders and frontline services.

We know that GOSH takes seriously collaboratively working with Camden Council and across other local sectors to achieve the best possible outcomes and experience. Perhaps progress can be reported in the next quality account.

We also know that the Trust takes exceedingly seriously its work with national and international partners, and it is pleasing to read about the Trust's participation in clinical research. The report would benefit from reflection on any other areas where there is collaboration.

4) Acting in an open, transparent and accountable way - using inclusive language, understandable to all - in everything it does

The 2018 CQC inspection is mentioned in the section on CQC registration and in Annex 2 of the report. The inspectors rated services as outstanding - effective and caring. Many sincere congratulations indeed.

However, 'Well Led' aspects which required improvement by CQC are not covered in the report. Only future processes to be followed are covered, which are not linked to the specific issue. Below average staff ratings in the quality indicators confirm the CQC results.

Some clearer actions are covered in the final column of the core indicators table, but the lack of clarity and transparency is disappointing and concerning.

There is some excellent practice in NCL in relation to these reports. It might be worth sharing good practice in this report and also learning from others.

We would like to finish by thanking GOSH for its huge commitment to putting the child first and always. And for all the hard work by so many, including volunteers, frontline staff, clinicians, the leadership team and board members. Your dedication is inspirational and hugely appreciated.

Councillor Alison Kelly

Chair of Health and Adult Social Care Scrutiny Committee

GOSH response to statement from Camden Health and Adult Social Care Scrutiny Committee

The Trust wishes to thank Cllr Kelly for taking the time to give feedback. We are grateful for the recognition of our ongoing work to continuously improve the care we provide to our children and young people. The suggestions of improvements to the report are helpful and we have either applied these or will do so in forthcoming years. We respond below to specific topics referenced by Cllr Kelly:

Strategy

We are currently doing a piece of work to hone our strategy under the new leadership team, which includes workshops with staff and clarification of specific deliverables that map to our quality domains. Greater clarity about priorities should therefore be evident in the 2019/20 Quality Report.

Leadership and staff experience

We recognise from a range of feedback sources that staff engagement and wellbeing need to be improved. We are committed to addressing these issues and improving the experience of our staff, including their sense of being valued and supported.

The Trust is currently in the process of developing a comprehensive People Strategy, which will encompass engagement from a wide range of staff in different roles across the organisation. The strategy will aim to address cultural issues identified in the CQC report, staff survey and other staff feedback mechanisms.

The Chief Nurse and Medical Director are attending the Health and Adult Social Care Scrutiny Committee in July and will be pleased to present in more detail our progress with strategy and improving the experience of our staff. We will also report these in detail in the 2019/20 Quality Report.

Statement from Healthwatch Camden

Healthwatch Camden thanks the Trust for the opportunity to comment on your Quality Accounts. It is always good to learn more about your important work. However, we are not making a formal comment on Quality Accounts this year. This decision should not be seen as any lack of interest in or support for your work. Pressure of other work in the context of falling core income and increased complexity in the local NHS means that we do not have the human resources to consider Quality Accounts in the detail that they deserve this year. We look forward to commenting in future years.

Feedback from members of the Council of Governors

Comments from Public governor, north London and surrounding area:

An entire year has passed since I last reviewed the GOSH annual report and evidently much progress has been made. The delivery of the national Referral to Treatment target which has saved the Trust 12.3m pounds is truly commendable. Plans to save over 20m pounds the following year are also very reassuring to read, and something I trust will be followed through. The implementation of the EPR System is a great contributing factor to the technological advancement the Trust is currently experiencing. The initiatives taken by the Trust to ensure inclusivity of its staff is greatly appreciated and an area I hope progress continues to be made in. It is very heartening to read about the Trust's commitment to the quality priorities, which for this past year are significant, and the introduction of the PEWS system is noted and commended. The focus that has been placed on ordering and delivering chemotherapy more efficiently is also lauded and a priority that I hope will continue to be delivered upon.

The introduction of a paediatric VHP framework as promised is welcomed. The fear of venous access is often a major hindrance in the recovery of young patients and the Trust's emphasis on this has and will continue to improve the efficiency of treatment and patients' experience. The digital logging of relevant information on the ePSAG and Epic systems has improved efficiency and accessibility to data for all staff - a measure that supports efficient inter-departmental communication. The decrease in cannulation attempts from 1.9 attempts per child to 1.2 is a notable improvement, and a figure I'd like to see further improvement on the following year. There has been a significant decrease in the number of extravasation injury referrals from an average of 12 to 5 per month - an excellent improvement. The plans for standardisation of the new framework are also sensible - this will prove sufficiently informative when combined with the introduction of the e-learning package and training video for doctors.

Having commented on the effectiveness of the PEWS system in the previous year's report, it is reassuring to read that the Trust has followed through on its commitment to improve the early recognition of deteriorating condition, especially the early signs of sepsis. It is reassuring to read that PEWS was successfully launched and that training was well received. The accessibility of the Early Warning Dashboard to hospital, ward and patient is fundamental to increasing awareness at all levels. The increase in percentage of completed observations from 62% to 75% is heartening and a figure I anticipate will be greater in the following year, with the PEWS system in place. The Trust's work to develop a national PEWS tool is welcomed and will greatly impact the wider NHS.

The efficient administration of chemotherapy is vital to providing world class cancer care. The results of the baseline audit in October 2018 which indicate that the number of phone calls to the chemotherapy unit have decreased from 40-60 phone calls per day to 0 following the implementation of Chemotracker are truly commendable.

To conclude, the Trust has had another busy year with much success. The developments and standardisation of frameworks will continue to ensure the Trust works towards fulfilling its 'always' ethos, and it is incredibly heartening to read about the great progress made from last year particularly in technological implementation. On behalf of the governing body, I'd once again like to thank the Trust for its extensive, sustained efforts in providing outstanding care to its patients and its manifest commitment to putting the child 'first and always'.

Comments from Staff governor:

I am a new Governor in what has been an exciting time for GOSH.

2018/19 has been dominated by preparations for Epic, our new Electronic Patient Record (EPR) system. This is a massive project to build a unified IT system for all of our patient-related activity, replacing the large number of smaller systems which had previously been in place. The whole Trust has been involved, from the front line point-of-care teams, through to back office functions such as Finance.

The system will have everything in one place; where, in the past blood test reports would be on one system, with radiology reports in another, now our staff will have what they need in one place at the click of a mouse. This will improve safety (for example, reducing medication errors) and the service we provide to our families. It will also allow for efficiencies and automation, such as test results automatically being returned as a message to clinicians and filed under the patient's notes, rather than staff having to chase results.

From a Governor's perspective, I have been reassured to see the diligence and care that has gone into the preparations for the system's implementation. The team directly working on the project were a mix, with a large contingent being current staff who were seconded to the project. This meant there was a deep level of local knowledge and, crucially, strong input from our Nursing and Medical teams. Due to the vital nature of the project it is discussed at several assurance committees, as well as at Trust Board.

No implementation will be glitch free, but I am content that the Trust has done a great job in preparing for the next step in GOSH's mission to provide excellent care to its patients.

The other main issue I would identify is the work that the Trust is doing around staff engagement and the organisational culture. This year the Trust carried out a staff survey to get the views of staff. This was sent to every staff member. The results were not always what one might want to see and small pockets of inappropriate behaviour were identified.

It is sad that this has been the situation, but I am fully convinced that the Board, and especially the Chairman and Chief Executive are absolutely committed to remedy the situation and improve the working lives of staff in those areas and ensure that all of the hospital lives up to our Always Values at all times. The Council of Governors stands full square in support of this aim. A great deal of work has already gone in to improving the experience of staff, including the creation of staff forums, which you can read about on pages 12-13 of this report.

The final thing I will highlight is GOSH's focus on research and the future. The 100,000 Genomes project closed to recruitment this year. This large national research study hopes to unlock information coded into the human genetic makeup to inform management and treatment of a huge range of conditions. It will have particular impact on rare diseases, which GOSH specialises in. GOSH was the largest single recruiter of families to the project, something we can certainly be proud of.

This is in line with our aim to become a Research Hospital, where research is completely integrated with the care we provide, so that we can offer cutting-edge treatments to our patients and maximise clinical outcomes. To this end, we have opened the Digital Research and Informatics Unit (DRIVE), which brings together healthcare experts, researchers and other partners to develop exciting new devices and systems to advance the care provided to patients. This is an exciting initiative and I am sure that it will lead to many future developments.

To conclude, it has been a very busy year for the Trust, with a lot happening and a lot yet to do. We have an energised Board, showing great leadership and I think the coming year will be one where we see GOSH making excellent progress.

Annex 2: Statements of assurance

External assurance statement

Independent auditor's report to the Council of Governors of Great Ormond Street Hospital for Children NHS Foundation Trust on the *Quality Report*

We have been engaged by the council of governors of Great Ormond Street Hospital for Children NHS Foundation Trust to perform an independent assurance engagement in respect of Great Ormond Street Hospital for Children NHS Foundation Trust's *Quality Report* for the year ended 31 March 2018 (the '*Quality Report*') and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the council of governors of Great Ormond Street Hospital for Children NHS Foundation Trust as a body to assist the council of governors in reporting Great Ormond Street Hospital for Children NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the *Annual Report* for the year ended 31 March 2018, to enable the council of governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the council of governors as a body and Great Ormond Street Hospital for Children NHS Foundation Trust for our work on this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period; and
- Maximum waiting time of 31 days from urgent GP referral to first treatment for all cancers.

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the *Quality Report* in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual' issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- The *Quality Report* is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual' and supporting guidance;

- The *Quality Report* is not consistent in all material respects with the sources specified in section 2.1 of the NHS Improvement 2017/18 'Detailed guidance for external assurance on quality reports'; and
- The indicators in the *Quality Report* identified as having been the subject of limited assurance in the *Quality Report* are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports'.

We read the *Quality Report* and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the *Quality Report* and consider whether it is materially inconsistent with:

- Board minutes for the period April 2017 to 31 March 2018;
- Papers relating to quality reported to the board over the period April 2017 to 31 March 2018;
- Feedback from Commissioners, dated May 2018;
- Feedback from governors, dated May 2018;
- Feedback from local Healthwatch organisations, dated May 2018;
- Feedback from Overview and Scrutiny Committee, dated May 2018;
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2018;
- The latest national patient survey, dated August 2016;
- The latest national staff survey, dated March 2018;
- Care Quality Commission inspection report, dated 06/04/2018;
- The Head of Internal Audit's annual opinion over the Trust's control environment, dated May 2018; and
- Any other information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- Making enquiries of management;
- Testing key management controls;
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- Comparing the content requirements of the 'NHS foundation trust annual reporting manual' to the categories reported in the *Quality Report*; and reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the *Quality Report* in the context of the criteria set out in the 'NHS foundation trust annual reporting manual'.

The scope of our assurance work has not included testing of indicators other than the two selected mandated indicators, or consideration of quality governance.

Basis for Qualified Conclusion

Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period

The 'percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period' indicator requires that the NHS Foundation Trust accurately record the start and end dates of each patient's treatment pathway, in accordance with detailed requirements set out in the national guidance. This is calculated as an average based on the percentage of incomplete pathways which are incomplete at each month end, where the patient has been waiting less than the 18 week target. Our procedures included testing a risk based sample of 27 items, and so the error rates identified from that sample should not be directly extrapolated to the population as a whole.

As set out in the *Quality Report* 2016/17, the Trust identified a number of issues in prior years in respect of the referral to treatment within 18 weeks for patients on incomplete pathways indicator. The Trust has taken steps to address these issues and recommenced reporting of the indicator in the final quarter of

2016/17. Whilst progress has been made on the Trust's process for managing and reporting RTT pathways, our testing in 2017/18 has identified a number of findings.

From a sample of 27, we identified the following:

- We identified 2 samples whereby the patient should not have been included for RTT reporting as per RTT guidance, and therefore we could not be assured as to the validity of pathways included in the dataset provided for testing.
- We identified 2 samples whereby the patient was missing from several months reported data as a clock stop had been recorded in error meaning breaches had been under reported by the Trust.
- We identified 3 samples whereby pathways were recorded as active but should have been stopped. These did not impact the number of breaches reported but did mean the number of active patients was overstated.
- We identified 2 samples where the pathway was not included on the month end position due to processing. The issue relates to RTT processing whereby it assumes that if an elective patient is booked for a 'treatment procedure' and has been admitted and discharged, that the treatment has taken place and therefore the clock stops. If coding subsequently indicates the planned procedure was not carried out, the patient pathway is automatically returned to the incomplete return. For both these errors, this happened post month end.
- We identified 6 samples where there was insufficient audit trail to validate the samples.

As a result of the issues identified, we have concluded that there are errors in the calculation of the "percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period" indicator for the year ended 31 March 2018. We are unable to quantify the effect of these errors on the reported indicator. The "Performance against key healthcare targets" section on page 49 of the NHS Foundation Trust's *Quality Report* details the actions that the NHS Foundation Trust is taking to resolve the issues identified in its processes.

Qualified Conclusion

Based on the results of our procedures, except for the matters set out in the basis for qualified conclusion section of our report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- The *Quality Report* is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual';
- The *Quality Report* is not consistent in all material respects with the sources specified in NHS Improvement 2017/18 'Detailed guidance for external assurance on quality reports'; and
- The indicators in the *Quality Report* subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and supporting guidance.



Deloitte LLP
Chartered Accountants
St Albans
23 May 2018

Statement of directors' responsibilities for the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the *Quality Report*.

In preparing the *Quality Report*, directors are required to take steps to satisfy themselves that:

- The content of the *Quality Report* meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual 2018/19* and supporting guidance *Detailed Requirements for Quality Reports 2018/19*.
- The content of the *Quality Report* is not inconsistent with internal and external sources of information including:
 - board minutes and papers for the period April 2018 to May 2019
 - papers relating to Quality reported to the board over the period April 2018 to May 2019
 - feedback from commissioners dated xx/05/2019
 - feedback from governors dated 24/04/2019
 - feedback from Camden Healthwatch organisation dated 08/05/2019
 - feedback from Camden Health and Adult Social Care Scrutiny Committee dated 08/05/2019
 - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2019
 - National Paediatric Outpatient Survey 2016
 - Children and Young People's Inpatient and Day Case Survey 2016
 - the national NHS Staff Survey 2018

- the Head of Internal Audit's annual opinion of the trust's control environment dated 22/05/2019
- CQC inspection report dated 06 April 2018
- The *Quality Report* presents a balanced picture of the NHS foundation trust's performance over the period covered.
- The performance information reported in the *Quality Report* is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the *Quality Report*, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the *Quality Report* is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.
- The *Quality Report* has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the *Quality Report*.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the *Quality Report*.

By order of the board

22 May 2019

Chairman

22 May 2019

Chief Executive

Great Ormond Street Hospital for Children NHS Foundation Trust

Great Ormond Street
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Designed and produced by Great Ormond Street Hospital Marketing and Communications.

Thank you to everyone who was interviewed for, or gave permission for their picture to be used in, this report, as well as the many members of Great Ormond Street Hospital staff who helped during its production.

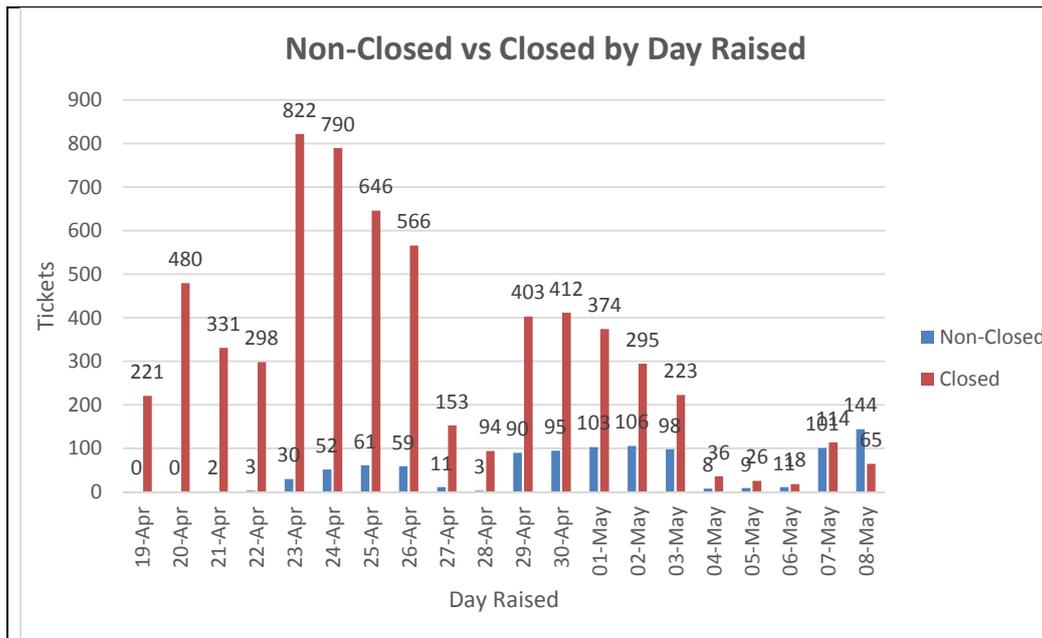
The *Annual Report and Accounts* is available to view at www.gosh.nhs.uk.

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Attachment Q

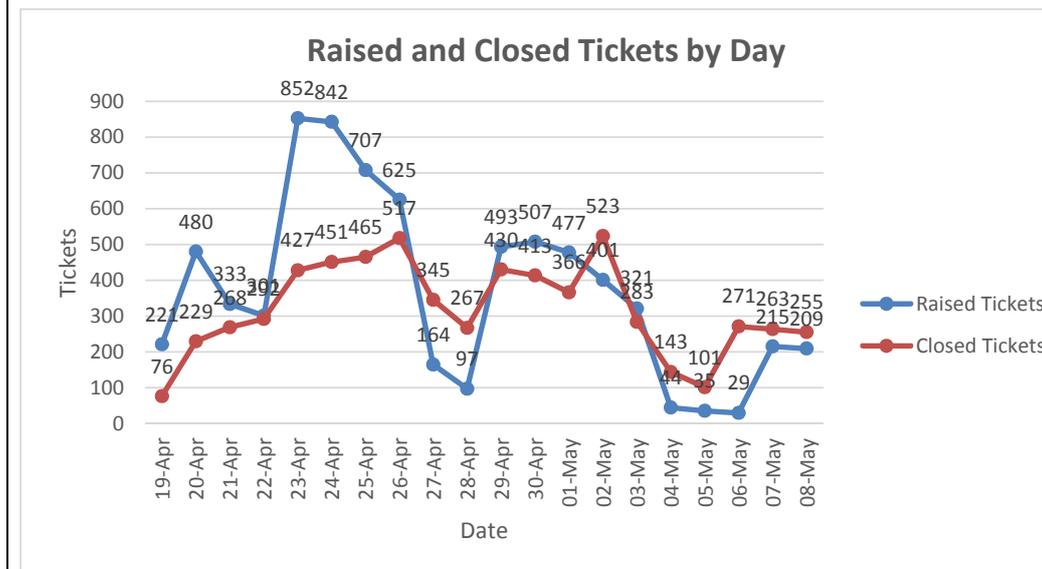
<p>Trust Board 22 May 2019</p>	
<p>EPR Programme May 2019 Update</p> <p>Submitted by: R Collins - EPR Programme Director</p>	<p>Paper No: Attachment Enc.: Epic Progress Report May 2019</p>
<p>Aims</p> <p>The aim of this paper is to provide members of the Trust Board with a summary of status of the Electronic Patient Record (EPR) Programme following go-live on 19th April.</p> <p>Summary</p> <p>The EPR Programme went live, as planned, on 19th April 2019. The Programme has remained within the budget for the first two years (the 'Implementation' phase) and continues to track to time and budget for the 'Optimisation' phase which runs to October 2020.</p> <p>There is broad agreement across the Trust (executive, leadership and staff) that the go-live has been successful. As predicted (and planned for) there have been a large number of issues raised since go-live with some key themes. There have also been a number of examples where some of the key patient and staff benefits have been evidenced; and whilst it is too early to empirically measure the impact of these, the anecdotal response suggests that the Programme has been effectively set up to start to deliver the benefits described in the EPR Full Business Case.</p> <p>Issues</p> <p>The graphs below show total number of issues raised (up until 9th May 2019) and the total number of issues closed. Whilst the total number of issues appears relatively high, the numbers are lower than was predicted by Epic, based on similar size and scope of implementations. A number of calls that were logged were requests for changes ('optimisation') and have been moved into the optimisation log.</p>	

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The above shows the status of tickets that were raised on a particular day (i.e. a total of 221 calls were raised on 19th April and all have now been closed, whereas 842 calls were logged on 24th April of which 52 remain open).

The graph below shows total number of new issues raised each day and the total number of issues resolved each day (i.e. of the 451 issues closed on 24th April, many would have been logged on previous days). It should be noted that the EPR analysts are working on additional tasks that have not necessarily been raised as issues.



Themes

The following are some of the key themes that have emerged since go-live:

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Printing

Printing (which is largely related to printer mapping) is an issue at all go-lives. Significant effort was put into testing all printings from each device in advance of go-live. However, there have still been a number of calls relating to printing not appearing where the user expects. The Programme established a team ahead of go-live to address these issues and in most cases, calls have been resolved quickly. Additionally, changes to mappings have already been requested as staff consider how the system can support different workflows.

Devices

The ICT and Programme teams deployed or updated thousands of devices ahead of go-live. There have been a number of different 'device' issues, including:

- The upgrade required for certain devices within the ICUs could only be completed at cutover and this took longer and was more complex than predicted
- Peripherals (e.g. bar code scanners / mice) being removed from one device to use with another has left some devices unable to be used until replacements are sourced
- Inability to connect to the correct network / access the Epic system (e.g. 'Rover' devices / mobile printers)
- Insufficient numbers of some devices in certain clinical areas based on new ways of working

Scanning

Scanning (wristbands, sample labels and medication barcodes) is a key element of patient safety. There has been a mix of scanning issues, which include issues with some barcodes. For a period of time immediately post go-live, there was an issue with the patient demographic barcode on the wristband not being 'read' consistently by the blood track machines which forms part of the blood administration process. Manual processes were in place to ensure there were no delays in patients receiving blood products. This issue was resolved over the initial Bank Holiday weekend and was caused by the legacy system being unable to read a GS1 compliant barcode.

Fluid Balance

Recording intake / output has changed with Epic and this has led to a number of unexpected difficulties both due to the change itself but also a need for nursing teams to take additional steps that were not required when using paper and legacy systems. The Chief Nursing Information Officer has worked with the nursing leadership to make changes to recording fluid balance which resulted in a more efficient process, although there are still some nursing teams who are more impacted than others. There is an optimisation project to link infusion pumps directly into Epic which should simplify this situation further (in addition to familiarisation).

Medications / CIVAS

The Epic system has introduced increased auditing of actions and patient safety (through closed loop medication administration). In order to configure the system to allow different nursing teams to both prescribe and administer medications in accordance with

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their scope of practice, the system cannot be locked down by role. For example, there are some medications (PGDs) where only certain nurses within the same core role should prescribe. This has required ongoing education for nursing teams. There has been clear direction provided that staff should continue to work within their scope of practice as they would have done prior to Epic.

Changes to the way some medications are prescribed in Epic led to the CIVAS service changing the % of different medications produced. This had an unintended impact on nursing teams on some wards (where they were required to manufacture medications previously provided by CIVAS). In the short term, this was mitigated by providing additional nursing staff to these areas and medium term, the CIVAS service will revert to manufacturing medications as per pre go-live.

Stock conversion from JAC to Epic has highlighted some differences in how stock is reported (e.g. packs versus single items) which are being worked through and have required additional stock checks and build fixes. Overall there have been a number of issues affecting pharmacy (both inpatient and outpatient) and the General Manager / Chief Pharmacist are working with local teams and with the EPR team to provide some additional resource and focus to stabilise this area.

Phases of care

Moving patients through a single integrated system is a difficult concept to understand and there have been a number of examples where staff working in one area (e.g. theatres / interventional radiology) cannot 'see' the patient on their pathway, or cannot see documentation completed by staff in other areas (e.g. on the wards). This is typically caused where the patient has not been moved to the correct location within the system and / or where the tools assigned to staff are specific to the area where care is being provided (e.g. nursing staff have different views / tools when working between inpatients and outpatients). There have been some wards more impacted as they treat outpatients, inpatients, day-case and ward attenders in the same location. The Programme team has resolved most of the access or workflow issues but this is an area where there is likely to be ongoing work required.

Wi-Fi

There were known issues with the Trust Wi-Fi in advance of go-live which had not been fully resolved. There have continued to be intermittent issues with consistent Wi-Fi coverage and although clear mitigation was put in place ahead of go-live, the temporary loss of service in some areas has continued to create challenges for staff as they enact the appropriate disaster recovery plans. Work is ongoing with the Wi-Fi network provider to identify the underlying causes of the issues.

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MyGOSH release of results

The MyGOSH patient portal has been well received by our patients / families (see below) but there have been some issues with the configuration of result message release which resulted in messages being sent to patients outside of the 9-5 planned time, which caused confusion to some families. In addition, some results which should not have been sent to relevant patients based on the rules agreed were released early. This led to a pause in sharing results while the system rules were reviewed and changes applied. No inappropriate results were released during this period and all clinicians and patients impacted have been contacted.

Benefits

The Trust selectively reduced some activity post go-live to ensure staff had the best opportunity to adopt and become more familiar with the system. Throughout the go-live period, the Trust has continued to deliver high class care to our patients; for example, on the day of go-live the Trust successfully operated on conjoined twins. One of the twins was the first new registration following go-live. The primary focus of the Trust leadership and EPR team over the first 4 to 6 weeks was to safely deliver go-live and respond to the issues identified by staff. However, there have been some good examples of improvements to workflows including:

- Two babies transferred from UCLH had records sent over through Care Everywhere – this demonstrates the benefit of shared patient records with other NHS organisations
- Clinical teams are already seeing data shared across teams giving a holistic summary (see below); the concept of ‘Essence’ was to give each clinical team a brief but informative overview of the current status of each child

Essence: Last Filed per Specialty			
	Value	Time	User
Cardiothoracic Transplant	Tacro level 15.2. No new changes. Level needed tomorrow am.	23/4/2019 18:41	Doxa KOTZIA, Clinical Fellow
Physiotherapy	Dry cough throughout bubble PEP. Needing encouragement++ to exercise. Physio community referral sent.	23/4/2019 15:30	Lee CARTER, PT
Nursing	Awake, playing. Settled. No complaints of pain.	23/4/2019 21:19	Hannah BURNS, RN
Social Work	Known to GOSH SW providing support during inpatient stay/will follow up in outpatient as necessary.	23/4/2019 13:37	Leah MOFFAT, SW

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- MyGOSH patient portal. Over 1,000 patients have already signed up. There has been anecdotal feedback from one parent to a member of the patient experience team who has three children under our care and who already thinks MyGOSH will revolutionise how she communicates with the hospital. Once parent wrote in a note to their care team *“Thank you for looking after our son! I hope the new computer system goes to plan. I am now logged in and it’s great so far. No hiccups this end. Thanks again for all your help.”*
- In addition 165 patients have an updated ‘fingerprint’ in Epic which is personalized to them, showing things like favourite colours, likes and dislikes etc. Fingerprint enables our staff to engage with our patients on a more personal level
- Over the two weeks post go-live we had over 150 International super users supporting our staff. Many have reported how well the staff are coping with the change and how welcoming they have been. The investment in the international super users, aligned with our own staff, has been a real success and has made a huge difference to staff as they gained familiarisation during the initial two weeks of system use
- Melanie Hiorns, the Clinical Director of IPP and a Consultant Radiologist wrote *“Single most amazing thing about EPIC..... Suddenly out of nowhere, there is a little picture of the actual patient in the corner of our reporting template in Xray - transformational and psychologically very powerful - they are a real little person looking at us and saying 'please try really hard as you report our collection of black and white pixels in your darkened room”*
- The patient safety dashboards, showing key metrics such as adherence to closed loop medications administration and allergy checking have been made available to the Nurse in Charge and we are already seeing improved compliance on a day by day basis for our key patient safety metrics
- The number of user / security issues (where staff are unable to access elements of the system that they would expect based on their role) has been low. This is largely due to focussed efforts before go-live to review and update a large number of roles. The impact has also been reduced (where staff have had problems) by placing staff around the hospital who are able to resolve access issues quickly

Epic Progress Report

The Programme improved to a score of 4.5 in the latest progress report which reflects a shared view that the go-live has been broadly successful. This equates to an average score of 4.13 for the training / go-live phase compared with 3.65 for other organisations at this stage. The report (enclosed) highlights some of the areas where the Trust has already started to see benefits and good use of the system. In addition to two issues also highlighted above, Epic has called out that the number of concurrent users being recorded by the system is greater than originally estimated. The technical teams are continuing to review this data to determine why this is the case; it is possible that it does not truly reflect concurrent use, but rather reflects the way in which the systems have been configured to enable fast access into the system for clinical users.

Attachment Q

<p>The EPR and Epic teams are currently planning for the first Epic post-live visit, where members of both teams will review use of the system 'on the shop floor' and use findings to support additional opportunities for optimisation. The team is also scheduling the upgrade plan to bring the Trust onto the latest version of Epic and continue to make use of newly developed functionality within the system. This first upgrade is likely to take place in September 2019.</p>
<p>Action required from the meeting To note the update from the EPR Programme</p>
<p>Contribution to the delivery of NHS / Trust strategies and plans The EPR Programme is an enabler to multiple strategic objectives as described in the Trust programme 'Fulfilling our potential'</p>
<p>Financial implications The EPR Programme has delivered the implementation phase within the budget agreed and is predicting to deliver the optimisation phase within budget.</p>
<p>Who needs to be told about any decision? N/A</p>
<p>Who is responsible for implementing the proposals / project and anticipated timescales Richard Collins, EPR Programme Director & Helen Vigne, EPR Programme Manager</p>
<p>Who is accountable for the implementation of the proposal / project Mat Shaw, Chief Executive Officer & EPR SRO</p>

Epic
GREAT ORMOND STREET HOSPITAL NHS FOUNDATION TRUST
EXECUTIVE SUMMARY – MAY 2019



OVERALL PROJECT STATUS Good 	OVERALL SCORE: 4.5/5.0	
	AVERAGE EPIC CUSTOMER SCORE FOR PHASE 4 ACROSS EPIC ORGANISATIONS: 3.65/5.0	GO-LIVE DATE: 19 April 2019

RECIPIENTS

To: Matthew Shaw, Andrew Taylor, Ian Chivers, Ward Priestman, Sanjiv Sharma, Alison Robertson, Helen Jameson, Shankar Sridharan, Neil Sebire, Sarah Newcombe, Peter Hyland

From: Katie Larson, Implementation Director

cc: Richard Collins, Helen Vigne, Megan Du, Alyssa Scriver

OVERVIEW

Congratulations on a successful go-live! We went live on schedule at 15:00 on 19 April with sufficient support for all users. Data migration and cutover activities completed to plan, and all teams worked hard to complete their go-live critical work ahead of the 19th. Since go-live, ticket volumes and help desk calls have remained manageable for the EPR and training teams and in the coming weeks we will continue to jointly monitor volumes to identify what ongoing volume will be considered “stable state” for the EPR team, knowing that there will always be some volume of calls and tickets.

Here are some key areas of success so far with go-live:

- As of 7 May, over 1,000 patients are signed up for MyGOSH, giving them a direct view into their schedule and the care they receive at GOSH.
- We are live and using Care Everywhere to exchange patient records with other live Epic sites. CATS specifically has commented on how useful this has been for patients seen at UCLH and CUH as it allows them a more comprehensive view of the child’s health.
- The Referral to Treatment Time (RTT) position did not materially change during the go-live period and remains at 91%. We successfully reconciled the positions on day three of go-live to validate any differences in position between PIMS, Epic, and the actual statutory return. The successful migration allows us to ensure we do not lose patients that need to receive treatment during the transition to Epic, with a robust and transparent PTL.
- GOSH is one of Epic’s early adopters on Mobile Housekeeping! Before go-live, erroneous Rapid Infection Clean requests required extensive back and forth communication among wards, the Rapid Team, and the HelpDesk. Now, Rapid Cleans are tied to clinical documentation, which has resulted in a significant reduction in cancelled requests as well as real time visibility into cleaning progress, a key patient flow indicator.
- We continue monitoring dashboards in our command meetings, leveraging real data to contextualise issues at go-live and identify potential areas of concern to follow up on.

Over the next month, we will focus on stabilising all areas of the Trust, particularly pharmacy and admin areas. We will continue to work with Information Services and the Performance team to monitor key performance indicators. Data quality will be an ongoing effort using the new dashboards and reports in the system to ensure we are meeting regulatory standards.

EPR training is now included as part of Trust induction as of 6 May and will continue in this state through BAU. We will also offer ongoing learning and up-skilling opportunities both to focus on the areas that need the most support and also on continuing to invest in the super user community that is now back embedded in the departments.

We will hold the first official post-live visit the week of 3 June in which the Epic team will be back on-site, partnering with the EPR team and clinical and operational leads to observe end users in their work, evaluate ongoing tricky workflows, and make recommendations to increase efficiency and ease of use.

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GREAT ORMOND STREET HOSPITAL NHS FOUNDATION TRUST
EXECUTIVE SUMMARY – MAY 2019

ISSUES NEEDING EXECUTIVE INTERVENTION

- There are no issues needing executive intervention this month.

ISSUES NEEDING EXECUTIVE OVERSIGHT

- **Day case areas have struggled with complicated workflows since go-live, impacting staff happiness and patient throughput.** Day case workflows are some of the most challenging in the system, and while all areas are now able to provide patient care and allow users to move through their day, there is still additional work to be done to ensure that users have a comprehensive view of all upcoming patients, users have clarity of who is at GOSH across all types of care in their areas, and that users are able to arrive and room all patients efficiently. The NIOs and EPR clinical and admin teams have sent experts out to the ward areas for observation and will continue to focus on improving workflows incrementally in the coming weeks.
- **There have been two unintended instances of results being released to MyGOSH in a way that didn't align with the approved plan.** In both instances, clinical leadership responded quickly and efficiently to contain the issue, liaise with patients and families, and notify clinical staff. The Trust remains committed to transparently sharing the approved results scope with patients directly via MyGOSH and will turn all intended scope back on after additional testing by the EPR team. Gold Command will review the results of the testing on 9 May and will determine whether to turn back on the approved scope of inpatient results release.
- **Since go-live, Cache and Citrix use at peak clinical times has reached ~1,400 concurrent users.** This is significantly higher than the estimated 700 concurrent users expected based on volumes the Trust provided during initial sizing. The Epic and GOSH technical teams continue to investigate issues that might be inflating these volumes including analysing visit volumes, monitoring time out settings, and comparing GOSH to other like-sized and other UK sites. Darren Berg, Alyssa Sriver, and Alex Nathanson will review these findings with Richard Collins, Helen Vigne, and Ward Priestman by 17 May and we will work together to determine how to mitigate any financial risks associated with higher than expected system usage.

Epic
GREAT ORMOND STREET HOSPITAL NHS FOUNDATION TRUST
EXECUTIVE SUMMARY – MAY 2019



PROJECT ASSESSMENT – AREAS OFF TRACK		
Pharmacy Stock & Financial Reporting		Medication stock and cost discrepancies are currently impacting pharmacy purchasing and dispensing workflows, as well as financial reporting (i.e. Pass Through Drugs, General Ledger). The Willow team is working closely with pharmacy to prioritise and resolve the highest impact issues affecting purchasing and dispensing workflows, with a current focus on stock lists and purchase contracts. For financial reporting, the Willow team is working with pharmacy to review medication package sizes, costs, and med record flagging for high cost drugs by 10 May. Pharmacy will then conduct an in depth review of financial reporting outputs for the month of April by 20 May.
PROJECT ASSESSMENT – APPLICATION WATCH AREAS		
Willow Inpatient		There continue to be a number of pharmacy-related workflows that the EPR and operational teams are jointly working through. The Trust leadership is actively engaged with the build team, and they are prioritising fixes together.
Cadence		Scheduling workflows remain an area of focus, particularly in more complicated areas like radiology and theatres. The team is also focused on updating and modifying clinic build to meet the needs of consultants and users across the Trust based on the new mapping in Epic. Please see the Day Admit INEO above for detail on the most complicated areas.
HIM		The Medicode integration with Epic is still slower than desired, causing delays in clinical coding. The Medicode technical team will be on-site at GOSH on 9 May to troubleshoot with the EPR HIM and interface teams in person and to make updates to their configuration to improve performance. Peter Hyland and Shankar Sridharan are also starting to focus on ways to improve the quality of clinical documentation to support patient care as well as the clinical coders' work.
Welcome		The outpatient directorate leadership team decided to deprioritise rolling out Welcome until all new kit arrived, is configured, and deployed. The old kiosks did not function as well as expected at go-live and the view is that patients and families will have a better experience with new kit. EPR and ICT will work together to confirm deployment in the month of May.

Epic
GREAT ORMOND STREET HOSPITAL NHS FOUNDATION TRUST
EXECUTIVE SUMMARY – MAY 2019



PROJECT STATUS					
INPATIENTS APPLICATION ASSESSMENTS					
	BEACON ONCOLOGY		INP-CLIN DOC		INP-ORDERS
	WILLOW OUTPATIENT		WILLOW INPATIENT		WILLOW INVENTORY
	INFECTION CONTROL		CLINICAL TRIALS		
OUTPATIENTS AND PAS APPLICATION ASSESSMENTS					
	CADENCE		OUTPATIENTS & MyGOSH		WISDOM
	GRAND CENTRAL (GC)		BONES		KALEIDOSCOPE
	HIM		CARE EVERYWHERE		PHOENIX
	WELCOME		PRELUDE		REFERRALS
	PAS				
PATHOLOGY APPLICATION ASSESSMENT					
	BEAKER ANATOMIC & CLINICAL PATHOLOGY				
THEATRES AND DIAGNOSTICS APPLICATION ASSESSMENTS					
	OPTIME & ANAESTHESIA		CUPID CARDIOLOGY		RADIANT RADIOLOGY
AREA	STATUS		AREA	STATUS	
CLINICAL CONTENT					
Order Sets			Doctor Content		
Medications			Nursing Content		
Preference Lists			AHP Content		
Haem/Onc & BMT Protocols					
PROVIDERS (SER), USERS (EMP) & SECURITY					
User Provisioning			SER		
CLINICAL AND OPERATIONAL READINESS					
CORe					
REPORTING & REGULATORY					
Statutory Submissions	First return submitted (Flu). The Financial Information Group is monitoring various data clean-up efforts to ensure we can submit DM01, RTT and CDS. Diagnostics requires a large clean-up effort, so FIG is monitoring the progress closely.		Operational KPIs	Execs and Command Meetings actively using dashboards to monitor.	

Epic
GREAT ORMOND STREET HOSPITAL NHS FOUNDATION TRUST
EXECUTIVE SUMMARY – MAY 2019



Clinical Submissions	Daily meetings with SMEs to review outputs, identifying front-end gaps and tracking submission of 56 reports in May.		
INTERFACES & DATA MIGRATION			
Functional Testing & Go Live		Clinical DM Full Scale Validation and PRD Loads	
Manual Data Migration		PAS DM Full Scale Validation and PRD Loads	
TESTING			
Integrated Testing	75 of 75 scenarios passed	Mapped Record	
Reimbursement		Usability Testing	
END USER TRAINING			
End User Training		Personalisation labs	33% of doctors have personalised both a note and ordering tool (which is an element of Good Install calculation), 74% have personalised one. Personalisation is key to help improve efficiency in clinic and inpatient settings.
Ongoing (Post-Live) Training		Specialist Train the Trainer	
GO-LIVE PLANNING			
Go-live Logistics		Super Users	
Cutover			
TECHNICAL			
Device Deployment	All devices in clinical areas have been deployed and we have now moved into BAU practice with the end point team owning new device requests and maintenance processes. New Welcome kiosks did not arrive until after go-live. Sarah Metson is working with Bill Gordon to deploy the kiosks during May.		

Attachment T

Trust Board 22nd May 2019	
Quality Priorities	Paper No: Attachment T
Submitted by: Sanjiv Sharma, Acting Medical Director	
<p>Aims / summary This document sets out 2019 Quality Priorities based on the national context and our own internal findings.</p> <p>It notes our successes in improving quality in recent years, and how we can build on that. It also recognises our areas for improvement, based on the findings of our 2018 CQC report and staff survey.</p> <p>The document identifies our vision for quality in 2019. We want to see that a just and open culture is embedded as our way of working.</p> <p>The recommended priorities are:</p> <ol style="list-style-type: none"> 1. Cultivate an environment in which we can openly discuss concerns and challenge behaviours 2. Embed a Learning Culture which supports our people to Learn and Thrive 3. Specific Quality Improvement projects to improve based on previous learning. This includes: <ul style="list-style-type: none"> • Medication Safety Project • Laboratory Sample Project • Quality and timeliness of Discharge and Clinic Letters 	
<p>Action required from the meeting Review and approve the identified priorities</p>	
<p>Contribution to the delivery of NHS / Trust strategies and plans The annual Quality Report, due to be published in June 2019 will include a public statement of 3 of our planned quality priorities, and the 2020 report will include a commentary on our progress towards the identified goals.</p>	
<p>Financial implications The identified projects will be delivered by staff already in post. Speak Up programme has a separate charity funding stream.</p>	
<p>Legal issues None</p>	
<p>Who is responsible for implementing the proposals / project and anticipated timescales If the priorities are agreed, the Head of Quality and Safety and the Head of Special Projects – Quality and Safety are responsible for developing an implementation plan for each priority identifying individual's responsible and anticipated timescales.</p>	
<p>Who is accountable for the implementation of the proposal / project Sanjiv Sharma, Acting Medical Director</p>	

Quality Priorities 2019

Attachment T

Quality Priorities 2019

Introduction and Overview

The Great Ormond Street Strategy 'Fulfilling our Potential' (2017) sets out 8 priorities. Collectively, these priorities will ensure that we help children with complex needs to fulfil their potential.

This Quality Priority strategy builds upon the first priority:

Achieve the best possible outcomes through providing the safest most effective and efficient care.

As the Hospital strategy is being refreshed in 2019, this document sets out the 2019 quality priorities and interventions to ensure that we are making progress towards our goal. This will be refreshed as part of the broader hospital strategy consultation later this year.

This document sets out the context for our quality priorities based on the national context and our own internal findings. It notes our successes in improving quality in recent years, and how we can build on that. It also recognises our areas for improvement, based on the findings of our 2018 CQC report and staff survey.

The document identifies our vision for quality in 2019. We want to see that a just and open culture is embedded as our way of working. We will work to implement a culture which recognises and reacts to the impact of behaviours, both positive and negative, on our patients and on our staff.

We commit to the following priority projects for the year to deliver this vision:

1. Cultivate an environment in which we can openly discuss concerns and challenge behaviours

This will be achieved through:

- The 'Speak Up' programme
- Developing exemplar practices to enable our staff to be open and exercise duty of candour effectively.

2. Embed a Learning Culture which supports our people to Learn and Thrive

This will be achieved through:

- The use and spread of reflective and learning practices throughout the organisation including DIARY, PRAISE and support for the Second Victim.
- A bespoke tool to enable better feedback from our children and young people on their experience so that our changes are directed to improving their experience.
- Develop a model of analysis for concerns raised by patients to drive improvement
- Triaging our 'Lessons Learned' opportunities into the most effective operational, educational and communication pathways to close the loop.
- Ensure effective implementation of Child Death Overview Panel Guidance
- Building capability and competence in the organisation

3. Specific Quality Improvement projects to improve based on previous learning

This includes:

- Medication Safety Project
- Laboratory Sample Project
- Quality and timeliness of Discharge and Clinic Letters

Quality Priorities 2019

Attachment T

Environment and context

In the wake of the catastrophic failures in care at Mid-Stafford Hospital in the late 2000s, as articulated in the findings of the Francis enquiry, the subsequent Berwick report on patient safety, A promise to learn – a commitment to act, argued persuasively that the NHS should become *'more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end'* (p 5).

The report's recommendations included the cultivation of an NHS culture in which learning and improvement are core to organisations by:

- Providing education and training to all staff (including executive teams) in quality improvement and patient safety theory and practices
- A renewed emphasis on our duty of candour and the transparent reporting of data on quality and safety
- Greater attention to the views and voices of patients and carers
- Support for improvement from leaders at all levels of an organisation

At a time of unprecedented financial challenge for the NHS, efficiency and value are also an imperative. We must deliver more with less, and find sustainable ways to do so, which do not compromise quality. The Carter review on efficiency, operational productivity and performance in English NHS acute hospitals was uncompromising in its message that the NHS must optimise its resources to remain sustainable, by reducing unwarranted variation, improving clinical outcomes and productivity, improving use of modern digital technology, and refining its real-time monitoring and reporting. This is also reflected in 'Getting it right, first time' (GIRFT) which is a national programme designed to improve the quality of care within the NHS by reducing unwarranted variations.

The NHS 10 Year Plan (January 2019) recognises the progress which has been made in the last decade in improving the quality of care and the outcomes for patients. However, it also recognises that in the next 10 years, we should be doing even better. Specifically working to reduce variation in service quality between clinical teams and different parts of the country. The plan specifically sets out improvement priorities for children and young people, including neonatal services, mental health provision for children and young people, improving support for people with learning disabilities and autism, care for children and young people with cancer, and transforming the delivery of services to ensure that the complex needs of children and young people are met effectively.

In September 2018, the Care Quality Commission (CQC) published Quality improvement in Hospital Trusts. In this document the CQC recognise that the increasing demand on health and social care system puts quality of care at risk, but their findings suggest that in hospital trusts that put a focus on continuous quality improvement have demonstrated that they can deliver high quality care. In Trusts rated as outstanding, the CQC found a culture of quality improvement embedded throughout the organisation. Informally they report that when we visit trusts that have an established QI culture, they feel different. Staff are engaged, they are focused on the quality of patient care, and they are confident in their ability to improve. This is also reflected in surveys of staff and patient satisfaction. However they recognise that embedding this culture is not easy. Rather than a quick fix, this is a challenging endeavour, changing behaviour in complex organisations and developing an effective leadership and organisational culture. It requires that all staff, but in particular senior leaders, are committed to delivering sustainable high quality care for patients, and supporting a culture that enables curiosity and humility in the context of improvement.

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In 2018 the CQC published 'Insights from a Just Culture'. This was based on the outputs from a focus group which brought together different organisations who had the highest percentage of staff that responded positively to the question "My organisation treats staff who are involved in an error, near miss or incident fairly" in the 2017 NHS Staff Survey. The report highlights that:

- 'Honesty' is not about 'good' and 'bad' people; staff need to feel 'psychologically safe' to engage in any process and their readiness to do so comes from Trust they will be treated fairly
- All Trusts present were very clear that patients and their families require support and deserve to know what happened when they were harmed
- Behaviours are easier to understand than 'culture'
- There is no such thing as a 'just culture' in isolation. It is really just 'your culture'.
- The belief was that the mutual trust build up in more everyday issues was an important basis for trust when staff were involved in an incident.

In 2019, the CQC published 'Learning from Deaths – a review of the first year of NHS Trusts implementing the national guidance. The report recognises that nationally we are at the beginning of the implementation, but that their review has shown the need for action to ensure:

- We are encouraging values and behaviours that enable engagement with families and carers as well as support for staff
- Providing clear and consistent leadership at senior level with challenge and oversight from non-executive directors
- Creating a positive, open and learning culture where people who use services, and staff, feel confident to speak out
- Providing staff with time, support and training to carry out robust review and investigations of deaths
- Develop positive working relationships with partner organisations to share information and learning following the deaths of people for whom they have provided care.

The report found that there was no one factor which guaranteed good practice, but that the existing culture of an organisation can be key factors in the approach to implementation. This echoes the findings of the CQC's report 'Opening the door to change'. While this guidance specifically applies to adults, it provides a helpful insight into the ways in which the organisation can support the effective implementation of Child Death Overview Panel statutory operational guidance issued in October 2018. The process of expertly reviewing all children's deaths is grounded in deep respect for the rights of children and their families, with the intention of preventing future child deaths.

Building on Success

Since the launch of our previous quality strategies in 2013 and 2016, we have made some great progress:

- increase in the collection, analysis and benchmarking of clinical outcomes data;
- improvements in awareness of children at risk of deterioration, patient flow, and discharge planning as a result of our electronic whiteboards
- reducing the incidence of neonatal jaundice
- increasing capacity and capability through in-house application development to support hospital and local QI projects including: patient activity tracker, chemo-tracker, clinical emergency team real time data, sepsis 6, ICU nurses induction and pressure ulcer analysis.

Following our most recent CQC inspection (January 2018), we were rated Good. The report recognised that our staff is outstanding in their commitment to providing compassionate and

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respectful care to our patients and their family. The report also recognised that we provide outstanding effective care based on national professional standards, guidelines and evidence based practice to achieve the best patient outcomes. The CQC also rated the safety and responsiveness of our care as good. They rated two of the trust's eight core services as outstanding and five as good.

Recognising our areas for improvement

The CQC report in April 2018 rated Well Led overall for the Trust as 'Requires Improvement'. The report identified:

- the impact on staff morale of multiple changes in senior and executive leadership.
- absence of a learning culture in which staff could articulate a shared understanding of key learning issues throughout the trust
- missed opportunities for positive and open engagement with stakeholders
- organisational defensiveness when challenged on performance and safety
- failure to sufficiently implement the national Freedom to Speak Up campaign
- a disconnect between leaders and frontline staff regarding morale, leadership and a vision for the workforce

Our staff survey (undertaken October 2018, results published in February 2019) outlines many areas for improvement to ensure that our staff feel safe and happy at work. The links between a content workforce and the quality of care provided are well documented. Specifically in relation to Quality of Care and Safety Culture, the staff survey tells us that there is much work to do in:

- Ensuring that staff feel able to raise concerns
- That we treat staff fairly when they do raise concerns
- That we collectively act as an organisation to respond to and learn from concerns raised by staff, and concerns raised by patients and their families.
- That we provide clear feedback to those who raise concerns on how we are learning and improving.

The survey also tells us that a significant number of our staff experience bully and harassment at work. We recognise the impact this has on the well being and morale of our workforce, and the risks this poses to the consistent delivery of high quality care.

Our vision

In order to ensure we are able to achieve the best possible outcomes through providing the safest most effective and efficient care for our patients we must listen to what our staff and our regulators are saying, and to be open and receptive to change.

This strategy sets out how we can create the best environment for our staff to deliver high quality care, by ensuring they are listened to, and empowered to make the changes required to provide the best possible care; and the best possible experience for our patients.

Our vision is to see that a just and open culture is embedded as our way of working. We will work to implement a culture which recognises and reacts to the impact of behaviours, both positive and negative, on our patients and on our staff. This culture aligns with the hospital values: Always Helpful, Always Welcoming, Always Expert and Always One Team.

Our vision means that:

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- We recognise, reward and celebrate positive behaviours, through learning from excellence as well as learning through error.
- We identify, speak up and challenge those behaviours which do not align with our values, and which pose a risk to the safety of the care we provide.
- We commit to being open and transparent with ourselves, our colleagues, our patients and our regulators

Our priorities and our interventions

In light of the above, these are our key quality priorities for 2019/20 and our planned interventions.

Our Priority: 1. Cultivate an environment in which we can openly discuss concerns

Our intervention: Speak Up

In January 2018 the Trust launched our programme with Cognitive Institute/Medical Protection Society (MPS) as the first UK partner in their Safety and Reliability Improvement Programme (SRIP). Signing up to this partnership demonstrates our commitment to achieving zero preventable harm and delivering the best possible outcomes through providing the safest, most effective and efficient care as outlined in 'Fulfilling our Potential'.

The Speak Up programme is based on the SRIP programme and is designed to meet our organisational needs by recognising existing systems and programmes (including the whistleblowing pathway and Freedom to Speak Up Guardian) and through education and training transform culture to support improvement in patient safety.

Our intervention: Exemplar practices to enable our staff to be open and exercise duty of candour

Within the NHS we all have a *Duty of Candour*. We aim to create a program that will make GOSH exemplary in their practice of candour, recognising the value of humility and curiosity in pursuit of this goal. This work will encourage open and honest dialogue internally and externally as the most effective way of enacting quality improvement.

The program will take us through a journey of raising awareness of candour, the practice of being open and honest for everyone that works in the organisation. We will then create learning and experiential opportunities for staff to build their wisdom around the concept of candour, working with our Youth Forum and parent representatives. This will all coalesce into a final step of developing experts in candour within the organisation that will enable GOSH to become a flagship site for the practice of candour, providing mentorship and support for other organisations.

Our Priority: 2. Embed a Learning Culture which supports our people to Learn and Thrive

We believe that a 'learning culture' is instrumental to the success of our organisation. We aim to maximise our potential to learn both from our successes but also our failures.

Our Intervention: Use and spread of reflective learning practices throughout the organisation

- We aim to support the application of tools such as DIARY, 'After Action Review' to enhance the quality of our reflective practices.
- We will spread and promote the use of tools like PRAISE that name and reward individuals

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and clinical and non-clinical teams that adopt, model and promote our collective endurance to exemplary safety and care. This will be partnered with a clear system for supporting both the patient and the 'second victim' following harm and complaints.

- We will encourage and support departments in their learning from Mortality and Morbidity through effective implementation of the Child Death Overview Panel statutory guidance
- We will increase the volume of the voice of our patients in patient feedback pathways through introducing an innovative bespoke electronic patient feedback tool for our Children and Young People.
- We will implement a model of analysis for the concerns raised by patients and their families which enables us to more effectively identify issues, react and respond.
- We will develop a model for triaging learning opportunities and 'closing the loop' in the organisation, based on the expertise of our clinical staff, Quality and Safety team, Patient Experience team, our Education and Training professionals and our Communications team. This will ensure that our opportunities for learning are directed consistently through most effective education and communication channels.
- We will build capacity and capability through an intended collaboration between the Quality & Safety Team, Patient Experience Team and the Education and Training Team to reflect and learn from our errors and successes; to build robust safety and risk management processes; and to be able to collectively lead on plans to recover and improve. We aim to design inclusive, multi-professional education and training opportunities delivered by a variety of learning platforms.

Our Priority: Specific Quality Improvement projects based on previous learning

Intervention: Medication Safety

The Trust will scope, develop and implement a focussed and methodical approach to medication safety. This is in response to the thematic quality concerns identified at a Trust wide level, which require a systemic and resourced response. The Quality and Safety Team will work alongside our colleagues in the Programme Management Office to deliver a programme of works, using the IHI Model for improvement methodology when appropriate, to ensure that the right medication is given to the right patient at the right time.

Identified Key work-streams include:

- The management of Controlled Drugs (CDs) which include dispensing, storage, documentation and destruction.
- The management of Total Parental Nutrition (TPN) which include prescribing, dispensing and administration.

This project will be supported by the Quality Improvement Team.

Our intervention: Laboratory Samples Project

In 2017, the Camelia Botnar laboratories at Great Ormond Street Hospital received more than 400,000 samples and performed more than 1 million tests. In the same year, approximately 4900 patient samples were rejected due to pre-analytical errors. The most commonly reported types of errors include; missing or incorrect patient ID, insufficient or clotted samples, incorrect sample types, contamination from infusion route and delayed delivery.

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Sample rejection can not only cause delayed diagnosis, treatment, and in some cases discharge of patients, but also wastes staff time and resources. A rejected sample means that the patient is subjected to another sample collection procedure (e.g. venepuncture). Feedback from patients and families demonstrates the significant negative impact that this can have on their experience. It was agreed that a strategic, Trust-wide approach is needed to reduce the number of pre-analytical sample rejections and improve patient experience.

The project is being supported by the Quality Improvement team.

Our Intervention: High Quality & Responsive Discharge Letters and Clinic Letters

In 2019 the organisation is implementing EPIC which will transform the organisation's management of the patient's electronic medical record. This change will also impact the way in which we prepare and send discharge letters and clinic letters. The hospital is committed to ensuring that these documents are of high quality and sent in a timely way to support the journey of our patients outside the organisation. A project to monitor and support the change will be developed and implemented in line with the EPIC implementation.

How will we know it's working?

Robust systems of clinical and corporate governance including risk management are crucial in underpinning the organisational approach to quality improvement.

Each of these projects will be structured in line with the appropriate governance structures within the organisation, to ensure that there is appropriate oversight of progress through the year.

We will commit to these Quality Priorities in our annual public Quality Report and report on our progress with them publicly next year.

Our partners and collaborators in improving Quality

We recognise the need to work collaboratively with partners to ensure the greatest possible opportunities for quality improvement. Our partners and collaborators for Quality Improvement include:

Quality Improvement Networks

The Quality Improvement team attend quarterly NHS Improvement 'Improvement Director Network' meetings. This meeting links us with all of the other main hospitals who are actively engaging in Quality Improvement using not only Model for Improvement, but an array of other QI tools and methodologies.

Paediatric Early Warning Score

The Trust is working with the National Patient Safety Collaborative (PSC) programme, on the National PEWS project. The program has set up 4 work streams, and we are inputting to 2 /3 or them, with the aim of influencing the development of one National PEWS.

The Safety Collaborative is the largest and most comprehensive programme of its type in the world, bringing together people with a passion and commitment to improve patient safety across England. It is funded and co-ordinated centrally by NHS Improvement, and organised and delivered locally by the 15 Academic Health Science Networks (AHSNs). The 15 regional

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collaboratives work with networks of NHS staff, patients, national and local partners, academics, businesses and voluntary organisations to implement patient safety initiatives.

The European Children's Hospital Organisation (ECHO)

This is a collaborative of leading paediatric hospitals across Europe, which aims to support improvement in quality of care, collaboration in research and innovation, and influence policy through advocacy. GOSH is a founder member and co-chairs the working group of the Quality, Safety, Outcomes and Value work stream, where the focus is currently benchmarking and the fostering of ERN (European Research Networks) links.

The Children's Alliance

The Alliance involves ten paediatric hospitals in the UK, initially to work together for better tariffs but in recent years to also collaborate on models and care and benchmarking. GOSH is leading on establishing with NHS commissioners the pilot access of the 10 hospitals to each other's Specialised Services Quality Dashboard reports, and has project managed the agreement of this between hospitals and the negotiations with NHSE.

Trust Board 22 May 2019	
Risk Management Strategy and Policy	Paper No: Attachment U
Submitted by: Sanjiv Sharma, Medical Director	
Aims / summary The Risk Management Strategy and Policy has been reviewed and updated to reflect the new organisational structures, to clarify reporting lines for risk review within the organisation and to clarify the roles of standing committees within the organisation. Key changes include: <ul style="list-style-type: none"> • Updated Risk Appetite Statements (as agreed at Trust Board in December 2018) • Clarification of the High Risk Escalation pathway through Operational Board and Risk Assurance and Compliance Group (RACG) to ensure that the BAF review is appropriately informed. • Inclusion of need for significant risks and thematic risks to be reviewed periodically at the RACG • Refreshed risk management committee structure. 	
Action required from the meeting Review and approve	
Contribution to the delivery of NHS Foundation Trust strategies and plans To ensure that all risks within the organisation are identified, assessed, managed and monitored effectively. To ensure that there is a clear pathway for risk escalation within the organisation including executive and non-executive scrutiny and oversight. To ensure there is a risk based approach to decision making within the organisation.	
Financial implications There may be financial implications associated with the mitigation and management of risks within the organisation.	
Who needs to be told about any decision? Medical Director Head of Quality and Safety Company Secretary	
Who is responsible for implementing the proposals / project and anticipated timescales? Head of Quality and Safety & Corporate Secretary	
Who is accountable for the implementation of the proposal / project? Medical Director	

PLEASE NOTE: Printed copies of this policy may not be the current version.

Risk Management Strategy & Policy

Key Points	
This strategy sets out the strategic direction for Great Ormond Street Hospital to systematically manage its risks and underpins the commitment by the Trust Board to ensuring a robust risk management system is in place. This extends across the organisation from the front-line service through to the Board to promote the reduction of clinical and non-clinical risks associated with healthcare and research and to ensure the business continuity of the Trust.	
Lead Author:	Head of Quality and Safety
Executive Lead:	Medical Director
Date Approved by Policy Approval Group:	<i>TBC</i>
Policy Category:	Clinical Management
Review Date:	<i>April 2020</i>
Target Audience:	All Great Ormond Street Hospital staff regardless of location. This includes Partnership and satellite sites where appropriate.

Document Control	
Previous Version Information:	
Previous Title:	Risk Management Strategy
Previous Approval Date:	01/04/2016
Relevant to CQC requirements:	Yes
Relevant to Information Governance Toolkit:	Yes
Other External Assessments	Yes: MHRA, HTA, Emergency Planning
Consultation:	
Individual(s) Consulted:	Chief Operating Officer, Head of Quality and Patient Safety, Corporate Secretary, Outcomes Lead, Patient Safety Lead
Department(s) Consulted:	Quality and Safety
Committee / Group(s) Consulted:	<i>Trust Board</i> Risk, Assurance and Compliance Group

RISK MANAGEMENT STRATEGY 2019

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	Executive Management Team Operational Board Policy Approval Group
Amendments Made:	Feb-April 2019 - Updated to include the approved risk appetite statement and to reflect staff and organisational structure changes.
Keywords:	Risk Management, Risk Assessment, Risk Appetite, Board Assurance Framework, BAF, Assurance, Risk Register
Related Trust Documents:	
<ul style="list-style-type: none"> • Health and Safety Policy • Incident Reporting and Management Policy • Complaints Policy • Assurance Framework and Operational Policy • Being Open and the Duty of Candour Policy • Freedom to Speak Up: Raising Concerns in the Workplace Policy <p>Note: This list is not exhaustive</p>	

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1. Introduction

The Trust strategy: *Fulfilling our potential* identifies the vision for the Trust and the key 8 priorities:



Those priorities are:

- We will achieve the best possible outcomes through providing the safest, most effective and efficient care
- We will attract and retain the right people and through creating a culture that enables us to learn and thrive
- We will improve children's lives through research and innovation
- We will transform care and the way we provide it through harnessing technology
- We will use our voice as a trusted partner to influence and improve care
- We will create inspiring spaces with state-of-the-art equipment to enhance care delivery and learning
- We will provide timely, reliable and transparent information to underpin care and research
- We will secure and diversify funding so we can treat all the children that need our care

The Trust is committed to achieving the best possible outcomes through providing the safest, most effective care and to create a culture that enables us to learn and thrive. The Risk Management Strategy identifies how the risks and hazards which may prevent this occurring are identified, assessed, prioritised, and controlled to support the safe development of clinical care and maintaining continuity of service delivery.

2. Scope

This strategy sets out the framework for Great Ormond Street Hospital to systematically manage its risks and underpins the commitment by the Trust Board to ensuring a robust risk management system is in place. This extends across the organisation from the front-line service through to the Board to promote the reduction of clinical and non-clinical risks associated with healthcare and research and to ensure the business continuity of the Trust.

It identifies the organisational risk management structure, the roles and responsibilities of committees and groups that have some responsibility for risk and the duties and authority of key individuals and managers with regard to risk management activities. It describes the process to provide assurance for the Trust Board review of the strategic organisational risks and the local structures to manage risk in support of this policy.

The Risk Management Strategy is integrated into the management, performance monitoring and assurance systems of the Trust to ensure that safety and improvement is embedded in all elements of the Trust's work, partnerships and collaborations and existing service developments. This enables early identification of factors whether internally or externally driven, which may prevent the Trust from achieving its strategic objectives of ensuring care is provided in a cost effective way without compromising safety. It provides the framework in which risk can be managed, reduced and monitored regardless of source and the process to be followed where gaps in risk management processes are identified. It assists the Trust Board to identify the scope of the Trust risk appetite (see Appendix 1).

The Trust is committed to this positive approach to the consistent management of risk, where managing for safety, in a culture that is open and fair, supports learning, innovation and good practice for the benefit of the child or young person.

Staff list - add

3. Aims and Objectives

The Risk Management Strategy identifies:

- reporting systems for the management of risk,
- duties, scope, responsibility, accountability and authority of individuals, teams, departments, committees and subgroups,
- requirements for local management of risk to reflect this policy and the link into existing committee structures, performance monitoring and assurance processes,
- the management tools which enable the Trust to assess its risks systematically at strategic and operational levels, document the outcome of risk assessment and improve transparency of decision making,
- the process to ensure consideration of risks and options of managing them is integrated into the wider management and operational processes of the Trust,

- the process to ensure regular review, monitoring of required actions to mitigate risks and obtaining assurance on mitigation,
- the process for monitoring compliance with this policy at strategic and local level and to remedy any deficiencies identified,
- the process to disseminate the policy and share lessons learned

This strategy does not consider the detailed management of financial risk as this is subject to statutory control systems documented elsewhere¹, but does recognise that poor management of risk whether clinical, non-clinical or financial can have an impact on the Trust's ability to meet its strategic and financial objectives.

The Risk Management Strategy drives the risk management process but this is underpinned by other operational policies and procedures.

