

**Meeting of the Trust Board
Thursday 18 July 2019**

Dear Members

There will be a public meeting of the Trust Board on Thursday 18 July 2019 at 12:30pm in the Charles West Boardroom, Barclay House, 37 Queen Square, Great Ormond Street, London WC1N 3BH.

Company Secretary Direct Line: 020 7813 8230

AGENDA

	Agenda Item <u>STANDARD ITEMS</u>	Presented by	Attachment	Timing
1.	Apologies for absence	Chair	Verbal	12.30pm
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.	Directorate presentation from Mental Health Chief of Service	Lee Hudson, Chief of Service for CAMHS	H – To Follow	12:35pm
3.	Minutes of Meeting held on 22 May 2019	Chair	I	12:50pm
4.	Matters Arising/ Action Checklist	Chair	J	
5.	Chief Executive Update	Chief Executive	K	1:00pm
6.	Patient Story	Chief Nurse	L	1:15pm
7.	Electronic Patient Record (EPR) Programme Update	Chief Clinical Information Officer/ EPR Programme Director	O	1:30pm
<u>STRATEGY and RISK</u>				
8.	Children’s Cancer Centre (CCC) Update	Director of Development	M	1:40pm
9.	GOSH Learning Academy: Charity Grants Case	Chief Nurse/ Director of Education	N	2:10pm
10.	Gastroenterology Review Update	Medical Director	P	2:25pm
<u>PERFORMANCE</u>				
11.	Integrated Quality and Performance Report – May 2019	Medical Director/ Chief Nurse/ Director of Operational Performance and Information/ Director of Operations	R	2:35pm
12.	Month 2 2019/20 Finance Report	Chief Finance Officer	T	2:50pm
13.	Better Value Update	Director of Operational	S	3:05pm

		Performance and Information/ Director of Operations		
14.	Safe Nurse Staffing Report (April and May 2019)	Chief Nurse	U	3:20pm
	<u>ASSURANCE</u>			
15.	Learning from Deaths Mortality Review Group - Report of deaths in Q4 2018/2019	Medical Director	W	3:40pm
16.	Guardian of Safe Working report Q1 2019/20	Medical Director	X	3:50pm
17.	Infection Control Annual Report 2018/19	Director of Infection Prevention and Control	Y	4:05pm
18.	Responsible Officer Annual Report 2018/19	Responsible Officer – Dr Andrew Long	Z	4:20pm
19.	Safeguarding Annual Report 2018/19	Chief Nurse	1	4:35pm
20.	Board Assurance Committee reports <ul style="list-style-type: none"> • Audit Committee update – May 2019 meeting • Quality, Safety and Experience Assurance Committee update – July 2019 meeting (verbal) • Finance and Investment Committee Update – June 2019 • People and Education Assurance Committee Update – July 2019 (verbal) 	Chair of the Audit Committee Chair of the Quality, Safety and Experience Assurance Committee Chair of the Finance and Investment Committee Chair of the People and Education Assurance Committee	2 Verbal 3 Verbal	4:50pm
21.	Council of Governors' Update – July 2019 (Verbal)	Chair	Verbal	5:10pm
	<u>GOVERNANCE</u>			
22.	Revised SFIs and Scheme of Delegation	Chief Finance Officer	4	5:20pm
23.	Register of Seals	Company Secretary	5	5:30pm
24.	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.)			5:35pm
25.	Next meeting The next confidential Trust Board meeting will be held on Wednesday 18 September 2019 in the Charles West Room, Barclay House, Great Ormond Street, London, WC1N 3BH.			

**DRAFT Minutes of the meeting of Trust Board on
22nd May 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
Dr Sanjiv Sharma	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
Dr Shankar Sridharan	Chief Clinical Information Officer
Ms Claire Williams*	Interim Head of Patient Experience and Engagement
Mr Christopher Jephson*	Consultant Paediatric ENT Surgeon
Dr Tim Liversedge*	Consultant Paediatric Anaesthetist
Dr Cho Ng*	Consultant Intensivist
Ms Sarah Newcombe*	Chief Nursing Information Officer
Mr Richard Collins*	EPR Programme Director
Ms Herdip Sidhu-Bevan*	Director of Nursing Operations
Mr Luke Murphy*	Freedom to Speak Up Guardian
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*

49	Apologies for absence
49.1	Apologies for absence were received from Professor Rosalind Smyth, Non-Executive Director.
50	Declarations of Interest
50.1	No declarations of interest were received.
51	Minutes of Meeting held on 3 April 2019
51.1	The minutes of the previous meeting were approved .

52	Matters Arising/ Action Checklist
52.1	Minute 22.4 – Dr Sanjiv Sharma, Medical Director said that the Trust owned almost 400 BD pumps and issues had been experienced whereby the pumps were becoming blocked. The pumps were maintained by the Trust however software updates were required which were being undertaken by the supplier, and the pumps had now been deemed not fit for purpose. A programme for replacement was on-going with higher risk areas being replaced first. Dr Sharma confirmed that this was not impacting on patient care.
53	Chief Executive Update
53.1	Mr Matthew Shaw, Chief Executive said that in addition to the well attended monthly staff briefing, an extraordinary briefing had been held in May which was attended by approximately 650 staff. The ‘speak up’ programme was being rolled out across the Trust. This was a cultural change programme which had been piloted in the Brain Directorate and results had been positive.
53.2	Action: A meeting had taken place with the Director of Policy and Strategy at NHS England to discuss specialised commissioning and tariff changes. A productive discussion had also taken place with the MP for Holborn and St Pancras and it was agreed that he would be invited to a future Board meeting.
53.3	The Board watched the ‘Speak Up For Safety’ video and Ms Alison Robertson, Chief Nurse said that in parallel with this work the conflict resolution policy had been revised and was being relaunched with a new name of the ‘Safe and Respectful Behaviour Policy’.
54	Patient Story
54.1	The Board received a patient story from ten year old Kai who had been a GOSH inpatient for nine weeks whilst he waited for a heart transplant. Kai’s story was about his experience over this time.
54.2	Kai said that he liked having the same school teacher each day and that in general he liked the food although sometimes his mother had to buy food as the menu was different than the meals he would eat at home. Kai said that the food was always hot but was often not as well presented at the weekends. He said in some cases when staff were talking about his treatment he overheard the conversations and he said that he would have preferred that conversations were either held with him or out of earshot.
54.3	Kai said that he could not use the hospital’s internet as he would at home. He could not play the computer games he was used to which involved talking to his friends via a headset through the game and he couldn’t access YouTube or music in the same way as he would at home. He said that there were also a large number of restrictions on the parents’ Wi-Fi settings. The teen room had been repurposed and the toys available in the play room were for very young children.
54.4	When EPR had gone live Kai heard about it through hearing nurses’ discussions rather than through posters however Kai’s mum had to leave the hospital to sign Kai up to My GOSH as the Wi-Fi was too poor in the hospital.

54.5	Ms Claire Williams, Interim Head of Patient Experience and Engagement said that Kai had found the Wi-fi restrictions extremely challenging however the Trust was required to consider safeguarding restrictions and therefore it would not be possible for him to speak to his friends online through computer games or play certain games. Ms Williams said that work had taken place to review the usage of the teen room on Bear Ward and as approximately 80% of patients on the ward were small children and babies the room was not being used sufficiently and had become a discharge room which was working well. Consideration was being given to establishing an adolescent cupboard with more age appropriate games.
54.6	Ms Williams said that work was taking place to review the issues Kai had with communication around EPR and overhearing discussions about his treatment.
54.7	Dr Shankar Sridharan, Chief Clinical Information Officer said that it was vital to manage patients' expectations around internet usage. He said that it was Kai's perception that the Trust's wifi did not work however this was due to deliberate decision making around online safeguards.
54.8	Lady Amanda Ellingworth, Non-Executive Director queried whether there was a distinction made between inpatients and long stay patients. Dr Sridharan said that Epic could be used to identify these patients to support making their stay as similar to life outside the hospital as possible.
54.9	Action: It was agreed that a future patient story would focus on patients and families' experiences over the time that EPR went live.
55	GOSH Foundation Trust Annual Financial Accounts 2018/19 and Annual Report 2018/19
55.1	Ms Helen Jameson, Chief Finance Officer said that the Trust made a £30.8 million surplus in 2018/19, exceeding the control total by approximately £100,000. Cash was strong at year end and the accounts had been produced in line with International financial reporting standards, including IFRS 9 and 15.
55.2	Mr Akhter Mateen, Chair of the Audit Committee said that the Audit Committee had reviewed the documents and had recommended the Annual Accounts and Annual Report for approval. He said that the External Auditors would finish their work on 23 rd May 2019 and anticipated that report on the Annual Accounts would be unmodified with no further notes on matters such as value for money.
55.3	Some minor amendments to the Annual Report had been passed to the Company Secretary and would be made prior to signing. Mr Mateen said that the Head of Internal Audit Report had provided a rating of significant assurance with minor improvement potential in line with previous years.
55.4	The Board approved the following documents: <ul style="list-style-type: none"> • Annual Accounts and Annual Report 2018/19 • Annual Governance Statement • Audit Committee Annual Report • Draft Head of Internal Audit Opinion • Representation letter.

56	Quality Report 2018/19
56.1	Dr Sanjiv Sharma, Medical Director thanked Ms Meredith Mora, Clinical Outcomes Development Lead for her work on the Quality Report which highlighted the good work which had been taking place throughout the organisation. Mr Mateen said that at the end of the report a number of issues had been raised by the London Borough of Camden and requested that engagement took place with the Council at an earlier stage to prevent this in future. Dr Sharma said that more open and frequent communication was beginning to take place with Camden Council.
56.2	Mr Mateen said that the Quality Report had been reviewed by the Audit Committee and recommended to the Board for approval. An unqualified opinion had been issued for the 31 day cancer wait metric however a qualified opinion had been provided on RTT and the errors found were in line with those found in the previous year. External Auditors indicated that if they had given an opinion on the locally selected indicator of PICU delayed discharges it was likely that it would have been unmodified.
56.3	The Audit Committee had discussed the improvement that was required in order to receive a clean opinion on RTT and it was likely that EPR would support some improvement however discussion had taken place with the external auditors around the possibility that, following substantial work which was well regarded within the NHS, GOSH would continue to receive a modified opinion. Professor Andrew Taylor, Acting Chief Operating Officer said that three of the five errors identified were a result of the Trust being too cautious and adding patients to an RTT pathway when this was not necessary. He added that this was a complex process for a tertiary and quaternary centre such as GOSH.
56.4	The Board approved the Quality Report.
57	Compliance with the Code of Governance 2018/19
57.1	Dr Anna Ferrant, Company Secretary said that Foundation Trusts were required to report against Monitor's Code of Governance each year in the Annual Report on a comply or explain basis. A review had been undertaken against each of the Code's provisions and had found that the Board had applied the principles and met the requirements of the Code of Governance during 2018/19 with the exception of three provisions where alternative arrangements were explained.
57.2	The Board approved the statement to be included in the Annual Report.
58	Compliance with the NHS provider licence – self assessment
58.1	Dr Ferrant said that the NHS Provider Licence was NHS Improvement's primary tool for regulating providers of NHS services and Foundation Trust Boards were required to annually declare compliance or otherwise with a number of licence conditions and a requirement under the Health and Social Care Act.
58.2	Dr Ferrant said that NHS Improvement required that the Trust take into account the views of the Governors when considering whether the Trust's compliance in the relevant areas. Governors had been satisfied with the Trust's responses but had queried whether, given the financial environment and tariff challenges, the Trust could confirm the availability of sufficient resources. It had been highlighted

58.3	to Governors that the statement was essentially a going concern statement and the Chair of the Audit Committee had confirmed that the Trust intended to sign the Annual Accounts on a going concern basis. The Board agreed the Trust's response to the four conditions taking into account the views of the Governors.
59	Quality Priorities 2019/20
59.1	Dr Sharma said that the paper set out the 2019 quality priorities based on both the national and local context. He added that it was important to document these in advance of the development of the Quality Strategy.
59.2	The Board approved the identified priorities.
60	Revised Risk Management Strategy
60.1	Dr Sharma said that the strategy had been updated to reflect the new organisational structures, clarify reporting lines for reviewing risks and clarify the roles of committees. Risk appetite statements had been updated following the discussions at Trust Board in December 2018.
60.2	Action: Mr Mateen said that this was a helpful paper and requested that a process flow diagram was added to the end of the strategy to show the inputs from the point at which risks were identified at risk action groups.
60.3	Action: It was noted that a top three risks exercise had not taken place recently and it was agreed that this would be done in 2019.
60.4	Action: The Board requested that a paragraph was added around the triangulation of system wide and external risks.
61	Board Assurance Framework (BAF) Update
61.1	Dr Ferrant said that the assurance committees reviewed the BAF at each meeting throughout the year including deep dives on risks within the Committee's remit on rotation. The BAF was also presented to the Board regularly for information.
61.2	The Audit Committee had reviewed the EPR risk and had recommended that the risk was reworded to focus on stabilisation following the period of implementation.
61.3	The Board discussed the medicines management risk and it was noted that this would be updated at the July Risk Assurance and Compliance Group to refresh the required actions.
62	Update on implementation of EPIC (with clinical team input)
62.1	Mr Richard Collins, EPR Programme Director said that the EPR programme had gone live as planned on 19 th April 2019 and there had been broad agreement that the go-live had been successful. As had been planned for there were a large number of issues raised since go-live however this had been fewer than anticipated. Approximately 8000 issues had been closed and around 830

62.2	<p>remained open. As with all go-lives printing had been an issue, primarily related to printer mapping and print outs being sent to different devices than anticipated.</p> <p>Mr Collins introduced some clinicians to the Board to provide first hand experiences of the go live process. Dr Cho Ng, Paediatric Intensivist said that there had previously been an electronic system in CICU and PICU which did not allow users to make changes. This had led to a large number of updates beginning on computers during go-live slowing the system down. Dr Tim Liversedge, Paediatric Intensivist said that an issue had arisen where an update had unexpectedly shut down a number of stations however there had been an extremely quick response from the EPR team which gave confidence to staff in the area. Ms Sarah Newcombe, Chief Nursing Information Officer said that there had been a substantial impact on nurses due to the change in documentation processes.</p>
62.3	<p>Mr Shaw said that the team had worked excellently and the go-live felt controlled and organised and Dr Liversedge said that it was vital to maintain the drive across the Trust as this was the beginning of a long term project. Ms Alison Robertson, Chief Nurse said that staff had responded well and were positive at this early stage but she added that teams were at an early stage of a very new way of working and had worked extremely hard. She said it was important to recognise this when considering beginning new strands of work. Sir Michael agreed but said that it was important to build on the positive cultural aspects of the programme.</p>
63	Integrated Quality and Performance Report – March 2019 including focus on clinical outcomes
63.1	<p>Dr Sharma said that the report covered data up to March 2019 and therefore did not include data from the EPR go-live period. He said that there had been a reduction in the rate of reporting and the reason for this was not yet clear. As a whole the Trust had reached the target for Friends and Family Test completion and this would allow focus to be placed on two directorates which required additional support. Rates continued to be monitored through performance reviews.</p>
63.2	<p>Improved tracking of action plan completion for complaints was being introduced which would facilitate improved reporting to the Board. Improvement was required in the completion of statutory and mandatory training and actions plans for this were being monitored. Over 130 audits had been completed in year which was positive and indicated that the Trust was interrogating its performance.</p>
63.3	<p>A Never Event had been declared as a result of a retained object during a complex surgery involving a number of teams. Mr James Hatchley, Non-Executive Director asked if there had been a failure of the WHO checklist and Dr Sharma said that the patient had been very unwell and the second count of materials had been performed after the patient had been moved out of theatres and into critical care. The use of the WHO checklist meant that the retained object was therefore discovered very quickly.</p>
63.4	<p>Sir Michael highlighted the continued red rated theatre utilisation and last minute non clinical cancellations and asked whether Epic had contributed to this performance. Professor Andrew Taylor, Acting Chief Operating Officer said that although epic had contributed there were delays London wide in cardiac surgery</p>