4. Duties and Responsibilities

The following gives the duties, roles and responsibilities for risk management activity in the Trust at individual, directorate/ department and team level. Due to the variable nature of risk, this is not exhaustive and may change depending on the type of risk identified and the action required to mitigate it. Where authority is devolved, the extent of this authority is identified with the member of staff or in the relevant job description. Assessment of risks (Appendix 2) assists in identifying how a risk will be managed and the level of management responsibility required.

All members of staff are responsible for adhering to the processes and policies set out in the organisation for their safety. Members of staff are required to report incidents when they occur and work together with colleagues to mitigate their effect. If in doubt, advice can be sought from the Patient Safety team.

All managers have authority to reduce risk within their areas of responsibility whether clinical, non-clinical or financial and are responsible for ensuring safe systems are in place.

4.1 Executives

All Directors, Executive and Non-Executive, have joint responsibility as a unitary board for the strategy and performance of the Trust.

Chief Executive

The Chief Executive is accountable to the Trust Board for ensuring that they receive the appropriate level of information to enable them to be assured that systems of internal control to manage risks are in place.

The overall and final responsibility for all risk and quality management rests with the Chief Executive, who is accountable for providing the Trust with the necessary organisational structure and resources to implement policy and manage risks effectively. The Chief Executive Officer delegates that responsibility through his executive team according to their portfolio.

¹ Standing Financial Instructions and Scheme of Delegation

As the Chair of Executive Management Team (EMT) and the Risk Assurance and Compliance Group (RACG), the CEO is aware of all key decisions made within the Trust and will act to ensure that risks are actively identified, and are subject to appropriate risk management processes when strategic, operational or financial decisions are made.

Non-Executive Directors

Assurance subcommittees of the Trust Board are chaired by a Non-Executive Director. They have a duty and the authority to seek the information necessary to enable them to make a reasoned judgement as to whether the elements of risk for which they assure the Board, are being managed with proper controls in place.

They have a duty and the authority to raise with the Trust Board any risk issue they believe is not being managed appropriately, that may be a threat or opportunity to the Trust or which has caused them concern.

Executive Directors

The Trust Board has designated accountability for risk management and quality service provision to nominated executive directors and as such this is identified within their job descriptions.

The Executive Directors are part of the Trust management structure and represent their specific areas of risk management responsibilities at Trust Board, Sub Committees and Senior Leadership team levels.

All Executive Directors are accountable for reducing risk within their areas of responsibility by best practicable means and ensuring the impact of decisions taken and effect on the viability and reputation of the Trust is assessed as part of this decision making process. They may delegate operational responsibility to nominated managers and to specific committees or project groups². They ensure a feedback mechanism is in place to monitor actions taken and compliance with internal and external regulatory or statutory compliance.

The Executive Directors with delegated responsibility for risk management are:

Chief Operating Officer

The Chief Operating Officer has executive responsibility and accountability for operational risk. In practice this means ensuring effective management and mitigation of risk as part of the day to day operational practice of the Trust. This includes, but is not limited to, objective setting, business planning, service development and performance management and information governance risk. The Chief Operating Officer has executive responsibility for major incident planning and implementation and overseeing the operational review process.

The Chief Operating Officer chairs the Operational Board and is the Senior Information Risk Officer (SIRO) for the Trust.

² Corporate risks – these are risks which need either a Trust wide approach or which may arise as a result of external factors over which the Trust may have limited control. They are owned by the Executive team who delegate their management to either a nominated individual, designated committee or designated, time limited project group. If a risk is accepted, i.e. no appropriate action to mitigate it identified, this must be agreed with by the Chief Executive or the Deputy Chief Executive and identified to Trust Board.

Chief Finance Officer

The Chief Finance Officer has executive responsibility and accountability for all aspects of financial risk and compliance with statutory financial requirements. This includes but is not limited to financial planning; financial objective setting; estates & facilities, including the management of contractors, safe operating procedures and safe systems of work, financial and service continuity risks associated with redevelopment programmes; and fraud identification and management.

Medical Director

The Medical Director has executive responsibility and accountability for the governance of clinical and non- clinical risk management. The Medical Director has executive responsibility for the implementation of the risk strategy and policy to mitigate the risks arising from clinical incidents, clinical negligence, clinical audit and effectiveness, litigation issues such as consent, confidentiality, data protection, medicines management and radiation protection (please note, this is not an exhaustive list).

The Medical Director has executive responsibility for medical postgraduate training and managing associated risks as a result of changes to medical workforce, whether internally or externally driven.

The Medical Director is also the executive lead for the regulatory compliance framework which includes the CQC readiness.

Chief Nurse

The Chief Nurse has executive responsibility and accountability for safeguarding, patient experience, nursing quality, infection prevention and control and the implementation of risk management systems with regard to nurse and Allied Health Care staffing, staff management, education and workforce issues within their remit. The Chief Nurse chairs the Patient and Family Experience and Engagement Committee (PFEEC) and the Education and Workforce Committee.

Director of HR and OD:

The Director of HR and OD has executive responsibility and accountability for delivery of the Trust's human resources and organisational development policy, strategy and improvement programmes. They are also responsible for Health and Safety. The HR Director is responsible for staff related risks, including compliance with mandatory training and the spread of organisational development. The Director of HR and OD chairs the Health & Safety Committee.

Director of Research and Development:

The Director of Research and Development has executive responsibility and accountability for ensuring that all risks related to research are mitigated and managed and that the research governance framework requirements are implemented.

4.2 Individuals

4.2.1 Company Secretary

The Company Secretary coordinates the Trust Board and its main high level sub committees and ensures relevant papers are provided in line with the agreed reporting schedules.

The Company Secretary ensures appropriate reporting occurs from the operational committees to support the governance framework oversees management of the document library (policy compliance); administration of the Board Assurance Framework (BAF); and, monitors compliance with the Data Protection Act (DPA) in their role as Data Protection Officer.

The Company Secretary monitors how the Risk Management Strategy meets the requirements for and links into, the systems for corporate and integrated governance.

4.2.2 Head of Quality and Safety

The Head of Quality and Safety is responsible for ensuring that there are robust governance processes to enable the Executive Team, Directorates and Corporate teams to identify, assess, mitigate and manage risks that affect their areas.

The Head of Quality and Safety will ensure that high risks are appropriately triaged for consideration by Operational Board to ensure effective management. In triaging high risks, consideration should be given to:

- the overall risk grading (particularly those increasing in grade)
- whether there is a trust-wide component to the risk
- risks which do not appear to be reducing over time
- those which have not been reviewed within policy timescales

The Head of Quality & Safety is required to report to the assurance committees and operational committee's on compliance with this strategy.

4.2.3 Directorate Management (Chiefs of Service, Deputy Chiefs of Service, Heads of Nursing & Patient Experience and General Managers)

The Chiefs of Service, Deputy Chiefs of Service, Heads of Nursing & Patient Experience and General Managers are responsible for implementing and overseeing Corporate and Directorate policies, guidelines and procedures within their specific clinical areas in accordance with this Risk Management Strategy and ensuring the internal structure within their directorates and specialities is in place to do so.

They ensure the Directorate Board review of risk management issues, whether clinical, non-clinical or financial and that these are included where appropriate on the local risk register and discussed as part of the Directorate Board rolling agenda.

They will ensure a governance framework is in place within their Directorates which enables information to be shared with their teams, deficits identified and actions monitored and reported back into the wider governance structure of the Trust through the Senior Leadership team and the Operational Board.

4.2.4 Chair of the Risk Action Group (RAG)

The Chair of the RAG is responsible for ensuring the risk register is reviewed and updated on Datix, according to this strategy and to ensure that the reports required for discussion at the meeting are available.

4.2.5 Senior Managers (corporate and directorate including service managers and Heads of Department):

Senior Managers are required to manage risks within their own areas of responsibility and to implement the requirements of this Risk Management Strategy. They ensure appropriate and effective risk management processes are in place to identify and manage risks within the work environment, implement and comply with corporate, financial and directorate policies and guidelines.

4.2.6 Lead Patient Safety Manager

The lead patient safety manager will provide expert advice and guidance on the identification, assessment and management of risks.

The Lead Patient Safety Manager will ensure that the Directorates / departments have a designated link into the patient safety team to provide expert support and guidance.

The Lead Patient Safety Manager will ensure there are appropriate reporting and monitoring systems in place to identify risk reviews and associated actions which are overdue, and escalate these appropriately. This will include the preparation of reports on compliance with the Risk Management Policy for appropriate committees.

The Lead Patient Safety Manager will support the Head of Quality and Safety in preparing a monthly report for Operational Board identifying risks for review.

4.2.7 Patient Safety Manager(s)

The Patient Safety Manager(s) are responsible for attending the monthly risk action group and provide expert advice and guidance on all matters regarding to risk assessment, identification, mitigation and management. They are responsible for supporting local teams to update the datix risk registers the RAG discussions as agreed.

4.2.8 Trust Solicitor

The Trust Solicitor is responsible for the effective functioning of the Legal team in early identification of potential risk in the on- going management of claims, legal action, or advice.

The Trust Solicitor reports to the Medical Director and provides legal advice to support decision making by the Executive team wherever necessary.

4.2.9 Performance and Planning team

The Planning and Performance teams liaise with Directorates and Corporate Departments to ensure access to appropriate and timely information on service provision and the key performance indicators to support the management and monitoring of risks. They support management of the Assurance Framework to ensure that the Trust objectives are linked to internal and external monitoring of high level performance indicators.

4.2.10 All employees

Employees, whether part of clinical or non-clinical teams, are made aware of the risks within their work environment, their personal responsibilities for reporting risks and minimising risk to themselves and others. They are given the necessary information and training to enable them to

work safely. All clinical and non-clinical staff are expected to report incidents when they occur and be involved where appropriate in any investigation to identify the cause of specific risks or as the result of an adverse event (See Incident Reporting & Management Policy and the Health & Safety Policy).

4.2.11 Visitors

While visitors have a responsibility for maintaining their own health and safety while on site in line with any instructions or guidance provided, employees have a responsibility to ensure that visitors are not exposed unnecessarily to risks, to report and take action to minimise any such exposure.

4.2.12 Contractors

Contractors carrying out work on the Trust's property are expected to comply with relevant statute and good practice guidelines. It is the responsibility of the Executive Director contracting with them on behalf of the Trust to ensure that contractors comply with the relevant safety procedures and, where appropriate, specify detailed health and safety and performance management requirements in any written terms of agreement before work commences in conjunction with the Health and Safety Team and the Estates Department.

4.3 Committees

The effective flow of risk management information in the organisation depends on an effective and functional risk management meeting structure. There are a series of operational risk committees, with delegated responsibility from the Executive Management Team. These committees are monitored by a series of assurance committees which then report to Trust Board.

4.3.1 Trust Board

The Trust Board is responsible for identifying the strategic risks and the effective functioning of the Trust, the provision of managerial leadership and accountability. Its purpose is to ensure that the Trusts systems and working practices support good corporate governance, financial probity and the management of risk to underpin safe high quality service delivery. To do this Trust Board will:

- Establish the strategic objectives for the Trust
- Set out the arrangements for obtaining assurance on the effectiveness of key controls across areas of principal risk, which may threaten achievement of those objectives
- Review the strategic risks as part of the Assurance Framework, at least once a year as per the schedule of reporting.
- Evaluates the key controls to manage the principal risks, using external and internal assessment and assurance processes.

Any high level sub-committee where the responsibility for overseeing the different elements of risk management has been delegated by Trust Board, clearly indicates by its terms of reference which aspects of risk management it is responsible for, and whether its role is one of assuring or being assured. It also identifies the extent of its delegated authority. Those Assurance Committees are:

4.3.2 Executive Management Team (EMT)

The Executive Management Team has delegated authority for the operational and performance management of the clinical services, research and development, education and training of the Trust. It is chaired by the Chief Executive and is responsible for co-ordinating and prioritising all aspects of risk management issues which may affect the delivery of the clinical service as stated in its terms of reference. It is the main operational decision making committee of the Trust. It is responsible for coordinating and prioritising all aspects of risk that have the potential to prevent the Trust meeting its strategic objectives:

- It ensures that all aspects of Trust activity are considered and risk assessed when decisions are made, to minimise organisational risks whether clinical, non-clinical or financial.
- Delegates authority to the directorates/departments to manage risk to local service provision as appropriate.
- Monitors performance against the Trust objectives, identifying variance, assessing risk management priorities and co-ordinating the Trust response.
- Supports directorates and departmental activities to ensure appropriate use and allocation of resources to support and maintain service delivery and to minimise and control risks.
- Receives updates on work and measures undertaken to mitigate risks by specific subgroups, operational committees and any other time limited group which it has established or delegated authority to, to take forward specific work.
- EMT is made up of the Executive team; its membership reflects its role to ensure appropriate consideration and endorsement of decision-making on specific areas of risk.
- The Chief Executive is the Chairman of the EMT and meetings are held fortnightly.

4.3.3 Assurance Committees

All of the organisational assurance committees are chaired by Non-Executive Directors.

4.3.3.1 Quality, Safety and Experience Assurance Committee

The Quality, Safety and Experience Assurance Committee (QSEAC) meets quarterly and reports to the Trust Board. It has a number of sub committees reporting to it including the Patient Safety and Outcome Committee and the Patient and Family Engagement and Involvement committee.

It has delegated authority to assure the Trust Board and to be assured that appropriate action is taken to minimise and control risks relating to clinical incidents, complaints, claims, litigation, health and safety, safeguarding, infection control and clinical audit as identified within its terms of reference. It receives relevant reports and updates on actions taken to comply with specific external assessments to fulfil this remit and within an appropriate timescale.

On agreement with the Committee Chair, it also receives additional items on any other activity which creates a potential or actual risk to good clinical governance.

The Chair is a Non-Executive Director. Its minutes are shared with the Audit Committee and received by Trust Board for information at the next available meeting.

4.3.3.2 Audit Committee

The Audit Committee reports to the Trust Board. The committee has the responsibility to assure the Trust Board and to be assured, that appropriate action is taken to minimise and control all aspects of non-clinical risk including financial within its remit. It receives relevant reports to enable it to do this including reports from internal and external auditors in respect of the Trust's effectiveness at mitigating specific risks. It monitors the actions taken and progress against all financial requirements, certain external assessments and reviews the effectiveness of specific objectives from the assurance framework and trust risk register to identify and control risks as per the reporting schedule.

As the assurance agenda crosses clinical and non-clinical boundaries, the minutes are shared between this committee and the Quality, Safety, Assurance and Experience Committee and received by Trust Board for information. The Chair is a Non-Executive Director and the Chair of the QSAEC is a member of the Audit Committee - cross membership of this committee assists in ensuring an integrated approach to managing all risk financial, non-clinical and clinical risk. The Audit Committee meets quarterly.

Additional members may be required to attend when necessary to inform the committee on any specific aspects of risk identified.

4.3.3.3 Finance and Investment Committee

The Finance and Investment Committee (F&IC) is a sub-committee of the Trust Board with the aim of assisting the Board in overseeing financial strategy and planning, financial policy, investment and treasury matters and reviewing and recommending for approval major financial transactions. The F&IC maintains oversight of the Trust's financial position and relevant activity data and productivity metrics.

The Chair of the committee is a Non-Executive Director (NED) with the membership comprising of the Chief Executive Officer, Chief Operating Officer, and the Chief Finance Officer.

4.3.3.4 People and Education Assurance Committee

The People and Education Assurance Committee is a subcommittee of the Trust Board, established to provide assurance to the Board and that the necessary structures and processes are in place to deliver the Trust's vision for a supported and innovative workforce, an excellent learning environment for clinical and non-clinical staff and a culture that aligns with the Trust's strategy and always values.

4.3.4 Operational Risk Meetings

The Operational Risk Meetings in the organisation are those where risks are actively identified, reviewed and managed.

4.3.4.1 Risk Assurance and Compliance Group (RACG)

The Risk Assurance and Compliance Group is chaired by the Chief Executive and has delegated authority from Trust Board to receive assurance on all elements of risk management and compliance. The RACG meets on a 6 weekly cycle. The RACG monitors the BAF through:

- approval of the net and gross scores of each BAF risk and any movement of these scores;

- confirming the breadth and robustness of the controls and any gaps in controls;
- assessing the robustness of the actions stated to reduce the likelihood/ consequence of the stated risk;
- assessing the significance and robustness of the stated assurance

The RACG will undertake regular stress testing of BAF risks to assess whether controls and assurances cited are effective and appropriate.

The RACG will undertake horizon scanning for external drivers which may risk delivery of the Trust’s strategic objectives.

Based on the above, the RACG will recommend:

- further actions to be taken to enhance controls or receive additional assurances;
- changes to the gross and net scores;
- changes to the assurance status.

The RACG monitors the Trust Risk Register with a specific focus on High Risks:

- RACG receives a copy of the Risk Report provided to Operational Board with an overview of the Operational Board comments/actions, highlighting any significant new Trust wide risks.
- Executive Directors will provide exception report updates highlighting any significant new risks within their portfolios. The RACG can challenge gradings of high risks as part of a constructive challenge process.
- The RACG receives an assurance report on Significant Risks (those with a potential impact of severe harm, or death) but which are not assessed as High Risks (based on their assessed likelihood score) quarterly.
- The RACG receives an assurance thematic risk review report with emerging risks within the organisation on a quarterly basis.

Risk Grade/Nature	Score on Risk Matrix	Frequency	Responsibility for Review
Trust Wide Operational Risks	Any	In line with Risk Grade	Operational Board
Trust Wide Thematic Risks	Any	In line with Risk Grade	Appropriate Trust Committee/Sub-Committee e.g. infection control, medication safety. RACG on quarterly basis (for assurance)
Significant Risks Register	Impact of 4 or 5	Quarterly	RACG on a quarterly basis (for assurance)
Corporate Risks (often Trust Wide)	Any	In Line with Risk Grade	Corporate RAG or equivalent
High Risks	Score of 12 or above	Monthly review (6 weekly for RACG)	RACG (High Risks via triaged report) Operational Board (Directorate High Risks plus Deep Dive) Directorate Board/RAG(s) (Directorate Risks)
Medium	Score of 8 to 10	Two monthly	Directorate RAG(s)
Low	Score of 1-6	Quarterly review	Directorate RAG(s)

4.3.4.2 Operational Board

The Chief Operating Officer chairs the Operational Board. The Board meets every two weeks and has oversight and delivery of Trust wide operational performance.

The Operational Board holds responsibility for review of High Risks. The triage and review of risks for consideration at the meeting is to be undertaken by the Head of Quality and Safety in conjunction with the Patient Safety Team and the Directorate Leadership Teams.

The Operational Board holds responsibility for review of all Trust Wide Risks impacting operational or clinical delivery. It has the authority to designate a risk as 'Trust Wide' and identify the appropriate risk handler (including the correct committee/group) to ensure the risk is effectively managed.

The Operational Board provides a forum for the review of Directorate Risks which are rated as 12+ to ensure that there is broad awareness amongst representatives of all directorates in the management of significant risks.

4.3.4.3 Other Standing Committees

A standing committee is a committee with delegated authority from EMT (Appendix 6 and 7).

Each standing committee is responsible for managing the cross Trust issues relevant to their area of expertise and as such has delegated authority within its terms of reference for a specific remit. This includes assessing the effectiveness of the control systems in place to reduce the risks relevant to their areas of expertise. A standing committee may be established either because it is required by statute or because it covers a key management function for the Trust to meet its objectives of efficient, effective and safe care.

Standing committees with responsibility for risk management include, but are not limited to:

- Patient Safety and Outcomes Committee
- Patient, Family Experience and Engagement Committee
- Health & Safety Committee
- Education & Workforce Committee

A standing committee may have a range of sub-committees reporting in to it. Where the sub-committee has responsibility for risk management, the standing committee must seek regular assurance that risks are being managed in line with policy expectations.

4.3.4.4 Directorate Boards

Each Directorate is responsible for identifying risks relevant to the services provided, ensuring these are included on the risk register where appropriate, that work is undertaken to mitigate or remove that risk, and that regular review of the risk register takes place.

Each Directorate Board has a responsibility to establish Risk Action Groups at specialty/department level, as appropriate, to ensure that the risk registers are reflective of the service. Each Directorate Board must be assured that the Risk Action Groups are effectively

managing risks affecting the directorate on their behalf. At a minimum the Directorate Boards must review the progress with high risks on a monthly basis.

At the Directorate pPerformance Reviews and at the Operational Board, the Directorate Leadership team can escalate risks for discussion and support, if the risk cannot be resolved at Directorate level.

4.3.4.5 Risk Action Groups (RAGs)

Local Risk Action Groups or an equivalent meeting will be established at which the local risk register will be discussed.

Their role, remit and areas of delegated authority will be identified by the Directorate Board or equivalent and reflected in their terms of reference (Appendix 4). Risk Action Groups will be multidisciplinary and may consist of a core group with additional expertise brought in pertinent to the level or type of risk identified.

Each specialty is responsible for identifying its specific hazards and risks relevant to its own area of clinical expertise and practice and ensuring these are included on the risk register where appropriate and that regular review of the risk register takes place.

RAG's receive information monthly on their clinical and non- clinical incidents reported through the central reporting system to identify key themes and where actions to control risks are required.

Corporate departments establish similar systems either through a dedicated Risk Action Group or an equivalent meeting. The RAG will review reported incidents and complaints and identify to the directorate board or departmental meeting, issues they think should be added to the risk register, re-graded or removed.

5 Organisational Structure for Risk Management

The Organisational structure for risk management provides an integrated framework for decision making, escalation and provision of assurance. It ensures the operational framework required to deliver the trust objectives links into the wider assurance and corporate governance processes, and that all reasonable action is taken to identify, assess and manage risks to the Trust and its stakeholders in a consistent and transparent way.

To manage risk effectively, the Trust must be aware of its risk profile across the entire range of its activities whether, clinical, non-clinical or financial. These may be strategic or operational and may relate to a change or development in an existing service, or in response to an internal or external driver. As such, they require regular review and a consistent approach to assessment as their priority may change over time. The Trust committee structure, which links into this process, can be found in **Appendix 7**.

6 Process for managing risk locally in support of this strategy

The management of risk locally will reflect this organisational risk management strategy. Directorates, Clinical and Corporate Departments will have in place:

- Internal meeting structures

- Authority within staff roles and responsibilities to manage risk at local level including financial and service risks
- Comply with the requirements of the Incident Reporting & Management Policy and Complaints policy
- Ensure that clinical, financial, service risks and complaints are used as an indicator of quality and as part of the process to identify safety indicators and required actions
- Quality Rounds are embraced and embedded into the directorate as a means of proactively identifying and remedying risks
- Comply with Trust policies in respect of workforce management
- Develop, review and update a risk register, escalating risks appropriately to others within the organisation as required.
- A multi-disciplinary risk action group to identify, review and challenge risk treatment strategies
- Process to monitor required actions
- Process to share information and learning
- Process to escalate unresolved risks

These processes will be managed by the Directorate Board or equivalent. The internal structures will meet the need of the directorate or department to deliver excellent clinical care and to identify, assess and control risk, with delegated authority to staff as appropriate.

Each Directorate will have a designated Patient Safety lead from within the Quality and Safety team, or the Health and Safety team were appropriate, who acts as a risk link for their areas.

7 Incident reporting

Directorates and departments will have a process to review their reported incidents and levels of reporting monthly. The Incident Reporting & Management Policy describes the process to report, record and investigate individual incidents in detail. Levels of reporting and management of the incidents will be monitored by the Patient Safety team and reported through to the Patient Safety and Outcomes Committee (PSOC) with feedback to the local teams.

8 Risk assessment

Each Directorate/Department will undertake risk assessments where appropriate. They will score, grade and prioritise the risks using a common approach (Appendix 1). A risk assessment will be undertaken prior to planned service changes or changes to service delivery to identify any additional risks that may be caused. They may be used to demonstrate consideration of risks as part of the business planning process, as part of a departmental review of compliance with statute; e.g. a Health Technical Memorandum related to specific aspects of corporate risk such as Fire, or following an actual event.

9 Local risk registers

The Directorate Board or equivalent, or Departmental meeting will have a process in place to keep their risk register updated. They will update the content of their risk register monthly on the Datix system. Risks will be reviewed within a stated time frame by the local team to ensure that controls in place are working, and assess whether the risk changes over time (Appendix 3).

Risks may be identified through internal processes e.g. complaints, incidents, claims, service delivery changes, risk assessments or financial interests. They may be identified by external factors e.g. national reports and recommendations. Reports are run monthly for the clinical / department teams on reported incidents for consideration by the RAG groups and Directorate boards or senior meetings. This information is used to inform the decision as to whether risks need to be added to the risk register, re-graded or removed. Changes to the risk registers are monitored centrally by the Patient Safety team.

11 Trust Wide Risk Register

The Trust wide risk register contains all risks that have been identified as affecting more than one Directorate.

These risks will be overseen by the Operational Board. The determination of a 'trust wide risk' should be agreed and accepted by the Operational Board. Careful consideration should be given to the identification of a handler for a Trust Wide Risk to ensure that they are of sufficient seniority to appropriately manage and mitigate the risk. This includes risks of all levels which have a Trust wide impact. Trust wide risks which are 12+ should additionally be assigned an executive owner to provide support and guidance to the risk handler.

Trust-wide risks will be managed by the appropriate standing committee within the organisation. For example, Trust-wide infection control risks will be overseen by the Infection Control Committee. The operational board can assign this responsibility accordingly in conjunction with advice from the Head of Quality and Safety.

The Operational Board will remain responsible for Trust Wide Risks which relate to operational and service delivery issues, or those for which an appropriate committee/sub-committee does not exist.

The RACG reviews the aggregated Trust Wide Risk Register on a quarterly basis for assurance that progress is being made. The RACG can request additional information on any of the identified risks to seek further assurance irrespective of risk grade.

12 High Risk Register

The organisation high risk register is comprised of all risks (directorate, trust wide and corporate) which reach the threshold 12+ in the risk scoring.

All high risks will have an executive owner, in addition to a handler. In some situations it may be appropriate for the executive to also be the handler.

13 Board Assurance Framework

The Board Assurance Framework provides a record of the principal strategic risks to the Trust achieving its objectives. It identifies the controls in place, the methods of assurance and the control and assurance gaps. It is informed by the risks graded 12 or above on the Trust risk register as well as internal, external and strategic risks which may affect the Trusts business.

It includes those identified by the Executive team or any additional source where local controls are not sufficient to manage the risk e.g. infection control, finance or information risk. It includes key risks identified through aggregated analysis of incidents, complaints and claims which may not already appear on the Trust wide risk register.

It provides a vehicle for the Trust Board to be assured that the systems, policies and people in place are operating in a way that is effective and focussed on the key risks which might prevent

the Trust objectives being achieved. Each risk is linked to a Trust objective and has an Executive lead, responsible for updating the controls and ensuring the actions required to mitigate the risk are completed at either local, operational or strategic level.

The BAF risks are reviewed by a relevant Board assurance committee to assess whether robust assurance is available to show that the controls in place are effective at mitigating the risks taking account of the risk appetite for each risk. The committees recommend to the Board changes to BAF risk scores, removal of BAF risks, inclusion of new BAF risks (arising from horizon scanning or escalation of high graded risks or Trust wide risks) and changes to risk appetites. The Board ratifies the BAF and any changes.

There are a number of ways that BAF risks are validated to ensure that they are appropriately referenced, scored and managed:

- **Top 3 risks** – this process is conducted twice a year to ensure that our BAF and risk registers are reflective of the most pertinent risks across the organisation. It involves asking all Board members and key Trust managerial staff to name their top 3 risks without reference to the BAF or risk registers. These are compared to the BAF and risk registers to ensure congruency. Where there is no congruency (i.e. where a gap appears when comparing the information received from the top 3 risk process and the information on the BAF, trust wide risk register or local risk registers), then these new risk are added and will appropriately highlighted.
- **Thematic Review**
Each risk entered on datix is categorised as a risk type. These types align to the categories for incident reporting in the organisation.
The risk type categorisation allows for thematic cross cutting review of similar risks/incidents in the organisation. For example, the Health and Safety Committee will be able to conduct a review of all health and safety risks in the organisation identified and calibrate the Trust wide risks managed by that committee accordingly.
- **Internal information** – Information from KPI monitoring, benchmarking, executive and other types of walkround/ compliance or quality assessments, internal audit, serious incidents and surveys is used to validate and assure existing risk and indicate where new risks are arising and require monitoring, and mitigation (stress testing the risks). The RACG oversees this process.
- **External information** – Information from external reporting (regulators, professional bodies, statutory bodies etc.) is used to validate and assure existing risks and indicate where new risks are arising and require monitoring and mitigation. The RACG oversees this process.
- **Horizon scanning** - The RACG is responsible for horizon scanning for external drivers which may risk delivery of the Trust's strategic objectives. In addition, it should also consider assessment of any catastrophic event (high impact/ low likelihood) as should be outlined in the relevant risk registers across the Trust.

14 Dissemination of this Strategy

The Trust Board recognises that good channels of communication are vital to the achievement of the aims of the Risk Management Strategy. An open and fair culture which welcomes direct

interaction between managers and staff at all levels assists in ensuring the aims of this strategy are achieved.

The strategy is available on the document library, with links from the Quality and Safety web pages.

Local Risk registers, performance reports and the outcome of any external assessments regarding the Trust's ability to manage risks are made available to staff via the internal communication systems.

15 Specialist advice

Further advice on any aspect of risk management, reporting, assessing, monitoring, compilation of risk registers etc. or to identify where additional information is available can be obtained from the Patient Safety team. Additional staff available to give specialist advice on aspects of managing risk are:

Medical Director: Advice on medical staffing, clinical issues, clinical scientists, partnership working and patient safety

Chief Nurse: Advice on nursing, clinical care, allied health professionals, child protection and safeguarding issues

Head of Quality and Safety: Advice and guidance on aspects of clinical and non-clinical risk management, analysis, effectiveness and audit, CQC readiness and compliance.

Trust Solicitor: Advice, guidance and training on aspects of litigation, consent, confidentiality

Health and Safety Advisor: Advice training and guidance on aspects of non-clinical risks, health and safety litigation and risk assessments

Radiation Protection Advisor: Advice training and guidance on aspects of radiation safety

Counter Fraud Adviser: Aspects of fraud or potential fraud or financial loss to the Trust

Company Secretary: The Trust constitution and data protection.

Information Governance Manager: Advice on information governance requirements

This list is not exhaustive but any of the above are able to give advice on additional sources of information whether internal or external to the Trust.

16 Process for implementation

The Risk Management Strategy will be promoted across the Trust in a number of ways including:

- Publishing on GOSHWeb under the Document Library and the Quality and Safety team intranet page
- Senior Leadership team will be briefed and asked to disseminate information to staff as required
- In addition, Patient Safety Managers will work with Risk Action Groups and key staff involved in Directorates and Departments risk processes to ensure they understand what is required under the Strategy.
- The RACG is responsible for overseeing the implementation of the Risk Management Strategy.

17 Summary of Monitoring Table:

A report will be received by the relevant committee to monitor compliance with ToRs which will include as a minimum:

- Rationale for the audit or review
- What is being measured e.g. attendance, receipt of minutes, completeness of minutes, and compliance with any reporting schedule or applicable measure identified to demonstrate compliance.
- Results of the audit or review and whether compliance was demonstrated.

Score for compliance	Grade	Action required
90-100%		Report to named committee as per reporting schedule
76-89%		Report to named committee with action identified to improve compliance and time scales. Monitoring to be incorporated into the named committee meeting schedule once agreed.
<75%		As above. Discuss with responsible person depending on deficit identified e.g. relevant committee chair, General Manager, Directorate Director, Director, to identify deficit and means to rectify.

18 Equality Impact Assessment

Equality Analysis Form – Risk Management Strategy

Title of Document:	Risk Management Strategy
Completed By:	
Date Completed:	
Summary of Stakeholder Feedback:	None Required

Potential Equality Impacts and Issues Identified		
Protected Group	Potential Issues Identified	Actions to Mitigate / Opportunities to Promote
Age	None	
Disability (including learning disability)	1 Colour blindness - Due to use of colour Coded risk matrix 2. Completion of risk assessments 3.Communication of outcomes from risk reports/risk assessments	1.A colour coded grid is used with the narrative of the colour in addition to the actual block colour 2.Staff are provided with training on the completion of risk assessments and risk management and this is provided in a suitable format and at a suitably accessible location 3.Reasonable adjustments will be made as appropriate for staff requiring support with any area of communication
Gender re-assignment	None	
Marriage or civil partnership	None	
Pregnancy and maternity	None	Arrangements relating to this area will be accounted for as per the Trust health and safety policy
Race	Translation of risk assessment forms and documentation	Translation services can be arranged as required
Religion or belief	None	Taken in to account as appropriate
Sex	None	Arrangements relating to this area will be accounted for as per the Trust health and safety and lone worker policies
Sexual orientation	None	

19 Appendices

Appendix 1- Risk assessment Process and Key Definitions

Assessment tools

Minimising risk requires the hazard to be identified, the risk assessed and a decision to be taken as to what control is required to mitigate that risk. The purpose of the grading assessment tool is to provide a consistent means for clinical and corporate staff to identify the key areas of risk which need to be incorporated into their risk registers, financial plans or into their business planning cycle. It assists in identifying the management responsibility and where this sits.

As a minimum, the risk assessment must include a description of the risk, the source of the risk, the likelihood of the risk occurring and the impact if it did. It should also include any current controls in place or additional controls that may be required. Where appropriate, consideration of resource and reputational risk should be included. Risks must be added to Datix.

Risk scoring

Using the 5x5 matrix the likelihood of the risk occurring is multiplied by its impact to produce a risk score and grading. For a potential risk or hazard or one that nearly happened, the risk is scored for its potential impact and likelihood of occurring again.

SEVERITY	LIKELIHOOD				
	1 Very Unlikely (Freak event – no known history- 1 in 100,000 or less)	2 Unlikely (Unlikely sequence of events 1 in 100,000 to 1 in 10,000)	3 Possible (Foreseeable under unusual circumstances 1 in 10,000 to 1 in 1000)	4 Likely (Easily foreseeable – 1 in 100 - 1000)	5 Very Likely (Common occurrence – 1 in 100 chance in any one year)
1 No harm (No injury, no treatment required, no financial loss.)	Low	Low	Low	Low	Low
2 Minor (Short term injury, first aid treatment required, minor financial loss)	Low	Low	Low	Medium	Medium
3 Moderate (Semi permanent injury, possible litigation, medical treatment required, moderate financial loss)	Low	Low	Medium	High	High
4 Major (Permanent injury, long term harm or sickness, potential litigation, fire, major financial loss)	Low	Medium	High	High	High
5 Catastrophic (Unexpected death, potential litigation, catastrophic financial loss)	Low	Medium	High	High	High

To support the interpretation of this matrix, the following tables can be used to guide the assignment of consequence scores. Firstly, the most appropriate domain for the identified risk must be selected from the left hand side of the table. Then, based on the description in each column in same row, the severity of the risk on the scale of 1 to 5 can be determined.

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/organisational development/staffing/competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/inspections	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices	Multiple breaches in statutory duty Prosecution Complete systems change required
				Low performance rating Critical report	Zero performance rating Severely critical report

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House)
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract /
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Grading of risks is most effective when undertaken using a multidisciplinary approach wherever possible or as part of the Risk Action Group and determines the frequency of review, and level of oversight required in the organisation.

Management responsibility and review of risks

Risk Grade/Nature	Score on Risk Matrix	Frequency	Responsibility for Review
Trust Wide Operational Risks	Any	In line with Risk Grade	Operational Board
Trust Wide Thematic Risks	Any	In line with Risk Grade	Appropriate Trust Committee/Sub-Committee e.g. infection control, medication safety. RACG on quarterly basis (for assurance)
Significant Risks Register	Impact of 4 or 5	Quarterly	RACG on a quarterly basis (for assurance)
Corporate Risks (often Trust Wide)	Any	In Line with Risk Grade	Corporate RAG or equivalent
High Risks	Score of 12 or above	Monthly review (6 weekly for RACG)	RACG (High Risks via triaged report) Operational Board (Directorate High Risks plus Deep Dive) Directorate Board/RAG(s) (Directorate Risks)
Medium	Score of 8 to 10	Two monthly	Directorate RAG(s)
Low	Score of 1-6	Quarterly review	Directorate RAG(s)

The following identifies the expected review schedule of risks included on the risk register for Directorate Boards and Corporate Departments based on the scores and grading.

Definitions:**Risk management**

Risk Management is the process to identify, assess and prioritise the Trusts exposure to risk whether clinical or non-clinical, which may affect its ability to meet its objectives. This may be as a result of loss or damage however caused, to patients, staff, visitors, contractors, finances, business continuity or the reputation of the Trust. Consideration of all service provision from a risk perspective and the factors which affect this, whether financial, environmental or staff related, assists the process to identify risks and mitigate their effect. It informs the decision as to whether a risk can be accepted, delegated, transferred or eliminated³.

Clinical risk

An adverse patient safety incident has been defined by the National Patient Safety Agency as 'any event or circumstance arising during NHS care that could have or did lead to unintended or unexpected harm, loss or damage'. Harm is defined as 'injury (physical or psychological), disease, suffering, disability, or death'. In most instances, harm can be considered to be unexpected if it is not related to the natural cause of the patient's illness or underlying condition. Those incidents that did not lead to harm, but could have, are referred to as prevented incidents. Loss or damage occurring within the context of clinical risk to the patient, can equally apply to their family, staff or the organisation and may be both financial and/or to reputation. Clinical risk can also occur due to latent decisions e.g. change to service delivery which create different risks not just an adverse event but which may not be apparent at the time the change is made.

Non-clinical risk

Non Clinical risks are any event or circumstance arising during NHS care that could have or did lead to impairment of the Trust's ability to deliver its objectives, whether intended or unexpected. These risks are the outcome of hazards that have the potential to cause, or actually cause, harm by affecting the organisations ability to deliver high quality services. They may relate to a number of the Trusts support mechanisms including health and safety, estates and facilities, technical, information technology, personnel, training or financial aspects of the Trusts business. They may have a direct or indirect effect on patient care, member of staff, visitor, contractor or other stakeholder and result in loss or damage. This loss may be both financial and/or to reputation.

Principal risks (Board Assurance Framework (BAF) risks)

The Trust Board's main focus is strategic. Board members must understand the business objectives and be able to identify the principal risks that may threaten the achievement of these objectives. The Board's role is to focus on those risks and events which may compromise the achievement of strategic objectives, and to support the creation of a culture which allows the organisation to anticipate and respond to adverse events, trend analysis and significant business and clinical opportunities.

The Board Assurance Framework provides a structure and process that enables the organisation to focus on those risks that might compromise achieving its most important (principal) annual objectives; and to map out both the key controls that should be in place to manage those

³ See Appendix 1

objectives and confirm the Board has gained sufficient assurance about the effectiveness of these controls.

High Risk

A high risk is any risk identified as any risk which attracts a risk score of 12+.

These risks will be assigned an executive owner, in line with their executive portfolios.

These risks will be reviewed in line with the RACG schedule.

However, these risks should and must still be reviewed in the appropriate local setting to ensure that there is clear communication from Board to Ward about how these risks are being mitigated.

Significant risk

A significant risk is defined as any risk identified as having a consequence of 4 (major) or 5 (catastrophic) and which requires an achievable action plan⁴ to identify the controls to be put in place and monitored for effectiveness at reducing the risk. Hazards are assessed using a matrix to identify the likelihood of harm occurring and the impact of the risk.

Risk Types (and thematic review)

Each risk entered on datix is categorised as a risk type. These types align to the categories for incident reporting in the organisation.

The risk type categorisation allows for thematic cross cutting review of similar risks in the organisation. For example, the Health and Safety Committee will be able to conduct a review of all health and safety risks in the organisation identified and calibrate the Trust wide risks managed by that committee accordingly.

Acceptable risk

The Trust makes every effort to ensure that all risks are as low as reasonably achievable. It is not possible to reduce all risks to zero, as there is no such thing as clinically neutral care and decisions must be made as to whether the benefits and best use of resources outweigh the risks.

Risk acceptance is an acknowledgement where a risk is mitigated to the level which the organisation is willing to accept. In other words, the resources required to mitigate the risk further will be disproportionate to the reduction in risk it would achieve.

The Operational Board is responsible for agreeing when a trust wide risk can be accepted, using the risk appetite statement and risk acceptance framework as a guide. This will be reported to the RACG.

The RACG is responsible for agreeing when a BAF risk, high risk or significant risk can be accepted, using the risk appetite statement and risk acceptance framework as a guide. Risks with a score of 20 cannot be accepted, due to the fact that the likelihood score is greater than 3 ('possible').

⁴ An action plan may be in the form of a business case, written report, included on the risk register or be presented in any applicable format. It must contain what action is required, who is responsible for taking the action, and when it will be completed

Directorate and Corporate Risk Action Groups may apply the risk acceptance process for risks below 12 on the local risk register using the Risk Appetite Statements as a guide.

Risk appetite

The Trust defines its risk appetite as the amount of risk it is prepared to accept, tolerate, or be exposed to at any particular time, in the context of highly specialised services the Trust offers. The Board is committed to doing everything possible to reduce risk for children and to deliver high quality, efficient and effective care.

The Board recognises that the Trust's clinical services and research activity are delivered within a high risk environment. The delivery of GOSH's strategic objectives and its relationships with its patients, the public, its funders and other strategic partners determines the Trust's long term sustainability. As such, the Board has agreed that the Trust has an overall low appetite for risks relating to its clinical service and research delivery. The lowest risk appetite applies to all safety and compliance objectives, including preventable patient harm, public and employee health and safety. The Trust has a marginally higher risk appetite for the pursuit of innovation and its strategic and operations objectives. This means that the risks originating from clinical and research processes as well as meeting legal and other regulatory obligations will take priority over other business objectives.

Appendix 2 – GOSH risk appetite

Last approved by GOSH Trust Board December 2018

Overview

The Trust defines its risk appetite as the amount of risk it is prepared to accept, tolerate, or be exposed to at any particular time, in the context of highly specialised services the Trust offers. The Board is committed to doing everything possible to reduce risk for children and to deliver high quality, efficient and effective care.

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Risk appetite by GOSH business model segment

Business Mode	Description	Risk Appetite
Quality	<p><u>Quality</u></p> <p>The Board has low risk appetite for preventable patient harm and patient experience. Clinicians manage risk in line with national clinical and research guidelines (where available) and evidence based practice and all staff are committed to delivering a service consistent with the 'always values'. (LOW RISK APPETITE)</p>	Low
Financial	<p>The Board has a low appetite for financial risk in respect of meeting its financial plan and achieving the financial risk ratios set out in the plan. In the current NHS economic environment, particularly that affecting Trusts with specialist services the Board is prepared to accept some financial risk created by external tariff and commissioning changes but not to the extent that the organisation cannot continue to be financially sustainable within the current and following financial period. Value for money, within the context of safe clinical service delivery, is still a primary concern, but the Board will consider other benefits or constraints consistent with its overall strategy. The Board recognises that at times we need to invest to achieve future financial and non-financial benefits and that we may need to support investments for longer term return while minimising the possibility of financial loss by managing associated risks to a tolerable level. The potential for increasing operational and financial value will be considered and resources allocated in</p>	Low

Business Mode	Description	Risk Appetite
	order to capitalise on opportunities. (LOW RISK APPETITE)	
Research and Innovation	Research is a key component of our strategy and our activity, and is, by definition, innovative. Innovation will be pursued with a desire to 'break the mould' and challenge all current clinical work practices. Whilst authority for seeking innovative practice is devolved to clinician and team levels, governance structures are in place to ensure that a detailed risk assessment (clinical, ethical, financial and multi-disciplinary) of all clinical programmes and projects is performed. (MODERATE RISK APPETITE)	Moderate
Commercial	In light of the specialist nature of the work undertaken at GOSH and the demand for some of its services world-wide, the Trust's business development strategy will consider potential international markets where children could benefit from the care available and demand is high. In the main, this will be within well-established business areas and markets on a controlled basis, where the delivery options available do not compromise delivery of NHS services. (MODERATE RISK APPETITE)	Moderate
Regulation and Compliance	The Board acknowledges that healthcare and the NHS operates within a highly regulated environment, and that, as a Foundation Trust, the Trust has to meet high levels of compliance expectations from an overwhelming number of regulatory sources. It will endeavour to meet those expectations within a framework of prudent controls, balancing the prospect of risk elimination against cost and pragmatic operational imperatives. The general approach would be one of ensuring a low degree of inherent risk. (LOW RISK APPETITE)	Low
Leadership	Organisational development is required to ensure that the organisation is well positioned for the future by creating an environment that allows employees to understand and deliver the organisation's objectives. The Board has a low appetite for having other than appropriately qualified and competent staff. Clear policies and procedures are key to ensuring staff understand the parameters within which they operate, whilst at the same time, promoting a culture of innovation which will involve risk (without compromising patient safety or statutory compliance). (LOW RISK APPETITE)	Low
Performance	The Trust is committed to meeting standards on high quality patient care, national standards or those that may result in financial consequences. The Trust will look at innovative ways to meet these standards. The Trust has a low risk appetite for breaching those standards which are directly linked to patient care. (LOW – MODERATE RISK APPETITE)	Low - Moderate
Reputation	The Board is prepared to take decisions consistent with the vision and values that have the potential to bring scrutiny of the	Moderate

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Business Mode	Description	Risk Appetite
	organisation. Prospective management of the Trust’s reputation is key with continual horizon scanning conducted by the Trust’s Communication Team. This requires some moderate risk to be accepted. (MODERATE RISK APPETITE).	
Partnership Working	The Trust recognises the importance and potential advantages for our patients and the wider community of developing closer relationships with our partners to develop integrated care pathways and reap improvements in quality, efficiency and patient experience. Working collaboratively requires some moderate risk to be accepted as we develop joint strategic plans to deliver a stronger and more resilient service. All actions taken will be subject to the highest standards of accountability and transparency. (MODERATE RISK APPETITE).	Moderate

Appendix 3- Risk registers

Purpose of risk registers

The risk register provides a means to identify and prioritise the principal risks that may affect either service delivery or the environment in which services are delivered. In this way they are applicable to every clinical and non-clinical directorate or department within the Trust and every layer of management within the Organisation.

Management of risk registers

Local risk registers are made up of the key reported events for each unit or department and any specific issues of concern affecting local service delivery or business continuity. They are maintained and updated by the Directorate or local Department by using the online risk management database (Datix).

Adding risks to the Risk Register

A risk identified for inclusion in the register may be from any source e.g. internal or external factors, adverse events, complaints, claims, PALS, audits, resource issues both staffing and/or financial or by potential changes to other services within the organisation. It could be as a result of a trend following analysis of reported incidents, or something which may affect service delivery or the ability of the unit or department to meet the Trust objectives. The Risk Action Groups reviewing and discuss risks to be added to the risk register, this is to ensure that robust assessment of impact and likelihood, controls, mitigations and escalation are considered and clearly documented on Datix. The risk registers are then reviewed at the Directorate Boards for further support and advice.

A Trust Wide Risk is a risk that has been identified as affecting more than one Directorate or is unable to be mitigated by the individual Directorate.

A member of the team will present the suggest Trust wide risk to the Operational Board where an appropriate Trust wide lead and executive lead will be allocated whilst the RACG monitor the compliance with this strategy.

Risk Action Groups and risk registers

The purpose of the Risk Action Group is to systematically review risks on the unit risk registers within the time scales identified in the Risk Assessment tool (Appendix 1). They also review the incidents that have been reported by the Directorate. Due to the specialty mix, it may be appropriate for a Directorate to have more than one Risk Action Group or one larger group with cross specialty representation. Corporate areas may combine this function within an existing meeting schedule.

Information to inform this process for clinical, non-clinical risk, complaints, and audit can be obtained from the Datix Risk Management System. Information specific to other risk such as finance, personnel, and information Services is supplied by the relevant link from each of these areas on request. RAGs are facilitated by the Risk Links. Compliance with the required frequency of high risk review is a performance indicator and is monitored by the Patient Safety team.

Appendix 4 - Risk Action Group Terms of Reference Template

Introduction

The Risk Action Group is a delegated sub-group of the Directorate Board with overarching responsibility for the system of patient safety and risk management in accordance with the reporting requirements of NHS London, National Patient Safety Agency and the Care Quality Commission.

Purpose

The Group will:

Ensure a systematic and multi-disciplinary approach is applied to the identification, recording, management and monitoring of patient safety issues and operational risk;

Provide assurance to the Directorate Board on patient safety and risk management, and where necessary escalate matters of concern to the Directorate Board;

Functions

The Group will:

- Review incidents, serious incidents, complaints, PALS enquiries and CAS Alerts reported, and where appropriate- initiate follow up or investigation;
- Obtain assurance that remedial action has been taken with regards to incidents, serious incidents, complaints, PALS enquiries and CAS Alerts;
- Identify opportunities and approaches for sharing lessons learned from incidents, serious incidents, complaints, PALS enquiries and CAS Alerts;
- Provide scrutiny and challenge in relation to investigations;
- Receive and review completed reports related to incidents, serious incidents, and complaints;
- Endorse or otherwise, report recommendations and ensure that appropriate action plans are implemented and monitored;
- Identify trends and associated risks from incidents, serious incidents, complaints, PALS enquiries and CAS Alerts and ensure that these are being addressed;
- Identify issues that need to be addressed through either clinical audit; service improvement quality initiatives; or risk management;
- Ensure consistency of approach in the methodology used to assess and score incidents and risks;
- Ensure risk register action plans, controls and risk assessments are up to date and reflected accurately on Datix during or following each RAG meeting;
- Promote a positive culture of patient safety and risk management by ensuring that effective communication is maintained by cascading information across the clinical specialty;
- Escalate matters of concern to the Directorate Board using the Escalation Report Template;

- Monitor compliance with the Trust Risk Management Strategy.

Membership

MEMBERSHIP	
LISTED MEMBER	AGREED DEPUTY
Chair [Senior Clinician]	Deputy Chair [Senior Clinician]
Service Improvement Manager	Na
Member 1	Deputy 1
Member 2	Deputy 2
Member 3	Deputy 3
IN ATTENDANCE	
Risk Manager	
Note Taker	

Accountability

The Risk Action Group is accountable to the Directorate Board.

Quorum

This should be agreed at the RAG and should include frequency of the meetings.

Appendix 5- Standing Committees

The purpose of a Standing Committee is to review specific aspects of work which falls within its area of expertise and which usually has a Trust wide remit. As such these committees are key parts of the structure to manage risk from clinical and non-clinical sources and may be operational or clinical in focus. The main standing committees⁵ with a remit for clinical risk are given in Appendix 7.

This role of a clinical standing committee is delegated by Senior Leadership Team and is an important part of managing risk in areas known to involve high risk to patients.

The Senior Leadership Team establishes other operational committees or time limited working groups to manage specific areas of risk as necessary.

The following outlines the basic requirements expected by Trust Board and with which Standing Committees are required to comply.

⁵ This list is not exhaustive and is reviewed annually as a minimum.

Guideline on the drafting of Terms of Reference

This section provides guidance on the drafting of committee/ board terms of reference. It has been produced in order to ensure consistency of approach by all committees/ boards at Great Ormond Street Hospital NHS Foundation Trust.

What is the purpose of a committee/ board's 'terms of reference'?

The terms of reference outlines the role and function of a committee/ board. The document provides a summary of the role and purpose of the meeting, who should attend the meeting, and where the findings of the meeting should be reported.

Who is responsible for monitoring implementation of the terms of reference?

The Chair of the committee/ board is responsible for ensuring that the terms of reference are followed, supported by the secretary to the committee. This will be achieved by drafting the agenda in light of the purpose of the committee/ board, ensuring that the meeting is quorate and ensuring that reports are made to the relevant committees. An Annual audit will take place to ensure compliance.

What areas should they cover?

The terms of reference for any committee or board at GOS should cover the following areas:

Duties – this first section should detail the role of the committee/ board and its authority. This can include responsibilities for approving or monitoring strategies and the implementation of policies; agreeing resources; recommending actions etc. The committee/ board may choose to agree an annual workplan.

Reporting arrangements to the board/ high level committee – the document should state where the committee/ board sits in the organisational structure (i.e. the committee is a subgroup of the Senior Management Team). It should also record where the committee/ board is expected to report to and the frequency of these reports.

Membership, including nominated deputy where appropriate – The terms of reference should detail the job title of each member. Names of members should not be included. It should be clear who the Chair of the committee/ board is. Scope may be given to invite additional members on to the committee/ board for specific items of business. Each member of the Board should have a nominated deputy who will be entitled to attend and 'vote' on the committee/ board.

Required frequency of attendance by members – It is important that members are clear about the number of meetings they are expected to attend in a year. For example, for a committee/ board that meets monthly, it would be prudent to expect attendance at a minimum of 10 meetings within a 12 month period. This list is not exhaustive and is reviewed annually as a minimum.

Reporting arrangements into the committee – The terms of reference should record those reports it expects to receive from teams or other committees and the frequency with which these should be made.

Requirements for a quorum – a quorum details the minimum number of officers and members of a committee, usually a majority, who must be present for the valid transaction of business. It should state the number of nominated deputies who may be included in the quorum to enable the committee to function (it would be expected that for a quorum of 4, a maximum of one member of the quorum would be allowed to be a deputy).

Frequency of meetings – The terms of reference should identify how often the committee / board shall meet and when papers will be expected to be received by members (usually 5 working days before the meeting).

Monitoring compliance with the terms of reference - The committee/ board will need to record in the document how it intends to monitor compliance with the terms of reference. Examples include reviewing:

- the frequency of meetings
- the attendance at meetings
- compliance with the duties of the committee/ board detailed in the terms of reference.
- evidence based outcomes resulting from decisions taken at the committee/ Board

How often should the terms of reference be reviewed?

The committee/ board should review its terms of reference annually to ensure that its purpose and duties align with the governance arrangements in the organisation and any relevant legislation (where applicable).

All terms of reference must be uploaded to the Meeting Papers' Library.

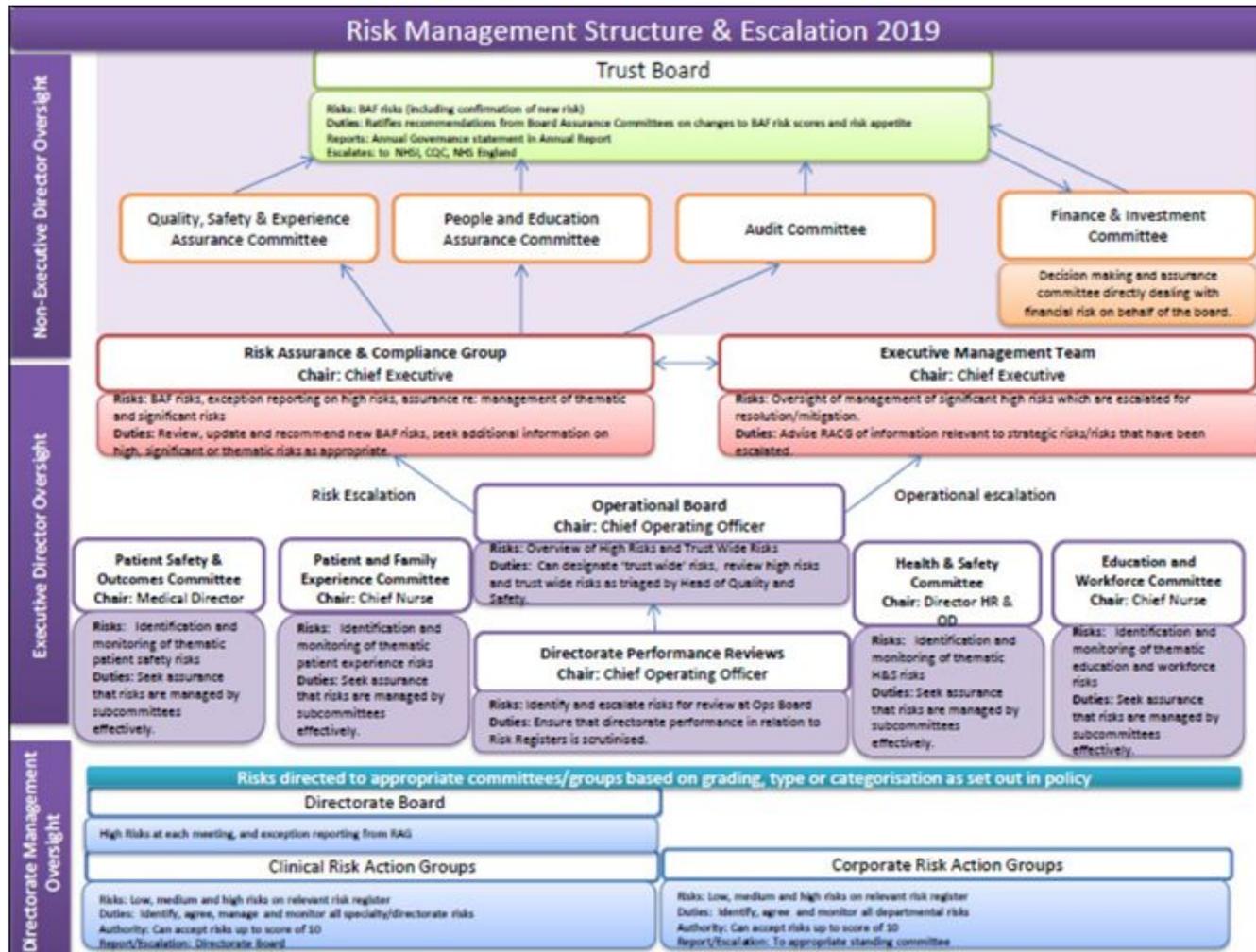
Minutes from standing committees and meetings are made available to staff on the Meeting Papers section of the corporate website. Advice can be sought on how to action this from the Company Secretary ext 8230.

On occasion, standing committees will be required to present examples of actions taken on key areas within their remit to the Clinical Governance Committee.

The above format is recommended as good practice for any time limited or group set to complete specific tasks including reporting lines. This is to ensure decisions taken are recorded and work monitored appropriately.

The clinical standing committees will report to the Patient Safety and Outcomes Committee (PSOC) committee at least twice each year to provide a summary of the work undertaken. The PSOC will provide a report twice a year to Senior Management Team. This process forms part of the system to monitor the effectiveness of the committee structure.

Appendix 6: Risk management and escalation at GOSH via groups/ committees



Attachment V

Trust Board 22 May 2019	
Update on Board Assurance Framework Submitted by: Dr Anna Ferrant, Company Secretary	Paper No: Attachment V
Aims / summary The purpose of this paper is to provide the Board with an update on the Board Assurance Framework (BAF). The Board assurance committees (Audit Committee and Quality, Safety and Experience Assurance Committee) review the risks on the BAF at every committee meeting during the year. A high level summary of the risks on the BAF is provided at Appendix 1 . Information on the controls and assurance are provided at Appendix 2 (for information only) . BAF risk owners update their relevant BAF risk on a quarterly basis, reviewing the controls, assurances and actions for each risk and any other internal/ external matters that may inform/ impact the risk. The assurance committees review the risks relevant to their authority on rotation over the year and conduct deep dives into the robustness of the controls and assurances. In February 2019 following a recommendation from the Risk Assurance and Compliance Group (chaired by the Chief Executive) and scrutiny by the Audit Committee, the Board approved six new risks on the BAF. These will be scrutinised by the assurance committees on rotation in the same way as existing BAF risks. Two of these risks (Brexit and Culture) will be reviewed by the Trust Board on a regular basis as per the approved Trust Board workplan. The Audit Committee is meeting in the morning of 22 May to review the non-clinical risks relevant to the committee and will provide an update on their findings at the Trust Board meeting.	
Action required from the meeting The Board is asked note the BAF update.	
Contribution to the delivery of NHS Foundation Trust strategies and plans Effective management of risk, particularly BAF risks, is critical to the achievement of all of the Trust’s strategic objectives.	
Financial implications There are no direct financial implications.	
Who needs to be told about any decision? Anna Ferrant, Company Secretary will liaise with staff affected by any decisions related to this paper.	

Attachment V

<p>Who is responsible for implementing the proposals / project and anticipated timescales? The risk owners are identified alongside each BAF risk.</p>
<p>Who is accountable for the implementation of the proposal / project? The Chief Executive Officer is accountable for the implementation of the Risk Management Strategy.</p>

Great Ormond Street Hospital for Children NHS Foundation Trust: Board Assurance Framework (May 2019)

No.	Short Title	Risk type and description	Gross Risk		Net Risk		Risk Appetite	Mitigation time horizon	Executive Lead	Reviewed By	Last Updated by Risk Owner	Assurance Committee	Last Reviewed by Assurance Committee
			L x C	T	L x C	T							
1	Financial Sustainability	Strategic & Operational Failure to continue to be financially sustainable due to: <ul style="list-style-type: none"> • Reductions in tariffs and impact of new 2019/20 tariff and potential reduction in MFF • Impact of inflationary costs and potential impact of Brexit of cost of drugs, supplies and staffing • Challenges in completing contracts with NHS Commissioners • Lack of capacity to deliver growth in activity /income targets for NHS and non NHS activities (including IPP); • Challenges is obtaining appropriate growth funding in Contract; • Inadequate local pricing in NHS contract; • Delivery of financial efficiency targets; • Failure to collect IPP debt; • Lack of capital funding in the NHS potentially limiting major capital projects to those that can be supported by the Charity • Changes to accounting standards could impact delivery of the control total • Robust financial management across all operational and corporate teams to ensure the cumulative impact of all decisions is understood • Risk to charity funding supporting both patient welfare and capital programmes in the current economic climate. 	4 x 5	20	4 x 5	20	Low (1-6)	1-2 years	Chief Finance Officer	Helen Jameson, Chief Finance Officer	25/03/2019	Audit Committee	April 2017 January 2018 October 2018 April 2019 (TB)
2	Better Value	Operational The risk that the organisation will not deliver productivity and efficiency targets and that targets indirectly impact on patient care	4 x 4	16	4 x 2	8	Low (1-6)	1 -2 years	Acting Chief Operating Officer	Jon Schick, Programme Director, PMO	19/03/2019	Audit Committee	April 2017 Jan 2018 October 2018 May 2019
3	IPP Contribution	Strategic & Operational The risk that the organisation will not deliver IPP contribution targets	4 x 5	20	4 x 3	12	Med (8-10)	1-2 years	Acting Chief Operating Officer	Chris Rockenbach, General Manager, IPP	01/04/2019	Audit Committee	May-16 April 2017 Jan 2018 Sept 2018 (TB) May 2019
4	Recruitment and Retention	Operational The risk that the organisation will be unable to recruit and retain sufficient highly skilled staff	4 x 5	20	3 x 5	15	Med (8-10)	1-2 years	Director of HR and OD	Alison Hall, Acting Director of HR and OD	18/03/2019	People and Education Assurance Committee	July 2016 April 2017 Oct 2017 May 2018

No.	Short Title	Risk type and description		Gross Risk		Net Risk		Risk Appetite	Mitigation time horizon	Executive Lead	Reviewed By	Last Updated by Risk Owner	Assurance Committee	Last Reviewed by Assurance Committee
				L x C	T	L x C	T							
5	Operational Performance	Operational	The trust is unable to demonstrate compliance with Performance Management Framework/ Monitor's licence	5 x 4	20	2 x 4	8	Low (1-6)	1 year	Acting Chief Operating Officer	Peter Hyland, Director, Planning & Information/ Anna Ferrant, Company Secretary	26/03/2019	Audit Committee/ Quality, Safety and Experience Assurance Committee	Oct-16 Oct 2017 (AC) May 2018 Jan 2019
6	GOSH Strategic Position	Strategic	Lack of priority given to specialist paediatrics in the NHS wide strategies leading to lack of progress in developing appropriate system wide services and support for GOSH's role	3 x 3	9	3 x 3	9	Med (8-10)	5-10 years	Acting Chief Operating Officer	Peter Hyland, Director, Planning & Information	26/03/2019	Audit Committee	Jan 2017 Jan 2018 October 2018
7	Unreliable Data	Operational	Failure to monitor data quality impacting on accurate, consistent and appropriate data reporting across the Trust and to external parties (commissioners etc.)	4 x 4	16	3 x 3	9	Low (1-6)	1-2 years	Acting Chief Operating Officer	Pippa Mullan, Head of Information, & Peter Hyland, Director, Planning & Information	26/03/2019	Audit Committee	Oct-16 May 2017 April 2018 January 2019
8	Research Income	Strategic	The Trust may not be able to provide the required level of research infrastructure or leverage additional research income as core research funding streams are reduced	3 x 3	9	2 x 3	6	Med (8-10)	1-2 years	Director, Research & Innovation	Jenny Rivers, Dep Dir, R&I	20/03/2019	Audit Committee	July 2017 April 2018 Jan 2019
9	Research Hospital Status	Strategic	The Trust may not deliver its full Research Hospital vision if key research alliances are not fostered	3 x 3	9	2 x 3	6	Med (8-10)	3-5 years	Director, Research & Innovation	Jenny Rivers, Dep Dir, R&I	20/03/2019	Quality, Safety and Experience Assurance Committee	Oct-16 July 2017 April 2018 February 2019 (TB)
10	Electronic Patient Records	Operational	<p><u>Short – Term – Project Implementation and Go-Live- 2 years)</u> The risk that the EPR programme will not be delivered on time or within budget. Key risks being monitored by programme board:</p> <ul style="list-style-type: none"> • Programme budget • Procurement risks • Capability/ resource risks • Clinician, Executive and other staff engagement • Risks associated with multiple clinical systems • The risk that at go live the system is not available for a period of time, data migration issues or operation of system causes data quality issues post go live impacting on reporting. • Change management is effective to ensure adoption of best practice. <p><u>Long – Term – Optimisation and Benefits Realisation</u> The risk that the 18 month period following EPR system implementation is not maximised to ensure optimisation of the system and the benefits are not maximised for the organisation as outlined in the Business Case.</p>	4 x 4	16	4 x 4	16	Low (1-6)	1-2 years	Chief Executive	Mat Shaw, Chief Executive/ Richard Collins/ EPR Programme Director	08/03/2019	Audit Committee	Oct-16 Oct 2017 May 2018 Jan 2019 April 2019 (and TB)

No.	Short Title	Risk type and description		Gross Risk		Net Risk		Risk Appetite	Mitigation time horizon	Executive Lead	Reviewed By	Last Updated by Risk Owner	Assurance Committee	Last Reviewed by Assurance Committee
				L x C	T	L x C	T							
11	Business Continuity	Operational	The trust is unable to deliver normal services and critical functions during periods of significant disruption.	3 x 4	12	3 x 3	9	Low (1-6)	1 year	Acting Chief Operating Officer	Camilla McBrearty, Emergency Planning Officer/ Andrew Taylor, Acting COO	11/03//2019	Audit Committee	May-16 May 2017 April 2018 (TB) April 2019
12	Redevelopment	Operational	Inadequate planning or management of infrastructure redevelopment may result in poor VFM or failure to deliver expected business benefit.	3 x 4	12	3 x 3	9	Med (8-10)	1-5 years	Dir, Development & Property Services	Stephanie Williamson, Dep Dir of Development & Property Services	14/03//2019	Audit Committee	May-17 Jan 2017 Oct 2017 April 2018 Dec 2018 TB April 2019
13	Information Governance	Operational	Personal and sensitive personal data is not effectively collected, stored, appropriately shared or made accessible in line with statutory and regulatory requirements.	4 x 5	20	4 x 5	20	Low (1-6)	1 year	Acting Chief Operating Officer	Peter Hyland/ Anna Ferrant	26/03/2019	Audit Committee	April 2019
14	Medicines Management	Operational	Medicines are not managed in line with statutory and regulatory guidance (procuring, storing, prescribing, manufacturing and giving of medicines (including self-administration)) and that processes are not appropriately documented or monitored.	4 x 5	20	4 x 5	20	Low (1-6)	1-2 years	Acting Chief Operating Officer	Steve Tomlin, Chief Pharmacist/ Andrew Taylor, Acting Chief Operating Officer	13/03/2019	Quality, Safety and Experience Assurance Committee	April 2019
15	Consistent delivery of quality services	Operational	All services are not appropriately managed or governed or are of the appropriate standing to deliver quality services within a complex, specialist health environment.	4 x 4	16	2 x 4	8	Low (1-6)	1-2 years	Medical Director	Sanjiv Sharma, Acting Medical Director, Salina Parkyn, Head of Quality and Safety	11/03//2019	Quality, Safety and Experience Assurance Committee	April 2019
16	Brexit	Strategic	Brexit will have an adverse impact on the ability of Trust to ensure continuity of effective patient care including but not limited to financial sustainability, availability of workforce, access to medicines and medical devices and participation in collaborative research and access to research funding, clinical trials and clinical networks.	4 x 5	20	4 x 5	20	Med (8-10)	1-5 years	Acting Chief Operating Officer	Anna Ferrant, Company Secretary/ Andrew Taylor, Acting Chief Operating Officer	19/03/2019	Trust Board	February 2019 (TB)
17	Service Innovation	Operational	Failure to embrace service transformation and deliver innovative, patient centred and efficient services including: <ul style="list-style-type: none"> failing to identify where transformation is needed and continuing to operate inefficient and ineffective services failing to work in partnership with staff and others (commissioners, referrers other stakeholders including the third sector) to identify, plan and design service transformation 	4 x 4	16	3 x 4	12	Med (8-10)	1-5 years	Acting Chief Operating Officer	Jon Schick, Programme Director/ Andrew Taylor, Acting Chief Operating Officer	19/03//2019	People and Education Assurance Committee	

No.	Short Title	Risk type and description	Gross Risk		Net Risk		Risk Appetite	Mitigation time horizon	Executive Lead	Reviewed By	Last Updated by Risk Owner	Assurance Committee	Last Reviewed by Assurance Committee
			L x C	T	L x C	T							
		<ul style="list-style-type: none"> failing to ensure appropriate resources (finances and workforce) are made available to lead and implement transformation of services failing to support staff in making change happen. 											
18	Culture	<p>Strategic</p> <p>Given the 2018 staff survey results which demonstrate the Trust to be below average in the majority of indicators and shows high levels of staff reporting bullying and harassment, there is a risk that GOSH fails to develop its culture and levels of staff engagement and motivation in alignment with its strategy and values, impacting on:</p> <ul style="list-style-type: none"> The effective implementation of plans and policies across the Trust and the associated impact on safety and quality of services and the patient and family experience. The ability of the Trust to attract competent staff and promote the Trust as a place to work and feel engaged. Missed market opportunities arising from a failure to remain agile and connected and adapt to the ever-changing NHS landscape. The Trust's reputation with partners, commissioners, regulators, the NHS and the public. 	4 x 4	16	3 x 4	12	Low (1-6)	1-5 years	Chief Executive	Caroline Anderson, Director of HR and OD	18/03/2019	Trust Board/ People and Education Assurance Committee	

GOSH BAF Risks – Gross Scores May 2019

Likelihood	Consequences				
	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
5 Almost Certain				5. Operational Performance	
4 Likely				7. Unreliable data 10. EPR 18. Culture 15. Consistent delivery of services 17. Service Innovation	3. IPP Contribution 14. Medicines Management 4. Recruitment & Retention 1. Financial Sustainability 16. Brexit 13. Information Governance
3. Possible			9. Research Hospital 8. Research Income 6. GOSH Strategic Position	11. Business Continuity 12. Redevelopment	
2. Unlikely					
1. Rare					

GOSH BAF Risks – Net Scores May 2019

Likelihood	Consequences				
	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
5 Almost Certain					
4 Likely		2. Better Value	3. IPP Contribution	10. EPR	1. Financial Sustainability 16. Brexit 14. Medicines Management 13. Information Governance
3. Possible			6. GOSH Strategic Position 7. Unreliable data 11. Business Continuity 12. Redevelopment	18. Culture 17. Service Innovation	4. Recruitment & Retention
2. Unlikely			9. Research Hospital 8. Research Income	5. Operational Performance 15. Consistent delivery of services	
1. Rare					



BAF Risk 1: Financial Sustainability Failure to continue to be financially sustainable due to: <ul style="list-style-type: none"> • Reductions in tariff; • Challenges in completing contracts with NHS Commissioners • Lack of capacity to deliver growth in activity /income targets for NHS and non NHS activities (including IPP); • Challenges is obtaining appropriate growth funding in Contract; • Inadequate local pricing in NHS contract; • Delivery of financial efficiency targets; • Failure to collect IPP debt; • Shortfall in capital funding available from the Charity to support major capital projects • Robust financial management across operational and corporate teams • Risk to charity funding supporting both patient welfare and capital programmes in the current economic climate. 			Executive Owner: Chief Finance Officer	
Risk Domain (NPSA): Financial	Gross (strategic) risk score: 20 (L = 4 x C = 5)	Net (current) risk score: 20 = (L = 4 x C = 5)	Target risk score (risk appetite): Low (1 – 6)	
Strategic Objective: 4.1 GOSH will develop a funding model which reflects its costs, the new collaborative clinical pathways and allows capacity to be flexed for variable levels of demand.	CQC Domain Well-led	Assurance Committee: Audit Committee	Date of last review by Committee: October 2018	
Current Controls and Assurance		Actions to Further Enhance Risk Management		
Current key controls to manage risks	Means of assurance	Action required to close any gaps in controls and assurances	Action owner	Action review date
a. National tariff: On-going engagement with the working groups set up by the central policy team at NHSI / NHSE to work with other providers, particularly the Children’s Alliance in contesting any changes to top up levels and the MFF which would materially adversely impact the Trust’s funding level.	a. The CA CFOs agreed to reform the group to identify how they can monitor the impact of the new tariff.	a. The CFOs of the CA will be holding further discussions in January 2019 /on release on tariff consultation documentation to determine possible opportunities for a working framework b. Contracts and Income Team have undertaken a review of impact of national tariff on GOSH, for internal monitoring and input to CA discussions.	N/A	N/A
b. Local Tariff: Have agreed patient level costing for 2017/18 Review of impact of national and local prices commenced with support from EY with report due in September 2018.	a. The new contract for 2017/18 & 2018/19 has included a change in PICU pricing, , local tariffs created with the services and shared with commissioners for 2018/19 to replace the increased block funding received in 2017/18 The completion of the additional service review will help inform the trust position for any new tariffs in 2019/20.			
c. Programme office established to assist in the development and implementation of key projects to improve operational efficiencies, control expenditure and reduce costs (Better Value programme developed). (Please refer to BAF risk 2: Productivity).	(Please refer to BAF risk 2: Productivity).	(Please refer to BAF risk 2: Productivity).		
d. The Trust has implemented a Performance Management Framework (PMF) to monitor operational and financial performance monthly.	f. Performance against the PMF is monitored at monthly Divisional Performance Review meetings, which is overseen by the Finance & Investment Committee			
f. The Trust continues to monitor the level and age of non NHS patient debt (see IPP debt) see risk 4 below for specific interventions. (Please refer to BAF risk 3: IPP).	(Please refer to BAF risk 3: IPP)	(Please refer to BAF risk 3: IPP)		
g. The Trust has established a strategy group to increase commercial (non-NHS) income and develop an IPP market strategy. As part of the work of the group an IP Board has been established to review research, innovation and commercial opportunities New IP agreements in place with partner organisations to identify and assist GOSH to exploit IP opportunities.	h. The Commercial Income Strategy Group meets quarterly and has established 2 subgroups – around IPP and Intellectual property i. The IPP strategy working group (including councillor representation) met in Q2 2017/18 and updated its terms of reference.			
h. The trust and charity continue to review the five year forecast for requirements for Charity funding to support key capital projects, research and revenue projects supporting families, patients and staff. A prioritisation process is currently being developed by both parties. This includes delivering robust business case for major projects in particular, EPR and Children’s Cancer Centre Redevelopment projects	f. Currently updating the 10 year plan for the replacement of High Cost Imaging equipment.	g. Develop detailed 5 year charity funding plan linked to Trust Strategic Plan and Operational plans. h. Complete 5 year Health Equipment Technology Replacement plan.	CFO for Trust and Charity	April 2020 Feb 2019

<p>k. Robust financial management across operational and corporate teams</p>	<p>n. new Budgeting IT system implemented to improve budget and forecast process.</p> <p>Rolling out interactive budget statements for all budget holders</p> <p>New LTFM model developed to support long term modelling.</p>	<p>Ensure the Trust has a robust reporting and forecasting programme</p> <p>Develop detailed annual planning timetable to ensure budgets are built up and information available for NHSI planning round in a timely manner</p> <p>Implement a front line financial management training programme for all budget holders</p>	<p>CFO</p>	<p>On going</p>
<p>l. Liaising with NIHR, NHSE and NHSI about the potential impacts of current and future accounting standard changes</p>	<p>Impact of IFRS15 on 2017/18 accounts assessed and discussed with NHSI</p>	<p>Liaising with other trusts and regulators about the impact to influence and have an early understanding of the guidance for NHS trusts</p>	<p>CFO</p>	<p>Ongoing</p>

Risk Reviewed By: Helen Jameson, Chief Finance Officer

Date Reviewed: 25/03/2019

BAF Risk 2. Better Value The risk that the organisation will not deliver productivity and efficiency targets/ and that targets indirectly impact on patient care			Executive Owner: Acting Chief Operating Officer		
Risk Domain (NPSA):	Gross (strategic) risk score:	Net (current) risk score:	Target risk score (risk appetite):		
Finance	16 (L = 4 x C = 4)	8 = (L = 4 x 2)	Low (1 – 6)		
Strategic Objective:	CQC Domain	Assurance Committee:	Date of last review by Assurance Committee:		
4.1 GOSH will develop a funding model which reflects its costs, the new collaborative clinical pathways and allows capacity to be flexed for variable levels of demand.	Well-led	Audit Committee	October 2018		
Current Controls and Assurance			Actions to Further Enhance Risk Management		
Current key controls to manage risks	Means of assurance		Action required to close any gaps in controls and assurances	Action owner	Action review date
1. Better Value performance addressed as part of overall financial performance, through the monthly integrated performance meetings with divisions.	1. Monthly financial performance reports to the Board, FIC , AC and QSAC Regular reporting to Trust Board via the Operational Delivery and Performance Group and Better Value Programme Board. Sign off process for current programme has included more emphasis on clarity about KPIs and metrics that can be used in year to evidence delivery.				
2. CEO-chaired executive level Better Value Programme Board established April 2018 to ensure that overall programme remains on track and emerging risks to delivery are mitigated	2. Exception reports provided to each Better Value Programme Board meeting, plus rolling programme of deep dives into the larger cross-organisational schemes. 3. Action and decision logs from newly-established cross-organisational procurement transformation board.		Revised flow programme as part of wider transformation programme – new Programme Board to be established, chaired by COO to go live in May 2019 post EPIC go-live (see BAF risk 17)	AT	May 2019
3. New PMO processes to assess likelihood of delivery with associated risk adjustments to scheme financial values aimed at ensuring they are as realistic as possible	3. Exception reporting in year to evidence whether schemes are delivering to their risk-adjusted values.				
4. PMO working with divisions and cross-cutting SROs to identify additional mitigating schemes in year in order to address gaps in BV performance.	4. Monthly financial performance reports to the Board as above. Divisions have access to detailed milestone trackers from the PMO database in order to ensure their schemes are on track PMO business partners assist divisions with tracking, delivery and unblocking of key issues stopping BV progress Reframed the programme and PMO business partnering arrangements to reflect the refreshed directorate structure.		Develop a longer term Better Value plan spanning more than one year, moving from stop start annual planning cycle (future hospital programme) link to BAF risk 17	AT	April 2019
5. Enhanced Quality Impact Assessment process implemented. The QIA process is led by the Chief Nurse and Medical Director. The QIA panel meets frequently and reports to the Quality and Safety Assurance Committee.	5. Series of 'deep dives' and post implementation reviews are planned, as well as routine tracking of quality KPIs, to ensure there is no adverse impact on quality as a result of the BV programme.				

Risk Reviewed By: Jon Schick, Director, Programme Management Office

Date Reviewed: 19 March 2019

BAF Risk 3: IPP Contribution			Executive Owner:	
The risk that the organisation will not deliver IPP contribution targets			Acting Chief Operating Officer	
Risk Domain (NPSA):	Gross (strategic) risk score:	Net (current) risk score:	Target risk score (risk appetite):	
Finance	20 (L = 4 x C = 5).	12 (L = 4 x C = 3).	Medium (8– 10)	
Strategic Objective:	CQC Domain	Assurance Committee:	Date of last review by Assurance Committee:	
4.3 Develop and grow new sources of commercial income within the UK and internationally by leveraging specialist expertise in patient care, education and diagnosis	Well-led	Audit Committee	September 2018	
Current Controls and Assurance		Actions to Further Enhance Risk Management		
Current key controls to manage risks	Means of assurance	Action required to close any gaps in controls and assurances	Action owner	Action review date
<p>1. Maintaining GOSH as a preferred recipient of paediatric referrals: Focused activities on relationship management, market development and brand recognition.</p> <p>International opportunities with partners are being reviewed. Potentially entering into an agreement for provision of: direct medical care; and education, training via a visiting programme.</p> <p>Expand referral partnerships in UK (PMI) and Overseas (specifically target territories).</p> <p>Maintaining visits to London health attaché and lower level relationship management to ensure all London bound paediatric referrals are directed to GOSH. Overseas engagement through the Gulf office and visits by Director of International Services.</p> <p>An increased online presence has been achieved in English and Arabic through: a referral app to increase brand awareness and assist with developing existing and new referral opportunities; social media channels have been implemented and dedicated IPP website. The website is now tri-lingual and includes Chinese; and implementation of social media is occurring on specific Chinese channels (WeChat and Weibo).</p> <p>Improved brand awareness via targeted marketing (GOSH stories and patient case studies) in Kuwait, UAE and Saudi Arabia. Attendance at appropriate trade exhibitions in same tier 1 territories.</p> <p>Marketing and PR agency review occurred and the existing providers was re-engaged but with increased focus on on-line rather than printed media.</p>	<p>Detailed referrals and activity report is monitored by the IPP General Manager on a weekly basis to identify trends that require early intervention, this is reported to the IPP Senior Management Team. The information further feeds the new productivity indicators on the Directorate scorecard reviewed with Executive at the monthly Performance Review Meetings.</p> <p>Marketing and PR performance is reported to the IPP Senior Management Team including year-on-year comparison. In addition to a monthly competitor analysis report reviewed by the IPP Senior Management Team.</p> <p>Marketing/PR and Social Media KPIs have been agreed across different on-line channels. For example the website has: -Increase in average monthly users from tier 1 markets; -Increase average number of referral enquiries; - Increase average monthly enquiries; -Increase monthly unique users -Reduce bounce rate from home page.</p> <p>Build upon discussions in new territories (China, Russia, India) through clinician to clinician engagement facilitated through "marketing road shows" in tier 1 territories.</p>	<p>a) Discussions with consultants to transfer work to GOSH from other London private facilities, this will require greater access to resources (dedicated theatre sessions and beds)</p> <p>b) Discussions with MENA countries to develop education, training, observations and longer term visiting programme. Work underway to review GOSH providing direct patient care in MENA country</p>	<p>a) Director, IPP</p> <p>b) Director, IPP</p>	<p>a) July 2019</p> <p>b) September 2019</p>
<p>2. Capacity and Performance: Referrals and activity are monitored to ensure the referral activity remains at required and manageable levels.</p> <p>The bed requirement continues to be mixed between IPP dedicated wards and IPP funded beds on NHS speciality wards.</p> <p>Current opportunities are reviewed with NHS Directorates to ensure GOSH remains the preferred provider for paediatric care using innovative and novel procedures. Discussions continue to implement business cases and service developments. Continued work to deliver growth by targeting key consultants to repatriate their private activity to GOSH from London competitors.</p>	<p>A detailed operational performance report/scorecard is issued to Executive team members, Directorate senior leadership teams and Senior IPP team on a monthly basis. Challenge and discussion occurs at the IPP performance review meetings.</p> <p>Regular meetings occur within IPP and between IPP and NHS Directorates to review performance and discuss potential new service development opportunities and overseas opportunities.</p> <p>A speciality by speciality review has commenced identifying which services have the ability to deliver growth through innovation; new GOSH services; new service lines; and recovery of previous under-delivery by exploring barriers, challenging 'rules' and understanding requirements.</p>	<p>a) Continued access to NHS speciality ward beds to maintain referrer relationship for increasingly complex patient referrals, as well as developing IPP clinical staff to accept more complex patients.</p> <p>b) Implement agreed actions of Turnover deep-dive to address nurse recruitment and retention and Sickness deep-dive presented to Executive at the IPP performance review meeting in late 2018.</p> <p>c) Increased engagement and focus with Chief Nurse's team to address significant nurse vacancy rate. Consider recruitment in new territories including for example Philippines, Oman, Jordan and India, and consider using existing Middle Eastern links to attract ex-pat nurses back to UK.</p>	<p>a) Director, IPP / NHS Chiefs of Service</p> <p>b) Director, IPP</p> <p>c) Director, IPP</p>	<p>a) July 2019</p> <p>b) July 2019</p> <p>c) July 19</p>

<p>Building capacity through utilising available resource at weekends including operating lists, MRI and outpatient clinics.</p>	<p>Maintaining dedicated bed capacity is materially linked to nurse recruitment and retention and ensuring staff feel valued: Workforce KPIs, aligned to the Recruitment and Retention Strategy, are reported monthly to the IPP Senior Management Team. These KPIs include the number of starters and leavers, statistics around future starters and leavers, vacancies out to advert and un-actioned vacancy numbers.</p> <p>IPP mandatory training is at 98% and PDR compliance at 95% (April 2019). IPP continue to contribute and engage with Trust wide initiatives and the corporate nursing team to maximise benefit to IPP Directorate on all Trust recruitment and retention projects.</p>			
<p>3. Debt: IPP work to minimise the debt value and aging of debt. The activities include: regular visits to Health offices; agreed escalation triggers with escalation actions; and management meetings to review individual clients</p> <p>The IPP credit control policy has been reviewed and updated along with the Standard Operating Procedures. A review has led to a change in the dunning letter production and cycle to escalate debt to external bodies (debt collectors and legal firms) where appropriate to recover debt more timely to increase recovery.</p>	<p>The detailed operational performance report/scorecard has a dedicated page on debt.</p> <p>IPP has agreed actions and escalation based on four key triggers to reduce debt levels. The International Director and IPP General Manager meet with the IPP Head of Finance and Information and the IPP Credit Control Manager fortnightly to review performance and discuss issues impacting on debt levels, along with age of debt for each major client.</p> <p>The debt at end of February 2019 was £43m. A payment assurance has been received from the largest debtor. Escalation has been actioned as follows:</p> <ul style="list-style-type: none"> • in home country with Ministries of Health linked with overseas visits. • through British embassy in home countries through network of contacts. • to home country Ambassadors in UK through Foreign and Commonwealth Office and GOSH CEO. 	<p>a) Systematic review of old debt to assess likelihood of collection and preparation of write-off schedules for audit committee approval.</p>	<p>a) Director, IPP / Chief Finance Officer</p>	<p>a) April 2019</p>
<p>4. Strategy: Work continues to operationalise the IPP strategy including the identification of ten additional beds to deliver phase two of strategy, enabling 10% growth per annum over the strategic period (up to 2020/21). This in turn will enable IPP to continue to meet its financial targets.</p> <p>The first phase of the dedicated 20 bed agreed growth has been delivered (Hedgehog ward 10 beds). Allocation of the circa 10 additional dedicated IPP beds required is still to be fully identified but additional speciality beds as part of PICB development has assisted accommodation of IPP patients.</p> <p>Overseas opportunities continue to be explored to both secure existing referral flows but also develop new relationships. These relationships will both diversify the GOSH offering and widen the referral base.</p> <p>Diversify income by implementing non-clinical opportunities (e.g. International Fellowships and Observerships)</p>	<p>The detailed operational performance report/scorecard has dedicated pages to monitor income and activity. Detailed information is also provided by Directorate and Speciality.</p> <p>Total IPP income at February 2019 was £57.8m against £53.0m in 2017/18, growth of 9.1%.</p>	<p>a) IPP will work with the NHS Directorates to generate and implement approved Business cases and other Service developments (e.g. ICU).</p> <p>b) IPP will work with Strategy and Planning to ensure demand and capacity modelling is updated to reflect current and future requirements both ahead of and for Phase 4.</p>	<p>a) Director, IPP / Chiefs of Service</p> <p>b) Director, IPP / Director of Operational Performance and Information / Deputy CEO</p>	<p>a) May 2019</p> <p>c) July 2019</p>
<p>5. Reporting: Clear and regular reporting against operational and financial targets</p>	<p>A well-developed reporting suite monitors performance and provide assurance at summary and granular level. For example a detailed operational performance report/scorecard is issued to Executive team members, Directorate senior leadership teams and Senior IPP team on a monthly basis.</p> <p>Challenge and discussion surrounding the report and the Trust agreed Scorecard and Dashboard occurs at the monthly Performance Review Meetings.</p>	<p>None</p>	<p>-</p>	<p>-</p>

Risk Reviewed By: Chris Rockenbach, General Manager, IPP

Date Reviewed: 1 April 2019

BAF Risk 4: Recruitment and Retention			Executive Owner:		
The risk that the organisation will be unable to recruit and retain sufficient highly skilled staff			Acting Director of HR and OD		
Risk Domain (NPSA):	Gross (strategic) risk score:	Net (current) risk score:	Target risk score (risk appetite):		
HR/OD	20 = (L = 4 x C = 5).	15 = (L = 3 x C = 5).	Moderate (8 – 10)		
Strategic Objective:	CQC Domain	Assurance Committee:	Date of last review by Assurance Committee:		
2.1 Appropriate Clinical professional resource for all clinical teams	Safe	Audit Committee and QSAC	October 2018		
Current Controls and Assurance		Actions to Further Enhance Risk Management			
Current key controls to manage risks	Means of assurance	Action required to close any gaps in controls and assurances	Action owner	Action review date	
1. A Trust wide Nursing Recruitment and Retention Program is in place, comprised of a number of specific workstreams, with targeted actions for specialist workforce in key areas	<p>Monitored by the Workforce Advisory Board (WAB) and the Education and Workforce Board</p> <p>Presented to the Trust Board in July 2018</p> <p>On-going monitoring of relevant workforce KPIs to identify and address issues</p> <p>A Real time Vacancy record is kept updated monthly in the Nursing Workforce Office and reporting to the Trust Nursing Board</p>	a. Development of leadership strategy	ACN Workforce	July 2019	
2. Recruitment	<p>Maintaining our talent pipeline of NQN's/Junior Band 5's from undergraduate student nurses by commissioning from 6 partner HEI's</p> <p>Implementing a range of actions to ensure GOSH is an attractive employer (across all work/professional streams)</p> <p>Work underway to develop a talent pipeline for Admin and Clerical staff</p> <p>Overseas Recruitment specifically for IPP, theatres and ICU nurses</p> <p>Specific campaign focussed around the 'Heroes' success of 2018.</p> <p>Medical workforce Recruitment and Retention Group with associated actions in place</p>	<p>GOSH Learning Academy Strategic Plan accepted by Trust Board in July 2018 will focus on the provision of education, training and development for the whole workforce(including nursing)</p> <p>Confirmed that GOSH will commission 110 first year students in September 2018</p> <p>Annual reporting of number of GOSH students who commence substantive posts</p> <p>Increasing our external profile by marketing our vacancies on Facebook, LinkedIn, MumsNet and other similar routes</p> <p>Medical Workforce Actions monitored by Medical Workforce Recruitment and Retention Group</p> <p>Education and Workforce Development Committee to oversee Recruitment and Retention plans Trust-wide</p>	<p>a. Development and sign off of Outline Business Case for GOSH Learning Academy</p> <p>b. Implement improvements to the website to use it more effectively as a marketing tool and to provide potential staff, especially nurses, with more targeted and motivational information on their opportunities at GOSH</p> <p>c. Following the analysis of staff surveys to understand staff expectations and review staff benefit package including accommodation and education opportunities</p>	<p>a. Director of Education</p> <p>b. ACN Workforce</p> <p>Director HR & OD</p>	<p>July 2019</p> <p>May 2019</p> <p>May 2019</p>
Develop relationships with Further Education Institutes (FEIs) to establish a supply of suitable individuals who can access employment on the 'Talent for Care' pathway (bands 2- 4)	<p>Number of applicants reviewed by Education and Workforce Board</p> <p>Quarterly meetings between Associate Dir of Education, ACN for Workforce and GOSH Apprenticeship Lead</p> <p>The Trust's first clinical apprentices start in January 2018</p> <p>Involved in the Pan-London procurement for undergraduate nursing apprenticeships</p> <p>Appointment of lead for development of talent management programme (including apprenticeships etc.)</p>	a. Development of draft talent management programme including apprenticeships, GOSH management scheme and expansion of leadership and management offering	a.-b. Dir HR & OD	a. June 2019	
Working in partnership with HEE North trusts to develop a standardised approach to apprenticeship training (STP programme)					
Talent management programme under development					
Delivery of Retention Plan	<p>Monthly reporting of KPIs and project plans at; Education and Workforce Board; Workforce Advisory Board and bi-monthly to Trust Nursing Board</p> <p>People and Education Assurance Committee established for 1 year</p>	<p>a. Development of clinical career pathways for the whole nursing workforce</p> <p>b. GOSH is joining the NHSI Retention Programme</p> <p>c. Dedicated email for staff considering leaving GOSH</p> <p>d. Continuing to lead on the STP external secondment project</p> <p>e. Careers Clinic offering advice and support</p> <p>f. Reintroduce Junior Sister Role to provide professional development.</p>	a-i ACN Workforce / Director of Education	June – September 19	

	<p>Three groups under establishment: Recruitment and Retention Group, a staff experience and engagement group and Workforce and Education group All three groups will report to the PEAC and ensure that their remits are trust wide and cover all staff groups. The governance framework will be revisited once strategies and plans are developed and in place.</p>	<ul style="list-style-type: none"> g. Bespoke Leadership Framework for ward managers h. Increased franchised academic education portfolio offering increased opportunities for staff at a reduced cost i. Development of career pathway booklet and career workshops as well as career mentoring introduced j. Revising 2 year professional development programme for newly qualified nurses k. Introduction of career conversations 	<p>K Asst Director of HR</p>	<p>June 19</p> <p>June 19</p>
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Reviewed By: Alison Hall, Acting Director of HR and OD and Alison Robertson, Chief Nurse

Date Reviewed: 15 March 2019

BAF Risk 5: Operational Performance			Executive Owner:	
The trust is unable to demonstrate compliance with the Performance Management Framework/ Monitor's licence .			Acting Chief Operating Officer	
Risk Domain (NPSA):	Gross (strategic) risk score:	Net (current) risk score:	Target risk score (risk appetite):	
Statutory duty/ inspections or quality	20 = (L =5 x C = 4).	8 = (L = 2 x C = 4). ↔	Low (1 – 6)	
Strategic Objective:	CQC Domain	Assurance Committee:	Date of last review by Assurance Committee:	
1.2 Provide the highest quality patient care, experience and health outcomes for patients and families.	Well-led	Audit Committee and Quality and Safety Assurance Committee	January 2019	
Current Controls and Assurance		Actions to Further Enhance Risk Management		
Current key controls to manage risks	Means of assurance	Action required to close any gaps in controls and assurances	Action owner	Action review date
1. The Trust has a Performance Management Framework process through which the performance of individual divisions under each of the CQC domains are reviewed and managed.	<p>Monthly Divisional and Trust-wide Integrated Performance Report</p> <p>Agreed actions/outcomes from Divisional Performance meetings are submitted to EMT for review and oversight.</p> <p>Review completed of the Performance Reviews and have moved to a two month model with a smaller scale Directorate review completed on the 'other' month.</p>	To ensure a consistent and equitable approach to performance reviews is adopted across the organisation, the Trust plans to undertake Performance Reviews across the Corporate Divisions also on a rolling basis.	Director, Operational Performance and Information	May 2019
2. On-going and escalated monitoring of revised and agreed delivery trajectories to achieve the incomplete RTT standard	<p>The Trust has consistently achieved the RTT Incomplete standard in January 2018, although compliance against the standard is becoming more of a challenge and we remain non-complaint in a number of key speciality areas.</p> <p>Weekly Trust wide Patient Tracking List (PTL) meetings with all clinical areas (supported by weekly local PTL meetings in the local divisional teams). PTL shows all RTT, cancer and diagnostic pathways and the length of time waiting, supported by speciality level action plans by the operational teams where necessary.</p> <p>Monitoring of delivery against all performance, quality and safety standards are picked up through the monthly Performance Reviews with the Divisional teams with escalation to the Executive Management Team meeting as necessary. For all 'red' actions, a highlight report has to be produced that details actions for recovery and timeframes</p>	<p>Revise and continue to monitor RTT recovery trajectories for specialities that remain non-compliant.</p> <p>In light of the implementation of the EPIC system ensuring that the reporting structure is in place to support the current governance structure or if necessary adapt the structure to reflect reporting</p> <p>Delivery of the Diagnostic recovery plan to ensure we return to a position of less than ten diagnostic breaches on a weekly basis.</p>	<p>Director, Operational Performance and Information</p> <p>Director, Operational Performance and Information</p> <p>Director, Operational Performance and Information</p>	<p>April 2019</p> <p>April 2019</p> <p>May 2019</p>
3. Continued monitoring of compliance against the Diagnostic and Cancer standards	<p>Weekly review through the PTL meetings, Divisional Performance Reviews and ODPG</p> <p>Completion of a deep dive into the reasons behind the increase within the Diagnostic breaches, particularly in Radiology through the PTL Meetings</p>			
4. Elective Care Access Policy refreshed and approved by PAG (Cancer Access Policy to be appended – being finalised)	<p>Published Access Policy on GOSH Web and Trust website.</p> <p>Ensure via the Trust wide PTL meetings that patients are being managed in accordance with the policy</p> <p>RTT and cancer training material has been refreshed and updated with a new training package being rolled out across the organisation</p>	The Trust is currently reviewing all SOP's and specifically in relation to the EPR go-live. The review of elective access SOP's will be picked up as part of this process	Director, Operational Performance and Information	May 2019
5. Implementing a range of initiatives to increase activity capacity such as operational bed meetings, theatre scheduling meetings. Flow work programme, outpatient redesign	<p>Programmes of work, with deliverables, key milestones dates, and identified operational leads, reported to the (to be established) Elective Care Programme Board</p> <p>Establishment of a redefined Flow Programme to meet the current challenges across the organisation</p>	Refreshed demand and capacity work is required to support services to sustainably deliver access standards. A review of the constraints including beds and staffing will be looked at as part of this work.	Directors of Operations (supported by Director, Operational Performance and Information)	July 2019
6. A range of activities are underway to reduce the likelihood of last minute, non-clinical hospital cancelled operations	Daily review of cancellations to ensure that cancellations are averted and lessons are learned	a. To ensure that reporting related to the cancellation of operations for non-clinical reasons is robust and timely to support the Divisional team with timely tracking through the use of the EPIC system	a. Director of Operational Performance and Information	April 2019

	<p>Monitored via the PMF and monthly Divisional Performance meetings</p> <p>Development of a new process for the cancellation of operations for non-clinical reasons including clear escalation for any patients who are likely to be cancelled.</p>	<p>b. Quarterly audit of compliance against the new process</p>	<p>b. Director of Operational Performance and Information supported by the Director of Operations</p>	
<p>7. The Trust has in place a compliance framework where monitoring and assurance against CQC criteria is collated and reported to relevant Board committees.</p>	<p>The CQC published its latest scheduled inspection report in April 2018. The Trust received a rating of 'good' overall and 'requires improvement' for the assessment of well led. The Trust received a requirement notice related to comments received from staff about procedures going ahead without patients information being available.</p> <p>The Trust has developed an Action Plan related to the requirements of the CQC report. Focus now continues around implementation of the Action Plan</p>			
<p>8. The Board monitors compliance with the governance requirements of the licence</p>	<p>Annual compliance report presented to the Governors for their comments and then to the Board for consideration and final sign off.</p> <p>Internal audit on risk management provided a rating of Significant assurance with minor improvement</p> <p>Risk management Strategy revised and presented at April Board for approval.</p> <p>Monthly directorate performance reporting</p> <p>Framework for managing compliance across the Trust and ensure readiness for the next CQC inspection</p> <p>The Trust has systems and processes in place to support staff and patients in escalating concerns in provision of care or management of systems. These include the complaints process, PALS, Freedom to Speak Up Guardian, Guardian of Safe Working, Raising Concerns Policy, Counterfraud service etc.</p> <p>A self-assessment is prepared annually against the Monitor code of Governance and will be reported to the Board in May 2019. The Trust Board considers that from 1 April 2018 to 31 March 2019 it was compliant with the provisions of The NHS foundation trust Code of Governance</p>	<ul style="list-style-type: none"> Assurance and Escalation Framework under review 	<p>Company Secretary</p>	<p>June 2019</p>

Risk Reviewed By: Peter Hyland, Director of Operational Performance & Information **Date Reviewed:** 26th March 2019

BAF Risk 6: GOSH Strategic Position			Executive Owner: Acting Chief Operating Officer	
Lack of clarity around positioning of GOSH in the broader NHS wide strategies leading to lack of progress and momentum in developing appropriate system wide services and support for GOSH's role				
Risk Domain (NPSA):	Gross (strategic) risk score:	Net (current) risk score:	Target risk score (risk appetite):	
Business objectives/ projects	9 = (L = 3 x C = 3).	9 = (L = 3 x C = 3).	Moderate (8 – 10)	
Strategic Objective:	CQC Domain	Assurance Committee:	Date of last review by Assurance Committee:	
1.3 To be recognised as (1.3.1) an expert in diagnosis and treatment for children with rare diseases; (1.3.2) for continuing clinical innovation; (1.3.3) as a leader of national and regional specialist paediatric services	Well-led	Audit Committee	October 2018	
Current Controls and Assurance		Actions to Further Enhance Risk Management		
Current key controls to manage risks	Means of assurance	Action required to close any gaps in controls and assurances	Action owner	Action review date
1. Refreshed our GOSH strategy to ensure, as an organisation, we are clear about our direction, role, strengths and weaknesses, external environment, planning, NHS-wide strategies, etc.	The Trust undertook the second Open House week on early October 2018. Fulfilling our potential document and objectives 2018/19 divisional and corporate business planning process Minutes of strategy focused sessions with teams in the hospitals	Further reiteration of the Trust Strategy to build on previous work completed related to the House and define the direction of the Trust for the next five years. This is a large programme of work which has been defined over the coming months. Milestones include: <ul style="list-style-type: none"> Planning and design of the engagement process Engagement workshops with key staff across the organisation Analysis of the output from the various workshops to define the Strategy Exhibition with workshops and meetings to obtain feedback on the vision, scenarios and other strategy elements Redesign and consolidate the Strategy based on the feedback encompassing the Trust Board Strategy Away Day Trust Board Approval Finalise and launch of the Strategy 	CEO, Acting COO, Director of Operational Performance and Information	March 2019 June 2019 July 2019 September 2019 October 2019 October 2019 November 2019
2. Continuing to strengthen our role in specialised and highly specialised services through networks, campaigns, and partnerships, alliances, and children's sector reviews.	2019/20 divisional and corporate business planning process Local strategy documents and business plans Membership of networks, campaigns, partnerships, alliance, and involvement in local and national reviews. The Trust continues to be an active member of appropriate networks, groups and alliances across the NHS and beyond which are appropriate to the delivery of paediatric care.	<ul style="list-style-type: none"> Local Strategies are also being developed where appropriate to align to the direction of the organisation. Recent examples include Neurosciences, Labs and Training & Education Strategy. 	Acting COO, Director of Operational Performance & Information and Head of Strategy and Planning	December 2019
3. Working to maintain involvement in North Central London (NCL) Sustainability Transformation Plan (STP), including working with NHS England, specialist commissioning groups and committees, and STPs	NCL STP document Trust has met and is working with the STP Director of Paediatric Care Continued work and engagement with the STP specifically around Redevelopment and potential funding			
4. Unified strategy amongst the Children's Alliance.	Continued work with the Children's Alliance and ensure that Strategy among paediatric centres is aligned			

Risk Reviewed By: Peter Hyland, Director of Operational Performance & Information

Date Reviewed: 26th March 2019

Current Controls and Assurance			Actions to Further Enhance Risk Management		
Current key controls to manage risks	Means of assurance (by control number)	Action required to close any gaps in controls and assurances	Action owner	Action review date	
BAF Risk 7: Unreliable data Failure to monitor data quality impacting on accurate, consistent and appropriate data reporting across the Trust and to external parties (commissioners etc.)			Executive Owner: Acting Chief Operating Officer		
Risk Domain (NPSA): Statutory duty/ inspection	Gross (strategic) risk score:	Net (current) risk score:	Target risk score (risk appetite): Low (1–6)		
Strategic Objective: 1.1 To provide timely access to care for all GOSH patients	CQC Domain Well-led	Assurance Committee: Audit Committee	Date of last review by Assurance Committee: January 2019		
1. A Data Quality Strategy has been approved	The Strategy was approved by Trust Board via the DQRG.	Review and revise the Data Quality Strategy in view of the EPIC implementation Alignment of the outputs of the work completed to date around the improvement of DQ and the EPR project, to ensure that best practice work is carried forward into the new systems and build upon.	Director, Operational Performance and Information	May 2019 June 2019	
2. The KPMG Data Quality Action plan sets out actions to review the quality of data reported to the Board and externally.	Progress against the action plan is monitored by the DQRG. The DQRG reports to the Information Governance Steering Group and also the Audit Committee A follow up review completed by KPMG demonstrates the Trust as being 'significantly assured with minor improvements required.' The Trust has closed off the original DQ Action Plan and has now developed a new plan to align with the work being completed to support EPR. Following a review of the governance structure in place to support the Data Quality Review Group, we have implemented a new operationally led structure to support future work. As part of the internal Audit programme, KPMG completed an audit in relation to theatres which did have a specific focus on data quality. Again this cited good processes with some specific recommendations related to roll out	Ensure that the current action plan in place to improve data quality is fully aligned with the needs of the EPR project at all times	Director, Operational Performance and Information	April 2019	
3. The Data Quality dashboard has now been produced and continues to be rolled out across the organisation to be implemented.	Kitemarking assessments have now been completed related to all KPI's that exist within the Integrated Performance Report and take into account the outputs from the Data Quality dashboard.	Development of the new data quality dashboard capturing the indicators necessary to support the new EPIC system. Review of the Kitemarking assessment made across all areas to ensure they are still relevant	Director, Operational Performance and Information	April 2019 April 2019	
4. The information warehouses used by the Trust have been reviewed and streamlined.	A follow up review by KPMG has taken place providing the trust with assurance of progress to date. This has now been completed				
5. A programme of training to support staff around implementation of (RTT) SOPs has been developed	The Trust has recently refreshed its RTT and cancer training to reflect current practice and this has been rolled out across the organisation	Developing a dedicated data quality training package dedicated to support the use of the EPIC system.	Director, Operational Performance and Information	June 2019	
6. Aligning DQ work and the EPR Project to ensure the EPR takes full account of known DQ issues and addresses these through changes in processes.	The Director of Operational Performance and Information is the chair of the EPR Existing Systems and Data and Reporting Readiness Group which has oversight of these issues There is a standard agenda item on the Existing Systems and Data and Reporting Readiness Group to provide oversight on data quality and GDPR.	Frequent review will be requirements of EPR will be required as we progress towards go-live	Director, Operational Performance and Information	April 2019	

	<p>In addition, the EPR team are now a core member of the Data Quality Review Group.</p>			
<p>7. Data Assurance team focus being shifted to support the EPR Programme work and the associated risks</p>	<p>Use of the Data Assurance team as Super Users and to support EPR work.</p> <p>Use of the established Data Assurance Officers to gain a super user understanding of the new system and to support the training of Trust staff</p> <p>Agreement to supplement the current Data Assurance Team at go-live with Validation resources</p>	<p>Long term alignment of the Data Assurance function and their role to the EPIC system to ensure that any highlighted issues are picked up in a timely manner.</p> <p>Review of the current resources in place to date to ensure the size of the team is appropriate.</p>	<p>Director, Operational Performance and Information</p>	<p>April 2019</p> <p>May 2019</p> <p>April 2019</p>

Risk Reviewed By: Peter Hyland, Director of Operational Performance & Information **Date Reviewed:** 26th March 2019

BAF Risk 8: Research Income			Executive Owner:	
The Trust may not be able to provide the required level of research infrastructure or leverage additional research income if core research funding streams are reduced			Director, Research and Innovation	
Risk Domain (NPSA):	Gross (strategic) risk score:	Net (current) risk score:	Target risk score (risk appetite):	
Finance	9 = (L = 3 x C = 3).	6= (L = 2 x C = 3).	Moderate (8 – 10)	
Strategic Objective:	CQC Domain	Assurance Committee:	Date of last review by Assurance Committee:	
3.2 Define a Research Funding Model within GOSH that supports clinical and translational research and raises further commercial income	Well-led	Audit Committee	January 2019	
Current Controls and Assurance		Actions to Further Enhance Risk Management		
Current key controls to manage risks	Means of assurance	Action required to close any gaps in controls and assurances	Action owner	Action review date
(1) Research Hospital Vision and 5 year plan, including financial targets is being implemented	<p>Six monthly reporting to Trust Board on performance against income targets</p> <p>R&I Board oversight, reporting to Executive Management Team</p> <p>Local financial performance reports as part of Directorate Performance reviews and specific commercial finance reports (to provide assurance locally to divisions they are receiving funding appropriately for their involvement in research activity).</p> <p>Second engagement event with Med City held in March 2018</p> <p>R&I KPIs included in the Directorate Performance Review scorecards</p>	<p>(1) BRC strategy continues to be implemented</p> <p>(2) Review model for supporting time in job roles for research</p> <p>(3) Continue to proactively manage the impact of BREXIT with respect to future EU funding opportunities - although government commitment to funding until 2020 recent concern raised over UK Leadership of European Reference Networks (locally negotiating to move from mono-beneficiary to multi-beneficiary contract to protect funding)</p> <p>(4) Forecast and manage the impact of reduced core infrastructure funding - the Trust will receive a reduced allocation of its core infrastructure funding, Research Capability Funding (RCF), from 1 April 2019. The loss in 2019/20 will be 11% (£230k) in Year 1, reducing by 75% (£1.6m) by 2023/24.</p>	<p>Director, Research & Innovation / Deputy Director of Research & Innovation</p>	<p>(1) March 2022</p> <p>(2) December 2019</p> <p>(3) December 2019</p> <p>(4) April 2020</p>
(2) New 5 year NIHR Biomedical Research Centre (BRC) Award, £37m (£1.5m increase)	BRC Science Board which reports to a BRC Strategy Board to oversee the delivery of the BRC as well as regular reporting to the R&I Board. In addition independent assurance from an external BRC Advisory Board (last EAB Nov 2018).	No gaps		
(3) New NIHR Clinical Research Facility (CRF) award (£3.04m)	<p>Regular reporting to the R&I Board</p> <p>Shortfall in funding has been met through the GOSH Research Capacity Fund, commercial research revenue and the BRC (agreed).</p>	Secure additional space for the CRF to enable growth – space identified for CRF including expanded capacity in light of phase 4 development (exact site tbc).	Director, Research & Innovation / Deputy Director of Research & Innovation	July 2019
(4) Implementation of the commercial funding model and an enhanced financial performance system to incentivise clinical teams to support research	<p>Improved reports to local areas on research costs and income</p> <p>R&I KPIs included in the Directorate Performance Review scorecards – engagement with new Clinical Directorates for provision and discussion of management information</p> <p>Improved research cost tracking recovery systems across Trust departments, including Laboratory Medicine and Gene Therapy GMP.</p>	<p>Implementation of new finance module (in Qlikview) to provide more meaningful reports to budget managers across the Trust to enable them to better understand research costs, budgets, grants and contracts in their local areas – working group and resource in place</p> <p>Recent NHS England consultation resulted in a recommendation to move to a single centre for Costing and contracting of commercial research, adherence to working with this centre and costing model developed has been added to the national contract. This is a potential risk as GOSH team has developed robust costing systems with transparent income returns across the Trust. GOSH R&I have nominated a member of their team to input to the development of this new centre.</p> <p>Ensure all contracts meet the requirements of the new financial regulations for income recognition and to ensure research funding can be used as intended in applications.</p> <p>Internal income distribution model to be reviewed in light of reduced RCF funding from 1 April 2019.</p>	Deputy Director of Research & Innovation	<p>April 2019</p> <p>April 2019</p> <p>April 2019</p>

				April 2019
(1) Continued investment in research infrastructure through the GOSH Research Capacity Fund (including matched funding by GOSH CC), to underpin a growing portfolio of research. New award letters issued (£1.1m awarded, clear guidance for research support departments and expectations around cost recovery). The process to review and allocate funding has been refined and implemented	Funding bid is overseen by the GOSH Research Capacity Committee Good evidence of sustainability for pharmacy and radiology	On-going review of sustainability of posts Review of funding scheme and mechanisms to ensure sustainability, especially in light of reduced RCF funding which provides the Trust element.	Deputy Director of Research & Innovation	April 2020
(2) Partnership working and horizon scanning with the Clinical Research Network: North Thames to maximise financial support to deliver research.	Recently awarded funding via the Clinical Research Network for two posts	Continue to explore opportunities for joint investment in posts with the Clinical Research Network: North Thames Regular attendance at CRN R&I meetings to enhance regional collaboration, sharing resources and leveraging additional income where possible (North Thames CRN and UCL partners)	Dir, R&I / Dep Dir, R&I	April 2020
(3) Research Accelerator and Grants Advice service is in place, to support researchers at any stage in their careers and research projects with grant applications	R&I Board monitors performance of the service, including grant success rates	On-going review of performance, including grant success rates.	Deputy Director of Research & Innovation	April 2020

Risk Reviewed By: Jenny Rivers, Deputy Director, R&I

Date Reviewed: 20 March 2019

Current Controls and Assurance			Actions to Further Enhance Risk Management		
Current key controls to manage risks	Means of assurance	Action required to close any gaps in controls and assurances		Action owner	Action review date
(1) Research Hospital Vision and 5 year plan is being implemented	R&I Board oversight, reporting to Executive Management Team Six monthly reporting to Trust Board on research income; research recruitment, international standing and performance against NIHR metrics. Refreshed research communications strategy with GOSHCC and ICH Directorates include research objectives in annual business plans Appointment of Trust Research Leads with defined objectives and targets for wider engagement with research EPIC go-live April 2019 enhancing research opportunities via enhanced data capture, access and analysis	(1) Laboratory medicine strategy under development; draft strategy under discussion with heads of lab services (2) Research to be embedded in decision making of the organisation (3) Identify and establish additional thematic areas / cross programme infrastructure for example laboratory medicine to bring together clinicians and basic scientists (4) Implementation of generic consent - pilot started September 2017, inpatient pilot started in July 2018 with further areas to begin consenting in 2019.	Dir, R&I / Dep Dir, R&I	(1) April 2019 (2) April 2019 (3) April 2020 (4) April 2019	
(2) Annual delivery plans are in place to support the operationalization of the Research Hospital vision. Business partnering model to support this is in place	Oversight of delivery through R&I Board, reporting to EMT Six monthly reporting to Trust Board on research income; research recruitment, international standing and performance against NIHR metrics.				
(3) Working closely with the UCL Group to ensure a cohesive strategy and partnership in day to day working wherever possible	The Child Health Campus Group (Joint GOSH and UCL Group) oversees and monitors the effectiveness of this partnership ZCR due to open mid-2019 to further joint working and increase capacity for research				
(4) 5 year NIHR Biomedical Research Centre award	Oversight of delivery through R&I Board, reporting to EMT.				
(5) Staff to be attracted to and undertake research at GOSH	Consultants have access to protected time for research Nursing and AHP training programme (including funding) available via the BRC Permanent contracts for research delivery staff (currently restricted to research nurses) Study coordinators being recruited to work alongside research nurses to support them in their work	Securing the appropriate posts for nurses and AHPs to return to following successful completion of studies – action plan to be developed in partnership with Chief Nurse and Deputy Chief Nurse for Research	Deputy Director of Research & Innovation/ Chief Nurse/ Deputy Chief Nurse for Research	September 2019	

Risk Reviewed By: Jenny Rivers, Deputy Director, R&I

Date Reviewed: 20 March 2019

BAF Risk 10: EPR Short – Term – Project Implementation and Go-Live-2 years) The risk that the EPR programme will not be delivered on time or within budget. Key risks being monitored by programme board: <ul style="list-style-type: none"> • Programme budget; Procurement risks ; Capability/ resource risks • Clinician, Executive and other staff engagement; Risks associated with multiple clinical systems • The risk that at go live the system is not available for a period of time, data migration issues or operation of system causes data quality issues post go live impacting on reporting. • Change management is effective to ensure adoption of best practice. 			Executive Owner: Chief Executive			
Long – Term – Optimisation and Benefits Realisation The risk that the 18 month period following EPR system implementation is not maximised to ensure optimisation of the system and the benefits are not maximised for the organisation as outlined in the Business Case.						
Risk Domain (NPSA):		Gross (strategic) risk score:	Net (current) risk score:	Target risk score (risk appetite):		
Finance (5) and Impact of Safety (4)		16 = (L = 4 x C = 4).	16 = (L = 4 x C = 4), ↔	Low (1 – 6)		
Strategic Objective:		CQC Domain	Assurance Committee:	Date of last review by C'tee:		
4.5 Develop a five year investment plan for business critical assets (e.g. equipment) required to deliver the strategy		Well-led	Audit Committee	October 2018		
Current Controls and Assurance			Actions to Further Enhance Risk Management			
Current key controls to manage risks		Means of assurance		Action required to close any gaps in controls and assurances	Action owner	Action review date
1. Robust programme governance led by the EPR Programme Board, including engagement with clinical experts, patients and families, finance, IT, research and operational management and key suppliers. The EPR Programme Board has oversight of: <ol style="list-style-type: none"> statements of vision, changed operating model (blueprint) and comprehensive system specification programme and project-based risk management to manage key risks to quality, time and budget procurement processes and contract management of supplier partners full business case, organisationally-owned benefits plan and tracking interdependencies with other strategies such as RTT/Data Improvement, the Research Hospital, ICT/infrastructure and the P&E programme. 		<ol style="list-style-type: none"> External Gateway review process at key points to provide independent assurance of the programme's governance and performance. Weekly EPR updates are provided to the SRO and monthly to other key Executives to provide additional oversight and assurance of progress. Monthly progress reports provided to executive team by both the EPR Programme Team and the Epic team Additional sub-groups to focus on clinical transformation and adoption, operational process redesign, impact on staff, technical readiness (including key focus on data migration and statutory & operational reporting) and finance Detailed Programme Plan developed including programme blueprint, scope, timelines, milestones, responsibilities and risk management The EPR Programme is reporting against defined readiness criteria to all Trust Boards and Board sub-committees through to go-live 		<ol style="list-style-type: none"> Continue to closely monitor the delivery of statutory reports in line with the current plan Regularly update EPR Programme Board and Trust Board (and its sub-committees) with progress against agreed go / no-go criteria 	1.EPR Programme Director / Director of Operational Performance and Information	March 2019 The programme has focussed on delivering the critical returns for go-live (including those required by Finance teams). There remains a high level of confidence that these reports will be baselined (ready for go-live) by the end of March 2019
2. Clinical and research leadership and engagement is incorporated via the Chief Clinical, Research and Nursing Information officers		<ol style="list-style-type: none"> The effectiveness of engagement with clinicians is overseen by the Clinical Design Authority group Ten Medical Information Officers (MIOs) and four Nursing Information Officers (NIOs) appointed to support CCIO / CNIO 		<ol style="list-style-type: none"> Enact plan agreed by EPR Programme Board for manual migration of Problem List 		April 2019 The team has commenced manual migration of the problem list and further plans are in place to assist with ongoing updates either through manual data entry or using an AI solution post go-live
3. Communication strategy in place, including specific strategies to ensure thorough engagement with clinicians and to ensure all staff and stakeholders are aware of programme and impacts of changes		<ol style="list-style-type: none"> Approved communications strategy which is refreshed at each key Programme stage (next due September 2018) and is informed by internal and external learning (e.g. latest refresh will include lessons learned from SickKids Epic implementation) Stakeholder engagement plan, including quarterly review of stakeholder power and influence map. 		<ol style="list-style-type: none"> Specific focus on communicating key activity (implementation tasks and change) to the new leadership team; through the Operational Readiness Group which will meet weekly from January 2019 	3.Programme Team	March 2019 EPR provides update to weekly SLT and at a detailed level through the Operational

	<p>k) EPR Programme update in monthly Staff Talks; programme presentation bi-monthly to specialty meetings / operational groups / regular 'EPR Roadshows' (which now include 'local' roadshows in clinical areas, such as theatres and ward areas, where staff find it more difficult to attend 'central' events).</p> <p>l) Communication feedback loop in place</p>			Readiness Group. Additional readiness meetings are scheduled through to go-live
4. The project is closely integrated with Quality Improvement and Operations teams to ensure the EPR is delivered as a change programme, rather than an ICT project	<p>a) EPR Programme Board oversees assurance.</p> <p>b) Weekly EPR updates are provided to key Executives to provide additional oversight and assurance of progress.</p> <p>c) Senior representatives from QI and Operational teams are embedded within programme governance. The new lead for EPR Transformation & Benefits reports to PMO lead and the two teams are jointly managing and progressing transformation and benefit opportunities</p> <p>d) Programme Oversight Group established to track dependency and contention across key programmes</p>	e) No further actions required at this time		N/A
5. Working through the recommendations of the Internal Audit on EPR Governance and Project Management	<p>(e) Recommendations have been adopted into the programme plan with detailed strategies developed to support delivery of the plan.</p> <p>(f) Updates will be provided to EPR Programme Board, Audit Committee and Trust Board.</p> <p>(g) Recommendations from 2017 Internal Audit complete; Benefits Strategy developed and signed off by EPR Programme Board</p>	f) No further actions required at this time		N/A
6. Engaged external expert advisors for legal, commercial and procurement processes.	<p>e) EPR Programme Board oversees risks and performance</p> <p>f) Weekly EPR updates are provided to key Executives to provide additional oversight and assurance.</p> <p>g) KPMG were engaged to conduct a review of supplier financial standing and to prepare the business case, including benefits realisation and financial assurance.</p> <p>h) GE Finnamore has completed 4 Gateway reviews (the latest in December 2018). Following three green reviews, the latest report has an amber status based primarily on the high level of risk contained within a programme of this size and complexity and the reducing time until go-live in April 2019. The next review takes place end of March and focusses on operational readiness</p> <p>i) Epic provide monthly reports to the executive team on progress against plan. The monthly report score has been above average for Epic implementations throughout the whole period and has increased back to 4/5 for the last reporting period</p> <p>j) An external assessment of technical / infrastructure readiness has been planned with colleagues from the Royal Marsden</p>	<p>g) Respond to issues identified during the March assurance review performed by GE Finnamore</p> <p>h) Further gateway reviews are scheduled throughout the programme.</p> <ul style="list-style-type: none"> • October 2019 <p>i) Act on key findings from the technical / infrastructure review performed by RMH</p>	6.SRO	April 2019
7. Linking with data quality review and system to manage data migration (refer to BAF risk 8: Unreliable data).	k) Refer to BAF risk 8: Unreliable data	j) Refer to BAF risk 8: Unreliable data		
8. Development of Financial Business Case including financial benefits and funding options	<p>l) Consultation with clinical and non-clinical groups undertaken to develop and approve financial benefits with ownership assigned.</p> <p>m) Grant application to Charity for partial funding complete.</p> <p>n) Benefits re-baselined underway and planned as ongoing throughout and post implementation. Progress on delivery of each benefit is reviewed on a monthly basis by the EPR Programme Board</p>	k) Update 2019 / 2020 financial plan to take into account other financial pressures (i.e. changes to the Trust LTFM)	8. EPR Programme Director	<p>March 2019</p> <p>A revised EPR budget for 19/20 has been submitted and is undergoing review and refinement as part of business planning. A key decision has been taken to remove revenue contingency which will not impact go-live but may result in pressure in 19/20 if unexpected issues arise post go-live</p>

9. Establishing strong operational engagement, leadership and change control management and processes to support effective implementation	<p>o) The programme team have now been trained and certificated.</p> <p>p) Effective governance in place at all levels of the programme which includes representation from leaders across the organisation; this includes the Implementation Steering Group which provides operational focus and the Clinical Design Authority providing clinical focus.</p> <p>q) Transformation & Benefits Group established (includes QI, PMO, operational and clinical leadership).</p> <p>r) Benefit sub-groups established</p>	l) No further actions required at this time		N/A
10. Engagement of third party experts to deliver complex technical elements	<p>s) The programme has engaged 3rd party suppliers for data migration services and integration.</p> <p>t) Monitoring of delivery incorporated into standard programme controls</p>	m) No further actions required at this time – all bar one third party interface has been fully tested and signed off. The programmatic data migration into the EPR live environment has commenced with minimal data errors for MPI (our core patient demographics), referrals and RTT pathways		N/A
11. Adoption of best practice from Epic Foundation and from similar sites (particularly RCH Melbourne) to drive design of a system which actively supports future state processes	<p>u) Principle for implementation phase to develop a system across the whole hospital but limit detailed speciality content; allowing staff to focus on the primary change initially and adopt (through optimisation) more complex change in post live phase.</p> <p>v) Clinical / programme team visited RCH Melbourne; lessons learned incorporated into system design principles. Clinical / operational leaders visited SickKids (Toronto) go-live in June 2018 and provided detailed report on lessons learned. CCIO + MIO colleague visited Boston to look at specific complex functionality. DCEO, CCIO, CNIO and members of programme team visited the American University of Beirut Medical Centre during their go-live weekend in November 2018. The Director of Planning and Information, with a GM, visited SickKids and Boston to review use of data with Epic</p> <p>w) Members of the operational leadership team visited CUH and brought back learning which has been fed into go-live planning. Over 125 doctors, nurses, pharmacists and lab staff from six 'Epic' sites are attending the go-live as additional super-users. The costs are netted off against a reduction in Epic staff fulfilling the same function</p> <p>x) Epic implementation team tasked with ensuring system design is in line with their experience internationally and that the teams (Epic and trust) identify change to include within the training approach.</p>	n) CHOP, CHEO, RCH Melbourne and Stanford to provide floorwalker support at go-live (sending teams of clinical users) to supplement GOSH and Epic teams	11.SRO	April 2019

Risk Reviewed By: Richard Collins, EPR Programme Director

Date Reviewed: 08/03/2019

Current Controls and Assurance			Actions to Further Enhance Risk Management	
Current key controls to manage risks	Means of assurance	Action required to close any gaps in controls and assurances	Action owner	Action review date
1. A Trust wide business continuity plan has been completed and signed off by the Major Incident Planning Group.	<p>The Major Incident Planning Group meets on a quarterly basis to oversee the management of the BC plan and emergency preparedness for the Trust.</p> <p>Deputy Chairman is NED overseeing business continuity.</p> <p>New Chair of MIPG agreed, Andrew Taylor, Accountable Emergency Officer.</p>	<p>Trust Business Continuity plan was reviewed at MIPG March 2019 and will be submitted to for sign off</p> <p>Overarching EPRR policy was presented at Feb PAG and awaits final amendments for sign off.</p>	<p>MIPG Chair</p> <p>EPO</p>	<p>July 2019</p> <p>April 2019</p>
2. Each department/service has completed the revised BC template.	<p>Completed service plans in place. These are reviewed by the Major Incident Planning Group and are expected to be reviewed annually (tracked by the EPO) or when there are significant changes to the service or estate.</p> <p>Business continuity plans are now at over 98% across the trust. The 1 outstanding plan is in final draft.</p>	<p>BC plans under development of implementation of EPIC, which is overseen by EPIC Steering Group. GOSH plan re: Epic downtimes and Business Continuity is in place.</p> <p>Create a central pool / database of departmental business continuity plans that are accessible by all staff.</p> <p>Business continuity incidents to be closed down on Datix</p>	<p>EPO</p> <p>EPO</p> <p>EPO working with teams</p>	<p>April 2019</p> <p>May 2019</p> <p>May 2019</p>
3. A robust emergency planning training program is in place to raise awareness across the Trust on how staff should respond in an emergency.	<p>EPO presents reports to the Major Incident Planning Group on lessons learned from all training exercises.</p> <p>A number of Live' and 'table top' exercises have been held and are planned to explore business continuity issues.</p> <p>A table top exercise was conducted with the CSP's re: un-booked attenders and fire, plus we have introduced some EPRR/BC elements to the fire training package delivered regularly across all clinical areas.</p> <p>Power outage reports have been signed off and closed – learning captured and owned by H&S Manager</p> <p>Testing of EPIC BC plans implemented prior to Go Live</p>	<p>A strengthened GOLD/Exec training package has been delivered with a further session planned for end March 2019.</p> <p>Further training/ rehearsal for all executives, duty managers and senior managers to be established.</p>	<p>EPO</p> <p>EPO</p>	<p>April 2019</p> <p>June 2019</p>
4. A workplan outlining compliance against the NHS Core Emergency Preparedness Standards is managed on an on-going basis.	<p>NHS England provides external assurance on compliance with Emergency Planning core standards (including cyber security for the first time). In November 2018, Against 69 standards, the Trust is green with 65, and amber with 4 These include business continuity plans, EPO attendance at Borough level forum, GOLD/Exec training records, command and control element of the Trust Business Continuity plan. The Trust has an official rating of substantial compliance against the standards.</p> <p>The Emergency Preparedness workplan and is shared at every Major Incident Planning Group meeting</p>			

	<p>EPO attended Borough Resilience Forum on 06/02/19</p> <p>Gold training done and new records being kept for all training and exercising being conducted.</p> <p>BCP will now include command and control and other recommendations (as above).</p>			
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Risk Reviewed By: Camilla McBrearty, Emergency Planning Officer