63.5	<p>and GOSH continued to work with network to improve this. Professor Taylor said that the Trust had met the RTT target in the period of the report but highlighted that the result for April would be 90.2% which was below target as a result of reduced activity for Epic go-live. There had also been some deterioration in diagnostic waits, due in part to reduced activity and in part as a result of a scanner being out of use. The margin for error at GOSH was a very small number of patients before the target was breached.</p> <p>Sir Michael asked whether the targets for theatre utilisation were realistic and Professor Taylor said that improvement was required and added that the data provided by Epic would be considerably more granular to address this.</p>
64	Learning from Deaths Mortality Review Group - Report of deaths in Q3 2018/2019
64.1	<p>Dr Sharma said that 29 children had died over the reporting period and case record reviews had been completed in all cases. It had been found that two cases had modifiable factors and a root cause analysis investigation was being undertaken for one case. The Trust was recruiting staff to work towards compliance with the Child Death Review Statutory and Operational Guidance (England) which was required by 29th September 2019. Significant changes would be required to adapt current GOSH processes to support the new guidance.</p>
64.2	<p>Sir Michael noted that one of the modifiable factors was around a disagreement in the clinical care plan between teams and asked for a steer on the contribution this had made to the death. Dr Sharma confirmed that this was not the cause of the outcome however the communication difficulties were identified during the review as not having provided best practice for the patient.</p>
65	Month 1 2019/20 Finance Report
65.1	<p>Ms Helen Jameson, Chief Finance Officer said that the Trust was required to achieve a breakeven position for 2019/20 and was £0.1million behind the control total at month one. This was due to underperformance against NHS Clinical Income on non-block contracts by £0.4million and IPP income being behind plan by £0.5million. Pay and non-pay spend were both underspent in month offsetting the reduced income position.</p>
65.2	<p>A reduction in depth of coding was being experienced following EPR go-live which would be impacting income which was not on a block contract. Dr Sridharan agreed that this was an issue and said it was important to be consistent about reminding clinicians of the importance of coding. Ms Jameson said that this could also impact contract negotiations for 2020/21 as the complexity of care could look less than that delivered in year. It was vital to support the pharmacy team who were working extremely hard to ensure income and expenditure for drugs costs can be accurately reflected in the accounts. Mr Chris Kennedy, Non-Executive Director raised a concern that IPP activity was behind plan at such an early point in the year.</p>
65.3	<p>Sir Michael reiterated the importance of improving the utilisation of assets as had been discussed at the last Board meeting and ensuring that assets continued to be utilised at an appropriate level throughout the year including at times such as throughout the school summer holidays. Dr Sharma said that he had met with</p>

65.4	<p>the Chiefs of Service earlier in May and had asked for this to be discussed within services. An electronic staff absence system would enable better tracking.</p> <p>Ms Jameson said that changes were being made to the way Trusts were able to carry out capital spending. She said that although GOSH was fortunate to benefit from substantial donated assets, it was possible that there could be unintended consequences of any new rules.</p>
66	Safe Nurse Staffing Report (March 2019)
66.1	<p>Ms Alison Robertson, Chief Nurse said that the implementation of Healthroster was complete in all clinical areas along with the introduction of Safecare which allowed nurses to measure the roster against patient acuity. This would enable better review of establishment if rises in acuity appeared to be a continuing trend. Activity data was linked to Epic so a near real time measure could be used in bed meetings.</p>
66.2	<p>Allocate rostering system had been rolled out which would ensure that shifts were allocated in an open and transparent way and give greater visibility of the way that rosters were managed across the Trust. Nurses were able to request shifts supporting their ability to develop their own work-life balance.</p>
66.3	<p>The nursing vacancy rate increased in March 2019 from 1.9% to 5.6% partly due to increased turnover but also due to budget which had traditionally been recorded against bank lines having been transferred to the substantive establishment to ensure consistency of vacancy reporting.</p>
66.4	<p>Ms Robertson highlighted that focus had been placed on reducing activity throughout the Epic go-live period however it had been extremely challenging to ensure that the nursing workforce as a whole had been Epic trained without a reduction in activity. It was possible that this had contributed to the increased cancellations in March.</p>
66.5	<p>Mr Hatchley asked about the impact of the children's hospital which was opening in Dublin on nurse recruitment from Ireland given that this was a key source of nurse recruitment for GOSH. Ms Robertson said that the Dublin children's hospital had not yet opened however the previous intake of nurses had not been especially focused on the recruitment of Irish nurses. She remarked that the highest numbers of EU nurses were working in critical care and this this had been drawn to the attention of the head of Nursing and Matrons.</p>
66.6	<u>Nurse Establishment Review</u>
66.7	<p>Following the Directorate review work had taken place to review establishments with Heads of Nursing. Some longer term deficits had been identified and it was shown that approximately 20 additional posts were required. Directorates had been challenged to review their service delivery and models of care to work towards recruiting smaller numbers of nurses. Mr Mateen queried whether this challenge had also been put to the Directorates which were sufficiently staffed and Ms Robertson confirmed that a review had been undertaken on a line by line basis.</p>
66.8	<p>Lady Amanda Ellingworth, Non-Executive Director asked what was being done to change the way Allied Health Professionals worked and Ms Robertson said that a skills mapping exercise was taking place with the Chief Allied Health</p>

	Professional and that over the next six months each nursing group would also have been reviewed.
67	Annual Reports
67.1	<u>Annual Freedom to Speak Up Report 2018/19</u>
67.2	Mr Luke Murphy, Freedom to Speak Up Guardian said that the number of cases reported had increased substantially from 13 to 68 based on the previous year. It was likely to be due to the focus senior staff were placing on the importance of being open and speaking up. Work had taken place to better categorise the themes that were raised and discussion had taken place at the Quality, Safety and Experience Assurance Committee about the cases that were raised as a result of poorly articulated performance management. Ms Caroline Anderson, Director of HR and OD said that the recommendations made in the paper were helpful and timely and would be included in the People Strategy.
67.3	Sir Michael asked to what extent the Trust could provide training in this area and Ms Anderson said that there was training available through schemes such as the Leadership Academy which was focused on upskilling individuals in these areas and there was specific training around difficult conversations.
67.4	Mr Murphy said that the Trust had appointed a Head of Employee Relations which had been extremely valuable. He said that many of the issues raised were not unique to the Freedom to Speak Up service and had also been raised in fora such as the staff survey.
67.5	The Board welcomed the report.
67.6	<u>Annual Health and Safety and Fire Report 2018/19</u>
67.7	The Board noted the report.
67.8	<u>Annual Sustainability Report 2018/19</u>
67.9	Mr Matthew Tulley, Director of Development presented the report, the format of which reflected the guidance provided by the NHS sustainability unit. He said that the Trust had appointed a dedicated sustainability manager which had been beneficial. The Trust remained on track to deliver its targeted CO2 emissions reduction despite temporary issues with the estate's energy infrastructure. A key success during the year had been the launch of the GOSH clean air framework which had been downloaded over 500 times.
67.10	Discussion took place around Great Ormond Street itself and the substantial traffic that used the street. It was suggested that the London Borough of Camden Health Scrutiny Oversight Committee could review whether changes could be made to the traffic regulations on the road to support the clean air framework and ensure the street was safer for staff, patients and local residents.
68	Guardian of Safe Working report Q4 2018/19
68.1	Dr Sharma said that exception reporting had reduced significantly from 50 reports in quarter 3 to 13 in quarter 4 which was lower than other Trusts. The