Date Reviewed: 1 May 2019

BAF Risk 12: Redevelopment			Executive Owner:	
Inadequate planning or management of infrastructure redevelopment may result in poor VFM or failure to deliver expected business benefit.			Director, Development and Property Services	
Risk Domain (NPSA):	Gross (strategic) risk score:	Net (current) risk score:	Target risk score (risk appetite):	
Business objectives/ projects	12 = (L = 3 x C = 4).	9 = (L=3 x C=3)	Medium	
Strategic Objective:	CQC Domain	Assurance Committee:	Date of last review by Assurance Committee:	
4.4 To ensure the capital investment plan	Safe	Audit Committee	December 2018 - Trust Board	
Current Controls and Assurance		Actions to Further Enhance Risk Management		
Current key controls to manage risks	Means of assurance (by control number)	Action required to close any gaps in controls and assurances	Action owner	Action review date
1. Effective and well informed Project Boards	<ul style="list-style-type: none"> - Senior Responsible Officer chairs - Programme, cost, market conditions and risk formally advised by SMEs, reported by Project Manager and interrogated by Project Board - Project Initiation Document (PID) provides benchmark and is updated throughout the project cycle as required to reflect change - External and independent evaluation of governance provided as required by CEO – audit / gateway - Redevelopment Programme Board established with oversight of all redevelopment work and reports to Finance and Investment Committee and QSAC which provides assurance to the Trust Board about need, scale of development, cost and affordability. - Regular review of Masterplan (2015, 2018) 	<p>Gateway taking place June 2019</p> <p>Next Masterplan Update due 2020.</p>	Deputy Director, Redevelopment	Summer 2020 in preparation for FBC approval
2. Project leadership	<ul style="list-style-type: none"> - GOSH retains clear leadership role for client body through the CEO and the Project Director - Reporting mechanisms and accountability clearly defined in PID - Role and remit of scrutinising stakeholders clearly explained in PID - Programme Manager to be recruited to support Deputy Director and programme delivery 	None	Deputy Director, Redevelopment	
3. Commercial Management	<ul style="list-style-type: none"> - Professional contract management (Employer’s Agent) procured from recognised and qualified providers and held to account through the Project Director and Project Board - Professional cost management procured from recognised and qualified providers and held to account through the Project Director and Project Board - Project Costs benchmarked against other schemes - Project Costs peer reviewed as part of the procurement strategy - Market conditions monitored and reported to project Board - Procurement process encourages early engagement with contractors to drive buildability and more proactive construction management 	NEC Contract Manager to be procured for Phase 4. Scope drafting and PQQ draft completed. Target framework appointment after OBC approval	Director, D&PS/ CFO	October 2019
4. Business case process	<ul style="list-style-type: none"> - Compliance with NHS I capital regime guidance for FTs. - 5 case model followed - Sensitivity analysis to reflect fluctuations in activity, income or market conditions - Activity & capacity model to underpin assumptions 	None	Deputy Director, Redevelopment	October 2019

Risk Reviewed By: Stephanie Williamson, Deputy Director, Redevelopment

Date Reviewed: 14 March 2019

BAF Risk 13: Information Governance Personal and sensitive personal data is not effectively collected, stored, appropriately shared or made accessible in line with statutory and regulatory requirements.			Executive Owner: Acting Chief Operating Officer	
Risk Domain (NPSA):	Gross (strategic) risk score:	Net (current) risk score:	Target risk score (risk appetite):	
Finance (including claims)	20 = (L = 4 x C = 5).	20 = (L = 4 x C = 5).	Low	
Strategic Objective:	CQC Domain	Assurance Committee:	Date of last review by Assurance Committee:	
We will provide timely, reliable and transparent information to underpin care and research.	Well Led	Audit Committee	New risk	
Current Controls and Assurance		Actions to Further Enhance Risk Management		
Current key controls to manage risks	Means of assurance (by control number)	Action required to close any gaps in controls and assurances	Action owner	Action review date
Collection of information				
<u>Information Asset Register</u> The Trust's list of all systems/information assets holding or sharing personal information is under review to ensure that it is up to date and collects the required information. This includes; owners of the systems, who has access and outstanding risks for systems are monitored and logged.	IGSG monitors these controls	There is a focused piece of work to review this and ensure it is reflective of the current position. Initial focus has been placed on the top 20 systems across the organisation, ensuring the system Owner and Administrator are correct. In addition a review to ensure that the appropriate controls and security requirements are in place against the GDPR guidance.	Joseff Eynon-Freeman, IG Manager	April 2019
<u>Data Protection Privacy Impact Assessments (DPIA)</u> These assessments assist the Trust in identifying and minimizing the privacy risks of new projects and policies.	IGSG monitors the controls for new projects The Policy Approval Group ensures that any new policies consider implications for collection and use of data	There is ongoing work to expand the role of DPIAs in projects to ensure all privacy risks are identified and minimised as part of any implementation. This will also help demonstrate that privacy has been taken into consideration at an early stage in all projects. The process for reviewing privacy impact assessments will be reviewed by the PAG administrator	Joseff Eynon-Freeman, IG Manager Paul Balson, Deputy Company Secretary	March 2019 March 2019
<u>Privacy notices</u> A patient and carer notice and research notice is published on the website outlining how the Trust gathers, uses, discloses and manages patient data.	IGSG monitors and ensures the notices are updated.	While the Trust has a privacy notice in place this is under review to confirm it provides all necessary information in the most accessible way. Furthermore, the Trust is planning to develop versions for all areas of processing (staff data, Trust membership) as well as one targeted for children and young people explaining how their data is used.	Joseff Eynon-Freeman, IG Manager	May 2019
Storage and security of information				
All I new systems require an appropriate security review by ICT with a focus with any data held offsite. The Information Asset Register monitors the security arrangements for data held by the Trust. Continuing ongoing work around cyber security and the implementation of national cyber requirements.	IGSG monitors updates to security risks. Information Sharing Protocols are completed for third parties and are reviewed and sign off by senior IG roles. The Cyber Security Committee meets monthly to review Trust Cyber Security issues.	While the process for reviewing the security of new systems is robust, in cases where projects originate from outside of ICT or don't directly relate to ICT systems these issues may be missed. The ongoing work to expand DPIAs should pick up any such issues. The planned review of the Information Asset Register should assist in reviewing security arrangements for existing assets. The PIA is being updated and communications are being sent around to remind all staff ab out the importance and requirement to review the impact on privacy of new and existing systems that collect and/or process data.	Joseff Eynon-Freeman, IG Manager	31 May 2019
Sharing and accessibility of information				
The Trust has a specific working group reviewing its processes for providing data subjects (usually patients or staff) with copies of their personal data it holds. Key issues exist around confirming what information should be removed from releases and	The working group reports directly into Records Management Committee which reports to IGSG. Information Sharing Protocols are completed for all sharing with third parties.	The working group is seeking advice from key stakeholders internally around records held while also discussing the legal requirements and best practice with external solicitors and other Trusts. This will inform its own development of policies and procedures.	Sian Hibbert, Records Manager	31 May 2019

<p>responding to requests outside of information held in the medical record i.e. personal data held on emails systems.</p> <p>FOI requests are managed the FOI team who comply with the requirements of the Act.</p>	<p>Quality and Safety Assurance Committee monitor compliance with the FOI Act. This was previously reported to IGSG.</p>	<p>Work to be conducted to provide a SOP for HR to manage staff SARs</p> <p>The FOI Policy is under review and will apply learning form FOI work since the previous update and reflect the new reporting structure for FOI compliance.</p>	<p>Salina Parkyn, Head of Quality and Safety</p>	<p>31 May 2019</p> <p>31 March 2019</p>
<p>Staff training and awareness raising</p> <p>Raising awareness internally of Information Governance breaches and reminding staff of their requirements with regards to confidentiality and the processing of personal data through the use of all user communications, face-to-face training sessions and refreshing of the Trust mandatory training.</p>	<p>IGSG monitor the communication plan for Information Governance.</p>	<p>IGSG understands that the main method of advertising IG is the use all user emails and screensavers but there is concern that this doesn't always reach all staff. New methods of communicating with staff are being reviewed.</p>	<p>Joseff Eynon-Freeman, IG Manager</p>	<p>July 2019</p>
<p>Data Security and Protection Toolkit 18/19 submission</p> <p>This assessment allows organisations to measure their performance against the National Data Guardian's 10 data security standards. All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practising good data security and that personal information is handled correctly in line with data protection legislation and specific healthcare regulations.</p> <p>The requirements inform all aspects of IG including; policies, reporting structure and required roles.</p>	<p>Standard leads are involved to provide additional information covering their areas; this includes; Records Management, Information Security/ICT and Data Quality.</p> <p>Compliance is monitored by the Information Governance Steering Group (IGSG). And will be presented to The Board prior to submission- March 2019.</p>	<p>The IG team will work as a priority to ensure that all evidence is collected to demonstrate compliance with the mandatory Toolkit requirements prior to submission.</p> <p>If any gaps are identified, action plans will be presented to demonstrate how the Trust will provide assurance and reach a suitable level of compliance.</p>	<p>Joseff Eynon-Freeman, IG Manager</p>	<p>Deadline for next submission 31 March 2019</p>
<p>Investigation process for IG incidents</p> <p>The Trust has implemented new GDPR guidance for scoring and reporting of Data Protection breaches.</p> <p>Local incidents are reported on Datix with alerts sent to the IG Manager and relevant leads.</p>	<p>Breaches of an appropriate level are reported on the Data Security and Protection Toolkit after sign off by senior Data Protection Roles.</p> <p>IGSG reviews all incidents quarterly.</p>	<p>While there is confidence in the reporting and investigation of high level incidents, there is less assurance related near misses and low level local issues. This process is being reviewed to clearly outline an incident review process which can be followed locally.</p>	<p>Joseff Eynon-Freeman, IG Manager</p>	<p>30th April 2019</p>
<p>Involvement in new EPR system</p> <p>As the system is built IG considerations have been taken and a 'Privacy by Design' approach. When launched this system will collect, store and manage the sharing of a large majority of the personal data processed by the Trust.</p>	<p>Discussions, decisions and confidentiality meetings throughout the design of the system have been documented. Confidentiality Decisions have been signed off by IGSG or appropriate senior roles in the Trust.</p>	<p>A Data Protection Impact Assessment document for different areas of EPIC is to be finalised. This will outline and clearly demonstrate that the data protection risks of the project have been analysed, identified and minimised</p>	<p>Joseff Eynon-Freeman, IG Manager</p>	<p>Signed off before April 2019</p>

Risk Reviewed By: Joseff Eynon-Freeman, IG Manager, Peter Hyland, Director of Performance and Information and Anna Ferrant, Company Secretary and Data Protection Officer

Date Reviewed: 26th March 2019

BAF Risk 14: Medicines Management		Executive Owner: Acting Chief Operating Officer		
Medicines are not managed in line with statutory and regulatory guidance (procuring, storing, prescribing, manufacturing and giving of medicines (including self-administration)) and that processes are not appropriately documented or monitored.				
Risk Domain (NPSA):	Gross (strategic) risk score:	Net (current) risk score:	Target risk score (risk appetite):	
Impact on the safety of patients, staff or public (physical/psychological harm)	20 = (L = 4 x C = 5).	20 = (L = 4 x C = 5).	Low	
Strategic Objective:	CQC Domain	Assurance Committee:	Date of last review by Assurance Committee:	
We will achieve the best possible outcomes through providing the safest, most effective and efficient care	Safe	Quality Safety and Experience Assurance Committee	New Risk	
Current Controls and Assurance		Actions to Further Enhance Risk Management		
Current key controls to manage risks	Means of assurance (by control number)	Action required to close any gaps in controls and assurances	Action owner	Action review date
<p>MEDICINES SUPPLY</p> <p>Drugs and Therapeutics Committee (DTC) in place – the committee must be involved with all new medicines brought into the hospital.</p> <p>Medicines are dispensed by competent pharmacy staff</p>	<p>New paperwork (2018) produced to ensure only DTC approved medicines are added to EPMA – all minuted and fed to PSOC.</p>	<p>DTC process needs to be tightened up with appropriate attendance. The ethical and financial decisions made are crucial to get right and documented</p>	<p>Stephen Tomlin, Chief Pharmacist</p>	<p>March 2019</p>
	<p>Medicines are sometimes not available and alternatives have to be sought. - Procurement and the clinical pharmacists combine efforts to look at new products</p>	<p>Decisions need to be documented and overseen by a lead pharmacist e.g. ensure appropriate strengths or excipients of new products etc.</p>	<p>Stephen Tomlin, Chief Pharmacist</p>	<p>May 2019</p>
	<p>Medicines brought into the Trust are assumed to be legitimate if in the correct original manufacturers packaging. QA currently look at unlicensed medicines in depth but others are assumed to be genuine</p>	<p>Falsified Medicines Directive software must be brought in by February 2019 (GOSH to delay until EPIC) to meet new standards</p>	<p>Stephen Tomlin, Chief Pharmacist</p>	<p>May 2019</p>
	<p>Errors are recorded via DATIX, but not internal near-miss errors</p>	<p>Pharmacy must record near-miss dispensing errors</p>	<p>Stephen Tomlin, Chief Pharmacist</p>	<p>June 2019</p>
	<p>Pharmacy Space and work flow is seen as a huge risk to dispensing errors and space to store medicines</p>	<p>Pharmacy Space and work flow must be addressed</p>	<p>Stephen Tomlin, Chief Pharmacist</p>	<p>September 2019</p>

<p>PRESCRIBING MEDICINES</p> <p>Prescribers have some training at induction</p> <p>Prescribing is electronic making it legible</p>	<p>Ward staff report on errors of prescribing but no formal assessments carried out</p> <p>DATIX is used to capture errors</p>	<p>A new eLearning module has been approved for use and tighter competence assessment is being reviewed</p> <p>EPIC should bring in a prescribing system with far more decision support built in, but only a limited amount will be useable at go live. Far more work will need to be conducted with EPIC</p>	<p>Stephen Tomlin, Chief Pharmacist</p> <p>Stephen Tomlin, Chief Pharmacist</p>	<p>June 2019</p> <p>September 2019</p>
<p>MANUFACTURE OF MEDICINES</p> <p>GMP is practiced for the production of PN, Cytotoxics and CIVAS</p> <p>Quality assurance process is in place to scrutinise the processes</p>	<p>QA oversee all problems and deviations of process and microbial monitoring</p> <p>MHRA regulators come to inspect the facilities - MHRA had several issues with the manufacturing facilities. The chief pharmacist has closed the main unit with problems, but some additional work is still required on those still producing.</p>	<p>The time to review and conclude all the deviations is too long and staffing is being reviewed to address this. This was seen as an issue with the last MHRA inspection.</p> <p>A plan is being worked through to improve facilities</p>	<p>Stephen Tomlin, Chief Pharmacist</p> <p>Stephen Tomlin, Chief Pharmacist</p>	<p>July 2019</p> <p>July 2019</p>
<p>ADMINISTRATION OF MEDICINES</p> <p>A Medicines Policy is available to help with good practice</p> <p>Omnicell aids selection of the right drug at ward level</p> <p>Controlled Drugs are securely stored and auditable paperwork</p> <p>A self-administration Policy is in place to support best practice of parents administering medicines where appropriate at ward level</p> <p>Formal paperwork is in place to allow self-administration</p>	<p>The policy is not easily seen at ward level and only major problems are picked up on DATIX</p> <p>Omnicell stock levels are closely monitored by pharmacy staff but deviations in stock is common</p> <p>Controlled Drugs are inspected 3 monthly by pharmacy to pick up on any discrepancies</p> <p>No overview of self-administration within the Trust, few bedside lockers for parents to access medicines, no great use of patients own medicines</p>	<p>To get as much of the policies in built and intuitive within EPIC and therefore available and in view of all relevant staff</p> <p>Need to get EPIC and Omnicell talking to each other – in the post go live schedule</p> <p>Inspections are not recorded and need to move to being formal audits that can be seen by CQC</p> <p>A full review of the process for self-administration is required</p>	<p>Stephen Tomlin, Chief Pharmacist</p> <p>Stephen Tomlin, Chief Pharmacist</p> <p>Stephen Tomlin, Chief Pharmacist</p> <p>Stephen Tomlin, Chief Pharmacist</p>	<p>September 2019</p> <p>July 2019</p> <p>May 2019</p> <p>May 2019</p>

Risk Reviewed By: Steve Tomlin, Chief Pharmacist

Date Reviewed: 13 March 2019

Current Controls and Assurance			Actions to Further Enhance Risk Management	
Current key controls to manage risks	Means of assurance (by control number)	Action required to close any gaps in controls and assurances	Action owner	Action review date
<p>Conduct, behaviours and team working</p> <ul style="list-style-type: none"> Trust Values framework in place Acceptable behaviour policy approved and being rolled out MHPS process for doctors (external) NMC process for nurses (external) Cognitive (SRIP) framework being piloted Freedom to Speak Up Guardian and Ambassadors available and advertised across the Trust 	<p>Freedom to speak up cases Concerns raised colleagues Complaints and PALS Whistleblowing cases Staff survey HR data – turnover, recruitment, retention, disciplinary/ grievance data Guardian of Safe Working Report to Board Cognitive (SRIP) cases</p>	<p>Acceptable behaviour policy being rolled out Cognitive (SRIP) framework being piloted</p>	<p>Luke Murphy, Head of PALS Andrew Long, Associate Medical Director</p>	
<p>Capability</p> <ul style="list-style-type: none"> Recruitment processes Annual appraisals and revalidation (doctors, nurses allied health professionals) Services contributing to national performance benchmarking data 	<p>Review of patient outcomes data Freedom to speak up cases Concerns raised colleagues Complaints and PALS Whistleblowing cases Review of national audit data Appraisal and Revalidation data Review of national performance benchmarking data by external bodies CQRG monitoring of outcomes and incidents etc. Guardian of Safe Working Report to Board Cognitive (SRIP) cases</p>			
<p>Assurance and Escalation Framework</p> <ul style="list-style-type: none"> Strategy and planning processes Performance management Policy framework Risk management framework Accountability framework Compliance framework Escalation framework Assurance framework 	<p>Monitoring by internal management committees (local M&Ms, local RAGs, management committees (Quality Improvement Committee etc., directorate Boards (via performance reviews) and assurance committees)</p> <p>Integrated Quality Report and Integrated Performance Report Review of patient outcomes data Freedom to speak up cases Concerns raised colleagues Complaints and PALS Whistleblowing cases</p>			

	Review of national audit data Output from revalidation Review of national performance benchmarking data by external bodies CQRG monitoring Guardian of Safe Working Report CQC report			
<p>Validation of clinical services</p> <ul style="list-style-type: none"> • Peer reviews of GOSH services • External reviews of GOSH services • Investigations into teams/ GOSH services • Themes arising from: <ul style="list-style-type: none"> ○ Serious Incident processes ○ Complaints and PALS ○ Learning from deaths ○ Datix incidents ○ CQC GOSH reports ○ Outcomes data ○ Horizon scanning of reports from other external organisations 	Information/ data reported to relevant committees and assurance committees	Development of SOP to conduct external reviews of teams/ services at GOSH and ensure consistency of process	<p>Anna Ferrant, Company Secretary</p>	<p>31 March 2019</p>

Risk Reviewed By: Sanjiv Sharma, Acting Medical Director

Date Reviewed: 11 March 2019

BAF Risk 16: Brexit Brexit will have an adverse impact on the ability of Trust to ensure continuity of effective patient care including but not limited to financial sustainability, availability of workforce, access to medicines and medical devices and access to collaborative research, clinical trials and clinical networks.			Executive Owner: Chief Executive	
Risk Domain (NPSA): Service continuity and environmental impact	Gross (strategic) risk score: L4 x C5 = 20	Net (current) risk score: L4 x C5 = 20	Target risk score (risk appetite): Medium	
Strategic Objective: 1.2 Provide the highest quality patient care, experience and health outcomes for patients and families.	CQC Domain Well Led	Assurance Committee: Trust Board	Date of last review by Assurance Committee: New Risk	
Current Controls and Assurance		Actions to Further Enhance Risk Management		
Current key controls to manage risks	Means of assurance (by control number)	Action required to close any gaps in controls and assurances	Action owner	Action review date
<u>Governance</u> Short-life Brexit Steering Working Group established, chaired by the Acting Chief Operating Officer Business continuity plans in place	Guidelines and advice collated from corporate organisations (NHSE, NHSI, DH, MHRA) and reviewed for cross-Trust impact Monitoring of returns to NHSE, NHSI, DH, MHRA and risks identified from the information collected. The trust is connected at various levels with national and local NHS networks and with local borough networks to scope and share information on the impacts of Brexit. Scoping and scenario planning completed: <ul style="list-style-type: none"> • Hard FM items which come from mainland Europe including lifts, motors, air conditioning filters. • Catering and soft FM supplies including cleaning products. Communications circulated to staff on Brexit and also posters being placed in OP, Pharmacy and day wards Decisions/ assurances received by Group are escalated to the EMT following every meeting.	Drafting safeguard letters to those organisations in the EU who receive GOSH data	Head of Information Governance	May 2019
<u>Financial sustainability</u> See controls under BAF Risk 1 Financial Sustainability And BAF Risk 3 IPP Contribution	See assurances under BAF Risk 1 Financial Sustainability And BAF Risk 3 IPP Contribution Tracking of price increases as a result of Brexit	See actions under BAF Risk 1 Financial Sustainability And See actions BAF Risk 3 IPP Contribution		
<u>Workforce</u>				

<p>Processes in place to support EU nationals working at GOSH including support with obtaining settled status</p> <p>Identification of the services that will be most impacted by a no deal scenario and mitigation plans being put into place (facilities etc.).</p>	<p>The trust ran a trust-wide engagement project to raise awareness for the Home Office's EU Settlement Pilot Scheme. The trust hosted on-site drop-in sessions, signposted the Home Office communications materials, issued reminders and an offered to reimburse the application fee, which was subsequently waved by the Government.</p> <p>130 staff have applied for the scheme to date and work continues to minimise impacts on staffing and recruitment, including with subcontractors.</p> <p>Estates and facilities are in contact with agency contractors and understanding mitigation plans in place.</p>	<p>Communications being sent out to those staff who have applied to manage payment of the application fee</p>	<p>Director of HR and OD</p>	<p>May 2019</p>
<p><u>Medicines, Medical Devices and reagents</u></p> <p>The Department of Health has mandated all NHS Trusts use an online system to track medicine stocks from 1st February 2019, so that supply and demand can be monitored at a national level and stockpiling is avoided.</p> <p>The supply of medicines (and ingredients for medicines) to the NHS is being monitored and risk-assessed nationally by the Department of Health and Social Care (DHSC). This includes supply of radioisotopes, vaccines, immunoglobulins.</p> <p>Engagement with specialty groups on plans for managing medicines, devices and re-agents including consideration of storage requirements</p>	<p>DEFINE system in place at GOSH</p> <p>The hospital pharmacy is complying with the national requirement to maintain medicine stocks at no more than 16 days' supply. The DHSC has required that suppliers of unlicensed medicines and specialised drugs arrange for a six-week supply to be in place by March 2019. The trust is increasing its stock levels for these drugs on a case-by-case basis.</p> <p>The DHSC's Chief Pharmaceutical Officer (for GPs, Community Pharmacists and Hospital Pharmacists) wrote to trusts on 17th January to outline the steps taken nationally to date to protect the continuity of supply for medicines.</p> <p>The GOSH chief pharmacist is engaging with DHSC's Specialty Clinical Group on Paediatrics and the all-England Chief Pharmacists Group meetings to contribute to the national process and obtain updates that may affect GOSH operationally.</p>	<p>Work underway to determine how the DEFINE system will integrate with EPIC</p> <p>Storage of re-agents (require refrigeration) is key and reliant on space and availability of fridges. A review is underway.</p>	<p>Richard Collins, Director of EPR</p> <p>Paul Ryves, General Manager Labs</p>	<p>May 2019</p> <p>May 2019</p>
<p><u>Research, clinical trials and clinical networks</u></p>	<p>R and I Directorate is working with the pharmacy department to understand what needs stocking etc.</p>			

<p>Contingency plans in place for clinical trials that are GOSH-sponsored to mitigate potential impacts on supply of drugs, devices and reagents.</p> <p>Contingency planning for clinical trials that are hosted at GOSH but sponsored by external parties (e.g. pharmaceutical companies) is being co-ordinated by the Department of Health.</p>	<p>The GOSH Research & Innovation team have contacted a selection of their key sponsors to obtain information on these contingency plans and seek assurance that they are practical for GOSH.</p>			
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Risk Reviewed By: Anna Ferrant, Company Secretary

Date Reviewed: 19 March 2019

BAF Risk 17: Service Innovation			Executive Owner: Acting Chief Operating Officer	
Failure to embrace service transformation and deliver innovative, patient centred and efficient services including:				
<ul style="list-style-type: none"> •failing to identify where transformation is needed and continuing to operate inefficient and ineffective services •failing to work in partnership with staff and others (commissioners, referrers other stakeholders including the third sector) to identify, plan and design service transformation •failing to ensure appropriate resources (finances and workforce) are made available to lead and implement transformation of services •failing to support staff in making change happen. 				
Risk Domain (NPSA):	Gross (strategic) risk score:	Net (current) risk score:	Target risk score (risk appetite):	
Human resources/ organisational development/staffing/ competence	4 (L) x 4 (C) = 16	3 (L) x 4 (C) = 12	Medium	
Strategic Objective:	CQC Domain	Assurance Committee:	Date of last review by Assurance Committee:	
We will attract and retain the right people through creating a culture that enables us to learn and thrive	Well Led/ Responsive	Quality, Safety and Experience Assurance Committee	New Risk	
Current Controls and Assurance			Actions to Further Enhance Risk Management	
Current key controls to manage risks	Means of assurance (by control number)	Action required to close any gaps in controls and assurances	Action owner	Action review date
<u>Identifying opportunities with partners</u> Ongoing liaison and benchmarking with external parties and learning from best practice (Advisory Board, Civil Eyes, Children's Alliance, ECHO, North Thames Paediatric Network etc.) Work with STP via professional lines (integrated care) Risky Business held annually with focus on paediatrics every 2 years DRIVE launched in October 2018 a digital hub in partnership with University College London (UCL) and leading industry experts in technology, artificial intelligence and digital innovation Visits to cardiac referrers to understand views on provision of service from GOSH	Monitoring of better value programmes via the Better Value Programme Boards Open House in November 2019 Programme Office and others holding discussions with teams to understand the barriers to efficient and innovate working	Identifying where service transformation can be supported via charity donors/ links with charity i.e. stock rotation systems, booking systems Development of a Stakeholder relations strategy and a reporting system to be implemented Deliberate reporting of discussions with partners about innovative ways of working via EMT and on to Board via CEO Update Review of GOSH vision and its place in the NHS and internationally Events with referrers being looked at to identify learning on efficient ways of working Proposal to establish a Digital Strategy Committee overseeing ICT, EPR and DRIVE. This will ensure engagement between the three areas, provide a framework for future development, aligned with the Hospital Transformation Plan	Programme Director Director of Communications Executive Assistant to CEO Chief Executive Acting COO Chief Executive	April 2019 May 2019 June 2019
<u>Identifying opportunities with staff and supporting to change to take place</u> Executive development programme Board development programme (masterclasses) Clinical professionals attend conferences, present papers, conduct research and implement learning.	Monitoring of better value programmes via the Better Value Programme Boards Open House in November 2019 Programme Office and others holding discussions with teams to understand the barriers to efficient and innovate working	To review other mechanisms for capturing staff views – SLT meetings to create ideas along with Staff Partnership Forum	Acting COO	May 2019

<p>Establishment of Flow Coaching – reviewing care pathways and considering how these can be improved (led by Imperial and based on IHI methodology)</p> <p>Staff Partnership Forum in place</p> <p>CEO Forums</p>				
<p><u>Identifying opportunities with our patients and parents</u></p> <p>Young Person’s Forum established</p> <p>PFEEC established with parent/ carer members</p> <p>Friends and Family Test Results</p>				
<p><u>Finances, workforce and culture</u></p> <p>Robust budgeting and annual planning in accordance with the 3-5 year strategy</p> <p>Workforce management and planning as part of a cultural review across the Trust</p>		<p>See BAF risk 1</p> <p>See BAF risk 18</p>		
<p><u>Estate and technology in place to support innovation</u></p> <p>EPIC to be implemented in April 2019.</p> <p>Development of OBC for Children’s Cancer Centre</p> <p>Opening of ZCR in 2019</p> <p>DRIVE launched in October 2018 a digital hub in partnership with University College London (UCL) and leading industry experts in technology, artificial intelligence and digital innovation</p>	<p>Monitoring of plans by EPR Programme Board</p> <p>Monitoring of plans by Redevelopment Programme Board</p> <p>Monitoring of plans by DRIVE Board</p>	<p>See BAF risk 10</p> <p>See BAF Risk 12</p> <p>Proposal to establish a Digital Strategy Committee overseeing ICT, EPR and DRIVE. This will ensure engagement between the three areas, provide a framework for future development, aligned with the Hospital Transformation Plan</p>	<p>Chief Executive</p>	

Risk Reviewed By: Jon Schick, Programme Director

Date Reviewed: 19 March 2019

<p>Given the 2018 staff survey results which demonstrate the Trust to be below average in the majority of indicators and shows high levels of staff reporting bullying and harassment, there is a risk that GOSH fails to develop its culture and levels of staff engagement and motivation in alignment with its strategy and values, impacting on:</p> <ul style="list-style-type: none"> The effective implementation of plans and policies across the Trust and the associated impact on safety and quality of services and the patient and family experience. The ability of the Trust to attract competent staff and promote the Trust as a place to work and feel engaged. Missed market opportunities arising from a failure to remain agile and connected and adapt to the ever-changing NHS landscape. The Trust's reputation with partners, commissioners, regulators, the NHS and the public. 			<p>Executive Owner: Chief Executive</p>	
Risk Domain (NPSA):	Gross (strategic) risk score:	Net (current) risk score:	Target risk score (risk appetite):	
Human resources/ organisational development/staffing/ competence	L4 x C4 = 16	L3 x C4 = 12	Low	
Strategic Objective:	CQC Domain	Assurance Committee:	Date of last review by Assurance Committee:	
We will attract and retain the right people through creating a culture that enables us to learn and thrive	Well Led	Trust Board	New risk	
Current Controls and Assurance		Actions to Further Enhance Risk Management		
Current key controls to manage risks	Means of assurance (by control number)	Action required to close any gaps in controls and assurances	Action owner	Action review date
<p>Organisational development</p> <ul style="list-style-type: none"> Values and behaviours framework in place Relevant policies and procedures that support the Trust and Staff to respond to poor behaviour, report safety concerns, including bullying and harassment and recruit and select staff with the right skills and behaviours Freedom to Speak Up Champion in place HR Business Partners working across clinical and corporate directorates ensuring poor behaviours are identified and tackled and leaders appropriately supported Cognitive Institute being rolled out including training on SRIP. GEMS staff award system in place Complaints reporting system and duty of candour policy in place Staff Survey action plans in place 	Regular reporting to QSAC from the Freedom to Speak Up Champion on cases received and themes identified.	Development of a People Strategy	Caroline Anderson Director of HR and OD	Sept 2019
	Regular reporting to QSAC on whistleblowing cases received and themes identified	Risk Management Strategy requires updating	Salina Parkyn, Head of Quality and Safety	May 2019
	Regular meetings with executives on all employment tribunal cases in train	Action plan to respond to staff survey results 2018	Alison Hall, Acting Director of HR and OD	June 2019
	EMT monitor the number of ER cases regularly	Refresh of Values and Behaviours framework	Caroline Anderson Director of HR and OD	Sept 2019
	Weekly medical ER meeting with MD and Director of HR and OD			
	Training attendance monitored for SRIP by Lead			
	High reporting on incidents across GOSH			
Staff survey results				
Complaints and PALS data about patient and family experience working with staff monitored by PFECC				
<p>Workforce Development</p> <ul style="list-style-type: none"> Workforce plan in place (but only relating to numbers of staff required to support services) Relevant internal equality groups established. Equality objectives signed off by Board Gender pay gap report 	Workforce plan is submitted to NHSI annually	Development of a People strategy	Caroline Anderson, Director of Human Resources and OD	Sept 2019
	Equality groups report to Board via the WRES report			
	Gender pay gap report presented to Board and annual report annually and reviewed.			
<p>Education and Training</p> <p>A GOSH Learning Academy strategy is in place</p>	Education Workforce Development Committee established	Development of OBC for Learning Academy	Alison Robertson, Chief Nurse	June 2019
	Directorate performance reviews monitor mandatory training and appraisal rates		Lynn Shields, Director of Education	
	Performance review for LMD, PGME and NNME and monitor mandatory training and appraisal rates			
	Mandatory training and appraisal rates reported to Board			
<p>Leadership</p> <p>Leadership framework and programmes in place</p> <p>Executive visibility – walkrounds, regular communications to staff etc.</p>	Appraisal process	Approval of current version of Leadership Strategy	Alison Robertson, Chief Nurse	April 2019 (Trust Board)
	Values Framework	(Will cite development of a talent management framework)		
	Freedom to Speak Up cases	Executive walkrounds being reviewed and updated	Claire Fletcher, EA to CEO	
	CEO fortnightly blog rolling out			
<p>Staff engagement and communications</p>		Staff engagement strategy under development	Cymbeline Moore, Director of Comms	

Stakeholder management and communications Internal communications External communications		Stakeholder engagement strategy under development	Cymbeline Moore, Director of Comms	
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Risk Reviewed By: Acting Director of HR and OD

Date Reviewed: 18 March 2019

<p>Trust Board 22nd May 2019</p>	
<p>Integrated Quality and Performance Report April 2019 (Reporting on March 2019 data)</p> <p>Submitted by: Sanjiv Sharma, Medical Director Alison Robertson, Chief Nurse Andrew Taylor, Acting Chief Operating Officer</p>	<p>Paper No: Attachment W</p>
<p>Aims / summary</p> <p>The Integrated Quality and Performance Report (IQPR) is a new report which combines (and replaces) the Integrated Quality Report (IQR) and the Integrated Performance Report (IPR). This brings together a range of essential hospital metrics aligned to the CQC key lines of enquiry: Safe, Effective, Caring, Responsive and Well Led. It asks the question: are our patients receiving high quality care?</p> <p>The report includes all metrics previously included in the Integrated Performance Report alongside many additional key quality metrics. These new metrics have been delivered in consultation with the Quality and Safety Team, Patient Experience Team, Human Resources, Safeguarding and the Corporate Secretary's office. Combining the reports together enables us to take a more holistic view of hospital performance, and identify areas of good practice as well as areas for improvement.</p> <p>The report includes qualitative analysis from Quality & Safety, Patient Experience, Performance, Human Resources & Finance in response to areas of underperformance, and to highlight key issues for consideration.</p> <p>The new metrics and new style of reporting have been developed over the course of March, and it is anticipated that the report will evolve over time in response to the needs of the organisation, external stakeholders and regulators. The parameters/targets for some of the KPIs are still in discussion (marked TBC) and it has been agreed that parameters/targets are not appropriate for some measures, but the metric is included because we recognise it is valuable to understand volume and trends each month.</p> <p>Key areas to note:</p> <p>Quality of Care for our patients</p> <p>There has been one Never Event in the hospital since the last report (17th April 2019). Following a complex procedure (involving multiple specialties), a pair of forceps were retained in the patient's abdomen. This was identified very quickly after the patient left the operating theatre. The patient had returned to CICU with an open, packed wound and therefore it was not necessary to re-open the wound to retrieve the forceps. Duty of candour has been completed with the patient and her parents. This has been reported to NHS England, and an investigation is underway.</p> <p>A serious incident was also reported in April relating to an incident in March 2019 whereby a portion (8cm) of a central line was retained in the patient when the line was removed. This has also been reported to NHS E and is under investigation.</p> <p>The Friends and Family Test response rate increase noted last month has been</p>	

Attachment W

sustained (25.8%) reflecting sustained hard work and collaboration between Patient Experience Team and Ward Teams. Overall recommend rates improved since last month: the FFT inpatient recommend rate was 96.5% and 94.1% for outpatient services.

Our Operational Performance

The Trust achieved the RTT 92% standard, submitting performance of 92.24%, with 541 patients waiting longer than 18 weeks. The Trust continues to underachieve against the 99% national standard for diagnostics, reporting 97.48% of patients waiting within 6 weeks for the 15 diagnostic modalities. This is a slight deterioration from February 2019. The number of diagnostic reported breaches has remained the same (18) as last month. For month of March 2019, the Trust reported a decrease in the number of patients cancelled, with 52 patients cancelled compared to 56 in February. The Trust reported 7 last minute cancelled operations not readmitted within 28 days in March, (compared to 1 in February). Since the start of the new financial year the Trust has reported no patient being cancelled for an urgent operation for the last eleven consecutive months. The number of CATS referral refusals into PICU/NICU from other providers during March has decreased to 14 from a February position of 25.

Our Workforce

Statutory and Mandatory Training compliance for the organisation is 93%. All directorates are >90% (Trust Target) with IPP at 98%. However, 6 of the 30 Stat&Man topics are <90% compliance (note that this is a reduction from 8 in February). The non-medical appraisal rate has remained at 85% in March but remains below the Trust target, however the Trust continues to benchmark well. Consultant appraisals have increased to 86%.

There have been two new bullying and harassment cases reported to HR in March. There have been no new whistleblowing cases reported this year, but one ongoing open case. There were 8 recorded Freedom to Speak Up cases.

Our Money

The Trust has a full year Control Total Surplus of £17.4m which is £5.3m ahead of plan, this includes £5.2m of additional PSF funding. The Trust is generating a full year net surplus of £6.0m which is £5.5m above plan.

Action required from the meeting

Board members to note and agree on actions where necessary

Contribution to the delivery of NHS Foundation Trust strategies and plans

The report aims to focus the organisation's attention on areas where we can improve the quality of care delivered to our patients. All the indicators within the IQPR contribute to the delivery of either regulatory or commissioner requirements, and as such are aligned to the objectives and strategy of the Trust.

Financial implications

For indicators that have a contractual consequence there could be financial implications for under-delivery

Who needs to be told about any decision?

Where appropriate and applicable: Internal stakeholders, NHS Improvement and NHS England Special Services Commissioners

Who is responsible for implementing the proposals / project and anticipated timescales?

Each Domain / Section has a nominated Executive Lead

Who is accountable for the implementation of the proposal / project?

As above

Integrated Quality & Performance Report

April 2019

(Reporting on March 2019 data)

Sanjiv Sharma

Medical Director

Alison Robertson

Chief Nurse

Andrew Taylor

Acting Chief
Operating Officer

Data correct as of: 14th May 2019

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Key Areas for Consideration

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Hospital Quality Performance – April 2019 (March Data)

Are our patients receiving safe, harm-free care?

	Parameters	Jan 19	Feb 19	Mar 19
Incident Reporting Rate (per 1000 bed days)	R<60 A 61-70 G>70	79.1	73.4	62.8
Incident Closure Rate (% of incidents closed within 45 working days)	R 0-64% A>65-75% G>76-100%	38.2%	60%	45.9%
Number of incidents closed	Trending performance	1497	612	564
Average days to close (2018 -2019 incidents)	R >50, A - <50 G - <45	61.7	46.1	63.7
Medication Incidents (% of total PSI)	TBC	21%	20%	32.4%
Near Miss reports (% of incidents reported)	R <8%, A 8-9%, G>10%	6%	5%	6%
Serious Incidents (Severe Harm, Death)	R >1, A -1 G - 0	3	1	0
Overdue SI	R >1, A -1, G - 0	N/A	1	1
Safety Alerts overdue	R- >1 G - 0	3	1	2
Safeguarding Children's Reviews	New	0	0	0
	Open and ongoing	6	6	6
Safeguarding Adults Board Reviews	New	0	1	0
	Open and ongoing	0	1	1

Are we delivering effective, evidence based care?

	Target	Jan 19	Feb 19	Mar 19
Specialty Led Clinical Audits on Track	R 0- 69%, A>60-75% G>75-100%	73%	76%	86%
Number of completed specialty led clinical audits per year	Aim =100 p.a G= YTD total at month end is on target	N/A	119	131
NICE guidance overdue for assessment of relevance	R=1+, G=0	N/A	0	0
Relevant NICE national guidance without a gap analysis	R=1+, G=0	0	0	0
Participation in mandatory relevant national audits	G=100%	N/A	100%	100%

Are our patients having a good experience of care?

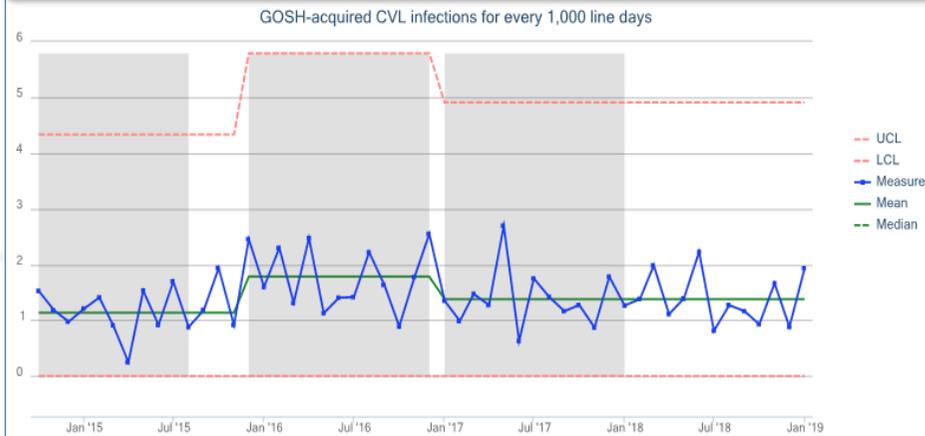
	Parameters	Jan 19	Feb 19	Mar 19
Friends and Family Test Recommend rate (Inpatient)	G - 95+, A- 90-94, R<90	96.6%	95.4%	96.5%
Friends and Family Test Recommend rate (Outpatient)	G - 95+, A- 90-94, R<90	93.5%	92.8%	94.1%
Friends and Family Test - response rate (Inpatient)	25%	24.45%	26.8%	25.8%
PALS Rate (per 1000 combined activity days)	N/A	5.02	5.67	6.42
Complaints rate Rate (per 1000 combined activity days)	N/A	0.24	0.27	0.27
Red Complaints (%total complaints YTD)	R>12% A- 10-12% G- <10%	5%	5%	7%
Re-opened complaints (% of total complaints YTD)	R>12% A- 10-12% G- <10%	10%	12%	13%

Are our People Ready to Deliver High Quality Care?

	Parameters	Jan 19	Feb 19	Mar 19
Mandatory Training Compliance	R<80%,A-80-90% G>90%	91%	91%	93%
PDR	R<80%,A-80-90% G>90%	84%	85%	85%
Appraisal Compliance (Consultant)	R<80%,A-80-90% G>90%	79%	83%	86%
Safeguarding Children Level 3 Training compliance	R<80%,A-80-90% G>90%	83%	83%	85%
Safeguarding Adults Training Compliance	R<80%,A-80-90% G>90%	89%	91%	92%
Sickness Rate	R -3+%, G= <3%	2.4%	2.4%	2.5%
Turnover - Total	R>18% G<18%	17.5%	17.6%	17.5%
Turnover - Voluntary	R>14% G<14%	14.7%	14.7%	14.8%
Vacancy Rate – Contractual	R- >10% G- <10%	0.1%	0.4%	-0.15%
Vacancy rate - Nursing		3.7%	4.2%	3.4%
Bank Spend		5.8%	5.8%	5.8%
Agency Spend	R>2% G<2%	1.04%	1.01%	1%

Do we deliver harm free care to our patients?

CVL Infections

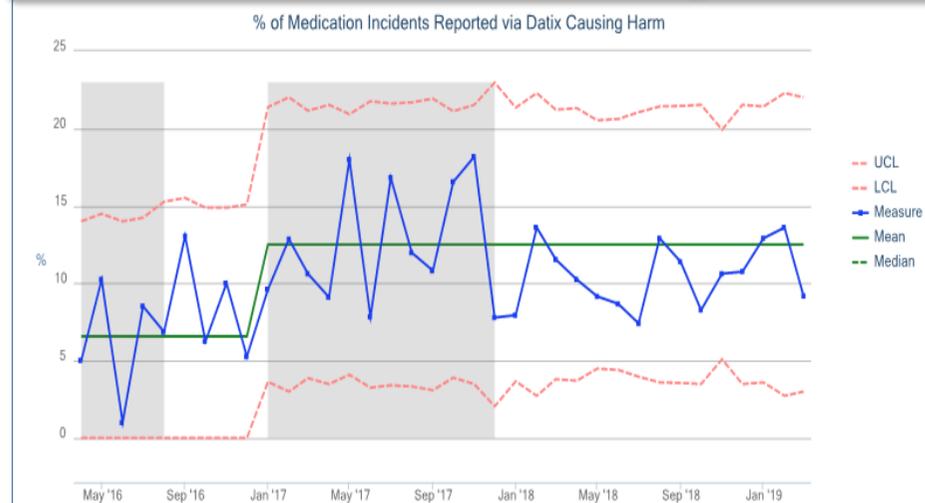


		Dec	Jan	Feb	March
Central Venous Line infections (per 1000 bed days)	Mean- 1.6	1	2.1	2.5	3.2

Infection Control Metrics

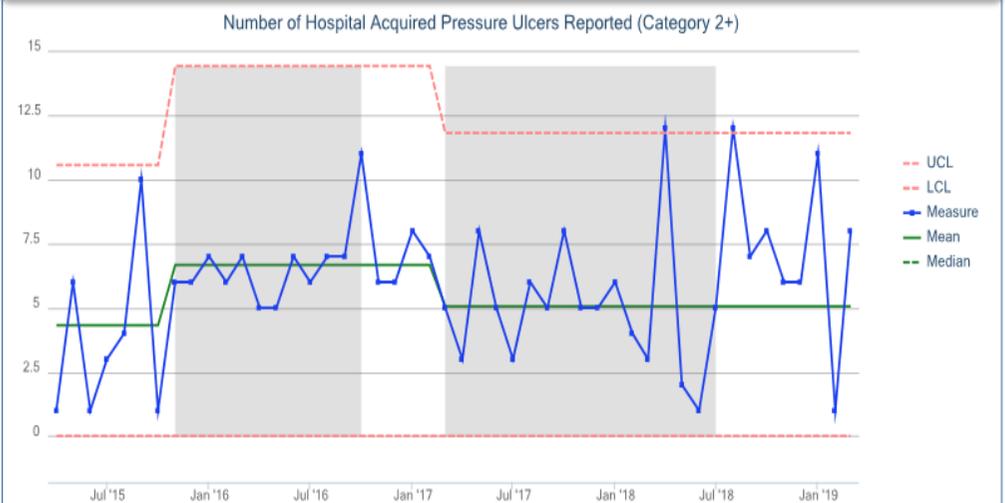
Care Outcome Metric	Parameters	Dec 2018	Jan 2019	Feb 2019	Mar 2019
Bacteraemias (mandatory reporting – MRSA, MSSA, Ecoli, Pseudomas Klebsiella)	In Month	9	4	7	5
	YTD	71	75	82	87
C Difficile cases - Total	In month	0	1	1	1
	YTD	4	5	6	7
C difficile due to lapses (Considered Trust Assigned but awaiting confirmation from NHS E)	In Month	0	1	1	0
	YTD	4	5	6	6

Medication incidents causing harm



		Dec	Jan	Feb	Mar
% of reported medication incidents causing harm	TBC	11%	13%	14%	9%

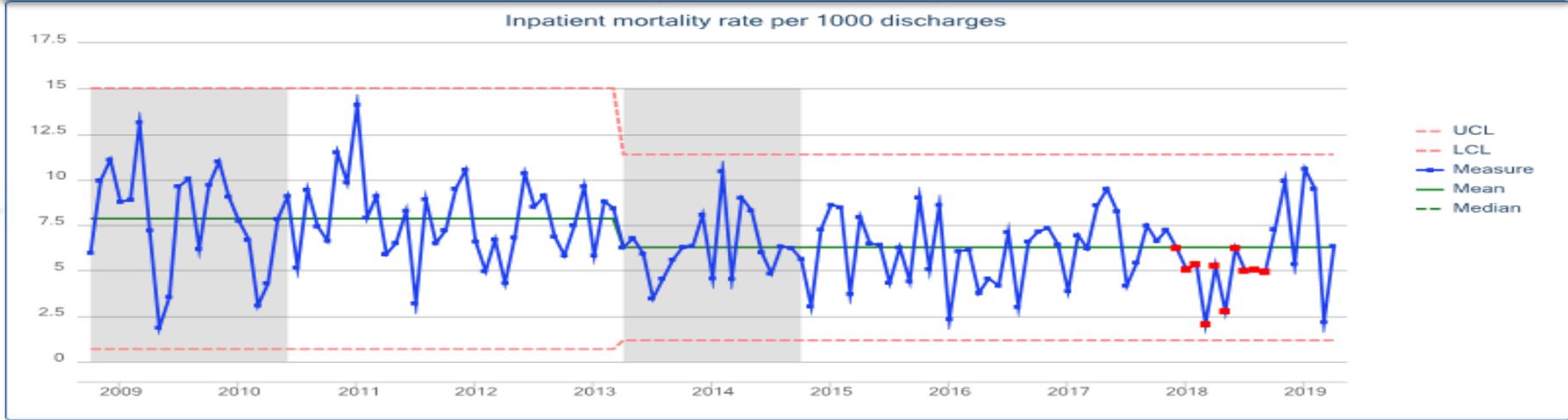
Pressure Ulcers



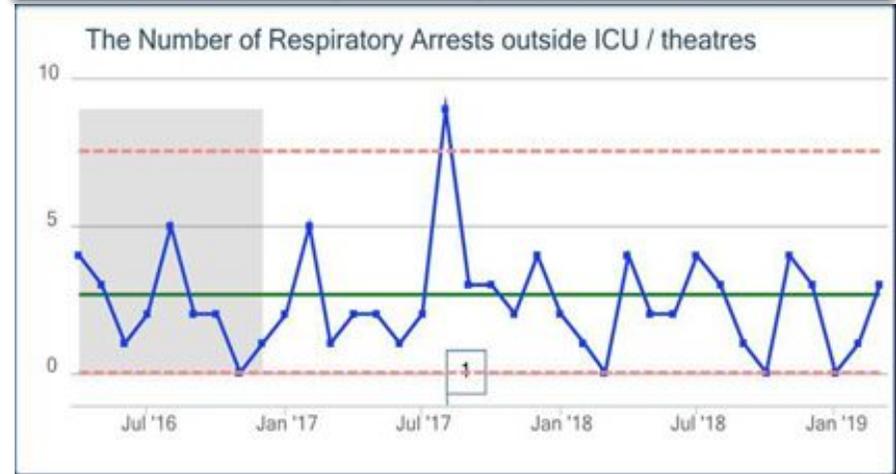
		Dec	Jan	Feb	March
Hospital Acquired Pressure Ulcer (2+)	R – 12+, A 6-11 G =0-5	6	11	2	8

Does our care provide the best possible outcomes for patients?

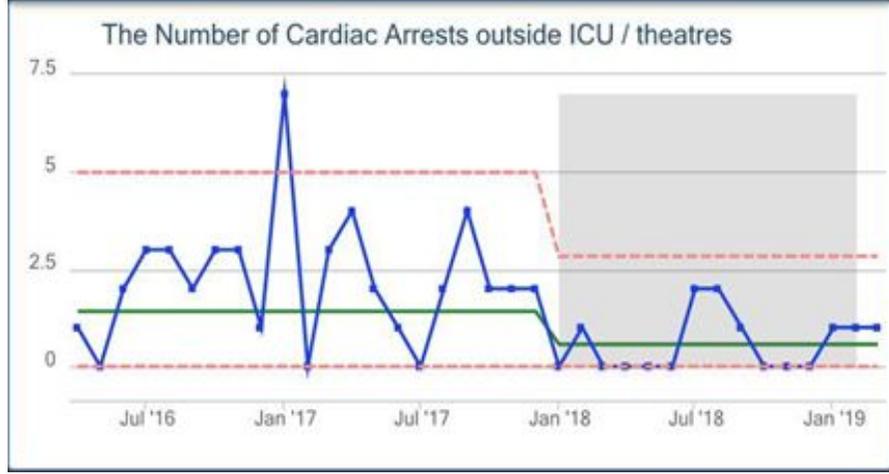
Inpatient mortality



Respiratory Arrests



Cardiac Arrests



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Are we delivering effective and responsive care for patients to ensure they have the best possible outcomes?

Responsive Hospital Metrics		Jan-19	Feb-19	Mar-19	Effective & Productivity Hospital Metrics		Jan-19	Feb-19	Mar-19
Diagnostics: patient waiting <6 weeks	R<99% G -99-100%	95.19% ↑	97.54% ↑	97.48% ↓	Discharge summary 24 hours	R=<100% G=100%	73.23% ↓	79.07% ↑	79.00% ↓
Cancer 31 day: referral to first treatment	R<85% G 85%-100%	No pts	100%	100% →	Clinic Letter– 7 working days		41.54% ↑	42.03% ↑	TBC
Cancer 31 day: Decision to treat to First Treatment	R<96% G 96-100%	100% →	100% →	100% →	Clinic Letter– 14 working days		73.90% ↑	68.14% ↓	TBC
Cancer 31 day: Decision to treat to subsequent treatment - surgery	R<94% G94-100%	100% →	100% →	100% →	Was Not Brought (DNA) rate		8.55% ↓	7.94% ↓	8.45% ↑
Cancer 31 day: decision to treat to subsequent treatment - drugs	R<98% G 98-100%	100% →	100% →	100% →	Theatre Utilisation – Main Theatres	R<77% G>77%	66.30% ↑	65.00% ↓	66.80% ↑
Cancer 62 day: Consultant upgrade of urgency of a referral to first treatment	-	100% →	100% →	100% →	Theatre Utilisation – Outside Theatres	R<77% G>77%	54.00% ↓	56.10% ↑	54.30% ↓
Theatre Cancellation for non-clinical reason	-	39 ↑	56 ↓	52 ↑	Trust Beds				
Last minute non-clinical hospital cancelled operations - breach of 28 day standard	R 1+ G=0	5 ↓	1 ↑	7 ↓	Bed Occupancy		81.90%	82.40%	79.10% ↓
Urgent operations cancelled for a second time.	R 1+ G=0	0 →	0 →	0 →	Beds available		384	392	392 →
Same day/day before hospital cancelled outpatients appointments	-	1.37% ↓	1.55% ↓	1.28% ↑	Avg. Ward beds closed		37	27	35 ↑
RTT Incomplete pathways (national reporting)	92%	92.59% ↑	92.18% ↓	92.24% ↑	ICU Beds Closed		5	6	6 →
RTT number of incomplete pathways <18 weeks	-	6137 ↑	6397 ↑	6430 ↑	Refused Admissions				
RTT number of incomplete pathways >18 weeks	-	491 ↓	543 ↓	541 ↑	Cardiac		1	1	6 ↑
RTT Incomplete pathways >52 weeks Validated	R - >0, G=0	3 ↑	2 ↓	4 ↑	PICU/NICU		17	25	14 ↓
RTT incomplete pathways >40 weeks validated	R - >0, G=0	29 ↑	28 ↓	28 →	PICU Delayed Discharge				
Number of unknown RTT clock starts – Internal Ref	-	0	0	0	Internal 8-24 hours		4	4	3 ↓
Number of unknown RTT clock starts – External Ref	-	268	194	231	Internal 24h +		10	14	13 ↓
RTT: Total number of incomplete pathways known/unknown - <18 weeks	-	6399 ↑	6587 ↑	6656 ↑	External 8-24 hr		2	0	4 ↑
RTT: Total number of incomplete pathways known/unknown - >18 weeks	-	500 ↓	547 ↓	546 ↑	External 24h+		4	8	7 ↓
					Total 8-24h		6	4	7 ↑
					Total 24h +		14	22	20 ↓
					PICU Emergency Readmission <48h		1	1	1 ↑
					Daycase Discharges				
					In Month		2,498	2,285	2,322 ↑
					YTD		24,060	26,345	28,667 ↑
					Overnight Discharges				
					In Month		1,394	1,339	1,440 ↑
					YTD		13,928	15,267	16,707 ↑
					Critical Care Beddays				
					In Month		894	776	972 ↑
					YTD		9,972	10,748	11,720 ↑
					Bed Days >100 days				
					No of Patients		7	11	17 ↑
					No of Beddays		1,569	1,953	3,131 ↑
					Outpatient attendances (All)				
					In Month		23,745	21,579	21,678 ↑
					YTD		222,930	244,509	266,187 ↑

Well Led Dashboard

Is our culture right for delivering high quality care?

	Target	Jan 2019	Feb 2019	March 2019
High Risk Review (% reviewed within date)	R<80, A 81-90% G>90%	87%	71%	68.5%
Serious Incident Actions (number of actions overdue)	R->2 A- 1-2 G- 0	Data collection will start for April data		
Red Complaints Action Plan Completion (no of actions overdue)	R->2 A- 1-2 G- 0	N/A	2	9
Duty of Candour compliance	TBC	Data collection will start for April data		
Policies (% in date)	R 0- 79%, A>80% G>90%	59%	56%	58%
Fit and Proper Person Test Compliance (self assessment)	R - <90%A 90-99% G - 100%	100%	100%	100%
Actions for Staff survey within timescale	TBC	N/A	N/A	N/A
Diversity % BAME staff	TBC	29.8%	29.7%	29%
Quality Improvement Led Projects – Trust Wide	Volume monitoring	3	3	3
Quality Improvement led registered Projects – Local	Volume monitoring	7	7	8
Freedom to speak up cases	Volume monitoring	3	8	8
HR Whistleblowing - New	Volume monitoring	0	0	0
HR whistleblowing - Ongoing	open cases	1	1	1
New Bullying and Harassment Cases (reported to HR)	Volume monitoring	0	0	2

	YTD	Variance	Jan 19	Feb 19	Mar 19
Control Total	11.7	5.3	1.9	(0.2)	6.4
Forecast Outturn Control Total	12.1	---	12.1	12.1	---
Debtor days (IPP)	120	(123.0)	232	243	243
Quick Ratio (liquidity)	1.6	0.30	1.9	1.8	1.9
NHS KPI Metrics	1	0.0	1	1	1

Are we managing our data?

	Target	Jan 19	Feb 19	March 2019
FOI requests	Volume	72	68	47
FOI % responded to within timescale	R- <65% A - 65-80% G- >80%	87.7%	96.5%	95%
FOI - Number requiring internal review	R>1 A=1 G=0	0	0	1
FOI Number referred to ICO	G=0 R=1+	0	0	0
Information Governance Incidents	volume	13	17	14
IG incidents reported to ICO	volume	0	0	0
SARS (Medical Record) Requests		94	80	108
SARS (Medical Record) processed with 30 days	R- <65% A – 65-80% G- >80%	100%	99%	100%
SARS (Email) Requests	volume	1	1	1
SARS (Email) Requests released	volume	0	1	2
SARS (Email) Requests released within 90 days	R- <65% A – 65-80% G- >80%	0%	0%	0%
SARS (Email) in progress	volume	7	7	6
SARS (Legal) Requests	volume	53	55	55
SARS (Legal) Compliance	R- <65% A – 65-80% G- >80%	100%	100%	93%
Mental Health Identifier: data completeness	R<97% G 97-100%	99.5%	99.6%	99.5%
Mental Health Ethnicity Completion %	R<90% G 90-100%	62%	66.2%	71.1%
% of patients with a valid NHS number - inpatients	R<99% G99-100%	92.7%	92.7%	TBC
% of patients with a valid NHS number - outpatients	R<99% G99-100%	93.8%	93.8%	TBC



Well Led Overview

Performance in the monthly high risk review has deteriorated over the last two months. March performance of 68.5% means that 17/54 risks were not reviewed within policy timescales (all high risks should be reviewed monthly). These risks are spread throughout the directorates. Changes to the high risk reporting pathway via Operational Board are expected to support improvement in this performance.

There are 9 overdue actions linked to Red Complaints. This is due partly to the recent transfer of actions plans to the Datix system to promote visibility and local ownership. It's expected that some of these actions have been completed but not updated formally on the system, with staff adjusting to the changes. Four actions are being held open pending a confirmatory audit which is currently underway. Further work to support closure of these actions will be undertaken by the Complaints team and through the Risk Action Groups. A new initiative to improve visibility and governance arrangements for closing the loop on lessons learned from Serious Incidents and Red Complaints has been developed and submitted to the Executive Team for consideration.

Compliance figures for Duty of Candour and Serious Incident Action completion will begin in the May report with the new financial year data.

Policy approval rates still remain below the expected compliance rates, with a performance of 58% for March. This represents a 2% increase in the month. The April Policy Approval Group (PAG) was cancelled, but the Agenda for May and June have been increased suitably to support greater throughput of policies and improve overall compliance.

Freedom to speak up cases for March remain constant at 8 cases per month. The total number of FTSU cases for Q4 is 19, which is the highest per quarter casework load to date. Key themes remain the same with issues being raised predominantly regarding safety, behaviours, performance/management and support with navigating Trust processes.

Our data management metrics demonstrate high levels of responsiveness to medical record requests and SARS requests dealt with by the legal team. Performance in email SARS demonstrates challenges in meeting the statutory timescales. No SARS requests in Q4 have been released within the required timescale due to the volume and complexity of the data being reviewed. There are currently 6 SARS in progress.

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Quality & Safety Overview

Are we learning and improving?

As of March there are over a thousand open incidents on Datix which require review, investigation and closure. Brain and IPP have worked hard over the past few months to review and clear their backlog of incidents. It is imperative that when managers leave the Trust incident forms are re-assigned to other staff members and that staff login to Datix on a daily basis to reduce the risk of a backlog forming in those areas.

The Trust also uses Datix to record the actions of Serious Incident (SI) investigations which require managers to login and update the system when the actions are complete. Currently there are 47 SIs with action plans not recorded on Datix, many of which are those from the last two years. The Quality and Safety team will ensure the outstanding plans are uploaded and work with the Directorates to update them.

In the month of March we have seen 68.5% of high risks reviewed within the timescale across the Trust as laid out in the Risk Management strategy, as of May 2019 all high risks will be shared with the Operational Board with 1 high risk per month being discussed and shared for oversight and cross directorate learning.

The insertion and removal of lines has been a theme this month within incident reporting, complaints and risk register reviews. The senior operations team worked with their clinical colleagues to put a plan together to clear the backlog of patients requiring the removal of lines.

The Debrief project supported by the QI team and lead by the Matron for BBM was presented to the QIC and highlighted significant improvement in staff wellbeing following the introduction of debriefs on Chameleon ward. The Matron is working with her colleagues to spread the learning with a view of other areas adopting the same approach.

Our Harm Free Care Measures for CVL infections demonstrate normal variation but note that the last three months have seen a rate consistently above the mean (1.6). 13 bacteraemia episodes are linked to one patient's clinical condition. Removal of these numbers (and line days) a March monthly rate of 2.7 and a final annual rate for 2018/19 of 1.4. Medication errors causing harm is currently showing normal variation. There are some outlying data points for pressure ulcers which may merit further indication as the data isn't showing stable system variation. There are no concerns in relation to our inpatient mortality rate or our respiratory/cardiac arrests occurrence.

The Clinical Audit report highlights the improvement made to Cardiac patients having the consent process started prior to the day of surgery, this is following an RCA in 2017 which indicated the need for cardiac consent clinics. A re-audit 3 months' time is recommended to ensure sustainability of action taken.

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Emerging trends in Patient Safety - March

Patient flow/ nursing shortages

- Short staffing across the Trust. IPP wards and Sky Ward have closed beds which is having a knock on effect on other areas such as PICU as those wards have no HDU beds currently.
- Staffing ratios mean that patients with tracheostomies require 1-1 nursing which in turn limits the capacity of wards further.
- This is having an impact on patient flow. There have been large numbers of cancellations across cardiac theatres and XMR due to lack of beds on CICU as well as staffing issues in Theatres.

Increase in ZAPPP cancellations

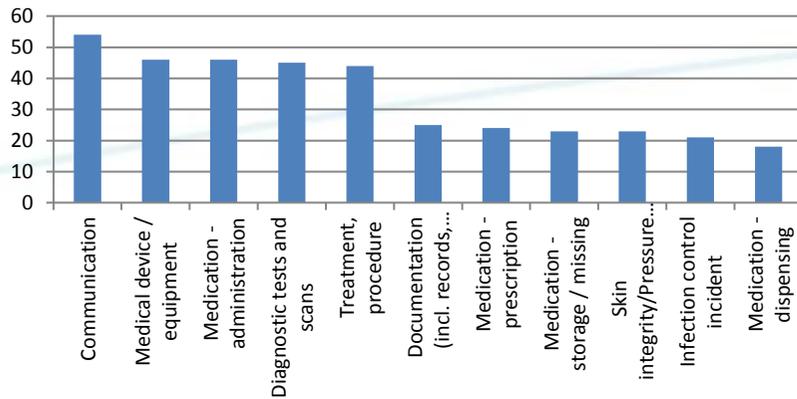
- When ZAPPP was first introduced cancellations were very low, however there appears to have been a subsequent rise in the number of patients cancelled due to poor patient preparation.
- Feedback from the wards is that their workflow makes it hard to prepare multiple patients for 8.15 due to doctor starting times. This could get even more challenging if ZAPPP is extended beyond IR.
- There has been no harm we are aware of as a result of cancellations however this does have a significant impact on patient experience. IR report cancellation numbers are still well below what they were pre-ZAPPP.

Incidents regarding insertion and removal of lines

- There was one SI declared this month around the removal of a line, where 8cm of line was retained in the patient
- More broadly, delays in line removals continue to be a major problem across the Trust and this is being considered for the new trust wide risk register. This links in to the IR capacity issues described above.
- Line insertion also remains a problem, both in and out of hours. Delays and cancellations of line insertions can delay crucial treatment. There was one complaint raised around delay of line insertion that linked to staff understanding of the proper escalation processes.

Understanding incidents

Incidents by category: 1 March to 31 March 2019



Managing Incidents – Learning in practice

There are currently over a thousand incidents trust-wide which are overdue and require investigation. Some of these date back more than 2 years.

The main causes of this are managers leaving and not being replaced, staff not logging into DATIX to check their outstanding incidents and staff allocating the wrong specialty or manager when reporting the incident.

We try to mitigate against these factors by discussing the issues at Risk Action Groups (RAGs), with staff during DATIX training, and by updating managers when staff leave.

Notable Practice: Brain and IPP have worked hard to review and clear their outstanding incidents and usually have less than ten each.

This is important as there is a limited amount of time when an effective investigation can take place.

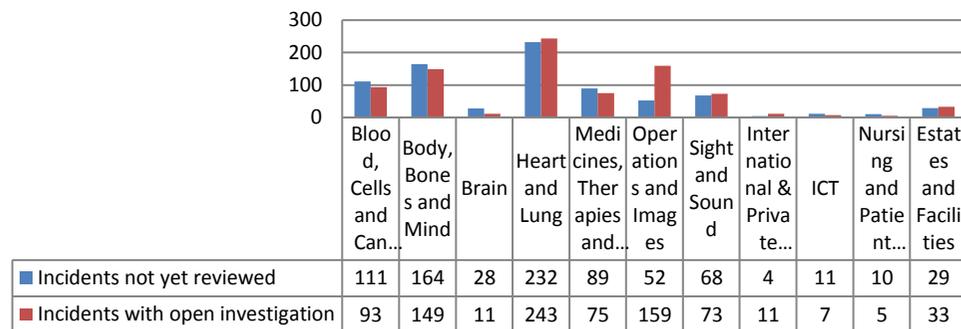
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Communication remains the most reported category across the Trust. No harm has been caused by these incidents but there has been an impact on patient experience and patient flow, meaning the actual impact is greater than it originally seems. In March incidents around communication have been reported in 29 clinical areas and 2 non-clinical areas. Incidents reported concern a wide range of communication issues including preparing and transporting patients between departments for procedures, requests for patient laboratory tests, reporting results of tests to treating teams or ward areas, changes to medication or dietary requirements and training of parents/carers to care for their child at home.

Medical device/equipment incidents have occurred in a number of clinical areas where there have been issues around functionality of newly purchased equipment such as a new gastroenterological endobase system. There are continued concerns around faulty BD giving sets where pumps continue to alarm during medication /treatment administration.

Medication: Incidents regarding medication errors have flagged in four areas; administration, prescribing, storage and dispensing. Medication errors are reviewed and discussed at Risk Action Groups across the trust as well as at a dedicated pharmacy RAG. Some clinical areas have set up specific training and teaching sessions tailored to incidents reported in their areas. A medication safety committee is also now in place to review medicines management across the organisation.

Incidents by Division and Approval status



Patient Safety Alerts

New and ongoing Patient Safety Alerts

NHS/PSA/RE/2018/006: **Resources to support safe and timely management of hyperkalaemia** (Aug 2018)

Update: Meeting to be scheduled to discuss progression and action plan requirements. **Due:** May 2019

NHS/PSA/D/2019/001: **Wrong selection of orthopaedic fracture fixation plates.** (Feb 2019)

Update: Clinical Lead for alert still to be assigned, but alert has been shared with orthopaedic consultants. Following PSOC this is now being followed up by the Deputy COS and GM for the associated directorate.

Due: May 2019

NHS/PSA/W/2018/009: **Risk of harm from inappropriate placement of pulse oximeter probes** (December 2018)

Update: Alert shared with Senior Nursing Lead for Education. Action Plan development required. **Due:** June 2019

Recently Closed Patient Safety Alerts

NHS/PSA/RE/2018/004: **Resources to support safer modification of food and drink** (April 2019)

Update: Action plan in place lead by dietetics **Due:** April 2019

Overdue Patient Safety Alerts

NHS/PSA/RE/2017/004: Resources to support safe transition from the Luer connector to NRFit for intrathecal and epidural procedures, and delivery of regional blocks. **DUE: December 2017**

Latest update: Members of the Patient Safety and Outcomes Committee (PSOC) made aware of status for all current open safety alerts

National Learning:

Healthcare Safety Investigation Branch

Piped supply of medical air and oxygen [report](#)

This report was in response to a near miss incident with an 85 year old woman being administered piped air rather than piped oxygen in response to sats of 85%.

The HSIB report highlights the inconsistency of implementation of national safety alerts noting that an NHSI Patient Safety Alert relating to management of risks with piped air and oxygen was issued in 2016 which did not prevent this error.

The HSIB calls on the National Committee for Safety Alerts to introduce a robust assessment process for alerts which includes advice on implementation and ongoing monitoring.

Wrong Site Nerve Block – RCoA [response](#)

Update: Following publication of a HSIB [report](#) in September 2018, the Royal College of Anaesthetists and Safe Anaesthesia Liaison Group will form a working group to examine the practice, and evaluate any human factors changes that can be made to improve the safety of this procedure.

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Patient Safety – Serious Incident Summary

New & Ongoing Serious Incidents

Directorate	Ref	Due	Headline	Update
Heart & Lung	2018/24654	09/01/2019	Major Haemorrhage	Final report being drafted
Body, Bones & Mind	2019/442	2/05/2019	Bowel obstruction	Independent investigation meeting scheduled for 02/05/19. Report drafted.
Operations & Images	2019/3785	14/06/2019	Set Sterilisation issues (aggregated)	Timeline in progress
Heart & Lung	2019/8273	11/07/2019	Retained part of abdocath	Timeline in progress
Operations & Images	2019/8826	17/07/2019	Never event. Retained surgical object	Timeline in progress

Serious Incident Performance

- **2018/24654:** This event was reviewed at several different forums and was also subject to external scrutiny and a coroners inquest. The delay has been amalgamating the outcomes into one comprehensive report. This is now being finalised and is expected to be with the exec for sign-off within the week.

Sharing Lessons Learned: SI 2018/21816

Situation: Wrong dose of GTN administered to a patient during a cardiac procedure.

Background – The only available concentration of intravenous GTN is 50mg in 10 mls, so this is routinely diluted in paediatrics prior to use. This was then labelled with a GTN label. However this label did not state the drug strength, as required in the Trust's Medication Administration Policy. The syringe was subsequently left with the ampoule on the surgical trolley ready for use. The nurse in charge was aware both the nurses were experienced in the clinical area but were unfamiliar with the use of GTN so checked with the scrub nurse if she had "taken the syringe down to 8 mls". This local terminology related to the need for a syringe not to be full to its capacity to allow the operator to be able drawback blood from the cannulation site catheter prior to the administration of any drug or flushing fluid.

Analysis

- The GTN was not formally prescribed on a medication chart but outlined in the procedure guidelines.
- Procedural guidelines are available with drug calculations for GTN administration, however this is not commonly known about with staff that may access the service when required.
- Verbal communication using descriptive language was not used and a number of assumptions were made regarding the knowledge of staff members who had joined the team for this shift. There was also a lack of "command repeat" communication prior to and when the task was being carried out.

Trust Wide: It is essential to ensure all drugs are correctly prescribed and checked prior to administration. Staff need to be aware of the mode of action, dose ranges, potential side effects and contraindications for medications they are preparing.

Notable Practice

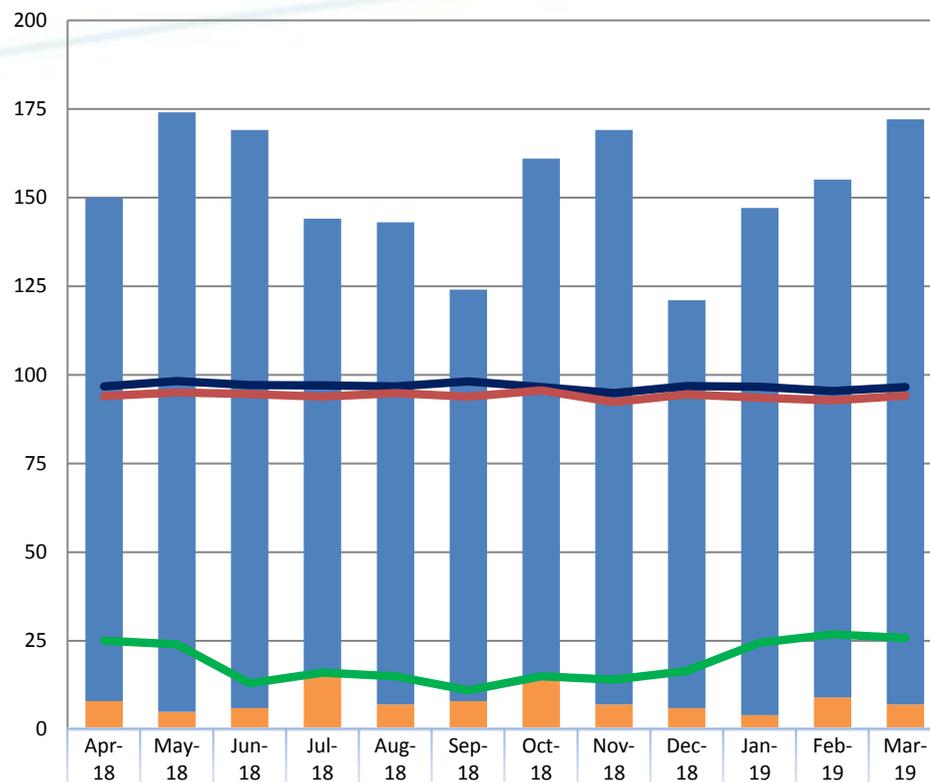
Liz Akers lead (Practice Educator) launched a new project called the Little Room of Horrors. The project is a type of clinical simulation where staff are introduced to a room with a large number of potential patient safety concerns and asked to identify them. The plan was for staff to do this in teams and to have a leader board to try and encourage staff to take part and introduce an interactive element to what is a very serious issue.

The patient safety team contributed with some ideas for this based on common DATIX incidents. The final version included suggestions such as cot sides left down, suction tubing set up incorrectly and tangled lines.

Patient Experience Overview

Are we responding and improving?

Patients, families & carers can share feedback via PALS, Complaints & the Friends and Family Test (FFT).



■ PALS	142	169	163	129	136	116	146	162	115	143	146	165
■ Formal Complaints	8	5	6	15	7	8	15	7	6	4	9	7
— FFT recommendation rate - Inpatients %	96.7	98.2	97.1	97	96.7	98.1	96.5	94.8	96.8	96.6	95.4	96.5
— FFT recommendation rate - Outpatients %	94	95	94.6	93.8	94.8	93.8	95.6	92.3	94.5	93.5	92.8	94.1
— FFT % response rate	25	24	13	16	15	11	15	14	16.5	24.5	26.8	25.8

Integrated Patient Experience Commentary

The Trust FFT % response rate target of 25% was met for the second month. However, outpatient FFT numbers have dropped by almost 39% since January 2019. While this is partly attributed to a decrease in outpatient appointments attended, we are liaising with the teams to better understand the reason for this reduction.

There was a further increase in Cardiology Pals cases month with concerns primarily about cancelled procedures/ appointments. In response to this, the Cardiology team are:

- improving pre-admission communication regarding the possibility of cancellations
- using a triage process to assess clinical risk of cancellations and offer assurance to families about any delays.
- working to ensure that clear information is given for cancellation and where possible, a new date is offered

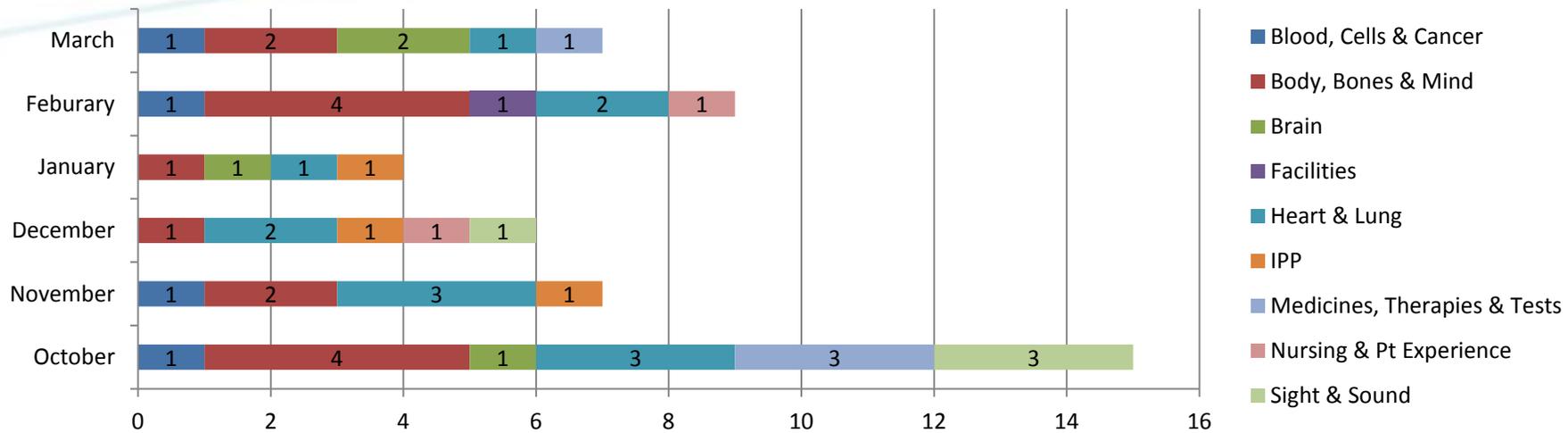
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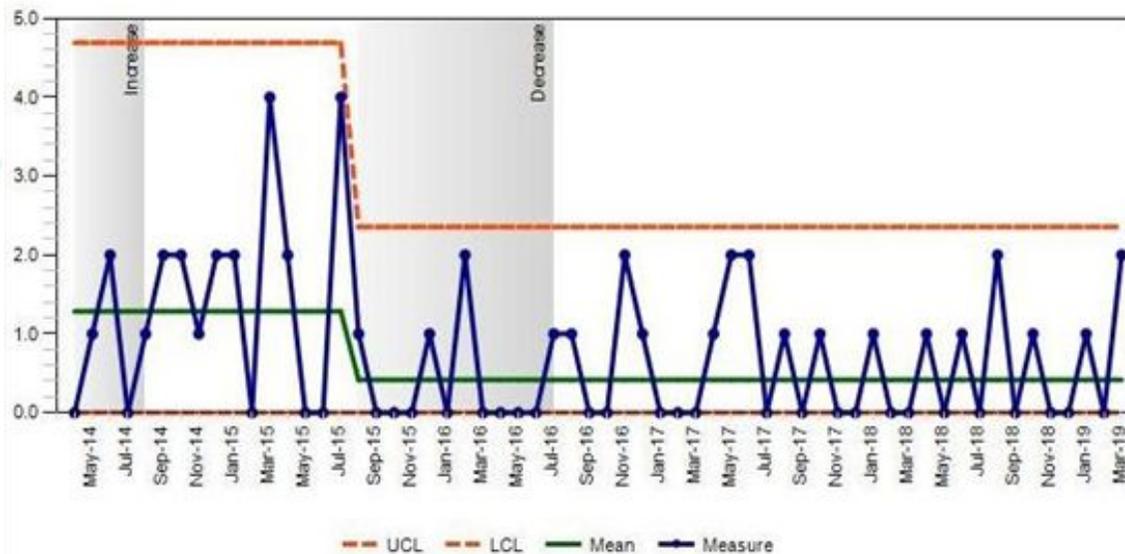
Complaints: Are we responding and improving?



There was a decrease in complaints in March (n=7) and numbers were lower than the monthly average which currently stands at 8.1 complaints. Complaints in March related to concerns about/ that:

- a failure to carry out diagnostic testing and delayed diagnosis and treatment
- information provided for safeguarding purposes
- communication with a family regarding the diagnosis and risks of treatment
- management of fluid balance and sedation
- standards of care and the hospital environment
- a clinician being unprepared for an outpatient appointment
- a decision to postpone surgery

Red Complaints: Are we responding and improving?



No of new red complaints YTD 2018/19: <i>*one complaint was later withdrawn</i>	9*
New Red complaints opened in March 2019	2
No of re-opened red complaints- YTD 2018/19:	1
Open red complaints (new and reopened) as at 31/03/2019	3
Red complaints in 2018/ 19 have exceeded 2017/18 (n=8). Red complaints this year related to serious concerns about care and treatment across the Blood, Cells & Cancer, Body, Bones & Mind, Heart & Lung and IPP directorates. Review is underway to identify any clear themes/ trends in red complaints.	

New red complaint

Ref	Opened Date	Report Due	Description of Complaint	Divisions Involved	Next Steps:
18/093	11/03/19	24/04/19	Parent is concerned about the management of fluid balance and sedation and is worried that this may have contributed to the patient's death.	Heart and Lung	Investigation is currently taking place
18/095	18/03/19	16/05/19	Parent is concerned about the environment and standards of care which they feel may have contributed to the patient's death.	Blood Cells and Cancer	Investigation is currently taking place

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PALS – Are we responding and improving?

Cases – Month	03/18	02/19	03/19
Promptly resolved (24-48 hour resolution)	175	136	144
Complex cases (multiple questions, 48 hour+ resolution)	15	9	21
Escalated to formal complaints	3	0	0
Compliments about specialities	4	1	0
*Special cases (e.g. large volume of contact following media interest)	0	0	0
Total	197	146	165

There was an increase in Pals cases this month particularly in the number of complex cases. This is in accordance with a focus by the Pals team on regular review of cases to ensure timely follow up and importantly appropriate categorisation. The Pals team report that this increase does not reflect a lack of responsiveness by directorates but an increase in the complexity of the issues being raised.

Themes for the top five specialities	03/18	02/19	03/19
Lack of communication (lack of communication with family, telephone calls not returned; incorrect information sent to families, transport)	56	63	63
Admission/Discharge /Referrals (Waiting times; Advice on making a NHS referral; advice on making an IPP referral, cancellation; waiting times to hear about admissions; lack of communication with families, Accommodation)	39	22	18
Staff attitude (Rude staff, poor communication with parents, not listening to parents, care advise)	19	14	14
Outpatient (Cancellation; Failure to arrange appointment; poor communication, franking of letters)	60	9	47
Transport (Eligibility, delay in providing transport, failure to provide transport)	3	3	7

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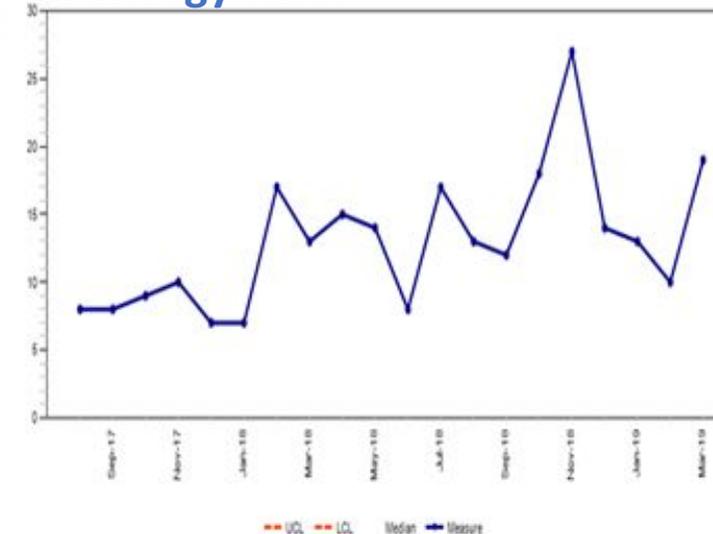
PALS – Are we responding and improving?

Specialities - Month	03/18	02/19	03/19
Cardiology	14	10	19
Gastroenterology	6	14	13
Urology	7	5	12
Dental	5	7	8
Epilepsy	3	4	8

In addition to concerns about cancellations, Cardiology cases highlighted concerns about communication. Specifically, difficulties in getting information/ test results. It is hoped that MyGosh will help to address this. Of note, FFT recommendation rates for Cardiology have increased in Q4 2018/9 (inpatient average 98.8%).

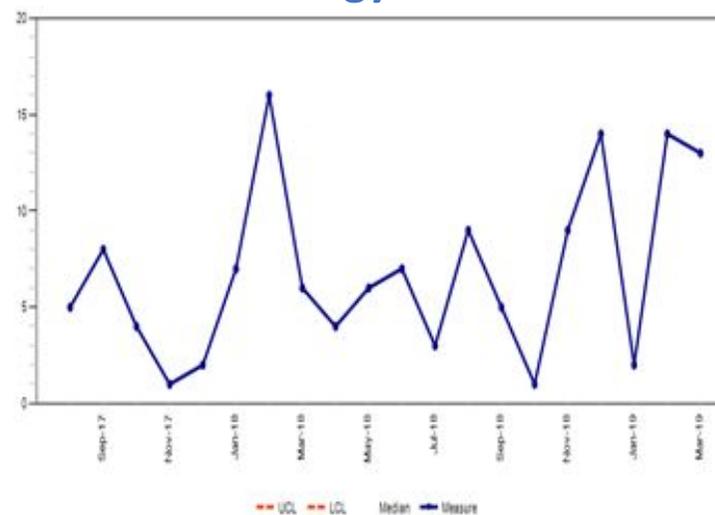
Gastroenterology cases broadly related to communication with some families raising concerns about their relative's care. Some families expressed dissatisfaction regarding delays in requests for information being actioned.

Cardiology cases



Theme Mar 2019	total
Delays/ Waiting	9
Communication	6
Care	2
Facilities	2

Gastroenterology cases



Theme Mar 2019	total
Communication	8
Care	3
Delays/Waiting	2

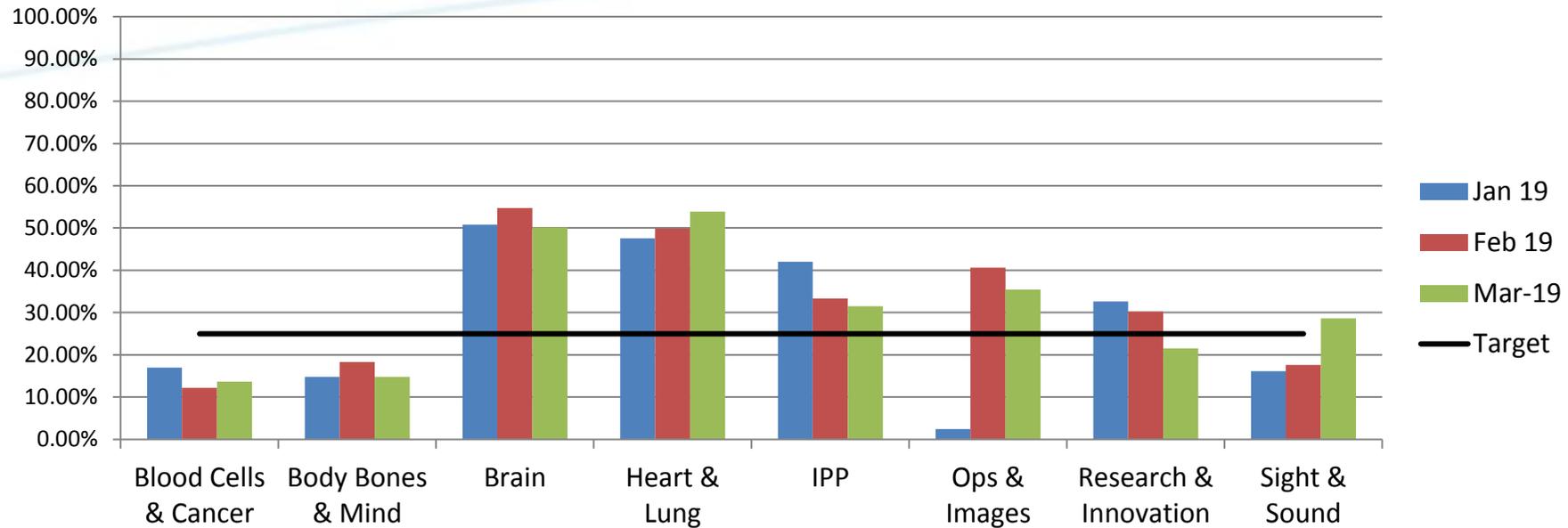
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FFT: Are we responding and improving?

FFT Response Rate by Directorate



The overall Trust FFT response rate in March exceeded the Trust target of 25%. 5 directorates achieved above the 25% target.

Benchmarking against 11 paediatric other hospitals (January 2019 NHS England Data) FFT response rates varied between 12% and 36%. The January rate of 24.5% places the Trust at the midpoint.

Operations & Images Directorate have significantly improved their response rate by encouraging families to provide online feedback while they are waiting.

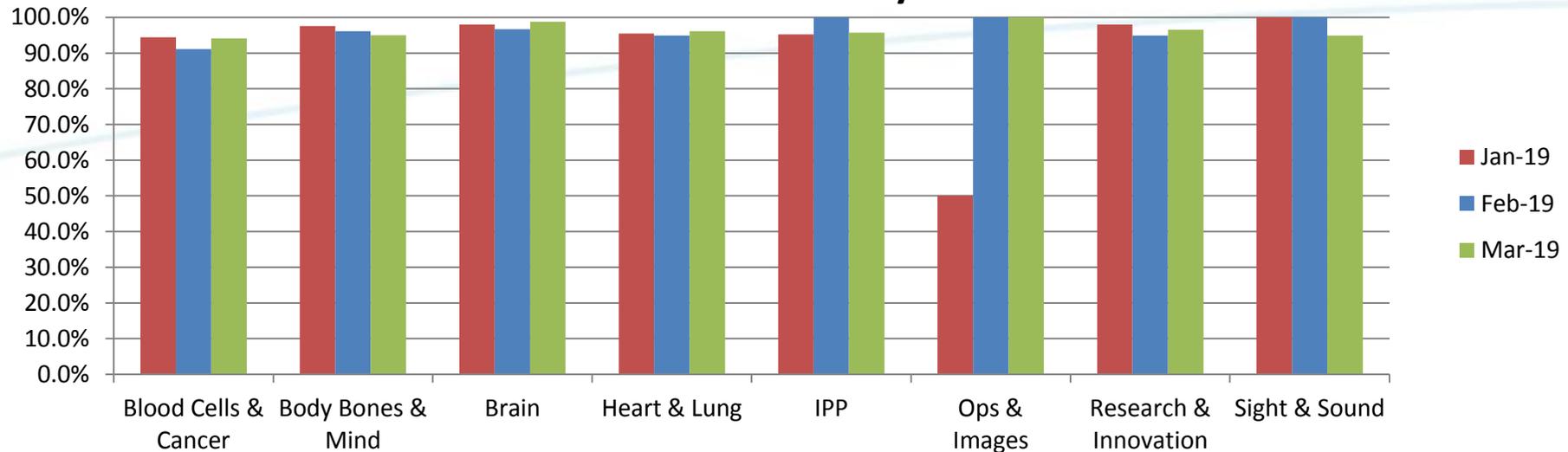
Sight and Sound have made a significant improvement this month by encouraging all families visiting Panther ward to complete an FFT card on departure.

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FFT: Are we responding and improving?

FFT % Recommendation by Directorate



FFT feedback at GOSH includes a high proportion of qualitative feedback. In March 81% of FFT responses included qualitative comments. The recommendation rate in March was 96.5% which is an improvement on the previous month (95.4%). There were many positive comments on the how staff go the ‘extra mile’ and how the care received feels personalised.

The Trust was at midpoint (97%) when benchmarked against other paediatric hospitals (range 76% to 99%) in January 2019.

	Inpatient Comments	Outpatient Comments	IPP Comments	Total Feedback	% with qualitative comments (All areas)
Jan 19	860	1099	63	2022	63.9%
Feb 19	877	780	48	1705	82.2%
Mar 19	876	673	48	1597	81.3%

Negative comments over the quarter primarily related to the Environment and One Team. Comments varied from rooms being cold to lack of bathroom facilities for patients and families and poor Wi-Fi.

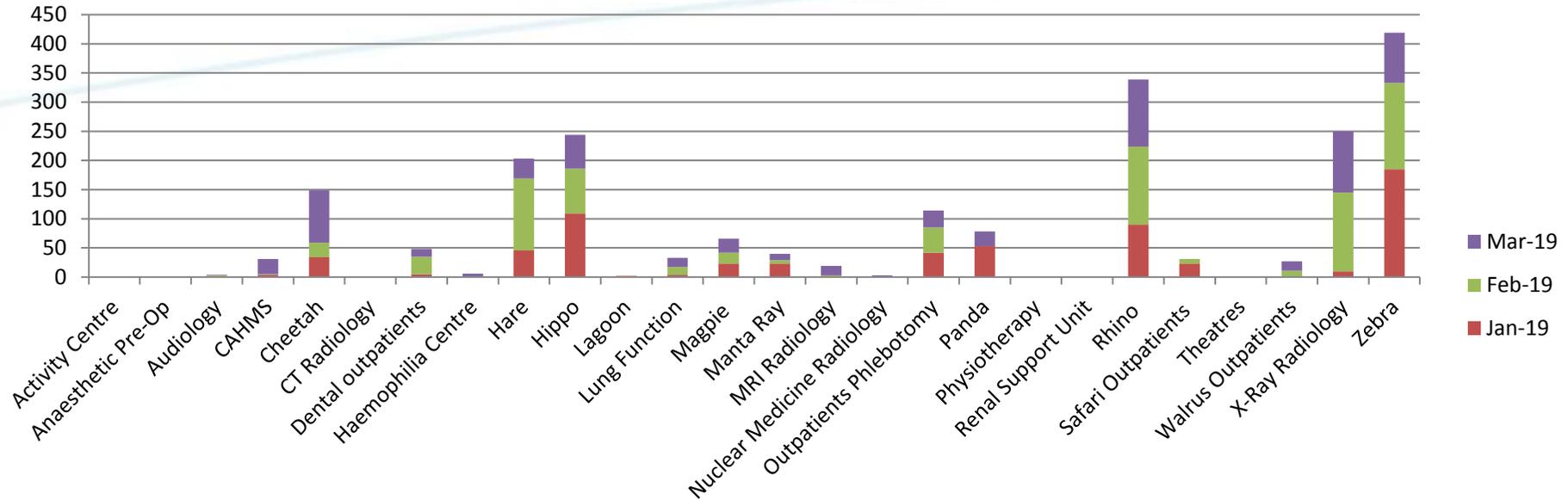
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FFT: Are we responding and improving?

FFT Outpatient responses



The above chart outlines the number of the FFT responses within Outpatients. There is currently no Trust or NHS target for outpatient feedback.

There a further decrease in outpatient feedback with 673 comments received in March compared with 780 in February and 1099 in January 2019. However, there has also been a reduction in the number of attended appointments. It is expected that the number of attended outpatient appointments will reduce further in April due to EPR go live and the planned reduction in clinics during this period.

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FFT: Are we responding and improving?

Qualitative Comments

Positive

Negative

“We were made to feel so welcomed and were treated with respect and kindness. The doctors were very thorough and patient with our many questions! Coming in for treatment is never easy but knowing that we will be meeting the team here makes it so much less scary and even a happy experience overall” – Pelican Day Care

“Having your child need medical treatment in a hospital setting is extremely scary and stressful. The level of care we received from every member of the staff (Surgeons, doctors, nurses, students etc...have been nothing short of incredible. We were treated with patience, professionalism, care, understanding, smiles. They bent over backwards to make this as smooth as possible and their level of attention was personal and they never left us needing anything. Thank you so much!” Chameleon Ward

“As my daughter puts it – this is the best hospital she has ever been to! The staff are always smiling, caring and wonderfully helpful!” – Urodynamics

“The level of care was fantastic thank you. Can’t fault it. one complaint however is the shower situation. We spent 1 month on HDU bay and having to wait for a shower wasn't great. My son had several viruses so for hygiene as well as infection control this really need to be addressed immediately.

Nurses were accommodating in findings shares even on other wards, however they shouldn't be expected to escort parents to another ward, while they are caring for patients” Koala Ward

Response: the lack of washing facilities for parents in the HDU had been escalated. Funding has been approved for another walk-in shower.

“This day has been awful, not one thing has gone right. I finally got to the ward and I am passed from person to person, when we are finally shown to patient names bed and t isn't in a private room as previously promised due to many other issues no one is willing to help and you are just left here. Awful, awful experience.” Panther Ward

Response: Following a call from the ward sister and apology given for a breakdown in communication, the family were thankful for the explanation given and did not wish to pursue their concerns.

Feedback is shared with the teams concerned. All negative comments are followed up with the families (subject to contact details being available).

Participation in National Clinical Audit

During 2018/19 13 mandatory national clinical audits and clinical outcome review programmes covered the NHS services that GOSH provides. GOSH has participated in them all.

The following national clinical audit reports and data were published from mandatory

Name of audit / clinical outcome review programme	Relevance to GOSH practice
Congenital heart disease including paediatric cardiac surgery	The 30-day survival rate for paediatric cardiac surgery is a nationally accepted benchmark that is used to judge outcomes. In the three years 2014 to 2017, there were 1885 cardiac operations performed a GOSH, of which 99.2% of patients survived to 30 days. The GOSH risk-adjusted survival rates for paediatric cardiac surgery are defined as 'much higher than predicted' More information about this can be found on the Cardiothoracic clinical outcomes page on the Great Ormond Street Hospital Website
Diabetes (Paediatric) (National Paediatric Diabetes Association)	The 2017/2018 report focuses on measuring care for type 1 diabetes patient. GOSH does not have sufficient numbers of typical type 1 diabetes to allow comparison of performance. 81.3 % of GOSH cases included have rare forms of diabetes
Inflammatory bowel disease Registry	No paediatric data has been published by the IBD registry at the time of writing. The Gastroenterology Service GOSH participates in Improve Care Now, an international collaboration between Paediatric Gastroenterology centres .The collaboration benchmarks improvement in quality and monitors clinical outcomes for children with inflammatory bowel disease. As part of the Improve Care Now initiative, GOSH monitors specific IBD outcome measures and have routinely collected data since 2011. These data include outcomes relating to disease remission rates, nutrition and growth for the children we treat. More information about this can be found on the Gastroenterology clinical outcomes page on the Great Ormond Street Hospital Website
National Cardiac Arrest Audit (NCAA) (ICNARC (Intensive Care National Audit & Research Centre).	<p>The NCCA 2017/18 audit report was published in 2018/19 and reports the incidence and outcome of in-hospital cardiac arrest in order to inform practice and policy. The annual audit report has been reviewed by Resuscitation Services.</p> <p>The number of paediatric cardiac arrests nationally is approximately 250-300 per year.</p> <p>The interpretation of the data for GOSH</p> <ul style="list-style-type: none"> • There were 24 in hospital cardiac arrests in 2017-18 • GOSH has a higher incidence of cardiac arrests per 1000 hospital admissions (0.6 per 1000) than the four other standalone paediatric centres who participate in NCCA. This data is not risk-adjusted, so it does not take into account the severity of illness. • Overall data from NCAA since 2011 indicate that GOSH has an excellent rate of survival to discharge for patients who have had a cardiac arrest. <p>The actions that have been completed in the last year to support best practice in management of cardiac arrests.</p> <ul style="list-style-type: none"> • Continued Clinical Emergency Team Simulation Training. • Re-organisation of the Clinical Emergency Team to improve efficiency and further embed quality cardiopulmonary resuscitation. • Increased numbers of resuscitation training places for all staff

Name of audit / clinical outcome review programme	Relevance to GOSH practice
Paediatric Intensive Care Audit Network (PICANet)	<p>The primary outcome measure used in Intensive Care Units (ICU) is the survival rate for patients, measured at the time when they are discharged. Raw survival/mortality rates may be challenging to interpret as patients that are admitted in a sicker condition are at greater risk, and therefore the outcomes need to be ‘adjusted’ to consider the level of severity of the patients in respect of case mix.</p> <p>The most recent PICANET report compares Trusts Standardised Mortality Ratio for the calendar years of 2015-17. The data in this report shows GOSH mortality as within what would be expected based around the case mix.</p> <p>More information about this can be found on the Intensive Care Unit clinical outcomes page on the Great Ormond Street Hospital Website</p>
Child Health Clinical Outcome Review Programme (NCEPOD) Cancer in Children, Teens and Young Adults: On the Right Course?	<p>The Cancer in Children, Teens and Young Adults report identifies areas for improvement nationally in the care of children and young people who receive chemotherapy. A GOSH Consultant is the national clinical lead for this study.</p> <p>The recommendations in the report apply across care settings and care pathways. A GOSH Haematology/Oncology Consultant is involved in the implementation of actions to achieve the recommendations with NHS England.</p>
UK Cystic Fibrosis Registry (Cystic Fibrosis Trust)	<p>The 2017 Cystic Fibrosis report was published in 2018/19 and includes data about individual cystic fibrosis centres, to help the centres benchmark themselves against their peers.</p> <p>The data shows that GOSH results for key clinical outcomes are within expected variation. More information about this can be found on the Cystic Fibrosis clinical outcomes page on the Great Ormond Street Hospital Website</p>

A central clinical audit function prioritises audits to support learning from incidents, risk, patient complaints, and to investigate areas for improvement in quality and safety.

An example of a completed priority audit that has supported “closing the looping” on learning from past harm is attached on the next slide.

Clinical Audit – avoidance of on the day consent for elective cardiac surgery via Walrus Ward

Background

35 clinical incidents reported in Cardiac Surgery around consent process in 2016/17

“The Surgical Consultant was contacted and came to the ward to do the consent for the procedure 5 minutes before the patient was taken to theatre”

March 2017 Learning from a completed RCA investigation

“This consent was taken the day before the surgery which the panel agreed is not ideal to allow the families sufficient time to process the information and then come back to the surgical team for further clarification. There is currently no dedicated clinic for surgeons to meet with families and children to discuss both the surgery, risks and benefits and also other options such as not operating and the risk of reoperation. **There are plans to introduce a consent clinic in the Trust.**”

June 2017 Audit presented to Cardiac M+M in 44% (11/25) of cases in Feb/March 2017 the parents/patient saw the consent form for the first time on the day of the procedure.

“Consent for major cardiac surgery is happening on the day of the procedure or day often than is desirable.”

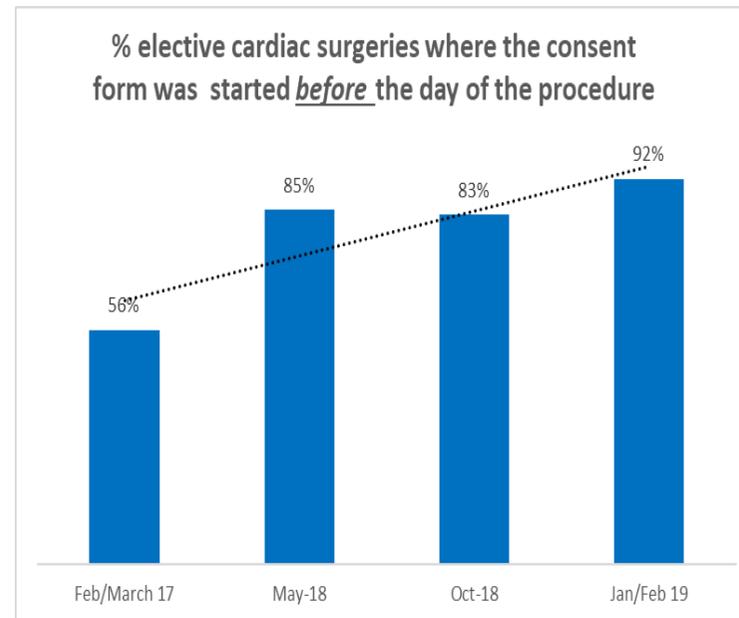
Consensus was reached that the position required improvement

May 2018 an update was provided from the Service Manager on progress with implementation of the Consent Clinic

“The consent clinic has been established and 3 of the 5 surgeons are using the clinic. The consent clinic is run alongside the cardiac pre-admission clinic on Walrus ward. “

Progress

Desired outcome – consent is not started on the day



*It has improved. Consultants are much more visible on the ward than a year ago”
“staff feel more confident in asking them to come and consent*

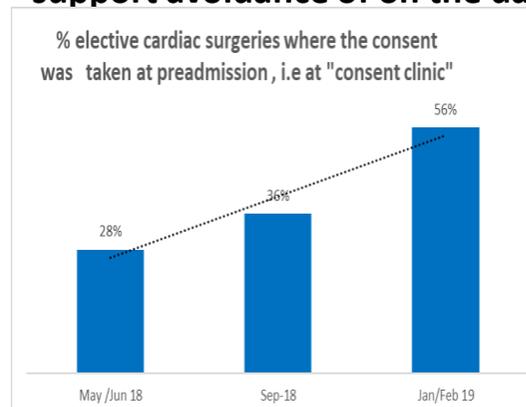
Feedback from ward sister

Recommendations

There have been improvements noted. Audit in three months to provide assurance about sustainability. Additional detail of cases in the audit, including cases where consent could not be achieved in advance shared with the Heart and Lung Chief of Service and Head of Cardiothoracic Surgery

Andrew Pearson, Clinical Audit Manager , 21st March 2019

Process –Utilisation of consent clinic to support avoidance of on the day consents



Quality improvement at GOSH

The QI Team works to support, enable and empower teams to continuously improve the quality of care provided to patients across GOSH. The following maps where registered QI activity is taking place across the Trust:



Brain

- TOF/OE Pathway
- Gastro/SNAPS debriefs
- Reduce unnecessary coagulation testing in SNAPS



Body, Bones and Mind



Operations and Images

- ZAPPP



Sight and Sound



Blood, Cells and Cancer

- Optimising Antimicrobial Stewardship programme
- Reducing IR delays & cancellations
- Pelican safety measures



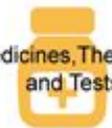
Heart and Lung

- Reducing blocked lumens in CVLs
- Improving handover quality and continuity of care for outliers in cardiology



International and Private Patients

- IPP flow



Medicines, Therapies and Tests

By Quality Improvement (QI), we mean a systematic approach to “making changes that will lead to better patient outcomes, better system performance, and better professional development”
(Batalden and Davidoff, 2007)

At GOSH, we use the Model for Improvement as a framework for developing, testing, implementing and measuring change
(Associates for Process Improvement)

Trust-wide projects*
Reducing incidences of extravasation harm and repeated cannulation
Reducing rejected laboratory samples
Improving Transition

*Click links to open project dashboard

Local QI projects

The QI team provides a service offering QI mentoring and support to staff delivering local projects. The team also offers a process to register any QI work going on across the Trust, in order to capture and share learning and improvement, prevent duplication, and provides a platform to raise the profile of QI.

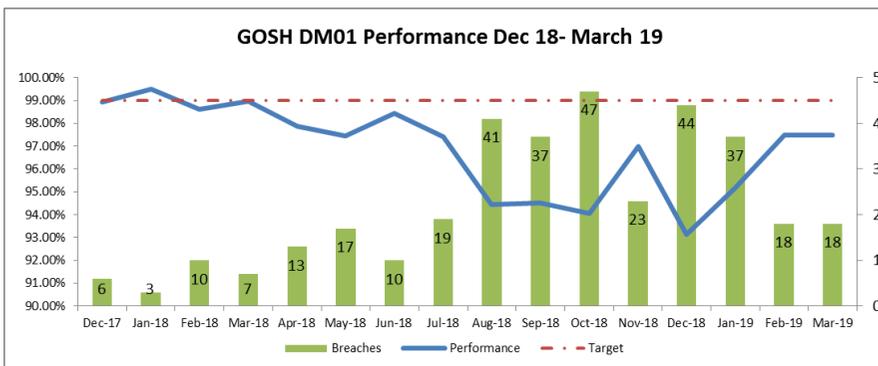
	Area of work	Project lead:
1	To streamline the management of patients with oesophageal atresia (OE) and tracheoesophageal fistula (TOF)	Caroline Gainsbury, SNAPS CNS
2	Implementing daily debriefs in Rainforest Gastro and Chameleon Wards	Carly Vassar, Matron SNAPS, Gastro and CAMHS
3	Optimising the Antimicrobial Stewardship Programme at GOSH	Alasdair Bamford, Infectious Diseases Consultant
4	Improving the maintenance of central venous lines and reducing blocked lumens on CICU	Alfredo Javier Alvarez Gavela, Cardiac Fellow
5	Decrease IR delays or cancellations in Blood, Cells and Cancer Directorate caused by patients not being ready / in IR on time	Anupama Rao, Haem/onc Consultant & Beth Corley, Haem/onc Fellow
6	Improve handover quality and continuity of care for outlying patients in the cardiology service	Craig Laurence, Cardiology Fellow
7	To reduce the number of unnecessary clotting samples on SNAPS	Sonia Basson, SNAPS SpR
8	To implement measures designed to support patient safety and quality improvement on Pelican ward	Tricia Bennet, Assistant Chief Nurse, & Emma Gilbert, Matron



Responsive – Diagnostic Waiting Times

March 2019 Summary

- The Trust continues to underachieve against the 99% national standard, reporting 97.48% of patients waiting within 6 weeks for the 15 diagnostic modalities
- This is a slight deterioration from February 2019
- The number of reported breaches has remained the same (18) as last month.



Of the 18 breaches, 16 are attributable to modalities within Imaging and the remaining 2 relate to Urological diagnostic tests.

The breaches fall into four distinct themes, 5 were tolerance breaches (patient unwell, equipment failure MR5 breakdown, scan abandoned), 2 were due to Trust process issues (late requests), 4 were due to Trust booking processes (no reasonable offers made and patient DNAd but was booked in 4 months later) and 7 were due to capacity issues (Lack of slots and no available bed)

The Trust continues to monitor the diagnostic recovery plan, with the reported number of breaches for March being ahead of trajectory.

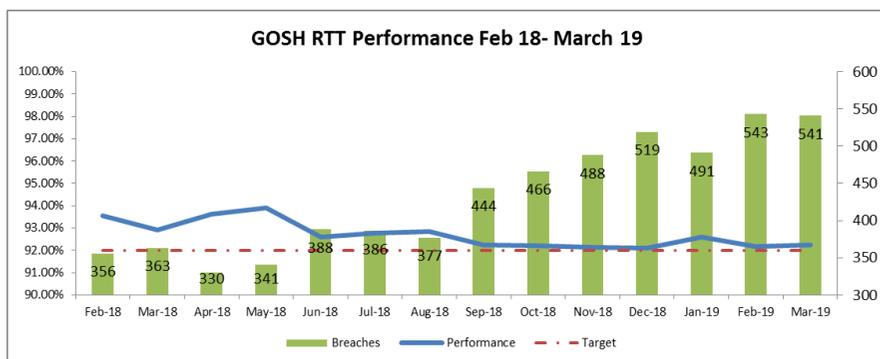
Cancer Wait Times

There were no breaches against the cancer standards attributable to the Trust in March, with performance being at 100%.

Responsive – Referral to Treatment

March 2019 Summary

- The Trust achieved the RTT 92% standard, submitting performance of 92.24%, with 541 patients waiting longer than 18 weeks.
- Specialties which continue not to meet the standard are Plastic Surgery (sub-specialisation within the service), SNAPS (bed capacity), Dental and Maxillofacial Surgery (theatre capacity and consultant absence), ENT (inherited breach waits from other providers), Urology (complex patients and capacity) and Orthopaedics (bed capacity).
- Five of the seven NHS directorates have met the 92% standard, with all specialties in Blood, Cells and Cancer achieving the national standard. Despite SNAPS being challenged, they have achieved their highest performance (91.84%) since March 2018.
- The number of patients waiting 40 weeks+ has remained the same as February (28)



National Benchmarking:

For the month of March half of the patients on the Trusts incomplete PTL were waiting less than 6 weeks (nationally 7 weeks), and 92 out of every 100 patients were waiting less than 18 weeks (nationally 22 weeks) on a PTL size of 6,972 patients.

Contextually when comparing GOSH with other Children's Trusts or other London tertiary / specialist providers, the Trust is not an outlier with differential levels of performance. Nationally out of 185 providers reporting against the standard (NHS Trusts only) 78 in March were delivering 92% or better. 15 providers reported 90-92%, 74 at 80-90% and 17 reported <80%. 1 provider did not report.

Nationally, GOSH is ranked as the 67th best performing Trust out of 184 providers. In London, GOSH is the 14th best performing Trust out of 28 Providers reporting RTT performance.

52 Week Waits:

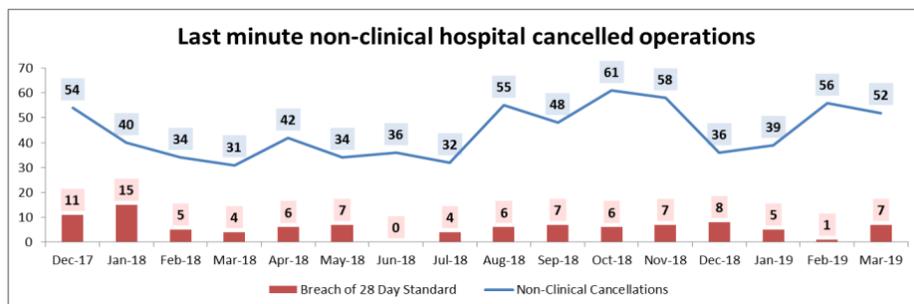
The Trust reported 4 patients waiting over 52 weeks in March. Two in Dental and Maxillofacial surgery of which one of them was treated on 12th April 2019 and the other patient has a TCI on 23rd May 2019. One ENT complex patient who needs to have joint surgery with dental and is still awaiting a TCI due to capacity constraints. One Urology patient who was treated on 9th April 2019.

Responsive – Last minute non-clinical hospital cancelled operations (and associated 28 day breaches)

Last minute non-clinical hospital cancelled operations:

Reported in the dashboard are the monthly breakdowns for this quarterly reportable indicator.

For month of March 2019, the Trust reported a decrease in the number of patients cancelled, with 52 patients cancelled compared to 56 in February. The areas contributing most to the monthly position are Cardiology/Cardiac Surgery (21), Radiology (9), Surgery (4), Neurosurgery (4), and ENT (4). The top three reasons recorded for the month are emergency/trauma patients taking priority (14), theatre list over run (10) & no ward staff (10).



Last minute non-clinical hospital cancelled operations: Breach of 28 day standard

The Trust reported 7 last minute cancelled operations not readmitted within 28 days in March, (compared to 1 in February). Two Neurosurgery patients, Two Radiology patients, one Dental/Maxfax patients, one Orthopaedic surgery patient and one Cardiac Surgery patient.

Urgent operations cancelled for a second time

- This indicator has been added the Dashboard for 2018/19 following agreement with NHSE the content of Schedule 4 of the NHS Contract.
- Since the start of the new financial year the Trust has reported no patient being cancelled for an urgent operation for the last eleven consecutive months.



Data Completeness – Mental Health Identifiers

Mental Health Identifiers: Data Completeness

The Trust is nationally required to monitor the proportion of patient accessing Mental Health Services that have a valid NHS number, date of birth, postcode, gender, GP practice and commissioner code. Within this area the Trust consistently meets the 97% standard with 99.54% of patients having valid data in March.

Mental Health: Ethnicity Completion - %

This indicator has been added the dashboard for 2018/19 following agreement with NHSE the content of Schedule 4 of the NHS Contract.

The Trust has seen an increase in collating ethnicity for patients accessing mental health services, with 71.14% (+4.88%) in March having a valid ethnic code. This continues to be addressed with operational teams via weekly monitoring, refreshed training and focused Data Assurance work.

Patients with a valid NHS Number

% of patients with a valid NHS Number Inpatients and Outpatients

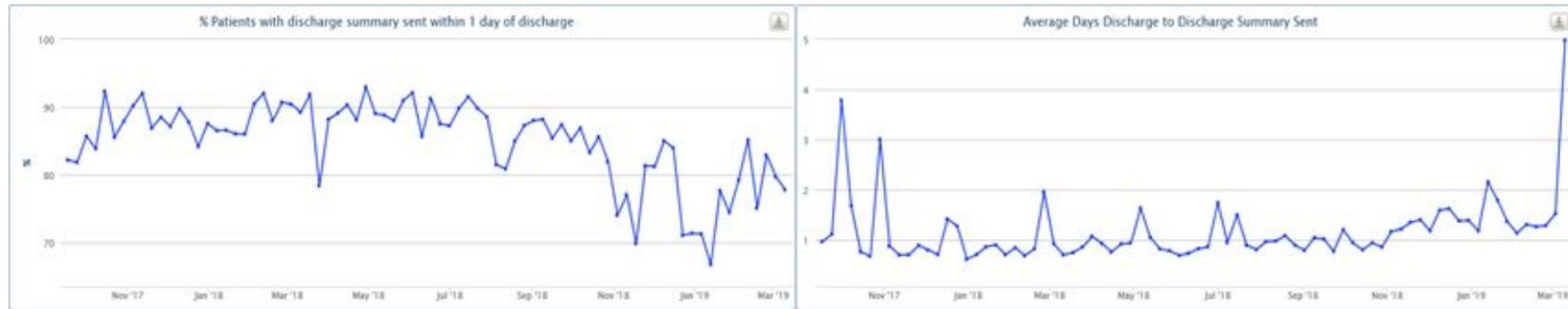
This indicator has been added the Dashboard for 2018/19 following agreement with NHSE the content of Schedule 4 of the NHS Contract.

Nationally the Trust is monitored against achieving 99% of patients having a valid NHS Number across all services being accessed. As the report depicts for both Inpatients and Outpatients this is below the standard, nationally the average for both indicators is above 99%. Work is continues to improve collating our patient's NHS number.

Effective – Discharge Summaries

March 2019 Summary

- Performance within this metric continues to fluctuate and be challenging to directorates with March 2019 seeing 79.00% of discharge summaries being sent within 24 hours, which is similar to February performance (79.07%).
- 86.13% of discharge summaries were sent within 2 days, rising to 91.08% within 3 days. Average performance for 18/19 is 83.52%
- Actions in place include daily reminders to HoCS/SM/fellows to complete the discharge summary within 24 hours, weekly reports generated and sent to the Service and Ward Clerks, ensure discharges flagged as exclude are clinically validated and documented. There is also reduced junior doctor clinical cover between all specialties which is impacting this measure. In some instances recruitment to posts has been unsuccessful on a number of occasions, work with HR and senior clinical leads is ongoing.



Clinic Letter Turnaround Times

For February 2019 (as this indicator is reported a month in arrears), there has been a deterioration in performance in relation to 14 day turnaround 68.14% from 73.9% in February. Some of the actions in place to improve performance are operational teams focusing on identifying where delays in the process reside within each specialty and implementing actions e.g. targeting sign off where weekly reminders for clinical teams to sign off letters are circulated, providing remote access to clinicians so they can sign off letters electronically, create and administer a robust monitoring system for administrators to be used on a weekly basis to check the upload and downloading of letters, clinic letter turnaround being part of service reviews, and extra admin time to work through the backlog of letters in specific areas. It should be noted that as part of investigating the deterioration a data discrepancy has been identified, the size of the impact is yet to be fully understood but is in the process of being resolved.

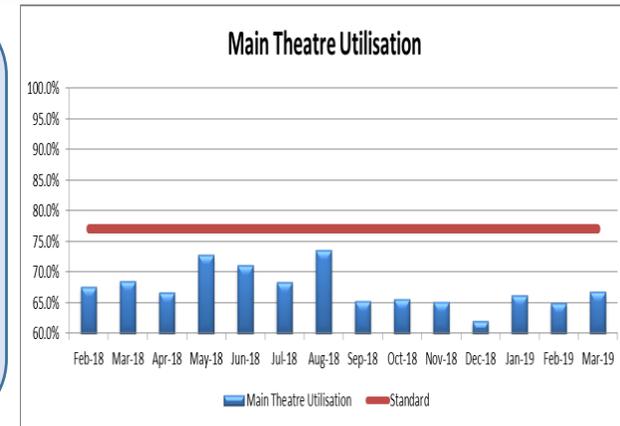


Productivity – Theatre Utilisation

Utilisation of main theatres increased in March to 66.8% from 65.0% (February). Specialties with utilisation above 70% are Craniofacial (71.3%), ENT (71.53%) Neurosurgery (71.04%) , Orthopaedic Surgery (72.73%), Spinal Surgery (74.40%) and Plastic Surgery (75.57%). One of the areas of concern is Cardiac Surgery (52.01%).

Short notice cancellations on the day and the day before for both clinical and non-clinical reasons were 358 for the month. 160 (45%) cancellations were attributable to the patient being unfit, not following pre-op instructions or the patient cancelling. The other main themes were 60 patients required further investigations or the procedure was no longer required, 15 patients were cancelled due to beds being unavailable, 17 due to lists overrunning and 20 due to an emergency patient.

Work continues on targeting fully utilising lists and addressing delays with clerking and consenting of patients.



Bed Occupancy and Closures

The metrics supporting bed productivity are to be improved for future months, however for now, reflect occupancy and (as requested) the average number of beds closed over the reporting period.

Occupancy: For the reporting period of March, occupancy decreased to 79.1%. From 82.4% in February. This indicator and methodology is currently under-review as part of the statutory returns work being completed to support EPR implementation.

Bed closures: There has been an increase in the average number of beds closed in March (35) compared to 27 in February, the reasons recorded are linked to staffing. This was mainly due to Sky having an average of 8 beds closed and Bumblebee 10 beds closed. NICU/PICU have experienced an average of 6 beds closed

Trust Activity

Trust activity: March activity for day case discharges are above the same reporting period for last year ytd, outpatient attendances, critical care bed-days and overnight discharges are below the same reporting period ytd. Further detail will be provided within the Finance Report.

Long stay patients: This looks at any patient discharged that month with a length of stay (LOS) greater than 100 days, and the combined number of days in the hospital. For March, the Trust reported 17 patient discharges that had amassed a combined LOS of 3,131 days of which 866 are attributable to critical care. 6 of the 17 patients discharged in February had 200 days plus LOS. The clinical coding of the admissions relate to the patients having many having complex conditions and comorbidities warranting that LOS.

Productivity – PICU Metrics

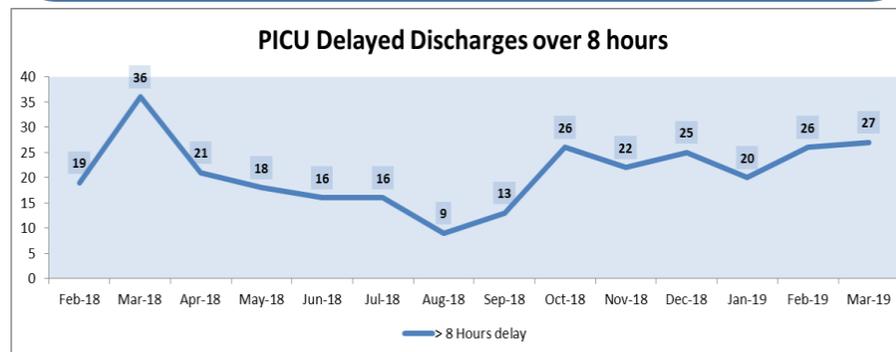
As previously reported the metrics supporting PICU shared in this month’s IPR are the first iteration of KPIs. The KPIs have been agreed collaboratively with the Trusts PICU consultants and are designed to provide a triangulated picture of the service. Further analysis and intelligence will be added in future reports.

CATS PICU/NICU Refusals: The number of CATS referral refusals into PICU/NICU from other providers during March has decreased to 14 from a February position of 25. The overall number of refusals for 2018-19 (189) were eight less than those in 2017-18 (197). During 2018-19 the Trust received 382 patients via the CATs retrieval service into PICU/NICU.

It should be noted that although The Trust has seen an improvement in the number of refusals, the Trust remains a national outlier. As part of the specialised services Quality Dashboard, a KPI is monitored on emergency admission refusals. It clearly shows the Trust refuses a higher percentage of patients than the national average, as demonstrated in the table below.

PICU Delayed Discharges:

Delayed discharges over 8 hours from PICU can demonstrate the challenges being faced internally and externally with regards to capacity issues on accessing beds. March has seen 27 patients delayed over 8 hours compared to 26 in February.



PICU Emergency Readmissions:

Readmissions back into PICU within 48 hours is one patient for the month of March. During 2018-19, thirteen patients have been re-admitted to the department.

Quarter	GOSH PICU/NICU/CI CU refusals	GOSH admission requests	GOSH % refused	National % refused
Q3 18/19	79	234	33.8	16.9
Q2 18/19	45	127	35.4	8.09
Q1 18/19	27	112	24.1	6.27
Q4 17/18	No Data	No Data	No Data	No Data



Well-Led – Are our people ready to deliver high quality care?

Workforce Headlines

- **Contractual staff in post:** Substantive staff in post numbers in March were 4686 FTE which is a slight decrease from February (4708.3 FTE). However this is 233.2 FTE (5.2%) higher than the same month last year.
- **Unfilled vacancy rate:** The Trust vacancy rate for March reduced to -0.2% (-7 FTE), well below the Trust target of 10%. When capital funded posts in EPR are excluded the Trust vacancy rate increases to 2.9% but this is well below the target. Trust vacancy rates have been below target since July 2017.
- **Turnover** is reported as voluntary turnover. Voluntary turnover has increased every month since November 2018, and remains above target and the same month last year. HR has established a Recruitment & Retention group, linking in with colleagues across the Trust to develop a retention plan, aligned to the existing Nursing retention collaborative work. The most common leaving reasons are Relocation and promotion. Total turnover (including Fixed Term Contracts) decreased to 17% which is below target. 2019/20 targets have been reduced to 13.75%/17.75% (Voluntary/Total) for Quarter 1. These targets will reduce to 13%/17% by the end of the year.
- **Agency usage** for 2018/19 was 1.0% of total paybill, which is below the local stretch target, and is also well below the same month last year (1.7%). Human Resources Business Partners continue to work with the divisions and corporate areas to address local pockets of agency usage. The target for 2019/20 remains 2% of total paybill.
- **Statutory & Mandatory training compliance:** In March the compliance rate across the Trust was 93%, which is the highest since August 2018. All Directorates reported above target (90%) compliance, however 6 of the 30 topics were below target. The target for 2019/20 remains 90%.
- **Sickness absence** increased to 2.5%, but remains below target, and below the London average figure of 2.8%. The Trust is implementing an integrated rostering system. The system will support improvements in the accuracy of absence reporting, which may lead to fluctuations in reported rates. The 2019/20 target remains 3%
- **Appraisal/PDR completion** The non-medical appraisal rate has remained at 85% but remains below the Trust target, however the Trust continues to benchmark well. Consultant appraisals have increased to 86%





Well-Led – Are our people ready to deliver high quality care?

Trust KPI performance March 2019

Metric	Plan	March 2019	3m average	12m average
Voluntary Turnover	14%	14.8%	14.7% □	14.5% □
Sickness (12m)	3%	2.4%	2.4%	2.4%
Vacancy	10%	-0.2%	-0.2%	1.9%
Agency spend	2%	1.0%	1.0%	1.1%
PDR %	90%	85%	85%	84%
Consultant Appraisal %	90%	86%	83%	84%
Statutory & Mandatory training	90%	93%	92%	92%

Key:

■ Achieving Plan
 ■ Within 10% of Plan
 ■ Not achieving Plan



Well-Led – Are our people ready to deliver high quality care?