	Trust continued to encourage junior doctors to be high reporters however reports tended to come from specific individuals.
68.2	The GOSH vacancy rate for junior doctors was around 10% against a national average of 20% however gaps in rotas continued to have a substantial impact. Excellent progress had been made in junior doctor sleeping facilities.
68.3	Sir Michael asked for a steer on the Junior Doctor morale and Dr Sharma said it was currently good and juniors were engaged in the modernising workforce and junior doctor 24/7 work. He added that their views were valuable as they had worked across a number of organisations and had seen what worked well and less well.
68.4	Action: Lady Ellingworth noted that the paper invited Board members to join meetings of the Junior Doctor Forum and it was agreed and she and Ms Kathryn Ludlow, Non-Executive Director would discuss the response to this invitation outside the meeting. Sir Michael said that he was also keen to attend a meeting.
68.5	Action: It was agreed that trend data would be added to the report.
69	Board Assurance Committee reports
69.1	<u>Audit Committee update – April 2019 meeting and May 2019 (verbal)</u>
69.2	Mr Mateen said that he provided the update on the April meeting to the Council of Governors at their April meeting. The May meeting, which had taken place directly prior to the Trust Board meeting, had reviewed the year end documents and undertaken a deep dive on the IPP risk, discussing diversifying referrals and improvement of metrics such as nursing recruitment and retention. Debtors had grown considerably over the course of the previous year and levels were becoming concerning.
69.3	<u>Quality, Safety and Experience Assurance Committee update – April 2019 meeting</u>
69.4	Lady Ellingworth said that a deep dive of the medicines management risk had been undertaken and this would be revisited as a result of the Audit Committee's request for the risk to be reconsidered on a regular basis.
69.5	<u>Finance and Investment Committee Update –March 2019</u>
69.6	Mr Hatchley said that the committee had considered the tariff, block contracts for activity and focus was being placed on the significant challenge of achieving the Better Value target. Consideration was also given to key projects such as the Children's Cancer Centre and Epic implementation.
70	Council of Governors' Update – April 2019
70.1	Sir Michael said that the Council continued to be a constructive and engaged group. A new Lead and Deputy Lead Governor had been elected and Sir Michael said that he would be meeting with these individuals. A review would take place of the NED and Governor buddying system to consider improvements which could be made.

71	Declaration of Interest Register – Trust staff
71.1	Action: Dr Ferrant presented the live declaration of interests register for staff. The declaration of interest and gifts and hospitality policy had been aligned with that of NHS England and the updated policy would be circulated to the Board. Under the revised policy decision makers were required to make an annual declaration including where this was a nil return. This currently involved approximately 650 staff but would be widened to include all budget holders.
71.2	Sir Michael emphasised the importance of being clear that submitting a declaration did not negate the need to take action if a conflict were to arise and Dr Ferrant confirmed that she reviewed all returns and those causing potential concern were considered by the Declarations Working Group. Individuals could be asked to adhere to a management plan.
72	Any other business
72.1	Professor Andrew Taylor, Acting Chief Operating Officer said that an external organisation had been employed to undertake a test of security when moving around restricted areas of the Trust and improvements were required.
72.2	There were not items of any other business.

**TRUST BOARD – PUBLIC ACTION CHECKLIST
July 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	On agenda
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	On agenda
53.2	22/05/19	A meeting had taken place with the Director of Policy and Strategy at NHS England to discuss specialised commissioning and tariff changes. A productive discussion had also taken place with the MP for Holborn and St Pancras and it was agreed that he would be invited to a future Board meeting.	MR, MS	September/ November 2019	Noted – to be arranged.
54.9	22/05/19	It was agreed that a future patient story would focus on patients and families' experiences over the time that EPR went live.	AR	Q2 2019/20	Noted – to be scheduled Q2 2019/20
60.2	22/05/19	A process flow diagram was added to the end of the risk management strategy to show the inputs from the point at which risks were identified at risk action groups.	SS	July 2019	In place in appendix of strategy
60.3	22/05/19	A top three risks exercise to be undertaken in 2019.	AF	October 2019	To be conducted in

Attachment J

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
					time for the Board Risk Management Meeting in October 2019
60.4	22/05/19	A paragraph on external and system risks to be added to the risk management system.	SS	July 2019	Added and Risk Management Strategy being uploaded to intranet
68.4	22/05/19	Lady Ellingworth noted that the paper invited Board members to join meetings of the Junior Doctor Forum and it was agreed and she and Ms Kathryn Ludlow, Non-Executive Director would discuss the response to this invitation outside the meeting.	AE, KL	July 2019	To be arranged
68.5	22/05/19	Trend information to be added to the Guardian of Safe Working report.	SS	July 2019	On agenda
71.1	22/05/19	Dr Ferrant presented the live declaration of interests register for staff. The declaration of interest and gifts and hospitality policy had been aligned with that of NHS England and the updated policy would be circulated to the Board.	AF	July 2019	The policy is subject to final approvals and will be circulated towards end July 2019.

Trust Board 18th July 2019	
Chief Executive Report	Paper No: Attachment K
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	

Part 1: People

1.1 Listening to staff

We continue to focus on improving staff engagement and I'm pleased that our new approach to internal communications is getting good feedback and has resulted in an increase in staff approaching myself at the rest of the exec team to speak up about issues that concern them. We have increased attendance at the monthly all staff briefing sessions (over 500 staff attended our finance talk in May), receiving more questions from staff via the new instant messaging app (Sli.do), increased readership of the weekly newsletter to over 50 per cent of staff and have 100 or so staff logging in each week to read the exec team blogs.

In spite of this progress there is still much to do to ensure our staff feel better supported by the organisation. Last week we launched the GOSH Safe and Respectful Behaviour Policy along with supporting training and communication materials. The policy has been revised in response to our staff feedback on emotional and physical safety. The supporting materials are designed to equip them with simple and practical ways to work together in challenging unacceptable behaviour and defusing conflict.

The analysis of the feedback from our recent strategy refresh sessions with staff will inform our work to develop a shared vision for the organisation's future. Some of the key high impact transformational changes that staff at these sessions wanted to us deliver over the coming five years included:

- **Investment in our People:** Supporting a culture of kindness and inclusivity, open communication, accountable leadership and continuous learning and improvement
- **Re-design of our services around what patients and families need:** Focusing more on their lives, rather than on their conditions, co-ordinating their GOSH care better and being more present for them across the health and social care pathway
- **Investment in and promotion of the GOSH Learning Academy:** Using GOSH's education offer as a mechanism to deliver a more fulfilling working life for staff, a better service for patients and to shape our place in the wider healthcare system
- **Developing and adopting technology:** Empowering staff with insight, supporting safer and smarter decision-making and making GOSH a true healthcare innovator
- **Redefining our role in the system:** increasing the focus on outreach and making the case for national policy change to a system that dis-incentivises partnership and innovation.