Directorate (Clinical) KPI performance March 2019

Metric	Plan	Trust	Blood, Cells & Cancer	Body, Bones & Mind	Brain	Heart & Lung	Medicine, Therapies & Tests	Operations & Images	Sight & Sound	IPP
Voluntary Turnover	14%	14.8%	15.9%	13.9%	13.6%	16.0%	11.6%	11.6%	17.1%	24.5%
Sickness (12m)	3%	2.5%	2.3%	2.1%	2.3%	2.9%	1.9%	2.6%	3.4%	4.2%
Vacancy	10%	-0.2%	-15.7%	-2.7%	0.5%	2.7%	-18.0%	1.4%	1.6%	15.3%
Agency spend	2%	1.0%	0.0%	0.3%	0.0%	0.1%	2.5%	1.0%	1.5%	0.0%
PDR %	90%	85%	91%	86%	97%	86%	87%	83%	90%	95%
Stat/Mand Training	90%	93%	92%	91%	95%	90%	94%	94%	93%	98%

Key:

■ Achieving Plan
 ■ Within 10% of Plan
 ■ Not achieving Plan



Directorate (Corporate) KPI performance March 2019

Metric	Plan	Trust	Clinical Operations	Corporate Affairs	DPS	Finance	HR&OD	Medical Director	Nursing & Patient Experience	Research & Innovation
Voluntary Turnover	14%	14.8%	18.7%	15.9%	11.1%	15.1%	18.3%	14.5%	13.3%	27.6%
Sickness (12m)	3%	2.5%	1.1%	0.0%	3.0%	0.9%	4.0%	1.4%	1.4%	1.7%
Vacancy	10%	-0.2%	30.2%	13.0%	15.4%	25.5%	10.3%	-1.4%	0.7%	-71.1%
Agency spend	2%	1.0%	0.7%	-0.2%	3.7%	5.6%	7.8%	0.0%	0.5%	0.0%
PDR %	90%	85%	79%	79%	84%	93%	89%	61%	75%	69%
Stat/Mand Training	90%	93%	94%	95%	96%	99%	96%	92%	97%	96%

Key:

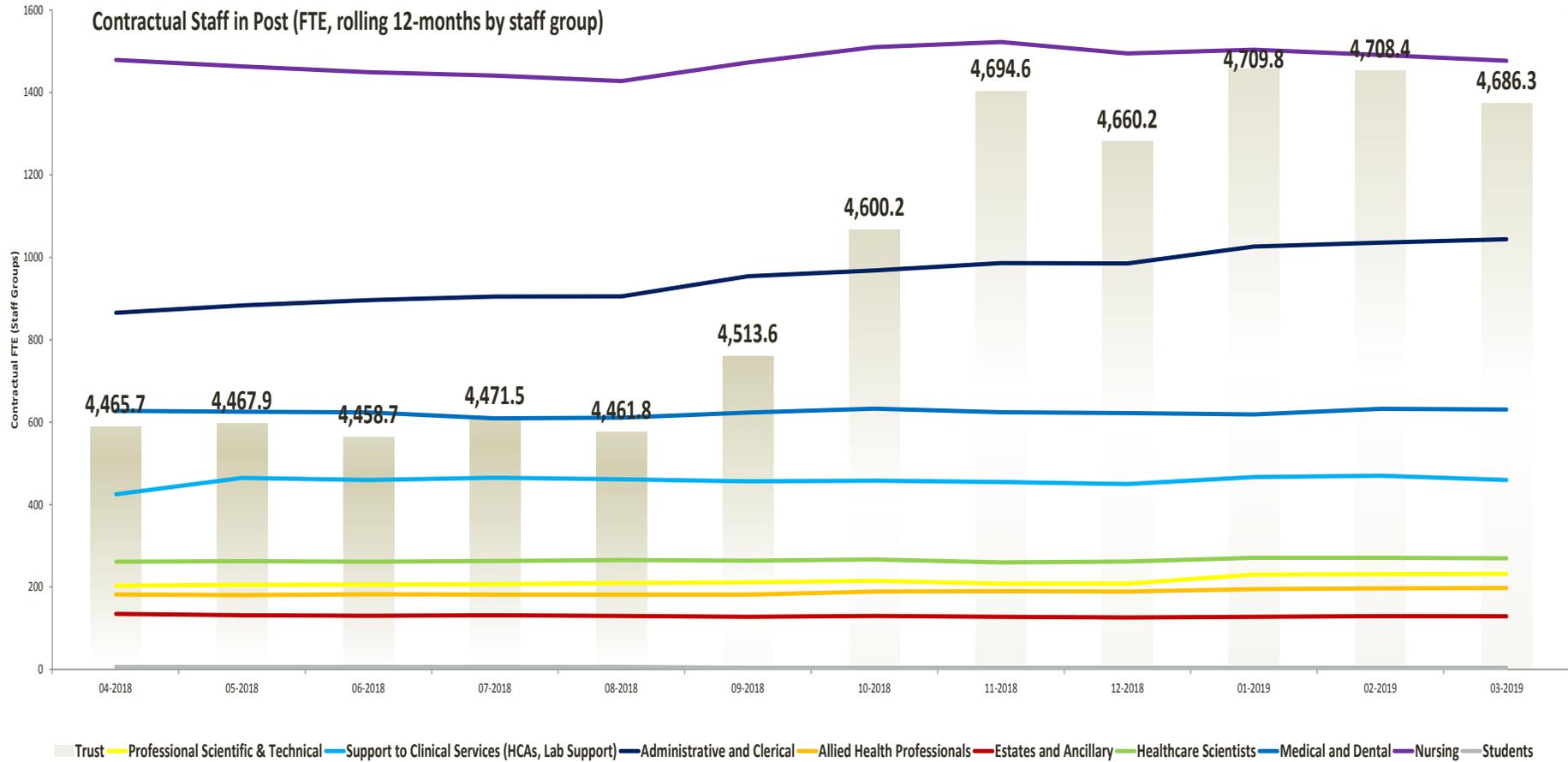
■ Achieving Plan
 ■ Within 10% of Plan
 ■ Not achieving Plan



Well-Led – Are our people ready to deliver high quality care?



Substantive staff in post by staff group



Well-Led – Are our people ready to deliver high quality care?

Non Compliant Statutory & Mandatory Training by Staff Group

Topic	Non Compliant	Allied Health Professional	Admin & Clerical	Additional Clinical Services	Add Prof Scientific & Technical	Estates & Ancillary	Healthcare Scientist	Medical & Dental	Nursing & Midwifery Registered	All Staff
Blood Transfusion - Level 2 - 2 years	160	-						75%		74%
Resuscitation - Level 3 - Medical Staff – 1yr	117	-						82%		83%
Resuscitation - Level 3 - Nursing Staff – 1yr	231	-							86%	86%
Safeguarding Children (V2) - Level 3 - 1 yr	413	90%	70%	87%	86%		91%	75%	88%	85%
Resuscitation - Level 2 - BLS New Staff (HCAs & AHPs) – 1yr	88	92%		89%	80%		92%			88%
Blood Transfusion - Paediatric - Lvl 1 – 2yr	205								86%	85%
Compliance across all 31 topics		96%	95%	93%	93%	93%	94%	84%	94%	93%

Key:

■ Achieving Plan
 ■ Within 10% of Plan
 ■ Not achieving Plan



Well-Led – Are our people ready to deliver high quality care?

Workforce: Highlights & Actions

Sickness %

- Monthly sickness absence reports distributed to managers from the HR Advisors to encourage a proactive approach to managing sickness absence.
- Regular meetings are held with Ward Sisters, service leads and departmental managers to discuss and provide support for sickness absence management.
- Health and wellbeing; a number of initiatives have been launched in order to support employees at work such as mental health awareness and healthy activities.
- HRBP undertook a refreshed deep dive into sickness for IPP with the General Manager in September, to be reviewed against one undertaken the previous year. Sickness in month of September was just over target, and the deep dive gave assurances that sickness was being reported accurately and managed appropriately.
- HRBP working with management teams to ensure sickness absence is being logged using the correct system so reporting can be accurate.
- Allocate HealthRoster is being rolled out across the Trust during 2018/19. The new system will enable more accurate reporting.

Voluntary Turnover Rate

- There has been a significant amount of work undertaken to better understand the broader turnover position - with specific focus on areas of low stability and high turnover. There have been developments in also understanding the reasons why people leave and where they go. In addition, the work around nurse recruitment and retention is now a focused project under the Nursing Workforce Advisory Board.
- Developing B5s into vacant B6 roles helps to decrease turnover of B5s
- Analysis of exit surveys received and recommendations for improvements to the process have been presented to the Trust Operational Board and Education and Workforce Development Committee.
- HRBPs actively involved in undertaking exit interviews with leavers for their areas to get underneath the reasons for leaving, then working with the specific areas with lessons learned
- HR&OD are actively engaging with EU colleagues to advise them of support available with applications for the governments Settled Status scheme after Brexit.



Well-Led – Are our people ready to deliver high quality care?

Workforce: Highlights & Actions

Agency Spend

- HRBPs continue to work within the Directorates to reduce agency usage. This includes converting individuals from agency to permanent or bank contracts.
- This work is inline with NHSI requirements to reduce agency and breaches of payrates and duration.

PDR Completion

- PDR reminders are now sent to managers on a monthly basis, flagging expired and upcoming PDRs.
- Simplifying the reporting process of PDRs has supported managers in working towards their PDR targets.
- HRBPs are continuing to support managers in identifying the PDRs that are required for completion, this includes consultant appraisals.
- PDR rates are a rolling agenda item for Performance Meetings within the Directorates.
- A Working group has been established to ensure changes to Agenda for Change are incorporated in to the PDR process from April 2019.

Statutory & Mandatory Training Compliance

- GOLD sends automatic reminders to staff and managers when they are due and overdue the training.
- L&D sends reminders to staff who are not compliant on the subjects that are currently below 90% overall Trust wide (excluding Resus) on a monthly basis.
- Improved visibility through LMS - staff encouraged to check their own records on GOLD
- Learning and Development & ER team work with managers to identify those who are non-compliant including further developments to the Trust GOLD LMS
- StatMan rates are a rolling agenda item for Performance Meetings within the Directorates.



Our Money



Summary

This section of the IPR includes a year to date position up to and including March 2019 (Month 12). In line with the figures presented, the Trust has a full year Control Total Surplus of £17.4m which is £5.3m ahead of plan, this includes £5.2m of additional PSF funding. The Trust is generating a full year net surplus of £6.0m which is £5.5m above plan.

- Clinical Income (exc. International Private Patients and Pass through Income) is £8.7m higher than plan
- Non Clinical revenue is £10.8m higher than plan
- Private Patients income is £1.4m lower than plan
- Staff costs are £6.0m higher than plan
- Non-pay costs (excluding pass-through costs) are £6.5m higher than plan

The child first and always



Attachment Y

Trust Board 22nd May 2019	
<p>Learning from Deaths. Mortality Review Group - Report of deaths in Q3 2018/2019</p> <p>Submitted by: Dr Sanjiv Sharma, Medical Director. Dr Isabeau Walker, Consultant Anaesthesia and co-chair of the MRG</p>	<p>Paper No: Attachment Y</p>
<p>Aims / summary</p> <p>In March 2017, the National Quality Board published national standards for the reviewing of inpatient deaths and learning from the care provided to patients. The guidance requires that Trusts share information on deaths to be received at a public board meeting.</p> <p>The Mortality Review Group (MRG) was established in 2012 to review the deaths that occur at Great Ormond Street Hospital (GOSH).</p> <p>This report meets the requirements of the National Quality Board by</p> <ul style="list-style-type: none"> • Outlining the Trusts approach to undertaking case reviews • Including data and learning points from case reviews. <p>This is an update of a report that was reviewed at the March 2019 Patient Safety and Outcomes Committee. That report highlighted an area for improvement around the completion of the Medical Certificate of Cause of Death.</p> <p>The Patient Safety Outcomes Committee has agreed that this issue should be taken to the Deputy Chief of Services meeting and to the "learning from" group to identify a process for establishing improvement.</p>	
<p>Action required from the meeting</p> <p>The board is asked to note the content of the paper.</p>	
<p>Contribution to the delivery of NHS Foundation Trust strategies and plans</p> <p>This report meets the requirements of the National Quality Board to report learning from deaths to a public board meeting.</p>	
<p>Financial implications- none.</p>	
<p>Who needs to be told about any decision? n/a</p>	
<p>Who is responsible for implementing the proposals / project and anticipated timescales?</p> <p>The Medical Director is the executive lead with responsibility for the learning from deaths agenda</p>	
<p>Who is accountable for the implementation of the proposal / project?</p>	

Mortality Review Group: Report of deaths in Q3 2018/19

Background

The Mortality Review Group (MRG) was established in 2012 to review the deaths of inpatients at Great Ormond Street Hospital (GOSH). The purpose of the MRG is to provide a Trust level overview of all deaths to identify any learning points, themes and risks and take action as appropriate to address any risks. This process is linked with local case reviews undertaken by specialty teams and provides an additional oversight of inpatient deaths in the Trust.

Child Death Review Statutory Guidance

In October 2018, HM Government published the Child Death Review Statutory and Operational Guidance (England). The guidance outlines the statutory NHS requirements for child death reviews, which must be delivered by the 29th September 2019.

The aim of the guidance is to standardise local child death review processes nationally, to ensure outputs are of a uniform quality to feed into the new National Child Mortality Database (live from April 2019). This database is the first of its kind on this scale, and aims to enable thematic learning at both local and national level to improve outcomes for children and young people.

Significant changes will be required to adapt current processes at GOSH to support the new guidance, with the new process requiring substantially more administrative and clinician resource than currently available. A working group has been established to implement the guidance, supported by a Quality Improvement Manager and chaired by the Medical Director.

Aim of report

The purpose of the report is to highlight modifiable factors and any learning from case record reviews at GOSH, in accordance with recommendations included in HM Government Child Death Review Statutory Guidance. Modifiable factors are defined as factors, which by means of nationally or locally achievable interventions could be modified to reduce the risk of future child deaths.

This report describes the findings from MRG reviews of GOSH inpatient deaths that occurred between 1st October and 31st December 2018.

Headlines

Twenty nine children died at GOSH between between 1st October and 31st December 2018. Case record reviews have been completed for all cases.

Of the 29 cases reviewed:

Two cases had modifiable factors in the child's care at GOSH that may have contributed to vulnerability, ill health or death (influence score 2¹).

- In one case the MRG have identified there was a disagreement in the clinical care plan between the specialty team and ICU at around the time that there was deterioration in the patient condition. It has since been agreed that consultant to consultant handover is required for ward patients referred to PICU.
- There was one unexpected death, where the management of deterioration has been flagged. This case has been subject to a completed complaint investigation, and a root cause analysis investigation is being facilitated by the Patient Safety Team

¹ An influence score offers an interpretation of the extent to which the factor may have contributed to the death of the patient: 0 – Information not available 1 - No factors, or unlikely to have contributed to death 2 - Factors may have contributed to vulnerability, ill health or death 3 - Factors provide a complete and sufficient explanation for death

These cases and the learning points have been reviewed at the Patient Safety and Outcomes Committee

The table below provides a summary of the deaths that occurred during the quarter using NHS England reporting guidance

Total number of inpatient deaths at GOSH between 1st October and 31st December 2018	29
Number of those deaths subject to case record review by the MRG	29
Number of those deaths investigated declared as serious incidents	0
Number of deaths where a modifiable factor was identified at GOSH with an influence score of 2	2
Number of deaths where a modifiable factor was identified at GOSH with an influence score of 3	0
Number of deaths of people with learning disabilities	0
Number of deaths of people with learning disabilities that have been reviewed	0
Number of deaths of people with learning disabilities where a modifiable factor was identified at GOSH with an influence score of 2 or more	0

Learning Disability Mortality Review notifications

The Learning Disabilities Mortality Review (LeDer) Programme is commissioned by NHS England to review the deaths of people with learning disabilities. All NHS Trusts are required to notify LeDer of deaths of a patient with a learning disability over the age of four. The Clinical Nurse Specialist for Learning Disabilities is the lead at GOSH for notifying deaths and coordinating requests for information.

Period of deaths covered	No. of notifications required by GOSH	No. of notifications made	No. of outstanding notifications
May 2017 to 31st December 2018	6	6	0

Learning points from deaths occurring in Q3 2018/19

The following general learning points have been identified from case note reviews. This does not imply that any factors were directly linked to the death of the child, rather that an awareness of these points will help us to continuously improve the care provided in the Trust for children and their families.

Completion of the MCCD

A Medical Certificate of Cause of Death (MCCD) is completed when a child dies, in accordance with guidance from the Office for National Statistics (ONS) and the Home Office. If the attending doctor is unable to complete the MCCD, they refer the matter to the Coroner. The Coroner decides on any further investigations required before a MCCD can be completed and provided to the Registrar. If a case is referred to the Coroner, this must be done in a timely manner. A Coroner's referral may result in a delay to the release of the MCCD – it is important to inform the family that this might happen and to manage expectations, particularly when early burial is a cultural requirement.

The process for scrutiny of MCCDs was reformed in 2018 as there have been concerns at national level regarding the accuracy and efficiency of completion of MCCDs for non-coronial deaths, also the extent to which current system of scrutiny would be able to highlight poor practice. A new Medical Examiner (ME) role was introduced to the NHS in April 2019, to be further developed in 2019-2020 with the appointment of a national ME and regional MEs. The regional ME will be one step removed from the Trust and will scrutinize all MCCDs independently of the certifying doctor and the Trust. The aim is to improve accountability in the NHS and accuracy of data captured by the ONS, but there are concerns that the new system could impose delays for bereaved families and increase the administrative burden on clinicians and others involved in the process.

At a local level, the MRG continues to identify cases where the MCCD is incorrect, for example, in this quarter:

- A significant medical condition affecting decision-making was not mentioned on the MCCD (new cerebral infarcts)

- The hierarchy of conditions was incorrect (MCCD suggested VA ECMO led to fulminant myocarditis, rather than the other way round)
- Prematurity was omitted as a contributing factor on the MCCD.
- If further information will be made available from a post mortem, this should be documented in the MCCD. Circling option 2 on the front of the MCCD indicates if information from a PM may be available later. By ticking box 'B' on the back of the certificate you can indicate if results from ante-mortem investigations may be available later.

Errors on the MCCD has led to certificates being rejected by the Registrar, potentially delaying burial, and increasing distress for families at a very difficult time. The Palliative Care Team have undertaken targeted training in the ICUs during 2018 and at all consultant inductions.

The data from MRG reviews about the accuracy of the MCCD in the last three calendar year.

Year of pt death	% of MCCDs reviewed by MRG which were appropriate
2016	72%
2017	75%
2018	80%

We would like to recommend that completion of the MCCD is considered as a potential Trust-wide quality improvement project in 2019.

Compliance with medication

A young person presented with a short history of acute rejection following cardiac transplant eight years ago; there was evidence of poor compliance with immunosuppression medication. Compliance with medication can be challenging, particularly for adolescents with long term conditions as they transition to adulthood.

Improving communication between clinical teams

For some patients with advanced heart failure, veno-arterial extracorporeal membrane oxygenation (VA-ECMO) may be possible as a bridge to recovery in the event of acute cardiovascular collapse. This is a high-risk intervention and should be initiated promptly in appropriate candidates if there is to be a good outcome.

If VA-ECMO is considered, the lead for cardiac intensive care must be included in discussions to assess whether ECMO is technically feasible, also whether this is the appropriate treatment modality for the child. Effective communication with the CICU team is particularly important when the child is presenting for non-cardiac surgery and will be cared for in a non-cardiac unit postoperatively. A representative from CICU must be involved in any multidisciplinary team discussions prior to elective surgery; MDT minutes should be shared and the meeting rescheduled if critical members of the team are unable to attend.

Recommendation made at the March Patient Safety and Outcomes Committee.

Completion of the MCCD is considered as a potential Trust-wide quality improvement project in 2019/20.

The Patient Safety Outcomes Committee has agreed that this issue should be taken to the Deputy Chief of Services meeting and to the "learning from" group to identify a process for establishing improvement.

4th April 2019

Dr Isabeau Walker, Consultant Anaesthetist & Co-Chair of MRG; Dr Finella Craig, Palliative Care Consultant & Co-Chair of MRG; Andrew Pearson, Clinical Audit Manager

Trust Board 22nd May 2019	
Month 1 2019/20 Finance Report	Paper No: Attachment Z
Submitted by: Helen Jameson, Chief Finance Officer	Attachment Finance Report M1
Key Points to take away	
<ol style="list-style-type: none"> 1. The Trust is required to achieve an overall control total that is agreed with NHSI annually. Excluding non-recurrent Provider Sustainability Funding (PSF), this is breakeven for 2019/20. The Trust is behind with its control total in Month 1 by £0.1m. 2. The Trust is behind its income target by £1.5m (excluding pass through) at Month 1. NHS Clinical Income is behind plan by £0.4m due to under-delivery of activity against non-block contracts in month, partly attributed to EPIC implementation. IPP income is £0.5m behind plan and lower than the previous two months run rate.. 3. Trust income has been reviewed in light of implementation of the new EPR system. This has affected reporting for the last 11 days of the Month. This has included <ol style="list-style-type: none"> a. A temporary reduction in the reporting of the level of complexity & comorbidities of our patients which could reduce the tariff value for cost and volume activity. b. An estimate for high cost drugs based on average usage whilst activity numbers are finalised from the new EPR system (for both income and expenditure). c. It is anticipated that all of the commissioner reporting timelines for activity and finance data will still be met. 4. Pay is underspent by £0.5m in month which is predominantly due to a number of vacancies across the Trust, not offset by temporary staff. 5. Non pay is £0.9m underspent in month (excluding pass through) which is mainly due to reduced activity in month associated with the EPIC Go-Live and predominantly relates to drugs and clinical supplies. Overall, the Trust's impairment of receivables is favourable to plan due to a number of receipts for aged debt received in month relating to IPP. 6. Cash is higher than plan by £11.1m (£54.2m against a plan of £43.1m) which is mainly due to higher than planned receipts for the Genomics contract and clinical excellence awards. 	
Action required from the meeting	
<ul style="list-style-type: none"> • To note the Month 1 Financial Position 	
Contribution to the delivery of NHS / Trust strategies and plans	
The delivery of the financial plan is a key strategic objective to ensure we have sufficient funding to meet the needs of our delivery of care.	
Financial implications	
The Trust must achieve its control total in order to receive £3.8m of PSF funds in year. Additionally, the Trust is expected to deliver a balanced financial position and if it is unable to do so, will attract additional scrutiny from external regulators.	

Legal issues None
Who is responsible for implementing the proposals / project and anticipated timescales Chief Finance Officer / Executive Management Team.
Who is accountable for the implementation of the proposal / project Chief Finance Officer.

Finance and Workforce Performance Report Month 1 2019/20

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KEY PERFORMANCE DASHBOARD

FINANCIAL PERFORMANCE

	In month			Year to date			Full Year Forecast	
	Plan	Actual	RAG	Plan	Actual	RAG	Fcst	RAG
INCOME <small>incl. passthrough</small>	£37.9m	£37.1m	●	£37.9m	£37.1m	●	£488.5m	●
PAY	£24.2m	£23.7m	●	£24.2m	£23.7m	●	£289.2m	●
NON-PAY <small>incl. passthrough</small>	£17.0m	£16.8m	●	£17.0m	£16.8m	●	£199.3m	●
CONTROL TOTAL <small>excl PSF</small>	-£3.3m	-£3.4m	●	-£3.3m	-£3.4m	●	£0.0m	●

RAG: on or favourable to plan = green, 0-5% adverse to plan = amber, 5%+ adverse to plan = red

AREAS OF NOTE:

As at the end of Month 1, the Trust position is adverse to the planned control total (£0.1m). The Trust has entered into a block agreement with NHSE for 2019/20. The position includes an estimate for high cost drugs based on average usage whilst activity numbers are finalised from the new EPR system. Month 1 Pay costs are favourable to plan (£0.5m) due to the vacancies across the organisation. Non-pay is favourable to plan (£0.2m) due to underspends associated with charitable funding offset by higher than planned pass through expenditure.

INCOME BREAKDOWN RELATED TO ACTIVITY

	Plan (£m)	Actual (£m)	Var (£m)	RAG
Income breakdown Year to Date				
NHS & Other Clinical Revenue	£22.7m	£22.3m	(£0.4m)	●
Pass Through	£4.8m	£5.5m	£0.8m	●
Private Patient Revenue	£5.5m	£5.0m	(£0.5m)	●
Non-Clinical Revenue	£5.2m	£4.6m	(£0.6m)	●
Total Operating Revenue	£38.1m	£37.4m	(£0.7m)	●

RAG: on or favourable to plan = green, 0-5% adverse to plan = amber, 5%+ adverse to plan = red

AREAS OF NOTE:

Operating revenue is adverse to plan (£0.7m) in month 1. The Trust has entered into a block contract with NHSE and some of the CCGs for 2019/20, this is represented in the NHS income figures with the underperformance arising from lower than planned levels of activity on those contracts that are not on block, this equates to 17% underperformance on these contracts. Pass through drugs remains on cost and volume and has over performed (£0.8m), this is offset by expenditure. IPP income is below plan (£0.5m) due to lower levels of activity. Non-Clinical income underperformance (£0.6m) is due to lower levels of charitable contributions which will be achieved later in the year when expenditure is incurred.

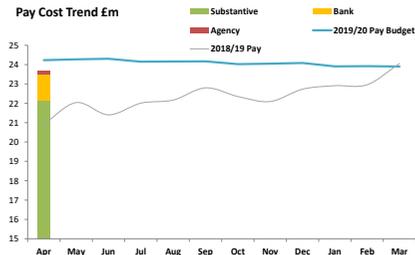
PEOPLE

	M1 Plan Av. WTE	M1 Actual Av. WTE	Variance
PERMANENT	4,630.5	4,480.5	149.9
BANK	292.8	265.9	26.9
AGENCY	56.5	38.9	17.6
TOTAL	4,979.7	4,785.3	194.4

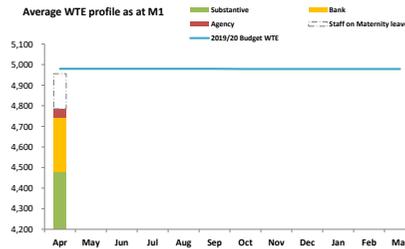
AREAS OF NOTE:

The pay costs have risen from last year due to the increase in NHS pay scales. This is combined with increased costs associated with the Go live of EPIC which will be reduce back down in future months. As part of Budget setting the establishment was reviewed and set in line with the Trust bed base. The Trust agency spend remains below the agency ceiling set by NHSI. The WTE excludes 170.2 contractual WTE's on maternity leave within the Trust.

Pay Cost Trend £m



Average WTE profile as at M1



CASH, CAPITAL AND OTHER KPIS

Key metrics	Plan	Actual
Cash	£43.1m	£54.2m
IPP Debtor days	120	243
Creditor days	30	30
NHS Debtor days	30	12

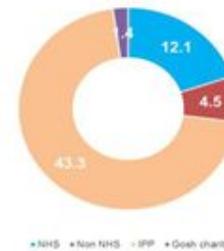
Capital Programme	YTD Plan M1	YTD Actual M1	Full Year Fcst
Total Trust-funded	£2.7m	£2.8m	£21.8m
Total Donated	£3.9m	£4.1m	£46.7m
Grand Total	£6.6m	£6.9m	£68.5m

NHSI metrics	Plan M1	Actual M1
CAPITAL SERVICE COVER	4	4
LIQUIDITY	1	1
I&E MARGIN	4	4
VAR. FROM CONTROL TOTAL		2
AGENCY	1	1
TOTAL	3	3

AREAS OF NOTE:

- Cash held by the Trust is higher than plan by £11.1m largely due to settlement of 2018/19 invoices by NHS England.
- The capital programme is slightly ahead of plan at M01.
- IPP debtors days decreased in month from 253 days to 243 days due to higher than average receipts from Embassies in month.
- Creditor days is in line with plan at M01
- NHS debtor days decreased in month from 20 days to 12 days which is lower than plan.
- The NHSI metric overall is a 3 which is in line with the plan submitted. A 3 is the best score you can achieve if you have any metric scoring a 4. The scores of 4 are both associated with the planned deficit position in month.

Net receivables breakdown (£m)



Trust Income and Expenditure Performance Summary for the 1 months ending 30 Apr 2019

Annual Budget	Income & Expenditure	2019/20								Rating	Notes	2018/19		
		Month 1				Year to Date						YTD Actual	CY vs PY	
		Budget	Actual	Variance	%	Budget	Actual	Variance	%				Variance	%
(£m)	(£m)	(£m)	%	(£m)	(£m)	(£m)	%	(£m)	(£m)	%				
296.47	NHS & Other Clinical Revenue	22.72	22.29	(0.43)	(1.89%)	22.72	22.29	(0.43)	(1.89%)	A	1	22.90	(0.61)	(2.66%)
59.94	Pass Through	4.78	5.53	0.75	15.69%	4.78	5.53	0.75	15.69%		2	4.80	0.73	15.21%
69.76	Private Patient Revenue	5.46	4.95	(0.51)	(9.34%)	5.46	4.95	(0.51)	(9.34%)	R	3	4.60	0.35	7.61%
66.01	Non-Clinical Revenue	5.18	4.62	(0.56)	(10.81%)	5.18	4.62	(0.56)	(10.81%)	R	3	4.10	0.52	12.68%
492.18	Total Operating Revenue	38.14	37.39	(0.75)	(1.97%)	38.14	37.39	(0.75)	(1.97%)	R		36.40	0.99	2.72%
(272.88)	Permanent Staff	(22.60)	(22.17)	0.43	1.90%	(22.60)	(22.17)	0.43	1.90%		4	(19.40)	(2.77)	(14.28%)
(3.48)	Agency Staff	(0.29)	(0.21)	0.08	27.59%	(0.29)	(0.21)	0.08	27.59%			(0.20)	(0.01)	(5.00%)
(12.81)	Bank Staff	(1.34)	(1.32)	0.02	1.49%	(1.34)	(1.32)	0.02	1.49%			(1.40)		0%
(289.17)	Total Employee Expenses	(24.23)	(23.70)	0.53	2.19%	(24.23)	(23.70)	0.53	2.19%	G	4	(21.00)	(2.70)	(12.86%)
(13.80)	Drugs and Blood	(1.10)	(0.85)	0.25	22.73%	(1.10)	(0.85)	0.25	22.73%	G		(1.00)	0.15	15.00%
(44.13)	Other Clinical Supplies	(3.29)	(3.29)	0.47	12.50%	(3.76)	(3.29)	0.47	12.50%	G		(3.10)	(0.19)	(6.13%)
(62.50)	Other Expenses	(5.80)	(5.65)	0.15	2.59%	(5.80)	(5.65)	0.15	2.59%	G		(5.00)	(0.65)	(13.00%)
(59.94)	Pass Through	(4.78)	(5.53)	(0.75)	(15.69%)	(4.78)	(5.53)	(0.75)	(15.69%)			(4.80)	(0.73)	(15.21%)
(180.37)	Total Non-Pay Expenses	(15.44)	(15.32)	0.12	0.78%	(15.44)	(15.32)	0.12	0.78%	G	5	(13.90)	(1.42)	(10.22%)
(469.54)	Total Expenses	(39.67)	(39.02)	0.65	1.64%	(39.67)	(39.02)	0.65	1.64%	G		(34.90)	(4.12)	(11.81%)
22.64	EBITDA (exc Capital Donations)	(1.53)	(1.63)	(0.10)	(6.54%)	(1.53)	(1.63)	(0.10)	(6.54%)	R		1.50	(3.13)	(208.67%)
(18.88)	Owned depreciation, Interest and PDC	(1.53)	(1.51)	0.02	1.57%	(1.53)	(1.51)	0.02	1.57%		7	(1.29)	(0.22)	(16.67%)
3.76	Control total	(3.06)	(3.14)	(0.08)	(2.48%)	(3.06)	(3.14)	(0.08)	(2.48%)	A		0.21	(3.35)	(1,592.86%)
(13.07)	Donated depreciation	(1.00)	(0.97)	0.04	3.60%	(1.00)	(0.97)	0.04	3.60%			(0.91)	(0.05)	(6.04%)
(9.30)	Net (Deficit)/Surplus (exc Cap. Don. & Impairments)	(4.06)	(4.10)	(0.04)	(0.99%)	(4.06)	(4.10)	(0.04)	(0.99%)			(0.70)	(3.40)	(485.71%)
(5.50)	Impairments	0.00	0.00	0.00	0.00%	0.00	0.00	0.00	0.00%		6	0.00	0.00	0%
46.72	Capital Donations	3.93	4.07	0.14	3.56%	3.93	4.07	0.14	3.56%			1.60	2.47	154.38%
31.92	Adjusted Net Result	(0.13)	(0.03)	0.10	76.92%	(0.13)	(0.03)	0.10	76.92%			0.90	(0.93)	(103.33%)

Summary

- In month the Trust is reporting an adverse position to the control total (£0.1m). Private patient income is below plan (£0.5m). NHS income not under the block contract is below plan (£0.4m) while pass through income is above plan and offset by expenditure (£0.8m).

Notes

- NHS & other clinical revenue (excluding pass through) is adverse to plan in month 1 (£0.4m). This is driven by lower levels of activity across the organisation on non-block NHS income. Pass through income is estimated while activity is finalised from the new EPR system, based activity levels prior to go live it is estimated to be above plan (£0.8m).
- Private Patient income has fallen in month and is behind plan at month 1 (£0.5m).
- Non-clinical income is adverse to plan (£0.5m) due to timing of charity funded projects.
- Pay is favourable to plan (£0.5m) due to vacancies. The Trust has a full year plan for agency (£3.5) and Bank (£12.8m) staffing which is also underspent at Month 1.
- Non pay (excluding pass through) is underspent (£0.9m) in month 1. Lower levels of activity across the organisation associated with EPIC go live have also contributed to the lower than planned levels of non pay on Drugs (non-pass through) and Clinical supplies.
- Income from capital donations is favourable to plan (£0.1m) in line with costs incurred.

DIVISIONAL CONTROL TOTALS

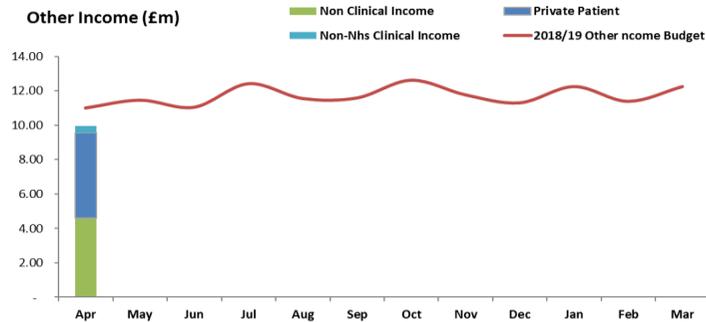
Plan Annual	Directorates	2019/20								Rating
		Month				Year to Date				
		Budget	Actual	Var	Var %	Budget	Actual	Var	Var %	
(£m)	(£m)	(£m)	%	(£m)	(£m)	(£m)	%			
(32.50)	Blood Cells & Cancer	(2.69)	(2.58)	0.11	4.09%	(2.69)	(2.58)	0.11	4.09%	G
(31.03)	Body Bones & Mind	(2.58)	(2.44)	0.14	5.43%	(2.58)	(2.44)	0.14	5.43%	G
(22.44)	Brain	(1.87)	(1.91)	(0.04)	(2.14%)	(1.87)	(1.91)	(0.04)	(2.14%)	G
(45.94)	Heart & Lung	(3.90)	(3.85)	0.05	1.28%	(3.90)	(3.85)	0.05	1.28%	G
(26.04)	Medicines Therapies & Tests	(2.18)	(2.58)	(0.40)	(18.35%)	(2.18)	(2.58)	(0.40)	(18.35%)	R
(32.78)	Operations & Images	(2.71)	(2.77)	(0.06)	(2.21%)	(2.71)	(2.77)	(0.06)	(2.21%)	A
(18.62)	Sight & Sound	(1.57)	(1.53)	0.04	2.55%	(1.57)	(1.53)	0.04	2.55%	G
25.18	International Private Patients	1.92	1.78	(0.14)	(7.29%)	1.92	1.79	(0.13)	(6.77%)	R
2.80	Research And Innovation	0.22	0.24	0.02	9.09%	0.22	0.24	0.02	9.09%	G
187.22	Corporate/Other	12.30	12.51	0.21	1.71%	12.30	12.50	0.20	1.63%	G
5.85	Control total	(3.06)	(3.13)	(0.07)	(2.29%)	(3.06)	(3.13)	(0.07)	(2.29%)	



2019/20 Other Income for the 1 months ending 30 Apr 2019

Other Income Summary

	Annual plan £000's	Current month			Year to date			RAG	YTD Variance
		Plan £000's	Actual £000's	Variance £000's	Plan £000's	Actual £000's	Variance £000's		
Private Patient	£69,759	£5,458	£4,951	(£507)	£5,458	£4,951	(£507)	R	
Non NHS Clinical Income	£4,887	£363	£396	£33	£363	£396	£33	G	
Non-NHS Clinical Income	£74,646	£5,821	£5,347	(£474)	£5,821	£5,347	(£474)	A	
Education & Training	£8,005	£617	£633	£16	£617	£633	£16	G	
Research & Development	£26,282	£2,173	£2,334	£161	£2,173	£2,334	£161	G	
Non-Patient Services	£1,001	£79	£31	(£48)	£79	£31	(£48)	G	
Commercial	£1,609	£127	£124	(£3)	£127	£124	(£3)	G	
Charitable Contributions	£10,716	£847	£355	(£492)	£847	£355	(£492)	A	
Other Non-Clinical	£18,401	£1,341	£1,141	(£200)	£1,341	£1,141	(£200)	A	
Non Clinical Income	£66,014	£5,184	£4,618	(£566)	£5,184	£4,618	(£566)	R	



RAG Criteria:

Green Favourable YTD Variance
Amber Adverse YTD Variance (< 5%)
Red Adverse YTD Variance (> 5% or > £0.5m)

Summary

- Private patient income is adverse to plan in month (£0.5m) and is lower than the previous two months run rate.
- Charitable contributions are below plan in month (£0.5m) due to timing of spend on the approved projects.
- Research income is above plan in month (£0.2m) due to additional activity in month 1 which is offset by additional expenditure.
- Other Non-Clinical income is adverse to plan (£0.2m) due to underperformance on work for other Trusts in month.

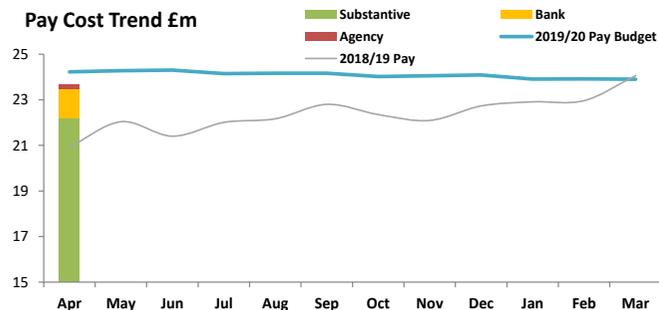
Workforce Summary for the 1 months ending 30 Apr 2019

*WTE = Worked WTE, Worked hours of staff represented as WTE

Em including Perm, Bank and Agency Staff Group	2019/20 plan			2019/20 actual			Variance				RAG
	YTD (£m)	YTD Average WTE	£000 / WTE	YTD (£m)	YTD Average WTE	£000 / WTE	YTD (£m)	Average WTE Vacancies	Volume Var (£m)	Price Var (£m)	£ Variance
Admin (inc Director & Senior Managers)	4.9	1,214.2	48.7	4.2	1,125.1	44.7	0.7	89.1	0.4	0.4	G
Consultants	4.5	368.0	146.6	4.4	340.2	155.8	0.1	27.9	0.3	(0.3)	G
Estates & Ancillary Staff	0.4	146.8	33.4	0.4	129.4	33.2	0.0	17.4	0.0	0.0	G
Healthcare Assist & Supp	0.8	305.6	32.1	0.8	280.6	32.8	0.0	25.0	0.1	(0.0)	G
Junior Doctors	2.3	381.9	72.5	2.3	357.9	77.7	(0.0)	24.0	0.1	(0.2)	G
Nursing Staff	6.9	1,623.9	51.3	6.9	1,571.2	52.4	0.1	52.7	0.2	(0.1)	G
Other Staff	0.0	10.0	55.3	0.0	5.0	51.6	0.0	5.0	0.0	0.0	G
Scientific Therap Tech	4.2	948.4	53.6	4.4	937.1	56.8	(0.2)	11.3	0.1	(0.3)	A
Total substantive and bank staff costs	24.2	4,998.8	58.0	23.4	4,746.4	59.1	0.8	252.4	1.2	(0.4)	G
Agency	0.3	56.5	61.6	0.2	38.9	64.0	0.1	17.6	0.1	(0.0)	G
Total substantive, bank and agency cost	24.5	5,055.2	58.1	23.6	4,785.3	59.1	0.9	269.9	1.3	(0.4)	G
Reserve*	(0.2)	(75.5)	0.0	0.1	0.0	0.0	(0.4)	(75.5)	(0.4)	0.0	A
Total pay cost	24.2	4,979.7	58.4	23.7	4,785.3	59.4	0.5	194.4	0.9	(0.4)	G
Remove Maternity leave cost										0.3	G
Total excluding Maternity Costs	24.2	4,979.7	58.4	23.4	4,785.3	58.7	0.8	194.4	0.9	(0.1)	G

*Plan reserve includes WTEs relating to the better value programme

Pay Cost Trend £m

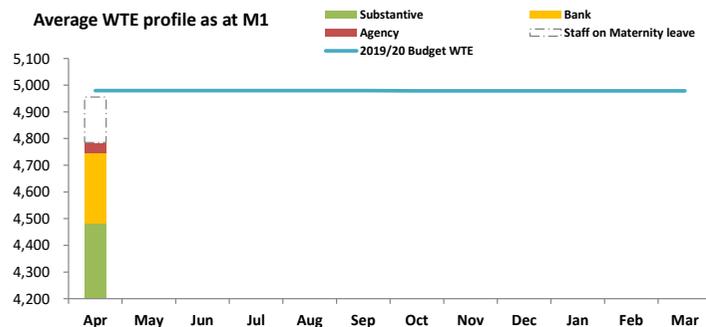


RAG Criteria:
Green Favourable Variance to plan
Amber Adverse Variance to plan (< 5%)
Red Adverse Variance to plan (> 5% or > £0.5m)

Summary

- Month 1 pay spend is £23.7m which is £0.5m favourable to plan. The key contributor to the underspend is the number of vacancies across the organisation that are currently not being backfilled by bank or agency, this can be seen by the volume variance (£1.3m).
- The Trust has put in a bank and agency budget alongside the permanent workforce budget in line with the NHSI reporting requirements. The agency budget has been set below the agency ceiling and is currently underspent.
- The table above does not include 170.2 contractual WTE for staff on maternity leave which cost £0.3m. If this cost is excluded then the average cost per WTE is higher than plan by £0.3k per WTE.
- The reserve line contains the unallocated pay better value target which is offsetting the underspend within pay.
- We are not expecting to breach the agency ceiling set by NHSI and the Trust is currently below the agency ceiling.

Average WTE profile as at M1

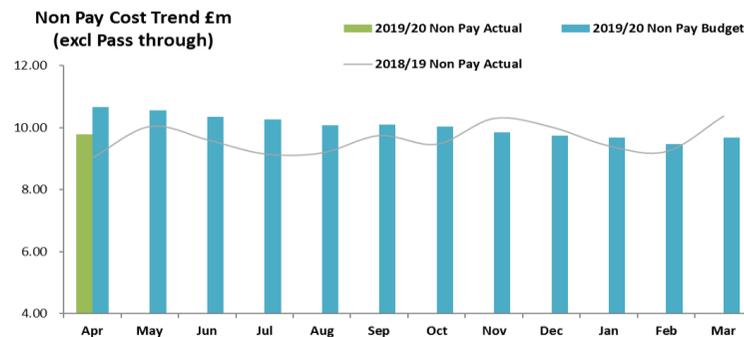


Non-Pay Summary for the 1 months ending 30 Apr 2019

Non-Pay Costs (excl Pass through) YTD				
	Budget (£m)	Actual (£m)	Variance	RAG YTD Actual variance
Drugs Costs	0.93	0.70	0.23	G
Blood Costs	0.17	0.15	0.02	G
Business Rates	0.35	0.34	0.01	G
Clinical Negligence	0.57	0.57	0.00	G
Supplies & Services - Clinical	3.76	3.29	0.47	G
Supplies & Services - General	0.43	0.40	0.03	G
Premises Costs	3.04	2.86	0.18	G
Other Non Pay	1.42	1.48	(0.06)	A
Total Non-Pay costs	10.66	9.80	0.87	G
Depreciation	1.88	1.83	0.05	G
PDC Dividend Payable	0.67	0.67	0.00	G
Total	13.21	12.30	0.91	G

Top 5 YTD Clinical* Non Pay overspends by Speciality (£m)				
	YTD 2019/20 Budget (£k)	YTD 2019/20 Actual (£k)	Variance (£k)	Trend
Respiratory & Trans Care Serv	121	156	(35)	→
Dermatology	42	58	(17)	→
Audiology	137	146	(9)	→
Medical Endocrinology	86	94	(8)	→
Neuromuscular	45	51	(6)	→

Top 5 YTD Clinical* Non Pay underspends by Speciality (£m)				
	YTD 2019/20 Budget (£k)	YTD 2019/20 Actual (£k)	Variance (£k)	Trend
PICU/NICU	358	252	106	→
Theatre	698	604	94	→
Clinical Immunology	170	80	90	→
Nephrology	273	207	66	→
Cardiac Critical Care	185	123	62	→



*Clinical non-pay excludes passthrough

Summary

- Month 1 non-pay excluding pass through is favourable to plan (£0.9m). Key drivers behind the variance is a release of the impairment of receivables (£0.1m) due to payment related to debts that had been provided for.
- Other underspends on clinical supplies and drugs costs are associated with the lower than planned levels of activity associated with the Go live of the EPR system. It is expected that as activity increases the costs of these will increase.

Top 5 clinical over/under spends

The key areas with Non-pay overspends are:

- Respiratory & Trans Care Serv** - Driven by increased spend on respiratory ventilators in month 1.
- Dermatology** - Overspend is driven by the estimated outpatients drug spend.
- Audiology** - overspend is on devices but in line with an over-performance on activity in April.
- Medical Endocrinology** - The overspend predominantly relates to Drugs expenditure incurred in Month 1.
- Neuromuscular** - There is slightly higher than planned spend relating to Services From NHS organisations in month.

The key areas of Non-pay underspends are:

- PICU/NICU** - Driven by lower than planned drug expenditure in month.
- Theatre** - Driven by low clinical supplies expenditure across theatres in month 1, and fewer theatre sessions during go live of EPIC.
- Clinical Immunology** - Lower activity levels have led to reduced spend on outpatient drugs in April.
- Nephrology** - There is a favourable variance relating to lower levels of spend on drugs.
- Cardiac Critical Care** - Driven by low ECMO clinical supplies expenditure.

RAG Criteria:

Green Favourable YTD Variance
Amber Adverse YTD Variance (< 5%)
Red Adverse YTD Variance (> 5% or > £0.5m)

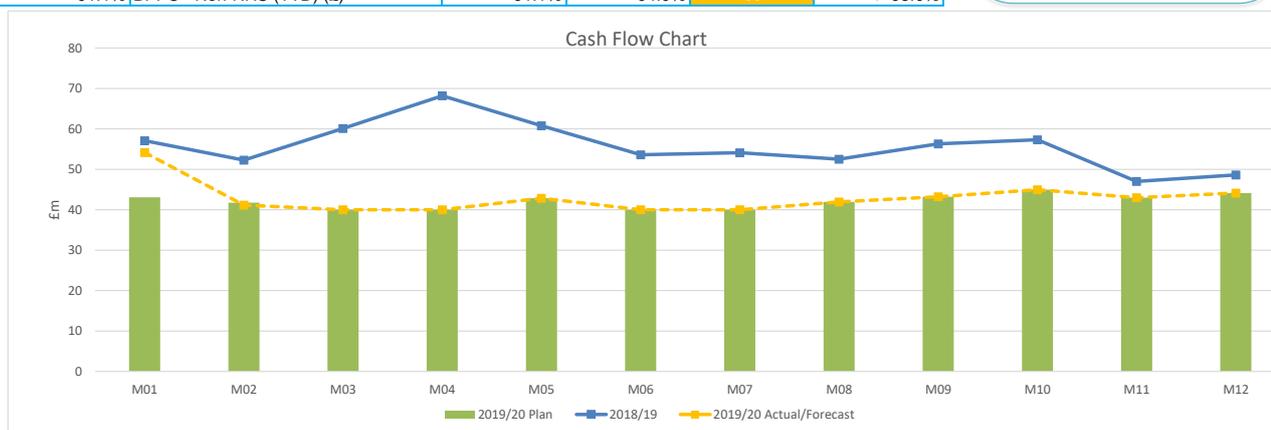
Cash, Capital and Statement of Financial Position Summary for the 1 months ending 30 Apr 2019

31 Mar 2019 Unaudited Accounts £m	Statement of Financial Position	Plan 30 Apr 2019 £m	YTD Actual 30 Apr 2019 £m	YTD Variance £m	Forecast Outturn 31 Mar 2020 £m	YTD Actual 31 Mar 2019 £m	In month Movement £m
499.04	Non-Current Assets	504.26	504.33	0.07	538.60	499.04	5.29
103.55	Current Assets (exc Cash)	87.83	99.79	11.96	88.79	103.55	(3.76)
48.61	Cash & Cash Equivalents	43.10	54.17	11.07	44.11	48.61	5.56
(74.89)	Current Liabilities	(62.11)	(82.06)	(19.95)	(66.27)	(74.89)	(7.17)
(5.01)	Non-Current Liabilities	(4.82)	(5.00)	(0.18)	(4.87)	(5.01)	0.01
571.30	Total Assets Employed	568.26	571.23	2.97	600.36	562.08	(0.07)

31 Mar 2019 Unaudited Accounts £m	Capital Expenditure	Plan 30 Apr 2019 £m	YTD Actual 30 Apr 2019 £m	YTD Variance £m	Forecast Outturn 31 Mar 2020 £m	RAG YTD variance
11.05	Redevelopment - Donated	1.83	1.54	0.29	35.25	A
7.70	Medical Equipment - Donated	0.27	0.52	(0.25)	9.30	R
14.03	ICT - Donated	1.83	2.01	(0.18)	2.17	G
32.78	Total Donated	3.93	4.07	(0.14)	46.72	G
4.57	Redevelopment & equipment - Trust Funded	0.86	0.93	(0.07)	9.36	G
2.40	Estates & Facilities - Trust Funded	0.20	0.07	0.13	3.06	R
14.50	ICT - Trust Funded	1.67	1.85	(0.18)	9.40	A
21.47	Total Trust Funded	2.73	2.85	(0.12)	21.82	G
54.25	Total Expenditure	6.66	6.92	(0.26)	68.54	G

31-Mar-19	Working Capital	31-Mar-19	30-Apr-19	RAG	KPI
20.00	NHS Debtor Days (YTD)	20.0	12.0	G	< 30.0
253.00	IPP Debtor Days	253.0	243.0	R	< 120.0
36.70	IPP Overdue Debt (£m)	36.7	36.9	R	0.0
5.00	Inventory Days - Drugs	5.0	N/A		7.0
94.00	Inventory Days - Non Drugs	94.0	92.0	R	30.0
34.00	Creditor Days	34.0	30.0	G	< 30.0
43.6%	BPPC - NHS (YTD) (number)	43.6%	43.3%	R	> 95.0%
80.3%	BPPC - NHS (YTD) (£)	80.3%	85.5%	A	> 95.0%
85.5%	BPPC - Non-NHS (YTD) (number)	85.5%	89.3%	A	> 95.0%
91.1%	BPPC - Non-NHS (YTD) (£)	91.1%	94.0%	A	> 95.0%

RAG Criteria:
 NHS Debtor and Creditor Days: Green (under 30); Amber (30-40); Red (over 40)
 BPPC Number and £: Green (over 95%); Amber (95-90%); Red (under 90%)
 IPP debtor days: Green (under 120 days); Amber (120-150 days); Red (over 150 days)
 Inventory days: Green (under 21 days); Amber (22-30 days); Red (over 30 days)



Comments:

- The capital programme is slightly ahead of plan at M01.
- Cash held by the Trust is higher than plan by £11.1m. This is largely due to higher than planned receipts from NHS England (£6.0m of which £3.9m related to Genomics and £1.2m related to Clinical Excellence Awards).
- Total Assets employed at M1 was £3.0m higher than plan as a result of the following:
 - Non current assets totalled £504.3m (£0.1m higher than plan)
 - Current assets excluding cash less Current liabilities totalled £17.7m (£8.0m lower than plan).
 - Cash held by the Trust totalled £54.2m (£11.1m higher than plan)
 - Non current liabilities totalled £5.0m (£0.2m higher than plan)
- Overdue IPP debt increased in month to £36.9m (£36.7m in M12).
- IPP debtor days decreased from 253 days to 243 days.
- The cumulative BPPC for NHS invoices (by value) improved in month to 85.5% (80.3% in M12). This represented 43.3% of the number of invoices settled within 30 days (43.6% in M12)
- The cumulative BPPC for Non NHS invoices (by value) improved in month to 94.0% (91.1% in M12). This represented 89.3% of the number of invoices settled within 30 days (85.5% in M12).
- Creditor days decreased in month to 30 days.
- Inventory days (drugs) have not been calculated in month whilst the new EPR system is being implemented..

Trust Board 22nd May 2019	
Safe Nurse Staffing Report for March 2019 Presented by: Alison Robertson, Chief Nurse.	Paper No: Attachment 1
<p>Aims / summary This report provides the Board with an overview of the Nursing workforce during the month of March 2019 (data for April was not available at the time of submission) and is set out in line with the National Quality Board (NQB) Standards and Expectations for Safe Staffing published in 2016 and further supplemented in 2018.</p> <p>It provides assurance that arrangements are in place to safely staff the inpatient wards with the right number of nurses with the right skills and at the right time.</p>	
<p>Action required from the meeting To note the information in this report on safe staffing including:</p> <ol style="list-style-type: none"> 1. Implementation of Heathroster is now complete in all clinical areas along with the introduction of Safecare, allowing nurses to measure the roster against patient acuity. A number of KPIs have been agreed which will allow us to track compliance with the rostering policy to ensure that we are using our nursing workforce effectively to deliver safe standards of patient care. 2. The Trust has joined NHSI Retention Collaborative to help focus improvements in nursing workforce. We are still waiting for our feedback. 3. Improved data reporting has indicated a higher level of vacancies, the new data set will be a realistic calculation of the current vacancies in the nursing workforce. Previously 'bank lines' have been omitted from the overall % calculation giving a lower than actual vacancy factor. 	
<p>Contribution to the delivery of NHS Foundation Trust strategies and plans Safe levels of nurse staffing are essential to the delivery of safe patient care and experience.</p>	
<p>Financial implications Already incorporated into 19/20 Directorate budgets.</p>	
<p>Who needs to be told about any decision? Directorate Management Teams Finance Department Workforce Intelligence</p>	
<p>Who is responsible for implementing the proposals / project and anticipated timescales? Chief Nurse; Assistant Chief Nurse, Director of Education and Heads of Nursing</p>	
<p>Who is accountable for the implementation of the proposal / project? Chief Nurse; Directorate Management Teams</p>	

Attachment 1

1. Summary

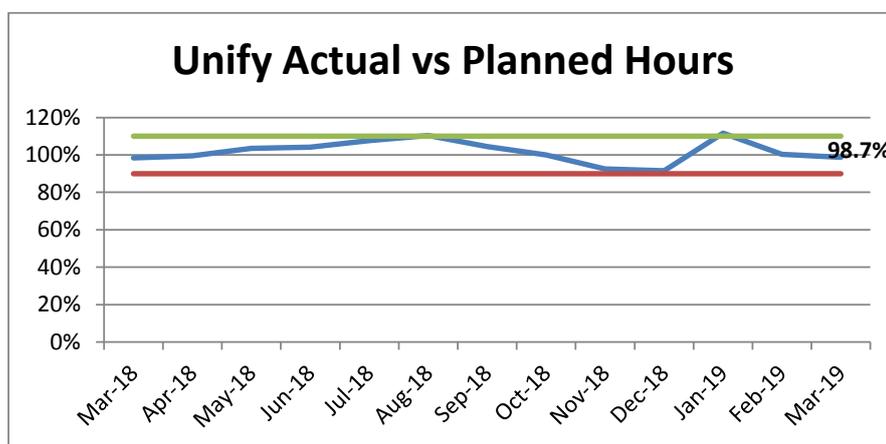
This report on GOSH Safe Staffing contains information from the month of March 2019. This paper provides the required assurance that GOSH had safe nurse staffing levels across all in-patient ward areas and appropriate systems in place to manage the demand for nursing staff. The report also includes measures taken to ensure safe staffing throughout the Trust.

2. Actual vs Planned

Actual vs Planned (AvP) Hours shows the percentage of Nursing & Care staff who worked (including Bank) as a percentage of planned care hours in month. The National Quality Board recommendations are the parameters should be between 90-110%.

In March 2019 the overall range of AvP was 98.7% which is within target but slightly lower than the same month last year (101.4%). While daytime fill rates were within the target range (Nursing: 113%, Care: 96.4%), night shifts for both groups were below (Nursing 89.1%, Care 70.4%). Heads of Nursing have verified that despite the lower rates of Actual hours no shifts were unsafe, and local management of available staff resolved any staffing issues.

During 2018/19 the overall rate fell within the target range in 10 of the 12 months, with an average fill rate of 102%. In March the final inpatient wards moved on to the new rostering system HealthRoster, which will allow for more accurate analysis of the Actual vs Planned hours alongside patient acuity.



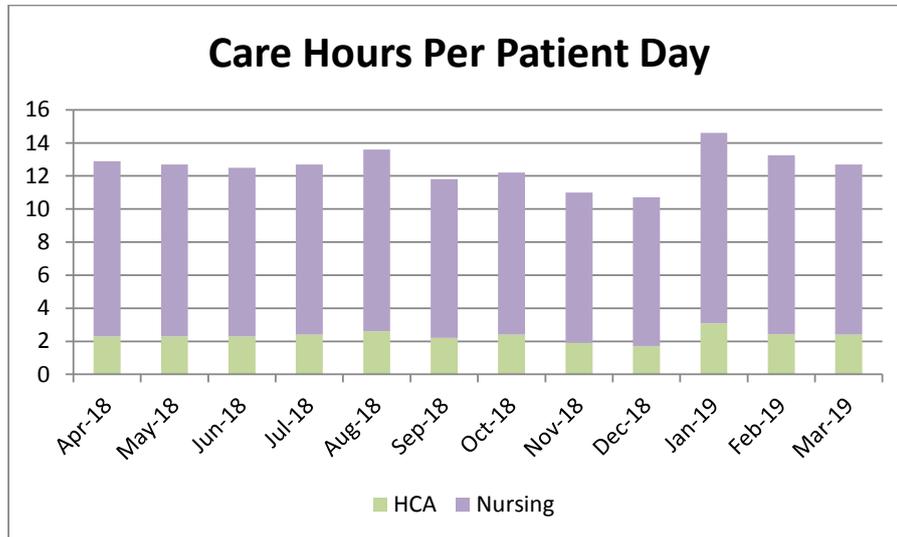
3. Care Hours Per Patient Day (CHPPD)

CHPPD is calculated by adding the hours of registered nurses and healthcare support workers available in a 24 hour period and dividing the total by the number of patients at midnight. CHPPD is reported as a total and split by registered nurses and

Attachment 1

HCA's to provide a complete picture of care and skill mix. CHPPD data is uploaded onto the national Unify system and published on NHS Choices on a monthly basis.

When we report CHPPD we exclude the 3 ICUs to give a more representative picture across the Trust. The reported CHPPD for March 2019 was 12.7 hours, made up of 10.4 registered nursing hours and 2.3 care hours. This was slightly higher than the 2018/19 average of 12.6 hours.



4. Safecare

In February the Trust rolled out SafeCare which links the rostering system to the Patient Acuity system (PANDA) allowing the measurement of the roster against patient acuity. The interface, which is the first of its kind between PANDA and HealthRoster, was rolled out in the 20 inpatient units using PANDA, with other units scheduled for later release in 2019. The rostering team has been working with the EPIC team to develop a workflow between PANDA and EPIC reducing the need for double entries.

Safecare will provide managers at all levels of the organisation with an easy to monitor view of staffing ratios against patient acuity. Using this tool nurse managers will be able to monitor Care Hours per Patient Day in almost real time and deploy available staff where needed in real time rather than review CHPPD on a monthly retrospective basis as now. This information will be available at the twice daily bed management meetings and will enable decisions to be made to deploy nurses in response to wards reporting higher levels of acuity than expected or shortfalls in nursing due to unplanned absences.

5. Rostering

In March the final Nursing units moved from RosterPro and as of the 18th March all inpatient wards are rostering through Allocate HealthRoster. This improved system will allow the Trust greater visibility of how rosters are being managed at Trust,

Attachment 1

Directorate & Ward level. The Nursing Board has approved the creation of a Rostering Scorecard which will report the following KPIs on a monthly basis.

- Advance Publication of a roster.
- Time Balances. (Measuring the effective utilisation of contracted hours)
- % Unavailability (% of staff on annual or other leave)
- Demand vs Budget. (Ensuring the roster requirements align with agreed budgets.)
- Additional Duties created.(Measuring post roster creation additions)
- % Staff working fair proportion of night and weekend duties
- Safecare Acuity & Staffing Utilisation.

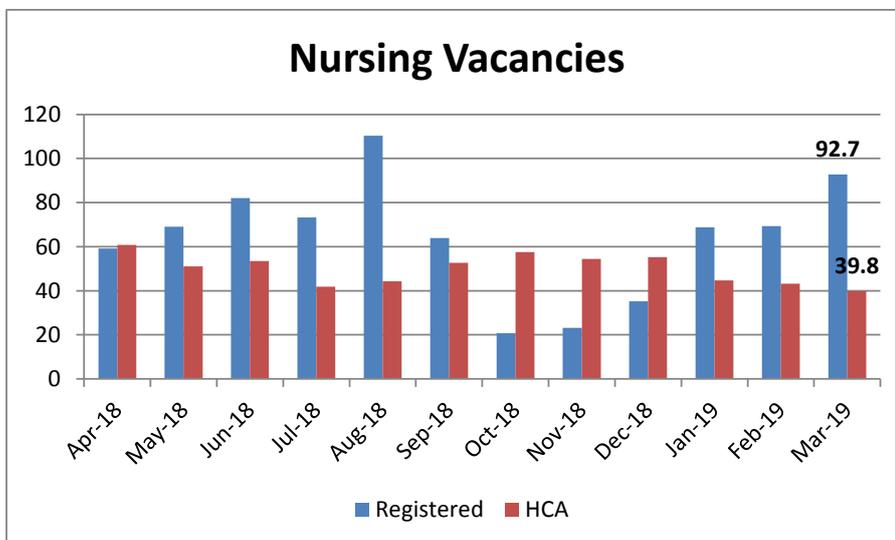
6. Nursing Vacancies

The Trust Nursing Vacancy rate increased in March to 5.6% (92.7 WTE), up from 1.9% in February, in part due to increased turnover but additionally some budget WTE (38.9 WTE) which has historically been recorded against bank lines have now been transferred to the substantive establishment. This will ensure transparency and consistency of vacancy reporting while not making any changes to managers ability to fill vacant posts with bank staff, should the need arise.

Band 6 Vacancies remains above the Trust target and average at 11.2%. One of the drivers of the Nursing retention plan is a refresh of strategies around career development which aim to support Band 5 Nurses to progress in their career at GOSH.

An international recruitment group has been established to look at the potential for filling vacancies in some of the areas with higher than average vacancies such as IPP, Theatres and ICUs. The group is developing links with other organisations in the STP and beyond to look at cost effective solutions available.

Healthcare Assistants vacancies are higher than the Trust average at 9.9% (39.79 WTE). The Nursing Workforce team will be reviewing the approach to recruiting HCAs to address the longstanding high levels of vacancies in this cadre of staff.

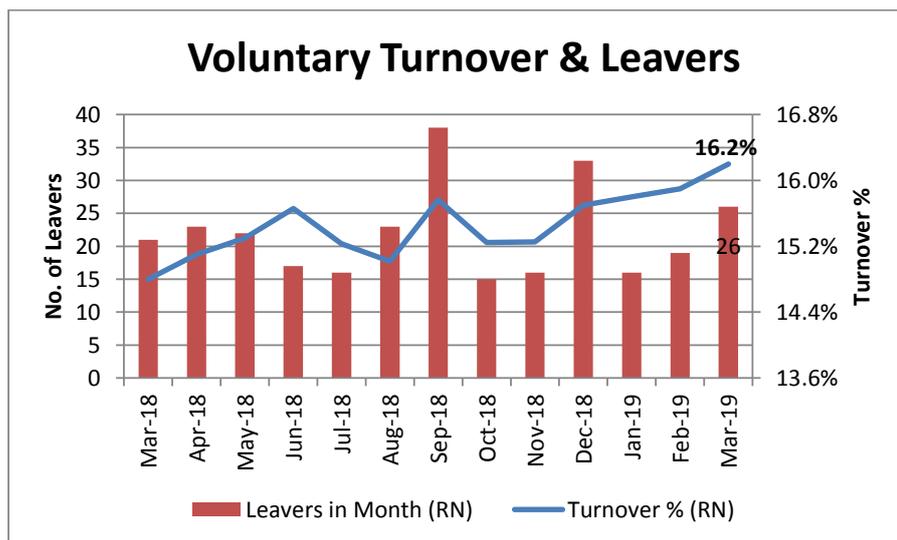


Attachment 1

7. Retention

The Trust has recently joined the NHSI Retention Collaborative which provides focussed support to trusts aiming to improve retention of their nursing workforce. As part of this work, a nursing retention plan has been developed which will look at practical ways to improve nursing experience. The high level plan was presented to the board in March.