We continue to explore our strategic vision and priorities through ongoing targeted consultation with the harder to reach staff groups, subject matter experts based at GOSH and in the wider system and patients and families.

1.2 Developing staff

In June we launched 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.

Sign-up and attendance at the workshops has been excellent – as of 1 July 2019, over 30% of staff and volunteers have booked onto or attended a workshop. The team has received several requests for workshops to be held at directorate and departmental meetings including from Theatres, Physio, Play Team, School, Audiology, Ophthalmology and ENT. A further 90 sessions are booked until the end of August and we are on course to achieve our 80 per cent attendance target.

During July we are running a series of Quality Rounds, which involve colleagues from different directorates visiting wards to see what is working well and where there's room for improvement. This work supports the cross-organisational collaboration and shared learning that we know our staff enjoy and provides fresh perspectives to drive service improvement.

1.3 Leadership

We are delighted to have successfully appointed to our new Director of Transformation role, a 12-month secondment to drive innovation and deliver projects that strengthen and refine the Trust. It was important that this position went to someone from within GOSH who knows the Trust well and we are really pleased that Richard Collins, the EPR Programme Director, has accepted the post. Our transformation will be delivered through a substantial portfolio of significant enabling work programmes including:

- Continuously developing a culture that enables us to learn and thrive
- Transforming patient care through harnessing technology and innovation
- Providing the highest quality services and care for our patients and families effectively and efficiently
- Creating inspiring spaces suitable for provision of leading edge care over the decades to come.

As part of our commitment to developing capable, collaborative and accountable leaders, we are running two developmental away days in the coming months – one for the executive team in August and one for senior leaders in the Autumn. With support from Morgan Stanley and the GOSH Charity, we are also launching a leadership mentor scheme that will pair senior divisional staff with effective leaders from Morgan Stanley.

Part 2: Financial sustainability

2.1 Better Value progress

Our Better Value programme will make a fundamental contribution as part of the transformation portfolio and work continues to finalise this year's Better Value schemes, covering key themes such as improved expenditure control, developing new commercial opportunities, driving through procurement savings and tackling waste.

Some £10m of schemes have already been signed off for delivery through the budget setting process and we are working to engage as many staff as possible to identify new ideas to address the remaining gap. That engagement began with two dedicated all-staff briefing sessions on financial sustainability and we are reviewing the many excellent ideas that our staff have subsequently submitted. There are some key themes on environmental sustainability and waste reduction which align with expectations of our patients and families.

A targeted communication and engagement programme is planned to take place through the summer to raise awareness, gain support for upcoming projects and empower our staff to develop their own local initiatives. The Better Value target is a significant challenge for us and we will continue to prioritise getting ideas and input from staff, patients and families as the most likely way to make sustainable changes that should result in better staff and patient experience as well as improved value for money.

2.2 Consultation on hospital priorities for charitable funding

We are working in partnership with the charity to align the hospital and charity strategies. Part of this process involves establishing exec-sponsored working groups covering six strategic themes (people, education, environment, people, patients & families and technology) to scope priorities for charitable funding, explore potential impacts and how investments can be made sustainable for the long term.

2.3 Specialist tariff

NHSE/I has agreed to do some work with the UK Children's Hospitals' Alliance members to look at case mix complexity, issues with the current tariff model and the potential for specialist top-ups or other solutions to mitigate the damaging impact of the current system.

Part 3: Service quality

3.1 Mental health services achieve 'outstanding'

Our mental health team deserve our congratulations following a recent commissioner inspection by NHSE. Verbal feedback has indicated that these services have achieved 'outstanding' status.

3.2 Consultation on Children's Cancer Services

Following the publication of NHS England's public consultation on children's cancer services there has been some press interest in the decision not to incorporate a recommendation from the National Confidential Enquiry into Patient Outcome and Death. The clinical recommendation that PICUs *must* be co-located with child cancer units has been altered in NHSE's proposed service specification to *should*. We are consulting with our partners and cancer service leads to prepare a response to the consultation, which closes on 4th August 2019.

3.3 GOSH Digital Strategy and project updates

We are working on a governance structure to support effective oversight of our digital programmes - ICT, DRIVE and EPR. (**See attachment 1.**) We are also working to recruit an external advisory board of experts in developing, licensing and commercialising new technologies – and in navigating the complex intersection between public services and commercial innovation – to advise us on how to translate the incredible potential of DRIVE into tangible benefits for GOSH patients and families.

Following the publication of 'The Topol Review', Health Education England (HEE) has provided initial funding for a pilot collaborative project between HEE, GOSH DRIVE and The Knowledge Lab (Institute of Education, UCL). The collaboration aims to assess workforce behaviours and educational needs in the field of healthcare technologies and develop and evaluate training resources. The project will start with examining the skills and behaviours required for optimal use of electronic health records e.g. EPIC.

On 20 June 2019 the GOSH Digital Ambassadors Programme was launched. This programme leverages Barclays' partnership with DRIVE, with their modified Digital Eagles training scheme being delivered to a cohort of GOSH staff across the clinical directorates. The programme aims to transfer learning from other industries, and consider of how GOSH might enable digital transformation through engaging and upskilling their staff.

Part 4: Performance

We continue to experience some real operational challenges associated with EPIC implementation and I would like to acknowledge the hard work of all of our staff who are working under pressure to find solutions. In particular I would like to acknowledge the efforts of our performance, information, data assurance and pharmacy teams in working collaboratively to iron things out.

The Board will recall that to mitigate the operational risks inherent in the EPIC roll-out we planned a decrease in RTT performance followed by a staged recovery over the following 12 months. We are anticipating some challenges over the coming months as we continue to align planning processes with EPIC – particularly on diagnostic targets. These will be reported into committees and are recognised on the BAF register.

Part 5: Partnerships

5.1 Opening of the Zayed Centre for Research into Rare Diseases in Children

The Chairman and I were delighted to welcome HH Sheikh Theyab, son of the Abu Dhabi Crown Prince and guests to the opening events for the Zayed Centre for Research into Rare Diseases in children on 1st and 2nd July 2019. The opening event was a wonderful opportunity to thank the Abu Dhabi Royal Family and the other donors for supporting our partnership with the GOSH Charity and UCL to create the world's first purpose-built centre dedicated to the scientific discovery and treatment of children's rare diseases.

Not only will the Centre act as a catalyst for global collaboration to diagnose, treat and cure more rare diseases worldwide – it also provides high quality, family-friendly outpatient facilities that will care for up to 200 children per day.

I'm really grateful not just to our donors but also to the clinical teams, inspirational scientists, researchers, artists, architects and engineers – and, of course, to the patients and families – that made this visit memorable for our guests.

5.2 NHSX Launch

NHSX officially launched on 1 July 2019 with the goal to drive digital transformation across the NHS and social care, giving patients and staff the technology they need. GOSH DRIVE

hosted a launch event which was attended by the Secretary of State for Health and Social Care and NHSX CEO Matthew Gould along with his senior team, NHS and social care leaders, colleagues from professional medical bodies and royal colleges (including the BMA and RCGP), big tech companies, SMEs, charities and NHSX staff.

I spoke at the event about a GOSH 'wish list' of things we would like this new unit to achieve – support for NHS organisations to shape commercial partnerships that deliver true patient benefit, changing the NHS commissioning model that disincentivises telemedicine and removing the NHS systemic barriers that prevent NHS organisations from collaborating and sharing systems, infrastructure and people.

5.3 Networks update

Last month I chaired the first meeting of a UK Children's Hospitals Alliance working group which is supporting work to establish a National Paediatric Pathology Network. We were joined by pathology experts from eight out of the ten member hospitals as well as David Wells, the Head of Pathology Consultation at NHS Improvement. This is a complex project, with four workstreams established to assess the impacts on specific specialist areas (Paediatric & perinatal, Inherited Metabolic Disorders, Newborn Screening, Paediatric microbiology) and three further workstreams on the cross-cutting issues for workforce, research and quality/accreditation. I have agreed to continue chairing the working group meetings on behalf of the Alliance CEOs but requested that project management resource is provided by NHSE/I to ensure that this highly capable and under-resourced group of pathology experts are supported to deliver robust service specifications for a successful national service.

5.4 GOSH Play Street and engagement with LB Camden



In March 2019, GOSH and Global Action Plan launched the first ever Clean Air Hospital Framework (CAHF). The framework set out actions NHS trusts can take in key areas including procurement and supply chain, travel arrangements and staff training to create a healthier environment.

To mark Clean Air Day on 20th June 2019, in a collaborative project between GOSH, the London Borough of Camden and local clean air campaigners, the street outside the hospital was closed to traffic for four hours and transformed into a rainbow themed play area, with a host of activities championing the therapeutic, emotional and psychological benefits of play, in a safe, clean-air environment.

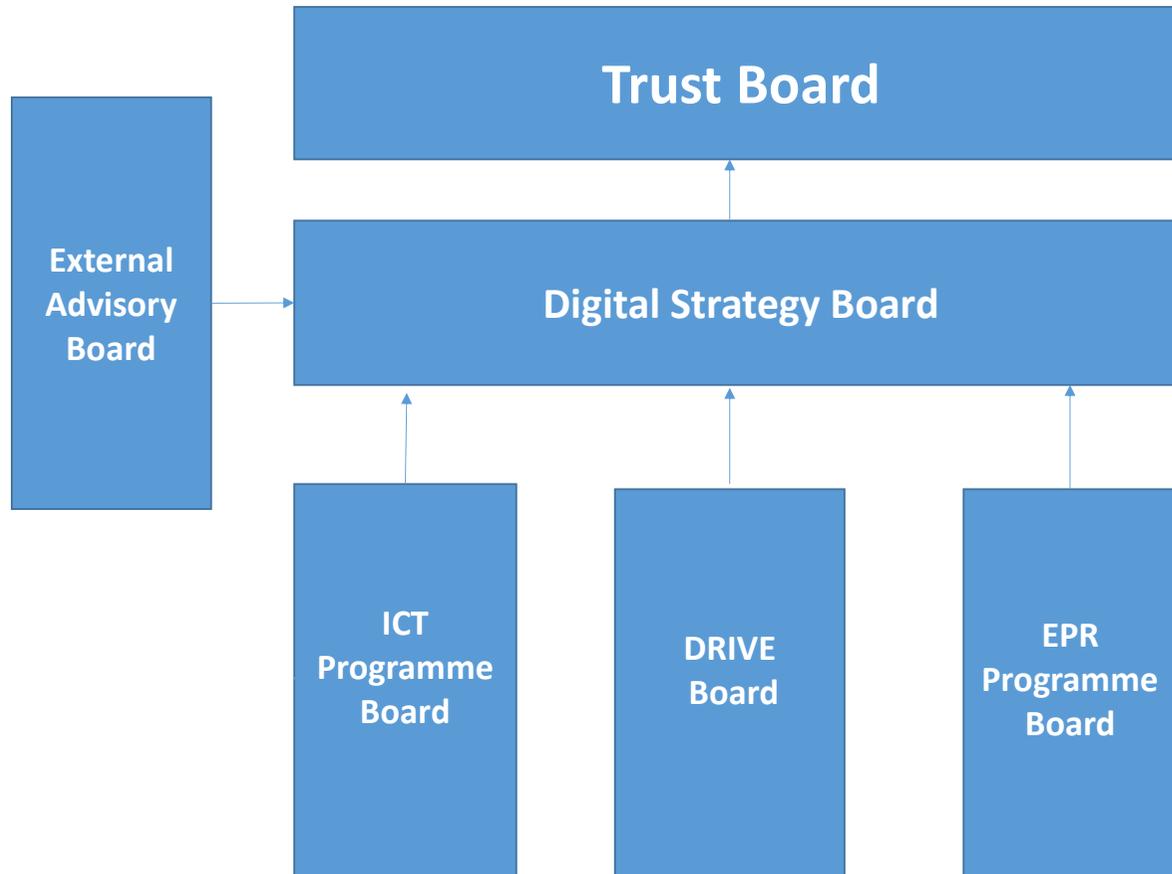
The Deputy Mayor of London for Environment and Energy, Shirley Rodrigues, joined us to celebrate this fantastic event and we had a good conversation about the benefits that limiting traffic movements around the site might have for GOSH patients and local families.

5.5 Brexit preparedness

The GOSH Brexit Working Group continues to meet periodically to maintain oversight on our own progress as well as policy developments and guidance. Health Secretary Stephen Hammond wrote to MPs on the 27th June (**see attachment 2**) to outline contingency plans for a no-deal exit from the EU on 31st October. The Department of Health and Social Care's Commercial Director Steve Oldfield has also written to suppliers of medicines, medical devices and clinical consumables (**see attachment 3**).

The approach outlined in these documents is very similar to that followed in March – including the requirement for NHS Trusts to limit stockpiling and advice to organisations running clinical trials and clinical investigations to consider their supply chains and that put appropriate arrangements in place to assure supplies in the event of any possible border delays. There is some indication that reporting requirements may be slightly less onerous and that information from the Department of Health and Social Care will be shared as early as possible.

[Ends]



GOSH Digital Strategy



Department
of Health &
Social Care

Stephen Hammond MP
Minister of State for Health

39 Victoria Street
London
SW1H 0EU

020 7210 4850

All Members of Parliament
House of Commons
London SW1A 0AA

27 June 2019

Dear Colleague,

‘NO DEAL’ BREXIT CONTINGENCY PLANNING ASSUMPTIONS FOR CONTINUITY OF SUPPLY OF MEDICINES AND MEDICAL PRODUCTS

Further to the Written Ministerial Statement made in the House yesterday by the Chancellor of the Duchy of Lancaster, David Lidington MP, I am writing to provide more detail on plans from the Department for Health and Social Care to support the continuity of supply of medicines and medical products into the UK in the event we exit the EU without a deal on 31 October.

On 25 February, I made a statement to the House on the Department’s planning in advance of 29 March. The plans I outline below are set out to ensure that we are at least as prepared for a ‘no deal’ Brexit in October as we were in March. These plans endeavour to ensure patients in England, the devolved nations and Crown Dependencies of the UK continue to have access to the medicines and medical products they need.

As in preparation for 29 March and 12 April, our contingency plans for 31 October will cover NHS, social care and the independent sector and covers medicines (prescription-only medicines, pharmacy medicines and general sales list medicines); medical devices and clinical consumables (such as needles and syringes); supplies for clinical trials; vaccines and countermeasures; and organs and tissues for transplants.

Before setting out the detail of our plans I want to put on record my thanks for the valued collaboration and shared endeavour in putting patients first from industry trade bodies, all those involved in manufacture and distribution, charities and many other stakeholders, as well as, of course, the NHS. I understand the complexity of

preparing for a no-deal Brexit but am confident that with the same collective commitment we can again put in place the necessary contingency plans.

In light of the agreed extension to the Article 50 period, Government has been reviewing its 'reasonable worst-case' scenario planning assumptions regarding disruption at the Channel short straits, issued by the Cross-Government Border Delivery Group. These assumptions have been revised to reflect our latest intelligence on both infrastructure (such as border inspection posts, holding bays and IT systems) and trader readiness (having all necessary paperwork in place at the border). At this stage, there is no material change in these assumptions that lead us to move away from the multi-layered approach put in place ahead of 29 March.