The Trust has a target of 14% Voluntary turnover, however the performance for March was 16.2%, which was an increase on the February rate and higher than the same month last year. 26 RNs left the Trust in March, the higher than average volumes reflect a seasonal spike that is reported each year.



8. Recruitment activity

A cohort of 19 new Junior Band 5's onto the Preceptorship/Graduate Programme. The second cohort of 6 Associate Nurse Apprentices commenced in March. 8 candidates were selected for the next cohort of the healthcare support workers programme.

9. Issues

March was a challenging month for nursing as the full impact of EPIC mandatory training requirements were felt. No activity adjustments had been made and some wards and departments struggled to deliver planned activity. Trust operational needs (admissions, referrals, repatriations and discharges) were managed as safely as possible via the twice daily bed management meetings to limit the disruption.

Attachment 11

Trust Board 22nd May 2019	
Nurse Establishment Review	Paper No: Attachment 11
Executive Lead – Alison Robertson, Chief Nurse	
<p>Aims / summary National Guidance stipulates that Trust Boards should receive regular assurance that the nurse staffing levels are regularly reviewed to ensure ‘the right staff with the right skills are in the right place at the right time’ The previous board paper (Nov 2018) recommended that following the operational restructure a more detail review should take place with the Heads of Nursing within the newly established directorates. This exercise has also been conducted to align with the number of beds required to deliver the 2019/20 activity plan.</p>	
<p>Action required from the meeting To receive assurance that a comprehensive assessment of the nursing establishments has been conducted</p> <ol style="list-style-type: none"> 1. The establishments align to the 19/20 activity plan 2. A number of adjustments have been made to some of the establishments (as detailed on pages 2 and 3) 3. All changes have been signed off by the Chief Nurse 4. Further work has been identified in the next steps section of the report to help to further inform this work 	
<p>Contribution to the delivery of NHS Foundation Trust strategies and plans National Guidance has confirmed a requirement to undertake this piece of work on a regular basis (National Quality Board, NHS England/Improvement)</p> <p>Safe staffing levels are essential to the delivery of safe patient care and experience</p>	
<p>Financial implications The Finance Team have been fully involved in this review</p>	
<p>Who needs to be told about any decision? All relevant teams were involved in this review (nursing, operations, finance, performance, PMO)</p>	
<p>Who is responsible for implementing the proposals / project and anticipated timescales? Director of Nursing Operations, Heads of Nursing</p>	
<p>Who is accountable for the implementation of the proposal / project? Chief Nurse</p>	

Attachment 11

NURSING ESTABLISHMENTS (2019/20)**Aim**

This paper outlines the method used to review the nursing establishments at GOSH and identify each of the ward requirements based on the number of established beds, patient acuity and the activity plan for 2019/20 in order to deliver safe, high standards of care.

Introduction

Great Ormond Street Hospital (GOSH) has a responsibility to ensure a safe and sustainable workforce. All Trusts have to demonstrate compliance with the 'triangulated approach' to deciding staffing requirements described by the National Quality Board (NQB) and in the recent 'Developing Workforce Safeguards' by NHS Improvement (2018). This methodology combines evidence based tools, professional judgement and outcomes to ensure the right staff with the right skills are in the right place at the right time.

The NQB guidance states that providers:

1. must deploy sufficient suitably, competent, skilled and experienced staff to meet the care and treatment needs safely and effectively
2. to have a systematic approach to determining the number of staff and range of skills required to meet the needs of the people using the service and to keep them safe at all times
3. must use an approach that reflects current legislation and guidance where it is available

This most recent nursing establishment review is able to demonstrate that the Trust is adhering to the outlined recommendations in order to provide assurance to the Board that the Nursing workforce decisions regarding the establishments are designed to promote patient safety and quality as well as meet the operational requirements of the Trust.

Methodology for Calculating Nursing Numbers

The staffing ratios have been worked out using the Royal College of Nursing (RCN 2013) and Paediatric Intensive Care Standards (PICS 2016) guidance; they also include the percentage uplift that supports annual leave, sick leave, study leave (22.5%). The ratios of nurses per patients will vary depending on the type of patient and their dependency. The ratios used by the Trust are:

- Intensive Care 1:1
- High Dependency 1:2
- Ward 1:3
- Enhanced Intensive Care - 2 Nurses: 1 Patient (this includes children requiring ECMO or renal replacement therapies).

Whilst using national tools to work out establishments it is also key to note that professional judgement will also be factored into the decision making.

Each directorate had the nursing establishments reviewed ward by ward with the Head of Nursing, Matron and Ward Manager. The funded bed base for each ward was validated as was the type of patients nursed within those beds taking into account the acuity and dependency as mentioned above. The dependency information is obtained from the Paediatric Acuity and Nurse Dependency (PANDA) Tool which is widely used across GOSH to determine patient acuity and helps to inform safe staffing levels. It should be noted that the nurse numbers calculated within PANDA are not used to inform the nurse establishments as the algorithms used within the system over estimate the nursing requirements.

Each ward area nursing establishment were based at 100% capacity. The Intensive Care areas have had the figures recalculated to 90% capacity in order to match available budget. This is in line with the activity plan. However, should occupancy increase above 90% bank resource will be deployed.

Outcome

Each ward staffing requirements can be seen in Appendix 1. It is important to note that these numbers reflect patient facing staff only, to ensure that it is transparent what the nursing requirements are to provide direct nursing care based on the number of beds and patient acuity. Roles such as Practice Educators, Advanced Care Practitioners and Nurse Practitioners were not included in the calculations.

We have clarified with each ward the number of beds that are funded, the type of bed (case mix), the service requirements (activity plan, 5 day or 7 day service) and patient acuity/dependency levels (general or high dependency) which then determines the staff requirements.

We have also mapped the requirements to ensure that the 19/20 activity plan can be delivered.

Recommendation and Rationale

Budgets for each ward and theatre area (except outpatients) were looked at in detail to determine the correct establishments. Below is a list of the changes that were made. Some final adjustments are being worked through.

1. **Blood, Cells and Cancer (BCC)** – there were no adjustments to the establishments within BCC as staffing was appropriately balanced across all the ward areas.
2. **Body Bone and Mind (BBM) – Nightingale and Woodpecker** did not have the correct budget for the staff required. The planning for this area and staff requirement during the PICB build did not align with the budget. The request for nurses across VCB theatres and Nightingale comes to a total of 20 whole time equivalent (WTE) staff (6 and 14 respectively). The cost pressures across nursing and the directorates leaves sufficient budget to support 14 WTE staff across both of these areas. This would be 6 WTE for VCB theatres and 8 WTE for Nightingale and amounts to £700k. The action will be to establish with both directorates how to make best use of this investment and to explore potential efficiencies of VCB theatres and Nightingale working more closely together. The staffing in Nightingale and VCB theatres will need to be revisited in the next review to ascertain if further funding is required. **Sky Ward** has had challenges with recruitment and has not worked to its capacity of 18 beds for a number of months. The decision to reduce the bed pool to 14 beds (4 HDU

and 10 ward beds) was made in alignment with activity requirements and the establishment has been calculated accordingly.

3. **Brain – Kingfisher** have reviewed their skill mix and will be aligned with the budget and a Quality Assurance Impact assessment will be completed. **Possum Ward** is currently not open however BBM have been using some beds when required. Any long-term use of Possum will require agreement of their establishment based on bed numbers, case mix and activity. **RANU Starfish** will have all beds opened with the same staffing establishment from 4 beds to 7 beds.
4. **Heart and Lung** – the bed base across **Flamingo and Alligator** is 23 beds. Alligator ward opened without substantive nursing staff in post and was briefly closed and has re-opened. Flamingo beds have been reduced and opened up in Alligator. The efficiency and effectiveness of this needs to be reviewed regularly because the flexibility of staff reduces if staff are spread across two ward areas with beds closed on both areas. The bank lines will also be aligned with the need for substantive posts which are more cost effective than bank and supports the focus away from the reliance of bank staff towards the recruitment of substantive staff. **Kangaroo** may use its 2 beds currently not in use but a business case will be required to approve additional funding. **Neonates (NICU) and Paediatric Intensive Care (PICU)** both have vacancies but there has been recent success with recruitment. There will also be a change in 19/20 in the types of patients to be placed across PICU and NICU. This was modelled on occupancy last year to ensure that the correct number of NHS beds are available to support the commissioned activity. Heart and Lung - PICU, NICU and CICU are to work staffing requirements at 90% occupancy to align the staffing with the available budget. This will be kept under review. Bank lines will also be reduced in favour of creating vacant posts for substantive recruitment..
5. **Sight and Sound** – outpatients staffing requirements are being addressed due to the ZCR and Sight and Sound which are due to open. The rest of outpatients will also be reviewed in the next establishment review which will be timed to coincide with the next round of business planning.
6. **International and Private Patients (IPP) – Bumblebee and Butterfly** have vacancies that are being addressed through recruitment. **Hedgehog Ward** briefly merged with Bumblebee Ward due to vacancies but this is only temporary and mainly to support the wards through Epic implementation. The ward areas in IPP do not have the nursing establishment requirements aligned to wards that provide similar care in other directorates. The Oncology Wards in BCC have a higher number of nursing numbers per patient. This may account for some of the vacancy issues in IPP. This will be reviewed when IPP resolves its current vacancies.
7. **Operations and Images** – this area has a large bank spend and the establishment work highlighted that the majority of the bank staff usage was due to staffing in the Satellite theatres such as Gastro suite resulting in a deficit of staffing numbers (recovery) in Ops and Images because the budget was not calculated correctly. (Please see BBM with regards to staffing changes in collaboration with Nightingale Ward).

All changes to the Ward establishments are mapped on the spreadsheet in Appendix 1 to ensure the latest information is captured. This will be a live document which will be updated as any further changes are made.

All establishment changes will have a Quality Impact Assessment and will be signed off by the Chief Nurse prior to implementation.

To ensure nursing staff of all levels have the appropriate understanding of staffing establishments and budgets, especially at Ward Manager level and above.

Next Steps

The development of Apprenticeships within Health seeks to provide innovative solutions to the gaps in the workforce that currently exist and will encourage widened participation in these roles. To date GOSH has 5 registered Nurse Associates, 6 trainee Nurse Associates with 6 more due to start in June this year. A Quality Impact Assessment is currently being compiled.

An external review of the nursing establishments is planned.

A review other nursing roles (Practice Facilitators, Practice Educators, Clinical Nurse Specialists, Advanced Nurse Practitioners) is also underway.

A review of the nursing workforce in outpatients will be included in the next review.

To include an analysis of quality measures against any areas of staffing concern.

To understand and incorporate the Paediatric Safer Nursing Care Tool into the methodology

To align the next review to the business planning cycle 1920/21.

Author: Herdip Sidhu-Bevan – Director of Nursing Operations

Acknowledgements: Polly Hodgson – Deputy Chief Nurse; Lynn Shields - Director of Education; Tricia Bennett – Assistant Chief Nurse Workforce; Nick Day – Deputy Head of Planning; Usman Rehman – Head of PMO

Directorate	Ward	Staff Grade	Original budget			Output of Engine + other workings		Overall increase (+) or decrease (-) on original budget	Notes	Opening Hours	Total Physical Beds	Approved IP Beds	Approved DC Beds	Total Approved Beds	Of Which are ITU Beds	Of Which are HDU Beds	Any non-Patient Facing Roles? (these are not included in the budget numbers)	Notes
			WTE Original budget (patient and non-patient facing)	WTE In Post (M10)	WTE Vacancy (M10)	WTE Patient facing	WTE non-patient facing to transfer out of ward budgets											
Operations & Images	Anaesthetic Staff Theatre	Band 5	20.5	15.00	5.50	15.10	-	5.40	Per Engine									
Operations & Images	Anaesthetic Staff Theatre	Band 6	22	25.15	-3.15	31.90	-	9.90	Per Engine									
Operations & Images	Anaesthetic Staff Theatre	Band 7	2	2.26	-0.26	-	-	2.00	Per Engine									
	Anaesthetic Staff Theatre Total		44.5	42.41	2.09	47.00	0.00	2.50										
Operations & Images	Recovery Theatres	Band 4	2	0.99	1.01	3.00	-	1.00	Per workings for recovery									kingfisher, safari, mri
Operations & Images	Recovery Theatres	Band 5	18.71	13.87	4.84	20.00	-	1.29	Per workings for recovery									do we need to adjust sessions or establishment to adjust
Operations & Images	Recovery Theatres	Band 6	13.95	16.99	-5.04	18.00	-	6.05	Per workings for recovery									Overspend, budget challenge, 7 half day theatre sessions per week, 28 undelivered sessions.
Operations & Images	Recovery Theatres	Band 7	1.5	1.50	0.00	-	-	1.50	Per workings for recovery									
	Recovery Theatres Total		34.16	33.34	0.82	41.00	0.00	6.84										
Operations & Images	Scrub Staff Theatre	Band 2	4	3.00	1.00	4.00	-	-	Per Engine									2 on pathway to move to B3, 1 other will moved to B3 once training completed
Operations & Images	Scrub Staff Theatre	Band 3	6	7.00	-1.00	6.00	-	-	Per Engine									
Operations & Images	Scrub Staff Theatre	Band 4	4	1.49	2.51	-	-	4.00	Per Engine									
Operations & Images	Scrub Staff Theatre	Band 5	24.08	20.59	3.49	34.60	-	10.52	Per Engine									
Operations & Images	Scrub Staff Theatre	Band 6	42	39.35	2.65	39.10	-	2.90	Per Engine									
Operations & Images	Scrub Staff Theatre	Band 7	10.5	9.67	0.83	15.80	-	5.40	Per Engine									
	Scrub Staff Theatre Total		90.58	81.10	9.48	99.60	0.00	9.02										
Operations & Images	Grand Total		169.24	156.86	12.38	187.60	0.00	18.36									0	

Trust Board	
22 May 2019	
Freedom to Speak Up Annual Report 2018/19	Paper No: Attachment 2
Submitted by: Freedom to Speak Up Guardian: Luke Murphy	
Aims / summary: To share themes from FTSU casework and to identify learning and actions for the Trust.	
Action required from the meeting. To note the report and support the recommended actions.	
Contribution to the delivery of NHS Foundation Trust strategies and plans: This work responds to the concerns raised by the CQC.	
Financial implications: NA	
Who needs to be told about any decision?	
Who is responsible for implementing the proposals / project and anticipated timescales? HR&OD and the Quality and Safety Team	
Who is accountable for the implementation of the proposal / project? HR&OD actions for the Director of HR Quality and Safety actions for the Medical Director	

Attachment 2: Freedom to Speak Up Guardian Annual Report 2018/19

Introduction

The Freedom to Speak Up (FTSU) Guardian role is one of the recommendations from Sir Robert Francis' FTSU review in February 2015 into whistleblowing in the NHS, which identified very poor experiences for NHS staff who raised concerns. All trusts are required to appoint Guardians to support their staff raising concerns at work

The FTSU service began in November 2016 with GOSH staff volunteering their time, these individuals were called Freedom to Speak Up Ambassadors. The goal was to have a range of staff from across a variety of staff groups to encourage access to the service regardless of role at the Trust.

It is important to note that in the 2018 CQC inspection report (published April 2018) it was noted that *"The Trust had not fully demonstrated their commitment to support the freedom to speak up agenda. They did not fully comply with recommendations set in freedom to speak up guidance issued by the National Guardian's Office. No Trust Guardian had been appointed."*

Prior to the CQC inspection in January 2018, the Trust was in the process of appointing a Freedom to Speak Up (FTSU) Guardian. The new Guardian took up post from 5th March 2018.

This is the second annual report from the Freedom to Speak Up Guardian service.

Service Provision and Resource

The FTSU service in the Trust is provided by a FTSU Guardian and a range of FTSU ambassadors.

The Guardian post 0.4WTE remunerated post and there are 4 staff members who volunteer as FTSU Ambassadors. The Ambassadors come from a range of roles and professions across the Trust.

The FTSU Guardian reports directly to the Medical Director.

The FTSU regularly meets with the Chief Executive to provide updates and an overview on thematic concerns.

There is a non-executive director who is responsible for FTSU and for Whistleblowing (James Hatchley).

The role of the Guardian:

- support our staff to raise concerns at work;
- promote awareness of FTSU to staff at GOSH
- listen and keep a brief record of concerns raised (confidential if desired);
- where appropriate, ensure that an investigation is arranged through the appropriate channels
- stay in contact with the individual during the process and ensure they are kept updated, and are supported;

Attachment 2: Freedom to Speak Up Guardian Annual Report 2018/19

- report regularly to the board, identifying thematic areas for improvement and providing challenge where appropriate
- escalate concerns to the executive lead, Dr Sanjiv Sharma Medical Director or to Mat Shaw, Chief Executive and the nominated Non-Executive Director, James Hatchley, as may be appropriate.

Accessibility

Following the appointment of the FTSU Guardian in March 2018, several steps have been taken to improve accessibility to the service including:

- Dedicated email account
- Dedicated mobile phone number
- Intranet page updates (including pictures of the Guardian and Ambassador)
- Production of an FTSU staff support leaflet
- Open house
- Listening events

There has been ongoing high level support from the management team for the FTSU Guardian in his other Trust role which has enabled flexibility in responding to cases and staff Monday to Friday.

FTSU Case Load Analysis

In the 2017/18 Annual Report there were 13 cases reported. There were a broad range of issues raised through the Ambassadors and Guardian. Cases were identified by a variety of staff group including administrators, managers, nurses, allied health professionals, health care assistants and doctors. Multiple concerns were raised by some staff members. Themes in **2017/18** included:

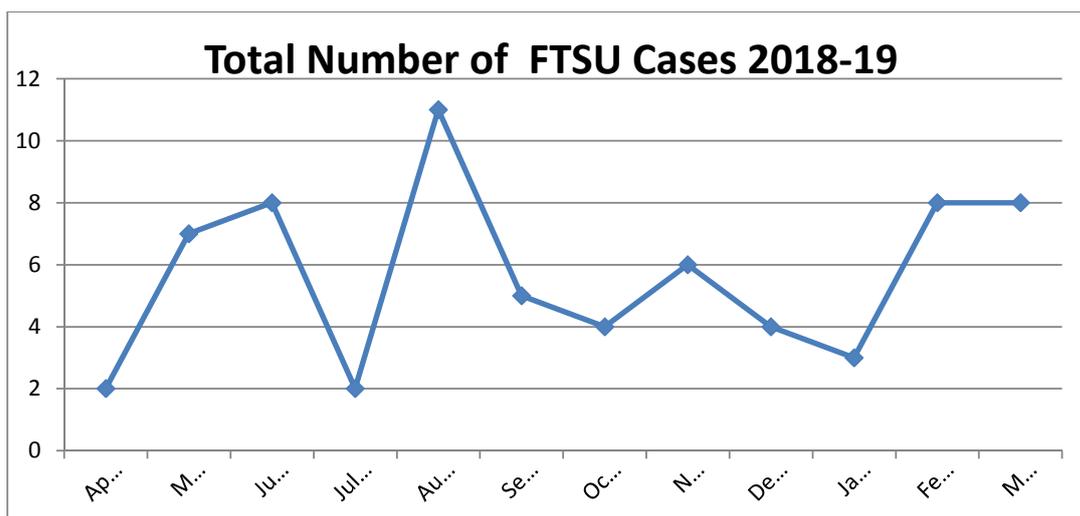
- staff concerned about safety (46% of cases)
- staff concerns about colleagues' behaviours (69%)
- staff concerns about leadership/management (31%)
- staff concerns about a negative team culture (23%)

The case load in 2018/19 has significantly increased. There were 68 cases reported in this time period which represents a five-fold increase in case load for the service. On average the service is involved in 17 cases per quarter. In addition to the case load described below, the staff members involved in delivering the FTSU service have also been appropriately signposting staff to pre-existing routes within the organisation including line management support and datix incident reporting. The signposting work of the service is not currently reported on within the caseload.

We believe the number of cases has increased in line with the greater accessibility of the service through the measures outlined above (under Accessibility above). Our numbers are broadly in line with the National Guardian Office Figures for 'small organisations' (~5000 staff members).

The chart below tracks the caseload over the preceding 12 months. Over the course of the year there have been 5-6 cases on average per month.

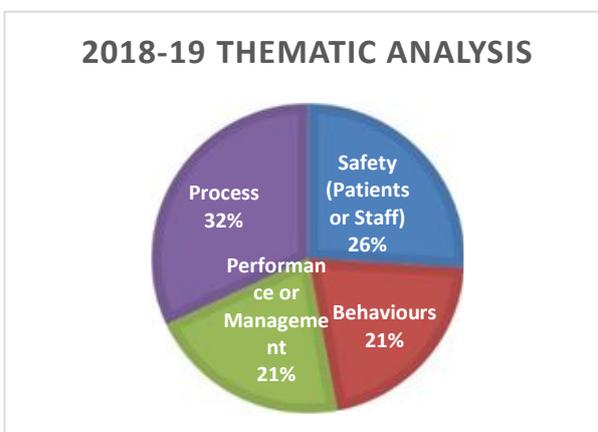
Attachment 2: Freedom to Speak Up Guardian Annual Report 2018/19



When considering the analysis of key themes, it's important to be cognisant that each case may raise multiple issues and this varies based on the nature and complexity of the concern raised.

The key themes include:

- Staff concerned about safety (of patients and/or staff) 26%
- Staff concerned about colleague's behaviour 21%
- Poorly articulated performance /management concerns 21%
- Process issues 32%



Concerns about Safety (Patient or Staff) 26%

Each time safety concerns have been raised via the FTSU, staff have been provided with support to raise issues via the pre-existing processes, both internally (e.g. via Datix) and externally (as required by the specifics of the case). These issues escalated through these routes have been dealt with appropriately and fairly.

Concerns about Colleague Behaviour (21%)

FTSU casework mirrors the concerns raised in the most recent staff survey (undertaken October 2018). Many of those who contact the service highlight concerns about behaviour and the impact that this has on their working life. We recognise that staff experience at work does have an impact on patient safety and patient experience. The casework analysis demonstrates that the clinical staff groups do have an understanding /awareness of the processes for dealing with behaviours, and are accessing the FTSU service for support while they are initiating or working through those processes.

Attachment 2: Freedom to Speak Up Guardian Annual Report 2018/19

The casework analysis suggests that Administrative staff are less clear about the Trust processes for managing/escalating these behaviours. The FTSU service is providing greater levels of support for these staff groups in highlighting or escalating issues about behaviour in the workplace.

Concerns about Performance and Management (21%)

Poorly articulated performance management is a consistent theme in concerns raised by administrative staff. FTSU analysis suggests that there is scope for greater clarity from managers about the nature of performance concerns (and support in how to improve performance) and articulating the procedure set out in the policy. Staff have experienced this as causing stress, as they have not been given clear information on how to improve their performance.

Issues with Process (32%)

Analysis of the casework suggests that lack of understanding or awareness of a variety of Trust processes is at the heart of approximately a third of cases handled by the FTSU service.

Process, for these purposes, includes:

- Role of the line manager's manager
- Role of HR, and in particular the Employee Relations Team
- Role of and access to Occupational Health Support
- Clarity on HR policy

It is noted that 9% of cases in 2018/19 were raised by subcontractor working at GOSH who are using the FTSU process in the absence of clear advice on escalation regarding safety concerns, as well as terms and conditions of employment.

Outcomes and Achievements

The FTSU service is pleased with the increase in cases reported, and the complexity of the issues which staff feel able to raise through this service.

We are working collaboratively with the Cognitive institute to promote 'Speaking Up', and will be branding the Trust wide programme to reinforce a consistent promotion of speaking up for safety at Great Ormond Street.

The successes of the FTSU service are in a large part attributable to the accessibility and openness of senior staff to resolving the issues which are raised through the FTSU process in a timely and responsive way. This includes, but is not limited to: the Chief Nurse, Medical Director, Chief Finance Officer, the Chief Executive and regular access to the non-executive director to provide oversight.

The FTSU Service also supported a range of listening events for nursing staff and health care assistants to enable conversations regarding changes to bank pay rates and other staff support provision e.g. accommodation and training. A separate report including recommendations on staff inclusions in decision making has been provided to Trust Board previously.

Attachment 2: Freedom to Speak Up Guardian Annual Report 2018/19

Areas for improvement:

The ambition of the FTSU service is to ensure that the concerns raised by the staff at GOSH are channelled effectively into improvements within the hospital, as part of our commitment to being a learning organisation. Based on the analysis of the casework for 2018/19, the following recommendations are made:

Patient and Staff Safety

It is crucial that staff are aware of the Datix incident reporting process and how they can seek support from the line management structure in relation to this.

Recommendation: promote and monitor increased incident reporting via Datix as part of the Speak Up partnership with the cognitive institute. Promotional events taking place in June 2019 for Speaking Up for safety and for the use of Datix and the Risk Action Groups.

Staff Experience

There is more that can be done to help staff understand our agreed processes which enable staff to raise grievances in line with hospital policy, including the dignity at work policy.

Recommendation: Clear process flow charts to be available to staff to support them with understanding policies easily.

Subcontractor experience

It would be valuable to have clarity on advice and support available for sub-contractors, as many are using the FTSU process in the absence of clear advice on escalation regarding safety concerns, as well as terms and conditions of employment.

Recommendation: Consider what information and guidance can be provided to our subcontractors on how issues can be raised.

Quality and Safety Commentary

The Speak Up Project Lead from the Quality and Safety team is preparing for our Trust-wide launch of "Speak Up for Safety" workshops. The mandatory workshops will commence in June 2019 with over 300 workshops scheduled from June until the end of 2019.

These mandatory workshops are facilitated by Safety Champions, 20 staff volunteers recruited from a number of staff groups across the Trust, who have been trained and accredited to both champion and deliver the key Speak Up messages. In addition to the 20 Safety Champions we are also training a further 6 champions, in the coming month, from our consultant body to support the work of the Speak Up programme.

As part of this launch and with support from the Communications Team this work will be launched in June 2019 and the Quality and Safety team will be hosting guests from international hospitals who have partnered with the Cognitive Institute.

Attachment 2: Freedom to Speak Up Guardian Annual Report 2018/19

As part of the range of ways that staff can Speak Up the trust remains committed to the use of Datix as the best way to record and track incidents. Datix reports and the Risk Action Groups will continue to be a forum for identifying risks and sharing learning from across the Trust.

To ensure that Datix and the Risk Action Groups are seen as part of the “family” of Speaking Up about safety the launch in June will include shared promotional branding with the Speaking Up for Safety and the Freedom to Speak Up Guardian.

HR & OD commentary

Whilst it is pleasing to see that staff are able to raise their issues and concerns with the FTSU service, the increasing trend of concerns raised around bullying and harassment which match results of our staff survey is worrying.

The CEO has made a direct commitment to staff that poor behaviour will be addressed and encouraged staff to speak up to their line managers and him if necessary. Undoubtedly there is far more conversation about bullying and harassment and in this environment it is expected that numbers of cases will rise. However, this does mean that we are in a better position to understand what is going on and take corrective action.

Among the actions planned include the excellent work with the Cognitive Institute on embedding a safety culture and reminding staff of the Trust Values. However, we need to go much further. Under development right now is the People Strategy which will, for GOSH, for the first time set out the Trusts vision for its people and match GOSH aspirations for patients and families with those for staff ensuring that we deliver on our promise of a culture where we can all learn and thrive. As part of the development of the People Strategy we will refresh the values, talk to staff about how relevant these are and ensure that we fully embed the behaviours that sit underneath them.

Action Plans to deliver on that promise are already in train. We know that our managers need to build their people skills enabling them to develop and motivate teams and individuals and deal with conflict and unacceptable behaviour. The Leadership Strategy has been signed off by Board and underneath that there will be a robust management development programme equipping managers with the skills needed to manage their people well.

In addition all Directorates have been supported to develop their staff survey action plans, focussing on key areas from their results and involving staff in the development of those plans. We need to bolster the capacity and capability of our employee relations team, clearly positioning it as a manager’s advisory service and ensuring these staff are able to provide high level and quality advice to managers in complex employee relations problems. We will also be providing a more joined up, integrated and holistic approach to staff support arrangements. Ensuring that they are easier to access and mutually reinforcing.

These actions will be form part of the capability strand of the people strategy so that whilst poor behaviour is clearly called out and tackled, the focus becomes one of building capability of managers not focussing on a minority of individual cases. In this way we will deal with the cases, create an environment and culture where less cases arise and shift the narrative from negative to positive.

Attachment 2: Freedom to Speak Up Guardian Annual Report 2018/19

Training and External Engagement

The FTSU Guardian has attended two FTSU Conference days run by the National Guardian for the Freedom to Speak Up in conjunction with the CQC and others.

Strategy and Goals for 2019/20

- Continue to work with the Cognitive Institute on the 'Speaking Up' programme as the project goals are very clearly aligned with the FTSU vision and strategy including:
 - Having a cohesive, simple, speaking up agenda that encourages speaking up in the moment
 - Ensuring there is support from the guardian when that process hasn't worked in the way we would expect
 - Supporting all staff to challenge poor behaviours, ensure professional accountability and still reinforcing speaking up for safety via the current processes.
 - Making the platforms and routes for speaking up (in all its forms) more accessible
- Working with HR alongside other key stakeholders (e.g. unions and others providing support to staff) to review for policy for raising grievances, support for staff to challenge behaviours, training for managers in articulating performance management processes and goals.
- Support HR in working with staff fora to map and aggregate data about concerns raised to unions, staff reps, guardian and others including our inclusion forums to better identify what and where the problems are and how we can work together to fix them.
- Define referral processes with the lead with Employee Relations so that cases are effectively handed over and dealt with, and outcomes are fed back
- Use the NHS Improvement FTSU Self-Assessment framework to evaluate Trust performance

Attachment 3

Trust Board 22 May 2019	
Health and Safety Annual Report	Paper No: Attachment 3
Submitted by: Chris Ingram, Head of Fire, Health and Safety	
Aims / summary To assure the Committee that the Trust is meeting its statutory and mandatory commitments and placing safety at the forefront of all its actions.	
Action required from the meeting None	
Contribution to the delivery of NHS Foundation Trust strategies and plans Zero Harm	
Financial implications If the Trust does not adhere to safety legislation then it could face punitive financial measures.	
Who needs to be told about any decision? This report has been presented to the Health and Safety Committee. This has a diverse membership who will disseminate the information to their departments/colleagues.	
Who is responsible for implementing the proposals / project and anticipated timescales? Head of Fire, Health and Safety	
Who is accountable for the implementation of the proposal / project? Head of Fire, Health and Safety	

Attachment 3
 Health and Safety Annual Report – 2018/19

Health and Safety Annual Report 2018 - 2019

The Health and Safety team support the Trust management and employees to meet their statutory duties in relation to controlling the risks and precluding the chance of harm to patients, visitors and staff.

The following work has been undertaken by the team during the year:

Description of work	Progress and lead	Timescale	Original RAG rating	Current RAG rating
<p>All Control of Substances Hazardous to Health (COSHH) information has been updated across the clinical areas.</p> <p>All relevant non-clinical areas such as Estates have also been completed.</p> <p>An audit to ensure staff are aware of their duties will take place in April 2019.</p>	<p>All clinical areas complete. All other relevant areas have been completed. Health and Safety Team</p> <p>The audit has started but has not yet been completed. Health and Safety Team</p>	<p>Complete</p> <p>May 2019</p>	<p style="background-color: #92d050;"></p>	<p style="background-color: #92d050;"></p>
<p>Train 90% of staff in Health and Safety</p>	<p>On the 1st April 2019 compliance with Health and Safety training was 93% (94% in 2018) Health and Safety Team</p>	<p>Monitored monthly</p>	<p style="background-color: #92d050;"></p>	<p style="background-color: #92d050;"></p>
<p>Safer Sharps - The Trust is required to comply with the Health and Safety (Sharps Instruments in Healthcare) Regulations 2013 (the regulation), which is monitored by the Health and Safety Executive (HSE). The elements the Trust must meet are as follows:</p> <ol style="list-style-type: none"> 1. Complete a risk assessment 2. Implementing control measures 3. Information, instruction and training on safe use of sharps 4. Ensure that suitable clinical waste disposal procedures, including use of sharps containers, are followed 5. Ensure standard 	<p>A working group has been set up to tackle all issues relating to sharps. The action plan is updated monthly.</p> <p>The measures taken by 31/3/19 include:</p> <ul style="list-style-type: none"> • Safer Sharps Group meets each month • Sharps Policy in situ • Standard Cannulas have been replaced with safer products. • The Trust is replacing or assessing all products within the Theatres Department. • Trust is currently reviewing stitch 	<p>Monitored at the Health and Safety Committee (Bi-monthly)</p>	<p style="background-color: #ffc000;"></p>	<p style="background-color: #ffc000;"></p>

Attachment 3
Health and Safety Annual Report – 2018/19

<p>precautions for infection control are in place</p> <p>6. Have clear procedures for response to sharps injuries, including speedy access to appropriate prophylaxis treatments</p> <p>7. Reporting work-related sharps injuries</p>	<p>cutters, insulin pens, scalpels, sutures and port-a-cath needles.</p> <ul style="list-style-type: none"> The Trust has completed a Sharps Bin audit for the entire Trust. An action plan has been drawn up and is monitored at the Health and Safety Committee. The Trust will be re-audited in June 2019. <p>Head of Fire, Health and Safety</p>			
<p>The Trust reports health and safety incidents on Datix. Any incident that involves a staff member being away from the Trust for more than 7 days or results in a serious injury must be reported under RIDDOR.</p>	<p>852 (800 last year) health and safety incidents were reported from 1/4/18 – 31/3/19. 5 incidents were reported under RIDDOR. A more detailed breakdown is included below.</p> <p>Health and Safety Team</p>	<p>The team aims to reply to each H&S incident within 1 working day.</p>		
<p>First Aid – The Trust must complete a First Aid risk assessment to ensure that there is a sufficient response to any H&S incidents that happen on-site.</p>	<p>A risk assessment has been completed. This has identified that First Aiders are required in some areas but in others someone with clinical experience can act as a ‘responder’. The team is currently ensuring that all areas in the Trust are covered.</p>	<p>Annually</p>		
<p>If workers use display screen equipment (DSE) daily, as part of their normal work, continuously for an hour or more, employers must do a workstation assessment.</p>	<p>27 staff members have identified issues with their work stations between 1/1/19 and 31/3/19. The Health and Safety Team have investigated 100% of these issues helping to provide ergonomic solutions. These interventions will help to prevent injuries from exacerbating and help to improve staff members working lives. This is done in conjunction with the Occupational Health Department</p>	<p>As and when required</p>		
<p>Risk Impact Assessments are</p>	<p>Assessments have been</p>			

Attachment 3
Health and Safety Annual Report – 2018/19

<p>undertaken when a project is ready to begin. Local staff will receive training prior to taking over the area.</p>	<p>completed for Barclay House, MRI 2 and 3, DRIVE, IMRI and ZCR. 100% completion (Chris Ingram) Further assessments will be required as the Trust moves into ZCR and the Sight and Sound Centre</p>			
<p>An on-going monthly meeting with the Institute of Child Health continues to happen. Any safety issues are raised which has led to increased co-operation between the 2 organisations. The latest action log is presented at the Health and Safety Committee.</p>	<p>This meeting continues to function well. With the joint venture of ZCR starting later in the year this will be a key forum to discuss any issues that arise. (Chris Ingram/Kate Thornton)</p>	<p>Meeting is held on a monthly basis</p>		

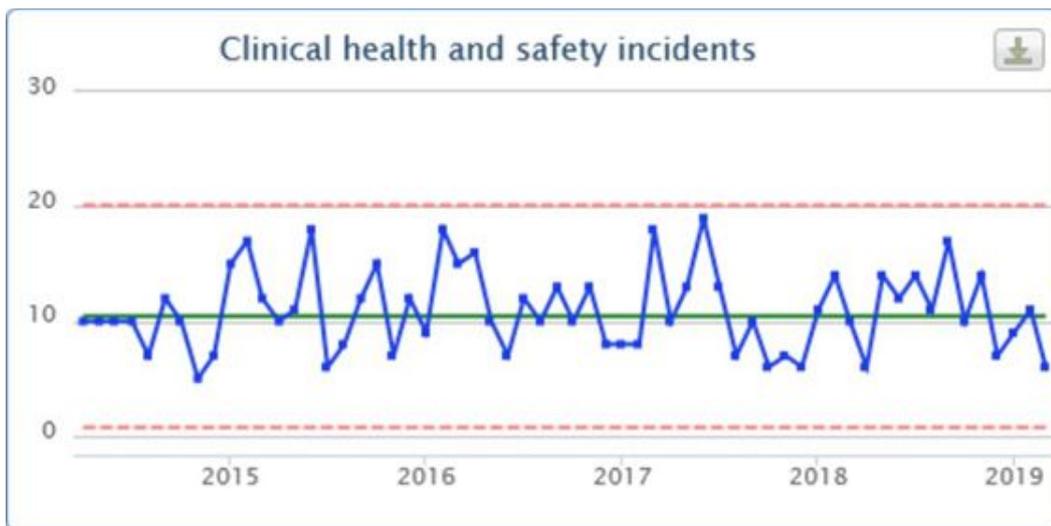
Number and severity of incidents reported (Pan Trust)

GOSH employees reported 852 (800 – last year) health and safety incidents in the year from April 2016. These included including 132 patient safety incidents. 1 incident was reported as causing as catastrophic.

- WEB58363 – Staff member passed away overnight between 30/12/18 - 31/12/18 whilst in the staff room in Estates Department following day shift. This has been reported as a Serious Incident to NHS England – STEIS No. 2019/346



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 Health and Safety Annual Report – 2018/19

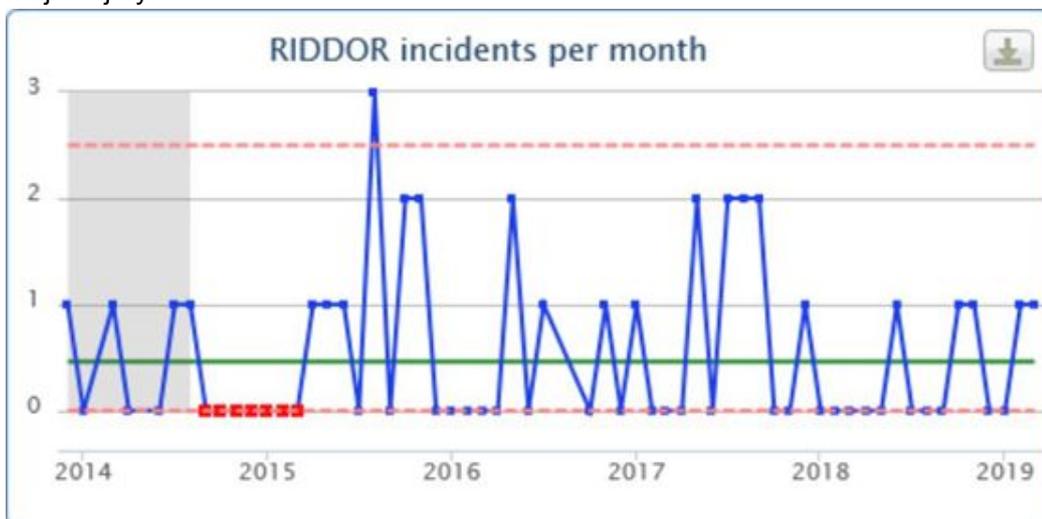


Reporting of Injuries, Diseases and Dangerous Occurrence Regulations

The Trust is required by law to report specified workplace incidents, such as work-related deaths, major injuries, over 7-day injuries, work related diseases, and dangerous occurrences (near miss accidents)

5 incidents were reported to the Health and Safety Executive (HSE) under RIDDOR.

- WEB57059 – Nurse ran over foot whilst changing patient’s linens. Resulted in a badly bruised foot and broken toes. Staff member was away from the Trust > 7 days.
- WEB54036 – Theatre Nurse caught in racking whilst another staff member moved it. Hurt arm and shoulder. Staff member was away from the Trust > 7 days.
- WEB59129 – Scientist caught finger in a blade whilst performing procedure with samples. Staff member was away from the Trust > 7 days.
- WEB59625 – Clinical Scientist fell as she left a lift. The fall resulted in a broken upper arm. Major injury.
- WEB58395 – Nurse banged wrist on metal equipment. Resulted in a fractured wrist. Major injury.



Attachment 3

Health and Safety Annual Report – 2018/19

Main aims for 2019/2020

- Complete COSHH Audit for in all clinical areas.
- Maintain Health and Safety training compliance above 90%.
- Respond to all Health and Safety incidents within 1 working day.
- Ensure compliance with the HSE's Safer Sharps Directive.
- Ensure collaboration between GOSH and the ICH in all safety matters.
- Ensure that our new buildings meet high safety standards and are safe for our staff and patients to move into before they are used.

Trust Board 22 May 2019	
Annual Sustainability Report 2018/19	Paper No: Attachment 4
Submitted by: Matthew Tulley, Director of Development	
<p>Aims / summary: The report and associated presentation aim to present a brief background to the achievements in regard to the Trust's Environmental Sustainability agenda in 2018/19. It contextualises this in relation to the important next step - currently underway - of creating then requesting the signing off our new SDMP (Sustainable Development Management Plan) laying out a Trust Strategy and targets for the years ahead. This will be brought to the next Trust Board for your attention</p> <p>The report highlights a number of key elements:</p> <ul style="list-style-type: none"> - Our current pivotal stage on this journey with the upcoming adoption of our new multiyear Sustainable Development Management Plan (SDMP) targets and the structured and holistic discipline it will bring to accountability, governance, innovation, partnership and measurable impact around our approach to sustainability. - GOSH's creation of the 'Clean Air Hospital Framework' – a world first – to inspire and guide activity, education and advocacy from health institutions in relation to the air quality health crisis. It has now been downloaded over 500 times - Our continued downward glide path in Co2 generation – due to technical innovation recognised across the sector - despite temporary problems with our estate's energy infrastructure. Further strong improvement is expected in the year to come due to more interventions being made - Brief vision for our future development projects in relation to innovation around the creation of sustainable healing environments. 	
<p>Action required from the meeting None specifically. However an awareness of the context and conclusions outlined within the executive summary would be most beneficial</p>	
<p>Contribution to the delivery of NHS Foundation Trust strategies and plans Measuring, monitoring and reporting on sustainability through the annual report supports the assurance process for meeting legal, reputational and policy requirements.</p> <p>Annual Sustainability Reporting is mandated for CCGs and Trusts through the Department of Health and Social Care Group Accounting Manual (DHSC GAM) and by the Foundation Trust Annual Reporting Manual (FT ARM); and from Arm's Length Bodies through the Greening Government Commitments. Along with regularly updated Sustainable Development Management Plan, annual reporting on sustainability is mandated by the NHS Standard Contract (Service Condition 18).</p>	
<p>Financial implications n/a</p>	

Who needs to be told about any decision? n/a
Who is responsible for implementing the proposals / project and anticipated timescales? Head of Sustainability & Environmental Management
Who is accountable for the implementation of the proposal / project? Director of Development

Great Ormond Street Hospital annual sustainability report 2018/19

Executive Summary

Introduction

This report outlines GOSH's action on 'environmental' sustainability over 2018/19 in the context of our ambitious plans to evolve this activity in the years to come. It covers various facets including impacts from our everyday functioning, links into the health of children and our ability to lead on the climate and health agenda nationally and beyond. This is the first year with our Head of Sustainability & Environmental Management in post.

Main Body

A clear focus on protection of our natural environment will nurture a culture and actions fundamental to safeguarding human health, building efficiency into our systems, linking our people together and embedding a beneficial outward facing ethos.

The report highlights a number of key elements:

- Our current pivotal stage on this journey with the upcoming adoption of our new multiyear Sustainable Development Management Plan (SDMP) targets and the structured and holistic discipline it will bring to accountability, governance, innovation, partnership and measurable impact around our approach to sustainability.
- GOSH's creation of the 'Clean Air Hospital Framework' – a world first – to inspire and guide activity, education and advocacy from health institutions in relation to the air quality health crisis. It has now been downloaded over 500 times
- Our continued downward glide path in Co2 generation – due to technical innovation recognised across the sector - despite temporary problems with our estate's energy infrastructure. Further strong improvement is expected in the year to come due to more interventions being made. A list of the above technical interventions made is available on request
- Our vision for our future development projects in relation to innovation around the creation of sustainable healing environments

Conclusion

Significant progress – building on past achievements - has been made in 2018/19 in regard to GOSH's impact, reach and outlook around 'environmental' sustainability. However we are at a cross roads and have the choice to forge a path – vividly depicting the health and environmental co-benefits of action - for the wider sector and society to follow. This will involve agreement at the next Trust Board meeting for challenging SDMP targets as well as prioritising the agenda internally and when wider external advocacy and leadership opportunities arise (as with the Clean Air Hospital Framework).

Modest and more substantial spend to save opportunities – that can be clearly detailed through the business case process - in regard to current and future infrastructure as well as behaviour and organisational culture programmes should be considered as part of better value and then as business as usual.

Sustainability at GOSH

We continue to develop our spaces to provide a holistic therapeutic environment supporting our patients, families and staff. Our priorities not only include the design and provision of clinical spaces but also support services which contribute to the overall hospital experience and a consideration of the wider environment.

Having been a founding supporter of National Clean Air Day we have taken the next step to delivering solutions that will improve air quality by launching the world's first Clean Air Hospital Framework (CAHF) for use across the health sector. We're also in the process of updating our overarching Sustainable Development Management Plan (SDMP) with the latest guidance from NHSI so that GOSH can deeply integrate sustainability into our culture, practice and training. However our holistic vision doesn't stop there and includes a focus on reaching outwards through sharing practice and partnering with others, linking with academic institutions to study topics including climate adaptation, designing research projects or running community activities we intend to test the boundaries of what's possible and our influence in this crucial arena.

This approach is supported not only by our Board and staff but by our children and young people, reminding us of our guiding principle of 'The Child First and Always.'

Who's accountable?

Progress against our SDMP and Clean Air Hospital Framework is reported to our Executive Management and Operational teams and will be to the Trust Board on an ongoing basis. Active support for this agenda is being harnessed within clinical teams, through our Green Champions network, contractors, external partners and patient's through our YPF and Play Services.

Our context

Using information & data

We intend over 2019/20 to expand our information gathering with relevant stakeholders in order to plan and deliver our sustainability ambitions through our SDMP.

This year GOSH developed a travel plan that committed us – over the next 5 years - to all but eradicate staff commuting in cars with a 1% reduction and staff underground use by 5% in favour of walking and cycling. We'll reduce single occupancy visitor car use by 6% and increase public transport use in its favour. A new yearly staff survey will measure this.

Travel Data

Travel undertaken

All travel is shown in miles.

	2015-16	2016-17	2017-18	2018-19
Patient and visitor travel	0	0	0	578,408
Business travel and fleet	0	0	0	488,419
Staff commute	0	0	0	0
Total	0	0	0	1,066,827

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Carbon emissions resulting



	2015-16	2016-17	2017-18	2018-19
Business Mileage - Road	0	0	0	0
Business Mileage - Rail	0	0	0	14.6
Business Mileage - Air	0	0	0	111
Patient and visitor travel	0	0	0	213
Staff commute	0	0	0	0
Total	0	0	0	339

The development and ongoing delivery of our Clean Air Hospital Framework involves regular dialogue with stakeholders including our Young People’s Forum, Executive Management Team and Boards as well as local community. For example – beyond face to face contact through staff – we’ll use our patient bedside displays to engage with patients about air pollution and wider sustainability.

We will enhance the existing process, analysis and use of data around utilities consumption and will begin to use our imminent supply of air quality data to inform decisions and messaging where possible.

Stakeholder engagement

To successfully deliver our ambitious sustainability agenda we’ll enhance existing relationships with partners. GOSH teams and leadership, green champions network, volunteers, patients and families, contractors, health sector and academic peers, Camden Council, NHS bodies, specialist businesses and third sector organisations, our local community and central government are all key to this.

Barriers and challenges to overcome

Ever increasing energy demands and costs mean the need to continue broadening our scrutiny of energy procurement, energy efficiency investment opportunities and renewable energy innovations.

Poor local air quality in our central London location presents a challenge and opportunity to work collaboratively on improvements to protect our staff, patients and local community.

An unstable national waste processing market continues to highlight vulnerability across NHS Trusts, necessitating an increased need for collaboration around innovation and security.

Development of our staff Green Champions and the creation of a young person's programme will be important for the success of our sustainability agenda over the years ahead. Increasing reach and relevance will enhance the effectiveness of this important driver of the change we are planning.

Taking further ownership of our Scope 3 (indirect) emission around procurement is an important challenge and opportunity for the year ahead.

Embedding these into our SDMP and connections to the UN Sustainable Development Goals gives us the framework to progress and lead the sustainability agenda.

Structure

The backbone for demonstrating our progress is our SDMP and CAHF (Clean Air Hospital Framework) reporting into Trust EMT and Board. That it's delivered in concert with staff and young people is key to its integrity.

We support programmes locally and beyond including the London Borough of Camden Clean Air Action Plan which we are named as leaders within, the London Mayor's Breathe London Project, Camden 2025 commitments, National Clean Air Day and NHS Sustainability Day.

Further integration

We'll further integrate sustainability organisationally through continuation of the 'Gloves are off', which this year has produced a staggering reduction of 2.1 million plastic gloves purchased (& associated environmental impacts) from last year.

We'll investigate delivering - and propose a business case - a Green Wards Competition supporting staff identification of everyday process efficiencies that result in environmental and financial savings.

We'll do the same for activity around optimisation of energy use in theatres, a specific Green Nephrology programme and delivering a Trust wide 'green' communications strategy.

The Clean Air Hospital Framework (CAHF)

This year GOSH staff worked with environmental charity Global Action Plan (GAP) to develop the Clean Air Hospital Framework. The World Health Organisation (WHO) and UK Government recognise air pollution as the largest environmental health risk we face. It causes heart and lung diseases, is linked to mental health issues, low birth weight and effects on children’s lung development. Yearly it’s estimated to cause 36,000 deaths in the UK.

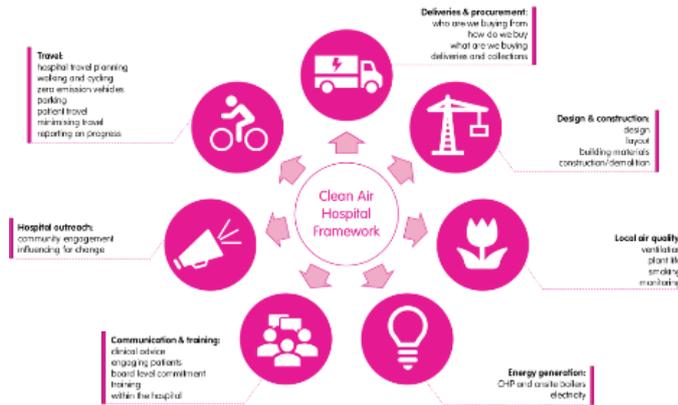
Action in hospital is particularly important as pollution worsens existing patients’ lives. The CAHF is a free resource conveying the vision of a clean air hospital & steps to achieving it, methods to reduce pollution hospitals create and messages to help people protect their health. Hospitals are able to self-assess their progress against 7 elements, develop an action plan to benefit the health of staff, patients, visitors and the local community, assign ownership and track/report progress including their ability to mobilise others.



It’s development involved workshops across the Trust, including our Young Person’s Forum, contractors and external stakeholders including the WHO, NHS Improvement and NHS England, the NHS SDU, Royal College of Physicians, Royal College of Paediatrics and Child Health and London Borough of Camden.

Trust teams and external partners are organising a GOSH clean air play street locally and with a specialist partner we’re designing research around home indoor air quality impacts on patient health. We’ve just installed outdoor monitoring equipment on Great Ormond Street through the Mayor’s Breath London project and are about to trial indoor air monitors and purifiers in some communal areas.

The CAHF focusses on 7 key areas and uses a points system. GOSH’s baseline score in February was 158 points -rated as a hospital that is ‘starting out’ – and we are targeting 540 points, rated as ‘Good’ within 18 months.

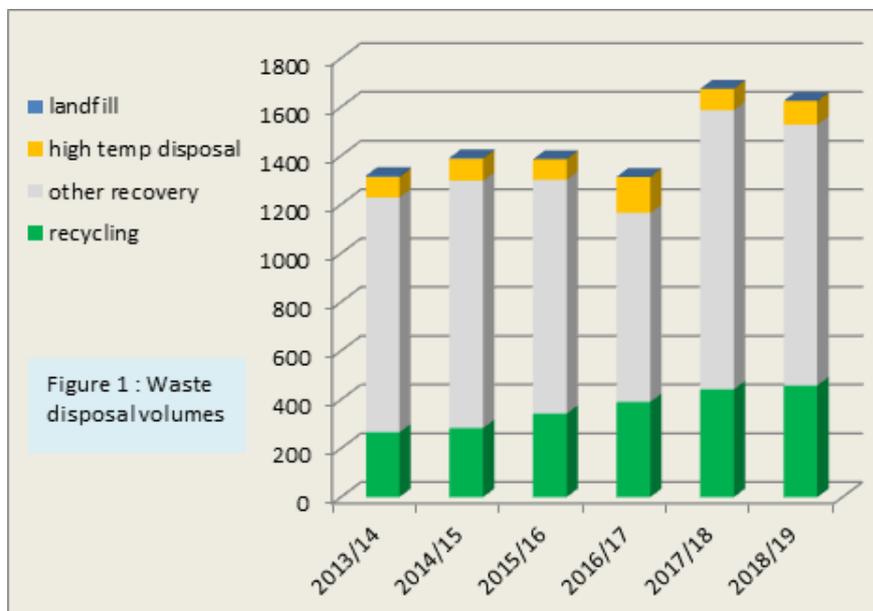


Waste minimisation and management and the GOSH Green Champions:

A successful year for the Green Champions, who’ve implemented initiatives to reduce, reuse & recycle bulk waste including an innovative online platform to redistribute it. Items suitable for reuse are offered to staff, supporting GOSH’s ‘Zero Waste’ strategy and budget savings through unnecessary new purchases. Remaining items are passed to Charity & Social Enterprises for reuse or to assist fundraising for their core work.

We’re also working with upholsterer upgrading existing furniture and furnishings – 5 discrete projects completed so far - to ‘as new’ standard for 40% of normal purchasing costs. The Champions were presented with a Green Apple environmental best practice award for our furniture restoration process at the Houses of Parliament.

Last year 1,625 tonnes of waste was produced in the Trust, an increase of 9%. Figure 1 shows the volume of wastes and destinations. Recycling continues to rise this year with an increase of approximately 42%. Waste sent to landfill is slightly up this year at just over 1 tonne, due to an overall increase in waste produced. It is still our aim to achieve ‘zero waste sent to landfill’ we continue to work towards this target.



	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Recycling	265.8	283.02	342.03	390.02	442.67	458.46
Other recovery	963.4	1014.2	958.95	774.93	1144.07	1068.97
High temp disposal	83.52	91.29	84.39	147.98	87.71	96.94
Landfill	6.03	2.88	0.99	0.99	0.99	1.36

In a challenging year in the clinical waste industry threatening service resilience GOSH is working with partners identifying clinical, hazardous and sharps waste innovation opportunities.

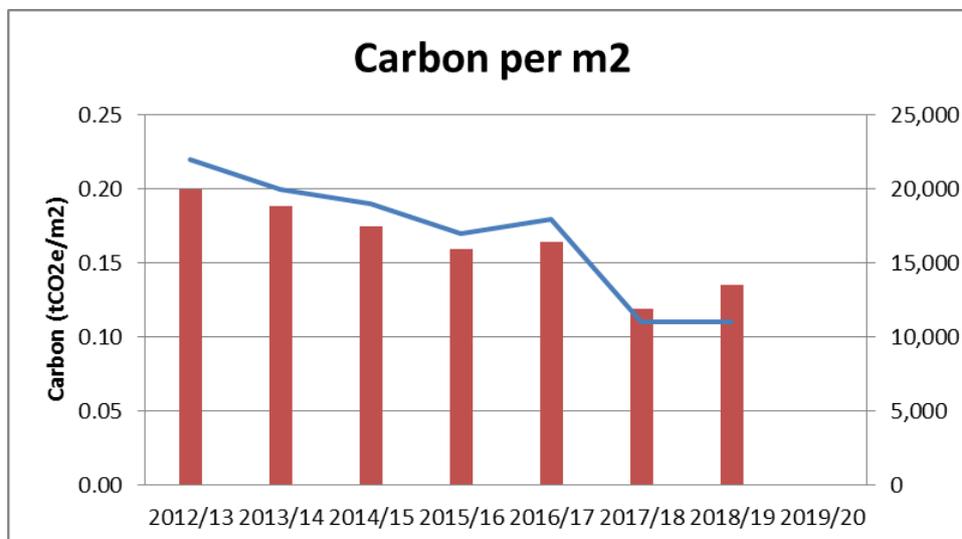
Co2 emissions

Our environmental impact is proportionate to staff numbers and building floor space. The table shows floor space - relatively unchanged for four years - increased by 14,045.67 m2, due to the Premier Inn Clinical Building (PICB) opening last year and staff numbers have risen to 5026.

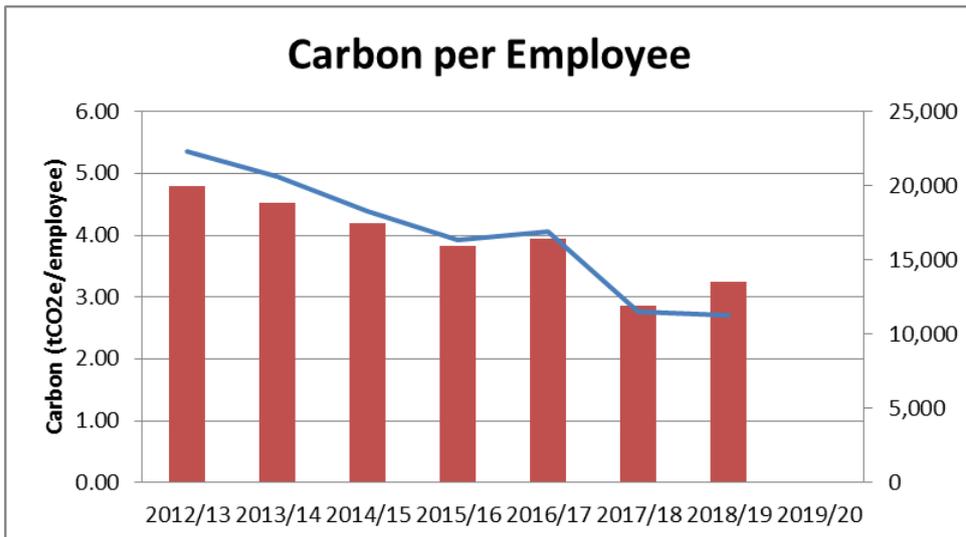
Context Info	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Direct Emissions (tCO2e)	19,947	18,836	17,448	15,950	16,468	11,893	13,547
Floor Space (m2)	92,199	92,125	93,752	92,501	92,501	111,913	125,959
Total number of staff (headcount)	3731	3900	4082	4123	4436	4787	5026

Direct emissions, total staff members and floor space

This data has been used to normalise direct emissions and compare against our 34% reduction target by 2019/20. Below shows that we retain an on-target profile despite estate changes. The organisation is normalised by floor space and slightly better when normalised by employee number. The percentage tCO2e change for each year is shown in the corresponding bar below.



Normalised direct emissions - tCO2e by m2 (LHS), line shows reduction glide path



Normalised direct emissions - tCO2e by employee, line shows reduction glide path

The increase in normalised carbon emissions is due to opening PICB, the high ambient temperatures last summer and need to use a large number of portable air conditioning units alongside a significant reduction in electrical output from the combined heat and power plant (CHP) against its full potential. This was due to electrical infrastructure issues requiring significant CHP downtime across a 6 month period (from September to February) leading to grid electricity imports and therefore greater carbon emissions and cost.

The remainder of this report uses figures that have been compared directly to the previous years, with no normalisation for floor area or staff numbers, so the year-on-year changes can be more clearly seen.

Energy use

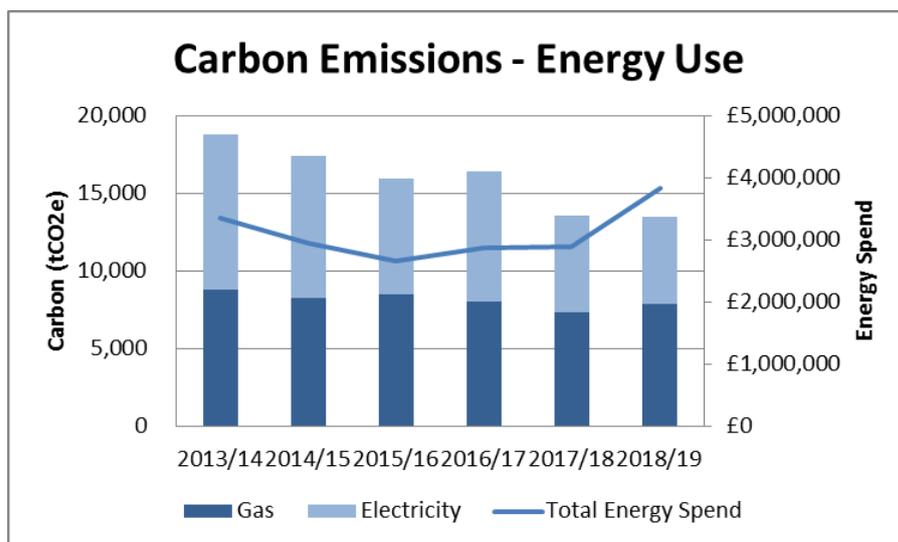
This looks at carbon emissions from energy, total energy spend and a view of energy type used. The biggest change to Trust usage profile is the CHP engine installation at the end of 2011 which significantly changed the proportions of gas and electricity used by the Trust. In 2018/19 the engine generated 39% of electricity requirements but consumed natural gas to achieve this.

Below shows we spent £3,847,204, an Increase from the previous year. This is due to PICB using more electricity due to it becoming fully functional in 2018/19 compared to 17/18 but predominately due to the 6 month CHP downtime. This meant relying on higher cost grid energy and therefore higher utility costs than expected. Additionally before final decommissioning our Enpod energy centre was also offline for 4 months adding to

As a result we experienced a significant reduction in onsite electricity generation – down from 10,643 Mwh to 7,746 Mwh - replaced by grid electricity and increase in gas use. We were also unable to realise the benefit of the CHP and the loss in heat generation from it, typically used to run our chillers. This and the high ambient summer temperatures resulted in using further expensive grid electricity.

With the CHP back online and decommissioning of Enpod an increase in electrical power and decrease in gas volume should normalise our energy use going forward. On top of this a 2nd CHP has

been commissioned which will further add to this performance in the year ahead. Operation and maintenance costs for the CHP engine are still incurred while it's offline.



Resource		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Gas	Use (kWh)	41,492,485	39,444,385	40,657,465	38,603,045	39,587,133	42,929,340
	tCO2e	8,802	8,276	8,530	8,068	7,335	7,897
Electricity	Use (kWh)	27,649,236	25,675,114	24,828,164	27,087,839	22,042,240	19,961,112
	tCO2e	9,993	9,172	7,441	8,400	6,262	5,650
Total energy tCO2e		18,795	17,448	15,971	16,468	13,957	13,547
Energy Spend		£3,360,678	£2,952,472	£2,663,725	£2,881,300	£2,900,919	£3,847,204

Last year 7,746 Mwh of electricity was generated from the CHP engine, equivalent to 39% of our total site electricity usage compared to 48% the year before. The site did consume all the generated electricity - reducing carbon emissions from the use of grid power – but to a far lesser extent than projected due to the CHP outage.

Generated electricity from the CHP is shown below. It produced significantly less electricity than last year due to the 6 month outage period – 7,746Mwh compared to 10,643Mwh - compared to only 2 months outage last year. Output of 10,500- 12,000 MWh per year depending on performance and maintenance requirements is expected. In March 2019 we've installed a second CHP which will further reduce energy costs next year.

Our 37kWp of photovoltaic cells are now functioning to capacity since the removal of shading caused by VCB chiller scaffolding.