My Department has continued to work closely with the Devolved Administrations, industry trade bodies and suppliers, the NHS and other key stakeholders. Prior to 29 March, my Department analysed the supply chains of 12,300 medicines, close to half a million product lines of medical devices and clinical consumables, vaccines used in national and local programmes, and essential non-clinical goods on which the health and care system relies, such as linen, scrubs and food.

We also assessed contract risks associated with a no-deal scenario in the broader NHS and social care sector in England and within the Devolved Administrations and are continuing to work with suppliers to ensure suitable mitigations are in place for non-clinical goods and services (e.g. hospital food, laundry, IT contracts, etc).

These analyses and assessments have been updated where necessary and will continue to be refined while a no-deal Brexit remains a possibility. This work has informed the plans I set out below.

This has been, and continues to be, a very large undertaking, but we are grateful for the excellent engagement from all parties. The plans I set out in this letter are robust and well advanced largely due to this engagement. We note that this is a difficult period for industry and that our ask is not always easy, particularly in relation to stockpiling. However, the planning and the successful execution of these plans in the event we do leave without a deal, rely on a positive response from colleagues in industry. We remain thankful for their continued constructive collaboration.

As per our planning in the run up to a potential no-deal Brexit in March and April, we are asking suppliers to analyse their supply chains and to make alternative plans if

they anticipate disruption, including rerouting to alternative ports or using airfreight where necessary. The Government's contingency measures to address continuity of supply of medicines and medical products aim to support industry-led measures and, where required, act as a 'last resort' to be used only when a supplier's own alternative arrangements encounter difficulties, to ensure uninterrupted supply.

My Department is maintaining some layers of contingency implemented previously, whilst adapting others to meet our and suppliers' needs ahead of 31 October.

1. Improving trader readiness for new border arrangements

Working with colleagues across Government, we are addressing the issue of trader readiness for the new customs procedures that will come into force on 'exit day'. This remains an area for improvement and we continue to work with industry to mitigate against its impact.

2. Building up buffer stocks

This approach is being taken across the following sectors:

- a) Medicines – Informed by the latest border assumptions, the Government asks suppliers of prescription-only medicines and pharmacy medicines with an EU or EEA touchpoint to put in place plans to secure supply for the expected six-month period of disruption. We ask that this includes a stockpile of an additional six weeks' supply in the UK, on top of operational buffer stocks, in addition to developing a robust re-routing plan away from the short straits. As before, for products with a short shelf life or where production constraints mean stockpiling is not possible (e.g. medical radioisotopes) we ask for alternative air freight plans to be made. While we would advocate the above approach to suppliers, we do understand that some companies may wish to adopt a different balance between stockpiling and re-routing to achieve the most effective and robust mitigation plan. In all cases, the Department will be asking companies to notify us of their plans.
- b) Medical Devices and Clinical Consumables – My Department, working closely with procurement and logistics services in the Devolved Administrations, developed a central stockpile of fast-moving medical devices and clinical consumables. It is intended that this stockpile will remain in place in readiness

for 31 October, with some small adjustments being made to reflect changes in demand and the time of year. As for March and April, this stockpile does not cover all product lines so there will be a requirement for suppliers to implement their own preparedness arrangements, considering the balance between stockpiling and re-routing to achieve the most effective and robust mitigation plan in the context of the anticipated disruption at the short straits. In all cases, the Department will be asking companies to notify us of their plans.

- c) Blood and Transplants – NHS Blood and Transplant (NHSBT) manages the blood supply in England and is putting in place stockpiles and other contingency measures to ensure a continuous supply of blood, including frozen plasma, and is working with the other UK blood services as required. NHSBT manages organ donation across the UK and is working with its EU counterparts to ensure that the current organ exchange arrangements can continue post-Brexit. The UK regulators, the Human Tissue Authority and the Human Fertilisation and Embryology Authority, are working with licensed UK establishments so the import of tissues and cells from EU countries can continue post-Brexit.
- d) Vaccines and countermeasures – My Department is taking the same approach to vaccines as to medicines (stockpiling, where possible, and replenishment) and is working with Public Health England (PHE), which is responsible for managing existing stockpiles in the course of their business as usual planning. PHE is working with vaccine suppliers to ensure replenishment of these existing stockpiles continues in the event of supply disruption in the UK. In the case of seasonal flu vaccine, which cannot be stockpiled, manufacturers have robust contingencies in place for example rerouting away from the short straits, if necessary.
- e) Supplies for Clinical Trials – Supplies for clinical trials are transported in small quantities and often via airfreight. As per our planning in advance of 29 March and 12 April, we are asking clinical trials sponsors to consider their supply chains and put in place contingency measures.
- f) Non-Clinical Goods and Services – My Department has continued to work closely with a range of NHS and social care providers to ensure mitigation

plans are in place for supplies of non-clinical goods and services, such as hospital food and laundry.

3. Procuring extra warehouse space for stockpiled medicines

To ensure sufficient space to store stockpiled medicines ahead of 29 March, my Department agreed contracts for additional warehouse space, including ambient, refrigerated and controlled drug storage. We will continue to provide warehousing capacity and will keep industry updated on how they can access this additional storage in advance of 31 October.

4. Securing freight capacity

As per the information provided by the Chancellor of the Duchy of Lancaster, across Government, it is planned to provide contingency freight capacity in two ways:

- a.** Procuring ‘roll-on, roll-off’ freight capacity – the Department for Transport, acting on behalf of government, will be starting a procurement exercise to put in place a framework to provide suppliers, including those of medicines and medical products, with the opportunity to use freight capacity along routes that operate away from the Channel short straits. There is a cross-Government agreement that all medicines and medical products, and other ‘category 1’ goods, will be prioritised on these routes to ensure the flow of all these products may continue unimpeded.
- b.** Procuring an ‘Express Freight Service’ – my Department will be procuring and managing a health-only freight solution. This ‘Dedicated Health Channel’ will provide access to an end-to-end solution able to deliver small consignments on a 24-48-hour basis and a two-to-four-day pallet delivery service. The Dedicated Health Channel is only to be used in the event that suppliers’ supply chains fail, and they are not able to bring products in via DfT’s central framework, or if there is emergency need for specific products.

The procurement exercises for both above freight services are launched yesterday, and we will provide updates to industry on how they can access this service in advance of 31 October.

In addition to the above four measures, the following two were put in place in advance of 29 March and remain relevant and applicable in the event of a no-deal Brexit in October.

5. Changing or clarifying regulatory requirements

So that companies can continue to sell their products in the UK in a no-deal scenario, the Government has made changes to, or clarifications of, certain regulatory requirements.

To inform these changes, the Medicines and Healthcare products Regulatory Agency (MHRA) has consulted on, and published, further guidance on how medicines, medical devices and clinical trials will be regulated. Following the consultation, three statutory instruments, covering the regulation of human medicines, medical devices and clinical trials were considered and approved by Parliament in February and March 2019. This legislation will take effect on ‘exit day’ if there is no deal. In August 2018, the Government also published a dedicated technical notice on the unilateral recognition of batch testing of medicines, if there is a no-deal Brexit. Both the guidance and the technical notice were made available in my Statement of 25 February.

The Department’s Medicine Supply Team has well-established procedures to deal with medicine shortages and works closely with the MHRA, the pharmaceutical industry, NHS England, the Devolved Administrations and others operating in the supply chain to help prevent shortages and to ensure that the risks to patients are minimised when they do arise.