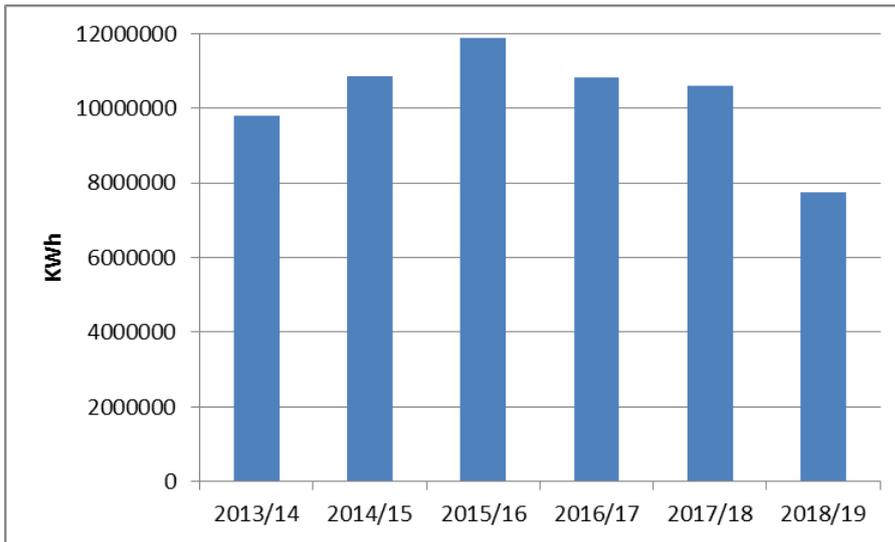


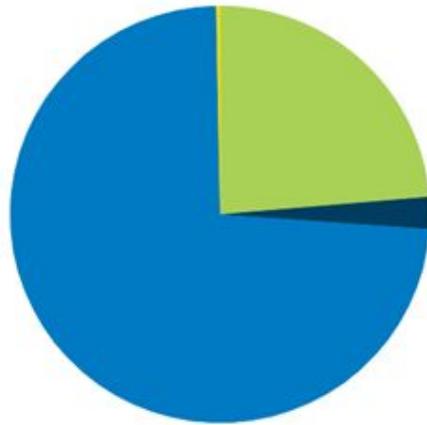
Table to follow: Electricity Generated from CHP

Whole Trust modelled CO2 emissions

These graphics give a picture of the Trusts overall CO2 footprint and breakdown into sections. This is an evolving piece of work.

Modelled Carbon Footprint

The information provided in the previous sections of this sustainability report uses the ERIC returns as its data source. However, we are aware that this does not reflect our entire carbon footprint. Therefore, the following information estimates the impact of our supply chain from our spend. More information available here: <http://www.sduhealth.org.uk/policy-strategy/reporting/nhs-carbon-footprint.aspx>



The values in the table below are percentages.

	2018-19
Core emissions	23.7
Commissioning	2.47
Procurement	73.6
Community	0.3
Total	100

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SDU whole organisation carbon profile

Calculated from operating expenditure of £453,600,000 of which £184,900,000 is non-pay spend based on typical values for an Acute Trust organisation.

CO₂ Emissions (tCO₂e)

	2015-16	2016-17	2017-18	2018-19
Patient and visitor travel	0	0	0	213
Staff commute	0	0	0	0
Business services	0	0	0	7,701
Capital spending	0	0	0	670
Construction	0	0	0	2,688
Food and catering	0	0	0	5,636
Freight transport	0	0	0	2,976
Information and communication technologies	0	0	0	1,184
Manufactured fuels, chemicals and gases	0	0	0	3,172
Medical instruments / equipment	0	0	0	16,455
Other manufactured goods	0	0	0	2,722
Paper products	0	0	0	2,237
Pharmaceuticals	0	0	0	6,506
Coal	0	0	0	0
Electricity (net of any exports)	14,274	13,999	9,825	7,041
Gas	8,509	8,068	8,393	9,118
Oil	0	0	3.99	105
Thermal energy (net of any exports)	0	0	0	0
Leased Assets Energy Use (Upstream - Gas, Coal & Electricity)	0	0	0	0
Business travel and fleet	0	0	0	126
Anaesthetic Gases	0	0	0	165
Waste and Water	133	237	136	145
Commissioning	0	0	0	1,747
Total	22,916	22,304	18,357	70,606

Sustainable Development Management Plan (SDMP)

Our new SDMP is near completion and will form the basis of our reporting structure for 2019/20 and beyond. Actions to progress it are based on the 3 factors of Environmental, Social and Financial impact which are contained under 10 areas of focus. These include our Corporate Approach, Asset Management & Utilities, Travel & Logistics, Adaptation (to future climatic conditions), Capital projects, Green Space & Biodiversity, Sustainable Care Models, Our People, Sustainable use of Resources and Carbon & Greenhouse Gases.

We'll consider each in relation to 4 cross cutting themes – our governance & policy, GOSH's core responsibilities, our procurement & supply chain and working with our patient's, staff and local communities.

Creating healing environments

Working with UCL Centre for Resource Efficiency and the Environment we were the industry partner for 5 Masters Level Environmental Engineering and Science students. Their focus is, *"Climate change pressures on the built environment in the UK: Implications for well-being of sick children and mitigation strategies for the Great Ormond Street Hospital"*. This resulted in individual technical reports based on the design of our proposed Children's Cancer Centre development. These covered internal air quality, ventilation, building envelope, water harvesting and indoor temperature control.

The students then combined these into a joint report helping to guide our thinking on climate change adaptation for future new developments. We're also investigating research opportunities around the benefits from increased access to natural light and virtual reality experiences in wards.

Trust Board 22 May 2019	
Guardian of Safe Working report	Paper No: Attachment R
Submitted by: Dr Renée McCulloch, Guardian of Safe Working Presented by: Sanjiv Sharma, Medical Director	
Aims / summary This report is the fourth quarter report to the Board regarding Junior Doctor working practice at GOSH. This report covers the period 1 st January to 31 st March 2019 inclusive.	
Action required from the meeting The board is asked to note the report and the issues influencing junior doctor's working, the challenges in monitoring compliance with the TCS 2016 and the achievements to date.	
Contribution to the delivery of NHS Foundation Trust strategies and plans The Guardian of Safe Working supports and enables a safe and positive working and learning environment for junior doctors. This contributes to the Trusts strategic objective relating to providing safe patient care and an excellent place to work and learn.	
Financial implications Continuing payment for overtime hours documented through the exception reporting practice.	
Who needs to be told about any decision? n/a	
Who is responsible for implementing the proposals / project and anticipated timescales? Dr Renee McCulloch, Guardian of Safe Working Mr Simon Blackman and Dr Jonathan Smith, Acting Deputy Medical Directors for Medical & Dental Education	
Who is accountable for the implementation of the proposal / project? Dr Sanjiv Sharma, Medical Director	

**Trust Board Report
Guardian of Safe Working
Fourth Quarter: 1st January – 31st March 2019**

1. Purpose

To inform the board on issues arising relating to the junior doctors working at GOSH and the work of the Guardian of Safe Working (GOSW). The GOSW is directly accountable to the Trust Board.

2. Background: See Appendix 1

3. Headlines:

3.2. Despite all encouragement there is still a culture of poor exception reporting at GOSH. The numbers of exception reports are exceptionally low this quarter: dropped from 50 (q3) to 13 (q4).

3.3. GOSH exception reporting levels are trending lower than most other Trusts however we have a different workforce as discussed in previous reports.

3.4. Exception reports usually come from specific individuals (all ERs this quarter are from three doctors – all are Trust doctors).

3.5. Exception reports do reflect 'hot spots' and give us valuable information:

3.5.1. IPP has been understaffed and one Fellow has submitted all reports. We are now approaching recruitment from a different angle.

3.5.2. There is one heart failure fellow and a high volume of patients. A business case for another Fellow cannot be supported due to block contract payments. Consultants have supported a differing approach to cardiac echo requests which may reduce work flow.

3.6. GOSH vacancy rate is lower than average (approx. 10 % vs. 17%) but still has a significant impact when there are consistent rota gaps in specific specialties.

3.7. Rest facilities have improved with the opening of Penguin ward. There are 14 beds; usage is being monitored for future planning.

3.8. The JD 24/7 task force is on track to deliver in June:

3.8.1. Full rota review

3.8.1.1.1. What doctors do we have in post? Who is contributing to out of hours working?

3.8.1.1.2. Questionnaire to staff re: current rota establishment and access to training and issues pertinent to the Junior Doctors

3.8.1.1.3. Understanding minimal medical staffing levels

3.8.1.1.4. Audit of tasks and work assigned to OOH working on MEGGA

3.8.1.1.5. Review of all staffing between 6 and 9.

3.8.1.2. Remodelling of the MEGGA rota.

3.8.1.3. Handover – getting the basics right

3.8.1.4. Assessing barriers to and improving access to education and training opportunities at GOSH

3.8.2. Meeting the requirement of the BMA facilities charter as appropriate

3.8.3. Developing an escalation and management plan for junior doctor medical workforce risk

3.8.4. How have we grown? – Internal benchmarking

3.8.5. How do we compare to others? - External benchmarking.

4. High Level Data

4.2. GOSH Junior Doctor Rotas

4.2.1. Number of Trust Doctors as of 31 March 2019 = 133
Number of Training Doctors as of 31st March 2019 = 173

4.2.2. The **overall vacancy rate** across junior doctor rotas as of 31/03/2019 **10.10% with 29.9 FTE** vacant out of a total of 296 rota slots

4.3. As of the 31st December 2018 the following junior doctor posts were vacant:

Specialty	Rota grade	Rota establishment	Vacant posts	Vacancy rate %
Anaesthetics	SpR	29	3	10.3%
Cardiology	SpR	10	1	10%
Cardiothoracic	SpR	8	1	12.5%
CICU	SpR	16	2	12.5%
ECMO	SpR	10	2	20%
Haem/Onc	SpR	12	2	16.6%
Haem Labs	SpR	7	3	42.6%
IPP	SpR	11	4.4	40%
ICON	SpR	8	1	12.5%
Neurosurgery	SpR	7	1	14.2%
Palliative Care	SpR	3	0.5	16.6%
PICU/NICU	SpR	21	2	9.5%
Gastro	SpR	7	2	28.6%
Gastro	SHO	3	1	33.3%
Metabolic	SpR	5	1	20%
Metabolic	SHO	2	1	50%
Endo	SHO	3	1	33.3%
Plastics	SHO	3	1	33.3%

5. Bank and Agency Spend 1 Jan to 31 March 2019

Specialty	Number of Shifts	Cost
CATS	35	£21,273.13
CICU	41	£26,855.54
Haematology/Oncology	195	£84,275.89
MEGGA	328	£99,378.92
Neurology	82	£32,682.57
NeuroResp Nights	16	£10,357.94
Neurosurgery	14	£6,097.50
NICU PICU ICON	17	£11,025.84
Ortho Spinal SpRs	27	£7,098.50
Plastic Surgery	8	£2,418.00
Respiratory Medicine	60	£18,785.30
Surgery SHOs	255	£91,052.91
Surgery SpRs	17	£10,525.75
Grand Total	1095	£421,827.79

6. Exception Reports

6.2. Number of Exception Reports Fourth Quarter 2018

Exception Reports January to March 2019 inclusive						
Number of ERs:	13		Number closed:	5		
Details by Specialty, Grade and Reason						
Specialty	Rota grade		ERs: hours	ERs: missed educational opportunities	ERs: Missed breaks	Service
	SHO	SpR / Fellow				
Endocrine		1	1		(1)	
Cardiology		4	4			
IPP		8	8			
Total		13	13		(1)	

6.3. Exception Report Outcomes:

Exception Report Outcomes (Per Episode- some have >1 outcome) October to December 2018 incl.					
Compensation with payment	TOIL	Work schedule review	Further information	Pending ES meeting	Level 1 review
5	0	8 (with GOSW)	-		

6.4. Exception Report Themes:

- Rota gaps
- High work flow & volume (arriving early and staying late to complete clinical duties)

7. Compliance with 2016 TCS

7.2. As far as current data sets allow, GOSH is compliant with the 2016 TCS

8. Fines and Payments

8.2. No fines have been levied by GOSW at GOSH. Fines would only apply for the doctors on the 2016 TCS on formal training programs. There is no automated system for checking breaches and doctors must raise concerns regarding their breaching their hours within the ER system. This has not yet occurred at GOSH.

8.3. Financial compensation has been paid to the majority of doctors submitting an ERs. Time off in lieu is often unachievable particularly if a rota is short staffed.

9. Junior Doctors' Forum

Regular monthly meetings are occurring. They are generally poorly attended but dialogue is often constructive. We are about to change the timing again to see if this improves attendance.

10. Summary

10.2. The MEGGA rota has been highlighted as a potential safety risk and action is being taken remodel the rota.

10.3. Appropriate rest facilities are now in place for junior doctors..

10.4. In the absence of any firm evidence to the contrary, GOSH is currently compliant with the 2016 TCS. However GoSW is aware that incidents of non-compliance are not always adequately reported through ER system. Rota gaps will adversely affect compliance and safety of junior doctor staffing in addition to access to education and training opportunities.

10.5. Modernising of the GOSH junior doctor working experience is underway. Addressing the multiple challenges of the paediatric medical workforce, is now part of a wider workforce strategy.

10.6. The Junior Doctor Forum would like to invite the Board members to join the meetings and be actively involved in discussing the role of the junior doctors at GOSH.

Appendix 1 Background Information

In 2nd October 2017 all junior doctors in training transferred to the new contract with 2016 Terms & Conditions (TCS).

The 2016 TCS clearly indicate the importance of appropriate working hours and attendance at training and education for junior doctors. Both issues have a direct effect on the quality and safety of patient care.

The statutory role of 'Guardian of Safe Working' (GOSW) was introduced in the 2016 and includes;

- overseeing the safeguards outlined in the 2016 contract
- ensuring that issues of compliance with safe working hours are addressed by the doctors and/or the employer
- facilitating the reporting structures
- overseeing the wellbeing of the junior doctors
- a requirement to provide quarterly reports to Trust board.

Exception reporting is the contractually mandated mechanism used by doctors to inform the Trust when their day-to-day work varies significantly and/or regularly from the agreed work schedule of their post. The purpose of exception reports is to ensure prompt resolution and / or remedial action to ensure that safe working hours are maintained.

Exception reports are submitted electronically by doctors to their educational supervisor. Upon receipt of an exception report, the educational supervisor will discuss with the doctor what action is necessary to address the reported variation or concern. The outcome of an exception report may be compensation, in the form of time off in lieu or payment for additional hours worked, or an adjustment to the work schedule of the post.

Whilst exception reporting is a mechanism of the 2016 contract for doctors in training, GOSH has elected to extend the use of the system to doctors employed under local (non-training) TCS, in order to encourage safe working practices for all doctors, provide equity and obtain a more comprehensive view of junior doctors working hours across the Trust.

The 2016 contract requires that a Junior Doctors Forum (JDF) is established in every Trust. The JDF primarily represent trainees and offers a forum for addressing concerns pertaining to working hours and conditions and education and training. This is in place and meets every month.

There are 45 different rota patterns currently in place within the Trust. All are compliant with 2016 TCS.

The Trust uses 'Allocate' software for rota design and exception reporting. There have been issues with navigation of software and consistency of use (wide range of inputs for the same exception reports). There are no automated ways to identifying breaches. This must be done manually. Allocate have improvement updates due in 2019 to include:

- Ability to close exception when trainee fails to respond
- Guardian quarterly board report
- Simplify the adding of overtime hours
- Process for tracking time of in lieu and overtime payments
- Allow supervisor and Guardian role for the same user
- Standardised themes for breach types

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**Summary of the meeting of the Audit Committee
Held on 9th April 2019**

Finance and Investment Committee

It was noted that all Committee members had been present at the Finance and Investment Committee meeting. The content of the report was noted.

Quality and Safety Assurance Committee –January 2019 Draft Minutes

It was noted that one Non-Executive Director who sat on both the QSEAC and Audit Committee had now stepped down from the QSEAC. It was confirmed that the Company Secretary, Chief Executive and the Committee Chairs meeting would ensure that no matters fell between committees.

Board Assurance Framework Update including update from the Risk Assurance and Compliance Group (RACG)

Discussion had taken place at RACG around reducing the likelihood score of the EPR BAF risk and the Committee agreed that the risk should not be reduced in advance of go-live. It was agreed that the profile of the risk was changing and that this should be anticipated in the BAF so a revised risk would be considered at the next meeting. The Committee discussed the Better Value risk which listed the impact as 'minor'. In light of the importance of meeting an extremely challenging Better Value target the committee asked that this was reviewed along with the medicines management risk which was scored 'high' with a low risk appetite.

Presentation of high level risks

- Risk 11: The trust is unable to deliver normal services and critical functions during periods of significant disruption. (to reference plans for Brexit)

The Trust had previously been rated amber by NHS England but had completed the outstanding actions and was now likely to be rated green. Weekly meetings of the Brexit Steering Group were continuing and GOSH had agreed to work with other Trust's in the event of a no deal Brexit. An email address was available for patients and families who had concerns about the availability of medications however only a very small number of queries were being received per week.

Discussions took place around the importance of undertaking live fire evacuations and the emergency planning had been asked to consider how this could be done.

- Risk 12: Inadequate planning or management of infrastructure redevelopment may result in poor VFM or failure to deliver expected business benefit.

Robust tender processes were in place through the use of the OJEU process and ProCure22 NHS Procurement Framework and the support of specialist advisors. The Committee agreed that it was important to develop a process to effectively review projects post implementations at an oversight level which was currently not in place.

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- Risk 13: Personal and sensitive personal data is not effectively collected, stored, appropriately shared or made accessible in line with statutory and regulatory requirements

A number of information governance breaches had taken place over the past year which, although fully investigated and not upheld by the ICO, it was vital that the Trust was aware. Work was taking place to publicise the issue among staff and learn from external and internal breaches.

Electronic Patient Record Update

The Committee received an overview of the work which had taken place to mitigate as far as possible the remaining risks to go live. An issue with Wi-Fi had been mitigated by providing wired equipment and the team was confident that hardware would be in place in time for go-live. The finance team was working on test scenarios particularly around provider to provider billing which was a risk. The Committee agreed to support application of the proposed go-live criteria and hold a teleconference prior to the point of go live to answer any additional questions.

Data Quality Update

Good progress had been made in improving data quality and post EPR go-live there would be further improvement. Kitemarking had been paused until post go-live and it was confirmed that this would be reflected in the annual governance statement.

Year End Update 2018/19

Discussion took place around valuing Epic and Aridhia and the Trust had contracted with an external firm to provide support. The External Auditors confirmed that the platforms must be assessed within the accounting rules and taking into account time and usage. Once the programme was live, associated costs could no longer be capitalised.

External Auditors reported that GOSH was the most prudent of their clients in terms of provisioning policies but confirmed that provisions were within a materially acceptable range.

Counter Fraud Annual Report March 2019, annual self review toolkit (SRT) and Counter Fraud Workplan 2019/20

The Trust had been rated amber on its counter fraud self-assessment as fraud was not a risk on the Board Assurance Framework. The plan for 2019/20 was presented which took into consideration GOSH's three amber rated areas and reviewed responses to counterfraud questionnaires.

External Audit: Interim update report to the Audit Committee for the year ended 31 March 2019

Work was progressing in line with plan and work had begun to validate the metrics in the Quality Report. In light of Epic coming into use it was likely that this would be escalated to a significant risk due to the complexity and the use of an external expert and the External Auditors were required to review the judgements made.

Internal Audit Progress Report, Technical Update and Draft Head of Internal Audit Opinion for 2018-19

The Committee expressed concern that actions related to the contract management recommendations had been removed from the tracker prior to implementation. It was confirmed that the actions had been partially completed and the removal had been promptly picked up and rectified.

Four reports had been completed since the previous meeting: financial controls, contract management, budget reporting and facilities management, all of which had received significant

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assurance with minor improvement potential with the exception of contract management which had received a rating of partial assurance with improvements required.

Internal audit recommendations – update on progress

Two recommendations related to theatres had been delayed due to EPR. The Committee emphasised the importance of ensuring that future recommendations did not become overdue.

Internal Audit Strategic and Operational Plan: 2019-20

The Committee approved the 2019/20 plan.

Better Value Programme Update

The Committee emphasised the importance of having a realistic risk adjusted better value total to ensure that the programme did not slip towards the end of the year.

Whistle blowing Update

One case remained open. The whistleblower had been dissatisfied with the outcome of the internal review and it had been referred to the RCPCH. The Committee emphasised the importance of ensuring staff were aware of the whistleblowing process.

Draft Annual Governance Statement 2018/19

The Committee was satisfied with the six principle risks reported and agreed to send any comments outside the meeting.

Update on Procurement Waivers

A reduction in the number of waivers was due to the completion of commissioning equipment for the Zayed Centre for Research.

Write Offs

It was confirmed that a new process had been introduced which meant that payment was taken in advance of treatment being given to overseas visitors and that this reduced the risk of bad debt from overseas visitors.

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**Summary of the meeting of the Quality, Safety and Experience Assurance Committee
Held on 4th April 2019**

Overview and Emerging clinical and risk issues – to focus the committee’s attention on the areas under its remit of most concern

The Committee received an update on Epic Go-live, Brexit preparedness and activity planning as well as working taking place to ensure that all Better Value schemes for 2019/20 had been quality assessed.

Integrated Quality and Performance Report

All red rated areas of performance had action plans for improvement in place and in many cases these were related to the capabilities of Epic. It was noted that due to the reduction in activity over the Epic go-live period, there was a strong possibility that the Trust would become non-compliant with the Referral to Treatment Target of 92% and it had been agreed that GOSH would return to compliance by the end of 2019/20.

Benchmarking in Infection Prevention and Control

It was reported that national benchmarking was conducted using metrics such as those which were mandated for reporting for all bloodstream infections and that these could be compared in real time. The national data for paediatric benchmarking were not felt to be appropriate and a meeting was scheduled with other paediatric Trusts in May to consider how benchmarking could be improved. The committee asked to revisit this in 6-12 months’ time.

Update on transition

A framework of ‘growing up and gaining independence’ had been developed and work was taking place to embed this across the Trust. The NHS Long Term Plan indicated that the age for transition for some services would be raised to 25 by 2028.

Internal Audit Progress Report (January 2019 – March 2019)

The Draft Head of Internal Audit Opinion provided a rating of ‘significant assurance with minor improvement potential’. The Committee received an audit report on theatres which provided a rating of significant assurance with minor improvement potential.

Internal Audit Strategic Operational Plan 2019-20

The Committee noted the draft internal audit plan for 2019-20.

Internal and external audit recommendations update

Progress had been made with completing outstanding recommendations related to workforce planning. Recommendations were also being monitored by the Risk Assurance and Compliance Group.

Update on issues arising from patient stories at Board

Epic would be positive in terms of ensuring that reasonable adjustments required for parents were highlighted to staff. A lot of information was available for families but it was vital that this was

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accessible. Work was taking place to review the accommodation policy and a working group had been formed to consider some issues related to accommodation.

Draft Trust Quality Priorities 2019/20

The Trust's Quality Priorities were presented with a focus on culture. Areas for improvement were based on the 2018 CQC report and staff survey.

Draft Quality, Safety and Experience Assurance Committee Annual Report 2018/19

The draft Quality, Safety and Experience Assurance Committee annual report for 2018/19 was presented and the committee was asked to provide comments to the Company Secretary.

Board Assurance Framework Update

The Committee considered the following high level risks:

- Risk 14: Medicines are not managed in line with statutory and regulatory guidance (procuring, storing, prescribing, manufacturing and giving of medicines (including self-administration)) and that processes are not appropriately documented or monitored.

There are likely to be national workforce difficulties around pharmacists and it was vital that GOSH was an attractive organisation to undertaken training and work in. The Committee discussed medication errors and the support that EPR would provide around standardised doses. Pharmacy space and workflow was a risk and was being kept under regular review.

- Risk 15: All services are not appropriately managed or governed or are not of the appropriate standing to deliver quality services within a complex, specialist health environment

The Committee noted the responses which had been provided to the Non-Executive Directors' questions.

Whistle blowing update - Quality related cases

There was one on-going open case and no new cases within the reporting period.

Freedom to Speak Up Guardian Update

The Committee discussed the open cases and the ways in which they had been escalated and the committee emphasised the importance of ensuring that staff felt confident in speaking up, particularly with the introduction of Cognitive.

Health and Safety Update

Two RIDDORS (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) had been reported in the period, both of which had been investigated. Discussion took place around one of the incidents and it was agreed that the Chief Executive would visit the workspace to review the safety arrangements. It was noted that two key health and safety roles were proving challenging to recruit and it was agreed that the Director of HR and OD would provide support.

Getting It Right First Time (GIRFT) Update

It was agreed that action plans would be provided to the committee in the future and the importance of a sense of ownership of the work was emphasised.

Trust Board	
22 May 2019	
Finance and Investment Committee Update – May 2019	Paper No: Attachment 7
Submitted by: James Hatchley – Chair of the Finance and Investment Committee Helen Jameson – Chief Finance Officer Paul Balson – Deputy Company Secretary	
Aims / summary This report formally documents the Finance and Investment Committee’s (FIC) work since its last written report to the Trust Board on 9 April 2019. The FIC held a formal meeting on 25 March 2019 and the Chair provided a verbal update of key issues from this meeting to the 9 April 2019 Trust Board meeting.	
Action required from the meeting Board members are asked to note the key issues highlighted by the Committee, note the rest of the report, and pursue any points of clarification or interest.	
Contribution to the delivery of NHS Foundation Trust strategies and plans The Finance and Investment Committee reports on financial strategy and planning, financial policy, investment and treasury matters and reviewing and recommending for approval major financial transactions. The Committee also maintains an oversight of the Trust’s financial position, and relevant activity data and productivity metrics.	
Financial implications None.	
Who needs to be told about any decision? N/a	
Who is responsible for implementing the proposals / project and anticipated timescales? N/a	
Who is accountable for the implementation of the proposal / project? N/a	

Key issues for the Trust Board's attention

- The Trust ended Month 11 of the 2018/19 financial year behind its control total by £0.8m.
- The Trust was ahead of its income target by £8.4m at Month 11.
- Pay was overspent year to date by £4.3m.
- The closing cash balance was higher than plan by £6.2m (£47.0m against a plan of £40.8m).
- The committee undertook reviews of the Body, Bones and Mind and Research and Innovation Directorates.
- Received progress reports on EPIC and the Children's Cancer Centre.

Performance and finance standing updates

Finance report 2018/19 Month 11

- The Trust was behind with its control total in Month 11 by £0.8m. The Trust continued to forecast a breakeven position at the year end to the control total.
- The Trust was ahead of its income target by £8.4m.
- Pay was overspent year to date by £4.3m.
- Cash was is higher than plan by £6.2m
- Trust IPP debt increased to £34.8m from £30.8m in Month 10. The Chief Executive outlined plans to expedite payment.

Integrated Performance Report Month 11

The Committee:

- Noted the Trust's performance planning processes for 2019/20. This involved identifying the number of beds the Trust required to deliver the block contract, with any additional capacity being modelled to deliver IPP care and other commercial ventures.
- Discussed RTT performance and the impact of EPIC. It was predicted that in the short term, RTT performance would be adversely impacted by EPIC and that the Trust would need to increase performance over the rest of the year to attain the target by 31 March 2020.

The Chair requested a thorough review of every red rated performance measure including: reasons for current performance, the performance level the Trust could attain and pathways, action plans and timelines to attain this performance.

Magic numbers

The committee considered and evaluated block contract arrangements and requested that the Quality Safety and Experience Assurance Committee remain vigilant of any adverse changes to quality of care as a result of service efficiencies or how the Trust is paid.

Productivity and Efficiency (Better Value) Monthly update

- The programme for 2019/20 was underway. At the time of reporting, the two main areas of concern were the procurement scheme and income scheme.
- The scale of the challenge of delivering the proposed £20m of savings was discussed and encouragement given to the executive team to challenge existing thinking to seek to maximise the outcome of the programme
- Initial meetings with Easyjet Executives introduced by Chris Kennedy – NED, showed potential for savings on a number of areas.

Directorate reviews

The committee conducted the first of its directorate reviews covering the new management structure. The first two directorates to present were:

- Body, Bones and Mind Directorate
- Research and Innovation Directorate

The Chair requested specific follow-up from the Body, Bones and Mind Directorate and that future Directorate reviews include reporting on their objectives and associated KPIs.

EPIC update

The Committee received the update and noted that the risk raised at the February 2019 FIC meeting regarding coding accuracy had been updated. While the risks around drug links had been reduced, full assurance was not yet available on other activity.

Children's Cancer Centre Update

The Committee noted that a decision paper for the Children's Cancer Centre would be presented to a future Trust Board.

The Committee also discussed the status of the Trusts capital building projects as a whole.

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**Summary of the Council of Governors meeting
held on 17th April 2019**

Lead Governor and Deputy Lead Governor Appointment

The Council thanked the outgoing Lead Governor for her work to support the transition to a new Council. Candidates gave a brief outline on their reasons for standing for the roles of Lead Governor and Deputy Lead Governor and the Council approved the uncontested appointments for Dr Claire Cooper Jones, Patient and Carer Governor as Lead Governor and Mr Paul Gough, Staff Governor as Deputy Lead Governor.

Update from Council of Governors' Nominations and Remuneration Committee

- Appraisal of two GOSH NEDs

The Council of Governors approved the appraisal outcomes of Lady Amanda Ellingworth and Mr Chris Kennedy.

- Remuneration of NEDs

The Council approved the proposal by the Non-Executive Directors not to receive a cost of living uplift in remuneration.

- Revised terms of reference for Committee

The Council approved the revised Terms of Reference.

- Nominations for members of the Committee

The Committee approved the nominations of two public governors, one patient and carer governor and one staff governor to hold seats on the committee.

Compliance with the NHS provider licence – self assessment

The Council discussed the Trust's proposal to confirm compliance with condition CoS7 (3) that there would be a reasonable expectation that the required resources would be available to deliver services. The Council highlighted the substantial challenge brought about by the changes to the tariff and the current gap in terms of meeting the control total. The Trust had lobbied externally both as a Trust and within the Children's Alliance and highlighted the issue to NHS England and NHS Improvement and noted that at an early point in the year it was anticipated that a gap would remain. It was noted that this was a going concern statement that would be appropriate even where a trust was looking at a potential deficit.

Draft Council of Governors' section in GOSH Annual Report 2018/19

Governors reviewed the content of the report and agreed to provide comments to the Deputy Company Secretary outside the meeting.

GOSH Strategy – Our vision and objectives for 2025

A presentation was provided on the Trust's initial work to consult on the next steps in developing the GOSH long term strategy and to consider aspects of the Trust that should be retained and changed. A number of engagement events had been scheduled to ensure that the consultation was

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as inclusive as possible. Governors were invited to the sessions and they also suggested that the Membership Engagement Representation and Recruitment Committee (MERRC) should be involved in the work as they were currently considering the benefits of being a member and being involved in a strategic review was a considerable benefit.

Chief Executive Report

It was anticipated that EPR would go live on 19th April 2019 and the Trust was currently in a good position. There would be two challenging points, the initial go-live at the start of the bank holiday weekend and the first working day after the bank holiday, although activity had been substantially reduced for the first two weeks following go live. An issue with Wi-Fi was currently being reviewed and a number of mitigations had been put in place. There had been significant clinical engagement throughout the implementation and staff Governors said that the potential benefits for patients and efficiencies to the Trust were clear.

- Integrated Quality and Performance Report February 2019 (highlights)

RTT performance continued at target however this would reduce as the activity level reduced as a result of implementation of the EPR. The Trust had agreed that this would be brought back to target by the end of 2019. A leading software company had expressed an interest in partnering with GOSH to support patient flow.

- Finance report February 2019 (highlights)

Draft year-end financial results had been submitted to NHS Improvement on 15th April 2019 showing that the Trust was £117,000 surplus to control total. This was a substantial achievement and the Council congratulated the finance and executive teams.

Update from the Young People's Forum (YPF)

The Forum had discussed the hospital clean air framework and made suggestions about ways in which the Trust could be more sustainable. The YPF had been instrumental in hosting a Teens Careers Festival. Following this a company had hosted a workshop event at their offices and other companies had been inspired to do the same. Members of the Forum were invited to teach apprentice Health Care Assistants about what it was like to be a teenage patient. The Council welcomed the excellent work taking place.

Reports from Board Assurance Committees

- Quality, Safety and Experience Assurance Committee (April 2019)

A presentation was received on transition which showed that the Trust was considering Young People's transition to adulthood as well as adult services. A new People and Education Assurance Committee was being established which would ensure there was sufficient time to discuss culture issues.

- Audit Committee (January 2019 summary and agenda and April 2019 agenda – summary will be verbal)

EPR had been the focus for a number of meetings and this would continue to be reviewed following go live. The nature of the risk would change so the committee requested that the BAF risk was updated. The Committee reviewed BAF risks on research income, business continuity and information governance. The draft Head of Internal Audit Opinion provided a rating of significant

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assurance with minor improvement potential. IPP debtors was discussed and external audit had reported that GOSH had one of the most prudent provisioning policies in comparison to other organisations both NHS and private. The Chief Executive had recently met with one territory with a very significant IPP debt to highlight the challenge to GOSH. The Committee had expressed concern about contract management internal audit recommendations which had been removed from the tracker prior without the actions having been completed.

Governance update

Regibox had been implemented to host a Governor library. This had been trialled by MERRC who had been supportive. MERRC would focus on youth engagement and a good engagement event had taken place. Governors were encouraged to take part in engagement events.

Attachment 9

Trust Board 22 May 2019	
Declarations of Interest Register – Staff	Paper No: Attachment 9
Submitted by: Anna Ferrant, Company Secretary	
<p>Aims / summary Great Ormond Street Hospital’s Declaration of Interest, Gifts and Hospitality and Sponsorship Policy requires that all members of staff (including temporary and agency staff) declare any potential or actual conflict on joining the organisation or when the potential for conflict arises.</p> <p>A conflict of interest occurs when the private or personal interests of a Board member could affect their role at the Trust in terms of bringing some possible advantage to them or close relatives. Further information is provided at Appendix 1.</p> <p>Any declared interests are reconfirmed annually until such time as the staff member leaves GOSH or the potential for a conflict of interest no longer exists.</p> <p>The GOSH policy has recently been revised in line with NHS England’s Conflict of Interest Policy. The policy explains that some staff are more likely than others to have a decision making influence on the use of taxpayers’ money, because of the requirements of their role. These people are referred to as ‘decision making staff.’ All decision making staff are required annually to review declarations they have made and, as appropriate, update them or make a nil return. All other non-decision making staff are reminded annually of the importance of making declarations or make a nil return. A copy of the revised policy will be circulated once finally approved by the Policy Approval Group.</p> <p>At present the process of declaring is conducted via submission of a form. In the future, staff will have access to a portal to make a declaration.</p> <p>The Company Secretary is required to draw up a register of interests declared by members of staff and members of the Board and to report on this annually in the public part of a Trust Board meeting. The returns are maintained in a register which is open for inspection. The live register for staff members (Appendix 2) is attached with this report and is continually updated. The live register for directors was presented at the April 2019 public Board meeting.</p>	
Action required from the meeting To note the content of the register for 2018/19 for staff members.	
Contribution to the delivery of NHS Foundation Trust strategies and plans Transparency	
Financial implications None	
Who needs to be told about any decision? N/A	
Who is responsible for implementing the proposals / project and anticipated timescales? The Company Secretary	
Who is accountable for the implementation of the proposal / project? Chief Executive	

Attachment 9

Appendix 1: NHS England Guidance: What is an interest?

A 'conflict of interest' is:

"A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold."

A conflict of interest may be:

- Actual - there is a material conflict between one or more interests.
- Potential – there is the possibility of a material conflict between one or more interests in the future.

Staff may hold interests for which they cannot see potential conflict. However, caution is always advisable because others may see it differently and perceived conflicts of interest can be damaging. All interests should be declared where there is a risk of perceived improper conduct.

'Interests' can arise in a number of different contexts as follows:

Where an individual may get direct financial benefits from the consequences of a decision their organisation makes. This could include:

- A director (including a non-executive director) or senior employee in another organisation which is doing, or is likely to do business with an organisation in receipt of NHS funding.
- A shareholder, partner or owner of an organisation which is doing, or is likely to do business with an organisation in receipt of NHS funding.
- Someone in outside employment.
- Someone in receipt of secondary income.
- Someone in receipt of a grant.
- Someone in receipt of other payments (e.g. honoraria, day allowances, travel or subsistence).
- Someone in receipt of sponsored research.

Where an individual may obtain a non-financial professional benefit from the consequences of a decision their organisation makes, such as increasing their professional reputation or status or promoting their professional career. This could include situations where the individual is:

- An advocate for a particular group of patients.
- A clinician with a special interest.
- An active member of a particular specialist body.
- An advisor for the Care Quality Commission or National Institute of Health and Care Excellence.
- A research role.

Non-financial personal interests: This is where an individual may benefit personally from a decision their organisation makes in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include, for example, where the individual is:

Attachment 9

- A member of a voluntary sector board or has a position of authority within a voluntary sector organisation.
- A member of a lobbying or pressure group with an interest in health and care.

Indirect interests: This is where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit from a decision they are involved in making. This would include:

- Close family members and relatives.
- Close friends and associates.
- Business partners.

LIVE GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST REGISTER OF INTERESTS OF DECISION MAKING

Name	Role	Description of Interest	Relevant Dates	
			From	To
Gregory James	Consultant Neurosurgeon	I undertake private practice only at GOSH IPP.	3/28/2019	
Gregory James	Consultant Neurosurgeon	I have grants from the Royal College of Surgeons and rhe BRC for clinical and scientific research in neurosurgery (all registered with GOSH R+D and UCL)	3/28/2019	
Stephen Tomlin	Chief Pharmacist	Baxter Pharmaceutical - Paid adhoc lectures (non-promotional) on Parenteral Nutrition. Fresenius Pharmaceutical - Paid adhoc lectures (non-promotional) on Parenteral Neutrition Rosemont Pharmaceuticals - Paid adhoc Advisory Boards Director and Professional Secretary of the Neonatal and Paediatric Pharmacists Group - unpaid Member of the NHSE Paediatric Medicines CRG	3/29/2019	
Stephen Tomlin	Chief Pharmacist	RCPCH - sit on the Medicines Committee and Medicines for Children Committee	3/29/2019	
Stephen Tomlin	Chief Pharmacist	Sit on several adhoc advisory groups for the DH and Parliamentary Group	3/29/2019	
Toni Lawrence	Service Manager, Brain	Nil	3/29/2019	
Lisa Brown	Matron, PICU/NICU	Nil	3/29/2019	
Benjamin Low	Lead Practice Educator	Nil	3/29/2019	
Diane Wilson	Head of Procurement	Nil	3/29/2019	

David Goldblatt	Director, R&D, Honorary Consultant Paediatric Immunologist	<ul style="list-style-type: none"> • Department of Health Joint Committee on Vaccination and Immunisation (JCVI) subcommittees: meningococcal and pneumococcal (2012- to date) • Occasional expert member/chair of panels for the World Health Organisation and European Developing Country Clinical Trials Partnership (EDCTP), and advisory boards for GSK, Sanofi Pasteur and Merck Vaccines (ongoing) • Treasurer, International Society of Pneumococci and Pneumococcal Disease (ISPPD) (2016- to date) • Chair, Scientific Advisory Board, LimmaTech Biologics AG (2018- to date) • Chair, International Scientific Advisory Board, Malawi-Liverpool-Wellcome Trust Clinical Research Programme, Blantyre, Malawi (2017- to date) • Chair, External Advisory Board, NIHR Health Protection Research Unit, London School of Tropical Medicine and Hygiene (2016-to date). • Co-Director, NIHR Global Health Research Unit, UCL 	3/30/2019	
David Goldblatt	Director, R&D, Honorary Consultant Paediatric Immunologist	The Laboratory that I direct at UCL's GOSICH receives, or has received in the last 5 years, funding from a variety of sources including the UK Dept of Health, the Bill and Melinda Gates Foundation, Glaxosmithkline, Sanofi Pasteur, Merck Vaccines, ImmBio and Limmatech and the UK National Institute for Health Research.	3/30/2019	
Chris Rockenbach	General Manager, IPP	Nil	4/1/2019	
Robert Evans	Consultant, Maxillofacial and Dental/Orthotics Caldicott Guardian	I work as an expert witness in a self employed capacity	4/2/2019	
Robert Evans	Consultant, Maxillofacial and Dental/Orthotics Caldicott Guardian	Gifts and hospitality - previously declared	4/2/2019	
Lisa Liversedge	Head of Staff Health and Wellbeing	Nil	4/3/2019	

Kate Khair	Clinical Academic, Orchid	Trustee for two UK haemophilia charities: Haemnet and The Haemophilia Society (Nov 2018-date). Chair, World Federation of Haemophilia Nurses Committee. Consultancy/Speaker fees: Bayer, CSL Behring, Novo Nordisk, Shire/Takeda, Sobi Dates for all except Haemophilia Society are all of 2018/19 financial year and on-going into 2019/20.	4/3/2019	
Jon Goldin	Consultant Child and Adolescent Psychiatrist	GOSH IPP Child and Adolescent Psychiatry Up to 3 hours/week, usually Tuesday and Wednesday evenings	4/3/2019	
Jon Goldin	Consultant Child and Adolescent Psychiatrist	Occasional leadership teaching at Judge Business School, Cambridge, during annual leave.	4/3/2019	
Crispin Walkling-Lea	Head of Healthcare Planning	Nil	4/3/2019	
Michelle White	Consultant Anaesthesia	Nil	4/4/2019	
Christine Morris	Lead Laboratory Manager	Nil	4/4/2019	
Tom Watson	Consultant Radiologist	Portland Hospital Women and Children Paediatric Radiology - all diagnostic modalities and body systems (except neurp and cardiac) Alternate Wednesday afternoons (equivalent to 0.5 PA per week) and on-call.	4/2/2019	
Melanie Hiorns	Consultant Radiologist Clinical Director IPP	I have some personal radiology private practice at the Portland Hospital which amounts to approximately 12 hours per month and is entirely outside NHS time and is declared in my job plan.	4/4/2019	
Melanie Hiorns	Consultant Radiologist Clinical Director IPP	I am giving two invited lectures for the European Congress of Paediatric Radiology in October 2019 - they will pay by economy airfare and two night's accommodation. There is no payment or honorarium.	4/4/2019	

Melanie Hiorns	Consultant Radiologist Clinical Director IPP	As Clinical Director of IPP I promote and develop opportunities for IPP/GOSH. As declared above I separately do a small amount of personal private practice at the Portland Hospital in my own time, however this is as a 'sole trader' on a self employed basis, with no benefits or share rights, and has no influencing or decision making component whatsoever and is entirely unconnected to my GOSH role.	4/4/2019	
Oystein Olsen	Radiology Consultant	Nil	4/5/2019	
Daniel Lutman	Chief of Service, Heart and Lung CATS Consultant	Member of Health London Partnership - Children and Young People's Programme - Clinical Leadership Group (unpaid)	4/5/2019	
Kate Cross	Consultant Paediatric Surgeon and Specialty Lead	Private Patient Wing Great Ormond Street Hospital and The Portland Hospital Clinic Monday evening and Friday mornings. Adhoc theatre lists. Types of referrals and procedures performed mirrors my NHS practice. Equivalent to less than 1 PA per week.	4/5/2019	
Kate Cross	Consultant Paediatric Surgeon and Specialty Lead	Alex Simpson Smith Trust Fund and Travelling Fellowship Trustee since 2014 (Institute of Child Health/GOSH) One of the departmental representatives for the GOSH affiliation with ERNICA (European Reference Network for Rare Diseases - Inherited and Congenital Abnormalities) since inception in 2017	4/5/2019	
Kate Cross	Consultant Paediatric Surgeon and Specialty Lead	Small infrequent gifts of single bottles of wine or spirits, chocolates, small tokens such as a scarf or vase, rarely small items of jewellery (value each item estimated £50 or less) Hotel accommodation paid for at the ERNICA conference and consensus meetings (two nights twice a year). Travel at own cost.	4/5/2019	
Phillip Cunnington	Consultant Anaesthetist	Portland Hospital and Great Ormond Street Hospital paediatric anaesthesia Occasional Tuesday afternoons and Wednesday mornings.	4/8/2019	
Phillip Cunnington	Consultant Anaesthetist	Trustee and Director for POEMS For Children Charity	4/8/2019	
Phillip Cunnington	Consultant Anaesthetist	\$5000AUS for flights and accommodation to lecture at Society of Paediatric Anaesthetists, Darwin, Australia, September 2018	4/8/2019	
Roshni Gohill	General Paediatric Consultant	Nil	4/8/2019	

Byrony Freeman	Head of Performance and Business Improvement	Nil	4/4/2019	
Daniela Nobre de Costa Pinto	Service Manager, Heart and Lung	Nil	4/8/2019	
James Fisher	COO, London North GLH	Monthly retainer to provide advice to Cellworks Inc.	4/8/2019	
David deBeer	Consultant Anaesthetist	Clinical Private Practice: Yes Where you practice: GOSH What you practice: Paediatric anaesthesia When you practice: Usually 1st and 3rd Thursday morning (Prof Mushtaq - urology)	4/8/2019	
Sam Stuart	Consultant Interventional Radiologist	Veincentre London. Vein treatments on dates off from my GOSH rota Everlight Radiology, reporting images. On days off from my GOSH rota. Both are ad-hoc basis when I have time off from my commitments at GOSH.	4/1/2019	
Nick Day	Deputy Head of Planning	Nil	4/9/2019	
Nagarajan Muthialu	Consultant Cardiothoracic surgeon	Private Practice at GOSH. Cardiac, thoracic and tracheal surgery all days of the week.	4/9/2019	
Nagarajan Muthialu	Consultant Cardiothoracic surgeon	Consultant cardiothoracic surgeon (NHS) at GOSH	4/9/2019	
Rebecca Yale	Service Manager, Endo and Metabolics, Brain	Nil	4/7/2019	
Alessandro Giardini	Consultant Cardiologist	Harley Street Clinics, Paediatric cardiology, evenings and weekends ad-hoc appointments	4/9/2019	
Philippa Wright	Chief of Allied Health Professionals, Head of Dietetics	Nil	4/9/2019	
Marina Easty	Consultant Paediatric Radiologist	Private practice at GOSH fitted in between NHS patients and time paid back to Trust 1 hour per week on average. US, X ray, Fluroscopy, CT/MRI. The Portland Hospital, 5 hours per month taken on a Tuesday afternoon outside contracted hours, US, plain film, CT, Fluroscopy	4/9/2019	

Stewart Boyd	Consultant, Specialty Lead for Neurophysiology	I report a proportion of EEGs for patients of this hospital arriving through IPP. There are no specified sessions; reports are dealt with at the end of NHS sessions or sooner if clinical emergencies. I also undertake some remote NHS EEG reporting for Royal Devon and Exeter Hospital acting as Locum. This is carried out outside my contracted GOSH Trust hours.	4/9/2019	
Stewart Boyd	Consultant, Specialty Lead for Neurophysiology	Training programme director for HEE clinical neurophysiology in N. London (No direct payment received. Trust received reimbursement of 0.25PAs)	4/9/2019	
Laura Walsh	Head of Play Service	Nil	4/9/2019	
Sarah Aylett	Consultant Paediatric Neurologist	International Private Patients, Great Ormond Street Hospital NHS Foundation Trust. Neurology/Epilepsy. 1-2 patients per month.	4/10/2019	
Sarah Aylett	Consultant Paediatric Neurologist	Medical Advisor to Children's Trust, Tadworth, Surrey	4/10/2019	
Sarah Aylett	Consultant Paediatric Neurologist	PI for EXIST 3, multicentre trial sponsored by Novartis 2013-2019.	4/10/2019	
Simon Hannam	Consultant Neonatologist	Private practice at Great Ormond Street Hospital. Neonatal medicine . I have had income as part of the fee charged by IPP when patients are admitted on the NICU or PICU.	4/10/2019	
Simon Hannam	Consultant Neonatologist	Honorarium of £1000 from Matrix Healthcare Solutions in February 2018 for consultancy work. Member of Neonatal CRG since May 2016	4/10/2019	
Simon Hannam	Consultant Neonatologist	I jointly run the yearly Neonatal and Paediatric ventilation course at the Institute of Child Health. The course received sponsorship in December 2018 from the following companies: Nutricia (Danone) £250 + VAT Inspiration Healthcare £250 + VAT SLE Ltd £500 + VAT Aquilant £250 + VAT Draeger Medical UK Ltd £250 + VAT INO Therapeutics UK £500 + VAT Orphan Europe £250 + VAT	4/10/2019	
Adrian Peak	Assistant Director of ICT Programmes	Nil	4/10/2019	

Ian Webber	Assistant Director of IT Operations & Service	Nil	4/10/2019	
Francesca Faravelli	Consultant Clinical Genetics	Nil	4/10/2019	
Elena Gelsthorpe-Hill	Service Manager, Outpatients/CBO	Nil	4/10/2019	
Claire Williams	Interim Head of Patient Experience	Nil	4/10/2019	
Angela Barnicoat	Join Chief of Genetics	Nil	4/10/2019	
Louise Wilson	Consultant in Clinical Genetics	I see ad hoc private in-patients where they are referred by other GOS consultants in return for 0.66PA through an arrangement between private out-patients and the GOS NHS Clinical Genetics service. I do not receive any other payment for seeing these patients.	4/11/2019	
Paul Gough	Service Manager, Clinical Genetics, General Paediatrics, Orthopaedic, Orthopaedic and Spinal Surgery	Nil	4/11/2019	
Linda Chigaru	Consultant, CATS/Anaesthesia	Nil	4/11/2019	
Ri Liesner	Consultant Paediatric Haematologist	Director of UKHCDO Ltd (2012 to present day) – non-remunerated	4/11/2019	
Lesley Cochrane	Consultant, Otolaryngology	Ad hoc private practice at GOSH in ENT surgery	4/8/2019	
Lesley Cochrane	Consultant, Otolaryngology	Travel and accommodation to 10th European Investigators Conference 3rd-5th October 2018 - accepted	4/8/2019	
Nicola Hewlett-Light	HR Business Partner	Nil	4/10/2019	
Ema Kavaliunaite	Locum Respiratory Consultant	Nil	4/12/2019	
Nikhil Thapar	Consultant Paediatric Gastroenterologist	Private practice at Great Ormond Street Hospital, paediatric gastroenterology, Tuesday afternoon, ad hoc average 1 hour/week. Portland Hospital, paediatric gastroenterology, Wednesday morning, ad hoc average 2 hour/week.	4/10/2019	
Nikhil Thapar	Consultant Paediatric Gastroenterologist	Symposium speaker May and November 2018 for Nutrica/Danone - modest travel, accommodation and meal.	4/10/2019	

Marina Hughes	Honorary Consultant, Cardiology	Private practice at: Chenies Mews Imaging Centre - London - Congenital cardiac MRI scanning and reporting - 0.2 sessions / month 4Ways Radiology reporting - Cardiac MRI reporting. 0.2 sessions / week.	4/14/2019	
Kristian Aquilina	Consultant Paediatric Neurosurgeon	Private practice: HCA International - Portland Hospital and Harley Street Clinic; ad hoc neurosurgery clinics; occasional ad hoc procedures related to paediatric neurosurgical practice.	4/12/2019	
Kristian Aquilina	Consultant Paediatric Neurosurgeon	I support the Department of Health in Malta with provision of paediatric neurosurgical care.	4/12/2019	
Spyros Batzios	Consultant in Paediatric Metabolic Medicine	I have received honoraria and participated in sponsored scientific symposium for Biomarin, Genzyme and Shire Pharmaceuticals companies	4/12/2019	
Ian Christopher Lloyd	Consultant and Clinical Lead - Ophthalmology, Sight and Sound Directorate	Private practice: Clinic 234, Great Portland Street, W1W 5QT. Paediatric ophthalmology, Thursdays.	4/15/2019	
Nadine Dobby	Consultant Anaesthetist	Private practice at GOSH only. Anaesthesia for all specialties. Ad hoc basis.	4/15/2019	
Graham Sherlock	Director of Estates and Facilities	Nil	4/15/2019	
Polly Hodgson	Deputy Chief Nurse	Nil	4/15/2019	
Brijesh Patel	Consultant, Maxillofacial and Dental/Orthotics	Private practice Orthoclinique. Orthodontics, Wednesday, Thursday, 1:4 Saturdays	4/15/2019	
Brijesh Patel	Consultant, Maxillofacial and Dental/Orthotics	Secretary of Hertfordshire orthodontic MCN	4/15/2019	
Garth Dixon	Consultant Medical Microbiologist	Private practice: At Great Ormond Street Hospital, my job plan includes 2 hours per week work Microbiology advisory service to International Private Patients, which occasionally occurs out of hours and weekends. All tax liabilities are personally accounted for annually.	4/15/2019	
Garth Dixon	Consultant Medical Microbiologist	I make occasional donations to Great Ormond Street Hospital Charity special purpose fund which is used by departmental staff to cover sundry costs and sometimes educational costs (courses, conferences).	4/15/2019	

Fevronia Kiparissi	Consultant Paediatric Gastroenterologist	IPP Great Ormond Street Hospital, OPA and GI investigations. Ad hoc sessions	4/15/2019	
Fevronia Kiparissi	Consultant Paediatric Gastroenterologist	Dr Falk IBD conference 05./06.10.2018, Milan, Hotel and conference fees, posters presented, I paid my own flights	4/15/2019	
Helen Dunn	Lead Nurse Infection Control	Infection Prevention Solutions- 2-4 days a year providing infection control training to clinical staff- since 2015 Joint Chair of the Children and Young Peoples Network, Royal College of Nursing- since 2018	4/15/2019	
Salina Parkyn	Head of Quality and Safety	Nil	4/16/2019	
Chantelle Sculfor	Service Manager, Psychology and Therapies	Nil	4/11/2019	
Julie Bayliss	Consultant Nurse/ Specialty Lead for Paediatric Palliative Care	BRC internship via Orchid Sept 18- Feb 19 (7.5 hours a week). 2 multicentred research projects via CSG pain and palliative care group to start in 2019.	4/29/2019	
Osavdo Borelli	Consultant, Gastroenterology	Private practice at GOSH in Gastroenterology on Friday am.	4/25/2019	
Catherine Stuart	Matron Radiology	nil	4/18/2019	
Bridget Callaghan	Consultant General Paediatrician	Private practice: GOSH only - General Paediatric Outpatients	4/26/2019	
Alex Barnacle	Consultant Interventional Radiologist	International and Private Patients Division, GOSH I see outpatients on an ad hoc basis (0-4 per month, on average) and perform imaging on them when clinically necessary, usually ultrasounds. I treat private patients as part of our routine workload within radiology, as part of the shared radiology consultant pool.	4/26/2019	
Alex Barnacle	Consultant Interventional Radiologist	Paediatric director for Minnova Ltd, a non-profit organisation working to develop and improve interventional radiology clinical equipment and consumables. I receive no financial remuneration for this role. I devote approx. 10 hrs a year to this role.	4/26/2019	
Trevor Clarke	Director of International and Private Patients	Nil	4/24/2019	

Janey Franklin	Headteacher - The Children's Hospital School and Great Ormond Street and UCH	Nil	4/23/2019	
Barbara Childs	Matron, CICU Tracheal Services	Nil	4/23/2019	
Jan Marek	Consultant Cardiologist, Professor of Cardiology	Private practice: Great Ormond Street Hospital and HCA Healthcare London in Paediatric and Prenatal Cardiology (ECHO, ECG, CXR, Clinical review on evenings and weekends	4/9/2019	
Jan Marek	Consultant Cardiologist, Professor of Cardiology	Smart Heart Imaging & Teaching (co-founder, 33% sharehold, international educational courses in cardiac imaging, bi-early)	4/9/2019	
Simon Critchlow	Consultant in Restorative Dentistry	Private practice: Woodbury Practice, 77 Woodford Road, South Woodford, London E18 2EA and IPP at GOSH Specialty: Restorative Dentistry When: 2 days per week (Woodbury Practice Monday and Wednesday, ad hoc IPP at GOSH)	4/23/2019	
Martin Tisdall	Consultant Neurosurgeon and Deputy Chief of Service, Brain Directorate	Private practice at Gosh IPP Paediatric neurosurgery Ad hoc – generally outpatients on Monday evenings Operating time at Gosh ad hoc	4/19/2019	
Martin Tisdall	Consultant Neurosurgeon and Deputy Chief of Service, Brain Directorate	Medtronic sponsored educational trip to Texas Childrens Hospital for teaching relating to new surgical procedure in Jan 2019 Industry sponsorship of Uk Seeg course co directed by myself and Dr Rachel Thornton planned Sept 2019. Sponsorship to be applied for from various medical companies but not yet confirmed'	4/19/2019	
Claire Waller	Matron, BBM	Nil	4/19/2019	
Matt Guilfoyle	Associate Director of HR Operations	Nil	4/19/2019	
Anupama Rao	Consultant Haematologist	IPP Haematology at GOSH inpatient wards and outpatient clinics	4/18/2019	
Anupama Rao	Consultant Haematologist	Attended an Advisory Board for Pharmaceutical Company, Sobi.	4/18/2019	

Samantha Chippington	Consultant, Interventional Radiology	Private practice: Great Ormond Street Hospital only. Interventional radiology	4/18/2019	
Kshitij Mankad	Radiology Consultant	Private practice: HCA; BUPA Cromwell; IPP GOSH. Neurology out of hours	4/18/2019	
Rodney Scott	Consultant, Neurology	Sponsored research: GOSHCC. Registered with R&D.	4/18/2019	
Harshini Katugampola	Locum Consultant, Endocrinology	Nil	4/18/2019	
Lorraine Beirne	Service Manager, BBM	Nil	4/18/2019	
Maureen A Cleary	Consultant Metabolic Paediatrician	Private practice: Great Ormond Street Hospital IPP IP and OPD in Metabolic Paediatrics. I see occasional private patients approximately 2-3 patients per year	4/17/2019	
Maureen A Cleary	Consultant Metabolic Paediatrician	I am a member of Sanofi Genzyme Advisory Board, Biomarin Advisory Board. I have provided consultancy to Vitaflor (Nestle), Sangamo. I have received lecture fees from Biomarin and Sanofi Genzyme.	4/17/2019	
Maureen A Cleary	Consultant Metabolic Paediatrician	Biomarin paid for my hotel and registration to attend WORLD LSD meeting February 2019.	4/17/2019	
Maureen A Cleary	Consultant Metabolic Paediatrician	I am PI for commercially sponsored research studies by Biomarin in the CRF. I am PI for Shire sponsored patient registry.	4/17/2019	
Imran Mushtaq	Urology Consultant	Nil	4/16/2019	
Biju Hameed	Consultant, Neurodisability	nil	4/18/2019	
Jack Bartram	Consultant Haematologist	Private practice: International Private Patients - Great Ormond Street Hospital Haematology (malignant and non malignant)	4/17/2019	
Alison Steele	Consultant General Paediatrician	Company Secretary and Director for Action 4 Equality Scotland Ltd. Director for QC Investments Ltd.	4/17/2019	
Alison Steele	Consultant General Paediatrician	40% shareholder Action 4 Equality Scotland Ltd. 50% shareholder for QC investments Ltd.	4/17/2019	
Alison Steele	Consultant General Paediatrician	RCPCH pays for travel and accommodation if I attend meeting/speak on their behalf as I hold post as Officer for Child Protection with them.	4/17/2019	
Alison Steele	Consultant General Paediatrician	Officer for Child Protection, RCPCH	4/17/2019	
Matthew Fenton	Consultant Cardiologist	Private practice: Great Ormond Street IPP, Cardiology, no identified sessions	4/17/2019	

Hugo Wellesley	Consultant, Anaesthesia	Ad hoc private work in my own time at The Portland Hospital. Includes regular (one weekend per month) on-call sessions – these never conflict with NHS commitments. No defined theatre sessions. The scope of my work is the same as at GOSH (paediatric anaesthesia not including for cardiac surgery).	4/18/2019	
Hugo Wellesley	Consultant, Anaesthesia	Gift (declared in August 2018) – crystal carriage clock (est £170). Given by overseas medical student at end of observership. Accepted as opened after student had left. Donated to department.	4/18/2019	
Renee McCulloch	Consultant, Paediatric Palliative Care	NICE Committee member - Cannabis derived products for medicinal use (travel and accommodation for meetings when in Manchester) 2019 February to September / October. Member independent Advisory Group Child Health Clinical Outcome Review Programme from November 2018 Plenary speaker - annual postgraduate education event in Paediatrics: accommodation and travel only May 2019 Plenary speaker - Europea Association of Palliative Care annual conference: accommodation (partial) and travel only (May 2019)	4/17/2019	
Mary Foo-Caballero	Matron/Lead Cancer Nurse	Nil	4/17/2019	
Suzan Kakat	Consultant, Cardiac Intensive Care	Nil	4/17/2019	
James Hatcher	Consultant in Microbiology	Private practice: Provide clinical microbiology advice to International Private Patients at GOSH.	4/17/2019	
James Hatcher	Consultant in Microbiology	Offer of travel and accommodation costs to attend as invited speaker the Welsh Trainees Training Day (4/7/19) and Welsh National Infection Training day on Paediatric Infection to give Keynote lecture (15/16 Nov 2019) – value as yet to be confirmed	4/17/2019	
Elena Cervi	Consultant, Cardiology	Nil	4/17/2019	

Premal Patel	Consultant Radiologist	I attended a speaker course: Presenting with impact understanding motivators and drivers to facilitate effective peer meetings. This was organised by BTG (but run by another company Quantum Coaching and Consultancy). The course was free. BTG is the company who make the cryoablation machine we use. We had already purchased the machine before I went on the course. There were no other cryoablation systems on the market in the UK (as far as I am aware). Permission to attend was requested and granted by the then Radiology Head of Clinical Service and the then Medical Director.	4/9/2019	
Reema Nandi	Consultant Anaesthetist and pain specialist	Private practice: The Portland Hospital, Paediatric Anaesthesia, Thursday afternoon 2:00pm - 4:00pm	4/17/2019	
Keith Sibson	Consultant Haematologist	Private practice: only in IPP, 1 hour per week.	4/17/2019	
Robert Robinson	Consultant Paediatric Neurologist	Private practice: GOSH private patients, paediatric neurology, 1 hour per week - variable	4/17/2019	
Adnan Manzur	Consultant, Neuromuscular	Private practice: GOSH IPP Wing, neuromuscular, paediatric neurology, IPP outpatient sessions - between 5:00pm - 8:00pm on weekdays, usually Tuesdays and Wednesdays or Fridays Inpatients - infrequent - seen at lunchtime or during the day, and longer consultations in the evenings 5:00pm - 8:00pm	4/17/2019	
Adnan Manzur	Consultant, Neuromuscular	Attended one meeting on advisory board for PTC Therapeutics Inc. This is a pharmaceutical company which manufactures Ataluren (Translarna) a medicine which was assessed by NICE a managed access agreement by NHS England. I am not active on the advisory Board, it was just one meeting.	4/17/2019	
Vesna Pavasovic	Consultant in Malignant Haematology and Late Effects Lead	Private Practice at GOSH in Haematology. Thursday wardrounds (daily when acting as attending Consultant in Haematology ie 5 weeks per year) and twice per month outpatients clinics	4/17/2019	
Munaza Ahmed	Consultant Clinical Geneticist	Private practice: Harley Street Clinic Diagnostic Centre, outpatient clinics in Cancer Genetics on Wednesday evenings	4/17/2019	

Gehan Abou-Ameira	Consultant paediatric dentistry	Private practice: GOSH IPP, paediatric dentistry, minor procedures, adhoc basis - sometimes clinic on 3rd Friday of the month pm.	4/15/2019	
Muthana Al Obaidi	Rheumatology Consultant	Private practice: Parkside hospital, Wimbledon, paediatric rheumatology two Saturday morning clinics every month	4/17/2019	
Muthana Al Obaidi	Rheumatology Consultant	I was sponsored with other team member to attend the 24th European paediatric rheumatology 14-17th of September 2017 Athens/ Greece (it's over a year, so not sure whether it needs to go on the register). It was approved by the department clinical lead at that time Dr Pilkington	4/17/2019	
Muthana Al Obaidi	Rheumatology Consultant	I am the PI of pharma funded research that are R&D approved within the CRF in the hospital, do I need to declare them?	4/17/2019	
Ciara McMullin	Head of Nursing and Patient Experience	Nil	4/10/2019	
Robert Hill	Honorary Consultant, Orthopaedics	Private Practice: Private consulting rooms, GOSH and Portland Hospital, London. Chief Medical Advisor Portland Hospital	4/11/2019	
Samantha Levine	Consultant, Histopathology	Report histopathology specimens from Gosh from private patients at GOSH when procedures carried out at GOSH – These are paid by GOSH private patient services into a private company known as 'Repath Ltd' of which all the consultant histopathologists, including myself are directors and shareholders. The Company is a mechanism for handling the consultants' private fees.	4/10/2019	
Jasveer Mangat	Consultant, Cardiology	Private Practice: IPP at GOSH, Paediatric Cardiology and Electrophysiology approx 1 hour per week. Admissions and procedures via GOSH.	4/10/2019	
Jasveer Mangat	Consultant, Cardiology	11th to 12th June 2018, attendance on Cook Medical Lead Extraction Workshop. Notification to my Clinical Lead in May 2018 via the industry representative.	4/10/2019	
Una McCrann	Specialty Lead, Child and Adolescent Mental Health	I am a specialist advisor with the CQC	3/28/2019	
Hanna Richardson	Consultant, Neurodisability	Hope for Hamartoma conference – Washington DC, USA. Economy flights and accommodation offered from the charity running conference for attendance and possible presentation at conference. Sept 12-14 2019. Approved by head of clinical service	3/28/2019	

Evangelia Papathanasiou	Locum Consultant, Paediatric Cardiology	Nil	3/28/2019	
Catherine Peters	Consultant Endocrinologist	Co-director for MSc module University of Warwick. One week teaching per year (wc25/2/19) and marking of student assignments	3/28/2019	