Medicines suppliers should continue to use existing medicines reporting arrangements and alert the Department’s Medicine Supply Team of any supply issues at the earliest point possible, so the team can undertake a risk assessment and implement a management plan where required to help mitigate any potential impacts affecting patients. Guidance about the information that should be reported to the Medicine supply team and how to report can be found at the following link:

<https://www.gov.uk/government/publications/reporting-requirements-for-medicine-shortages-and-discontinuations>.

6. Strengthening the processes and resources used to deal with shortages

In addition to the normal shortage management routes, my Department has also put in place legislation to enable Ministers to issue serious shortage protocols that, where appropriate, would enable community pharmacies to supply against a protocol, i.e. to issue a substitute medication instead of the medication indicated on the prescription without going back to the prescriber first.

Our multi-layered approach is similar to the measures put in place in advance of 29 March and 12 April and remains essential to help ensure the continuation of medicines and medical supplies in the event of a no-deal Brexit in October.

Local stockpiling over and above business as usual ahead of 31 October is unnecessary and could cause shortages in other areas, which could put patient care at risk. It is also important that patients keep taking their medicines and order their repeat prescriptions as normal.

I hope this information provides you with clarity on what the Government and my Department are doing to ensure the continuity of supply of all medicines and medical products in the event of a no-deal Brexit on 31 October.

With all best wishes



STEPHEN HAMMOND



By email
26th June 2019

Dear Colleagues,

Continuity of supply of medicines and medical products in 31st October no-deal EU exit scenario

Further to my note of 26th April, I want to update you on the Government's approach to delivering our shared goal of ensuring the continued supply of medicines and medical products to patients in the UK in the event of a no-deal EU exit on 31st October; and to set out how we believe suppliers of those products to the UK can best prepare to achieve that objective. In compiling this guidance, we have listened carefully to industry feedback on our 29th March no-deal exit contingency programme, as well as building on latest insight into company preparedness from trade bodies and suppliers, and using the most recent borders planning assumptions (explained below).

Border assumptions and the need for a continued multi-layered approach

The main risk to the unhindered supply of medicines and medical products presented by the UK exiting the EU without a deal remains the predicted reduced traffic flow at the short straits crossings (i.e. between Calais/Dunkirk/Coquelles and Dover/Folkestone). Around three-quarters of medicines and over half the clinical consumables the UK uses come from (or via) the EU and the vast majority are reliant on those crossings.

Contingency planning for 29th March involved a multi-layered approach of stockpiling, regulatory flexibility, and putting in place a coordinated National Supply Disruption Response system to manage issues arising following the exit day. These were supported by buying additional warehouse space for medicines and securing freight capacity on routes away from the short straits.

That approach was a response to the reasonable worst-case (RWC) planning assumption regarding the short straits issued by central government at the time, and our approach for 31st October will be determined by the latest version of these. To that end, the Government's Border Delivery Group (BDG) has been reviewing the readiness of border infrastructures and of traders to comply with customs and borders processes in the UK and the EU.

While the predicted flow rate across the short straits has improved slightly since 29th March, significant disruption would be expected for six months following a no-deal exit, with the most severe period being the first three months. Given this, it remains necessary to maintain a multi-layered approach to contingency, in order to secure continuity of supply for medicines and medical products, ahead of a potential 31st October no-deal exit.

Guidance to suppliers: A flexible approach to stockpiling and re-routing

The Department and Ministers recognise, and are extremely grateful for, the work that suppliers of medicines and medical products did in advance of 29th March and would like to thank you once again for your collaboration and efforts. Many companies have put in place detailed rerouting and stock management plans, and we are aware that many of you are currently reviewing your position, and other contingency measures. Building on this, the Government's guidance to prepare for 31st October is set out below:

Medicines suppliers

Our aim is to achieve at least the same level of assurance as before, but to give suppliers greater flexibility in terms of the balance between their stockpiling and re-routing plans to ensure a continuity of supply of their products.

All no-deal preparedness plans should therefore contain a mix of the following, depending on each company's specific situation:

- Secured capacity for rerouting freight away from the short straits after no-deal exit day, in order to avoid the worst restrictions on flow outlined above.
- Stockpiling product above and beyond business-as-usual inventory levels; as a default, this is recommended as six weeks' stock above business as usual inventory, the same as last time.
- Assurance on the readiness of a company's logistics and supply chains to meet the new customs and border requirements for both import and export (sometimes referred to as "trader readiness").

Where companies have already made plans containing these three elements, we will continue to work with you on ensuring these are robust, and help you deal with any specific product issues by exception. Where companies have not yet done so, the Government asks that they build a plan which includes a stockpile of an additional six weeks' supply in the UK, on top of operational buffer stocks, in addition to developing a robust re-routing plan away from the short straits. As before, for products with a short shelf life or where production constraints mean stockpiling is not possible, for example, medical radioisotopes, we ask for alternative air freight plans to be made.

While we advocate the above approach, we do understand that some companies may wish to adopt a different balance between stockpiling and re-routing to achieve the most effective and robust mitigation plan. In all cases, the Department will be asking companies to notify us of their plans.

In the coming days, companies will be asked to provide information at product level, focused on the minimum key data set necessary for assurance of the programme. This will build on information from the 29th March exercise, including stock levels expected to be held on 31st October and plans for re-routing away from the short straits.

Following this data collection exercise, we will ask suppliers to notify us by exception of any subsequent changes to their plans. The assurance process underpinning the programme has been refined and streamlined following feedback.

While the above advice and guidance is primarily aimed at suppliers of prescription only medicines (POMs) and pharmacy medicines (Ps) with an EU touchpoint, we have also been considering the implications of the latest border planning assumptions on suppliers of other categories of medicinal product, including critical general sales list medicines, unlicensed medicines, 'specials', and parallel imports and exports, as well as on UK manufacturers of products where raw materials may come from/via the EU/EEA. While a combination of stockpiling and re-routing, together with trader readiness, would also be advisable for these products too, we will be engaging separately with companies on their contingency plans over the coming weeks.

Medical devices and clinical consumables suppliers

In advance of 29th March, the Department, working closely with procurement and logistics services in the Devolved Administrations, developed a central stockpile of fast-moving medical devices and clinical consumables. It is intended that this stockpile will remain in place in readiness for 31st October, with some small adjustments being made to reflect changes in demand and the time of year.

As for March, this stockpile does not cover all product lines and, therefore, there will be a requirement for suppliers to implement their own preparedness arrangements, considering the balance between stockpiling and re-routing to achieve the most effective and robust mitigation plan

in the context of the anticipated disruption at the short straits. In all cases, the Department will be asking companies to notify the Department of their plans.

Government measures to support suppliers

In addition to the above guidance to industry suppliers, the Government is also taking its own steps to ensure continuity of supply of medicines and medical products in a no-deal scenario on 31st October.

Measures spanning medicines and medical products

Securing freight capacity

As above, we strongly recommend that suppliers of medicines and medical products review their supply routes and, where necessary, put in place robust plans to re-route supply away from the disrupted short straits routes into the UK, especially during the first three months following 31st October when the most significant disruption is anticipated.

In addition, the Government has also taken steps towards delivering Government-led solutions to support product re-routing, to be used to address urgent need where suppliers' arrangements encounter difficulties:

- a. DHSC will commence a procurement exercise for 'Express Freight Services' to provide access to an end-to end solution able to deliver small consignments on a 24-hour basis and a two-to-four-day pallet delivery service.
- b. The Government also intends to commence procurement of 'roll-on, roll-off' freight capacity on which medicines and medical products would be prioritised to ensure the flow of all these products may continue unimpeded.

The Department will continue to keep suppliers updated on developments on both procurement exercises once more information is available.

Changing or clarifying regulatory requirements

So that companies can continue to sell their products in the UK even if we have no deal, the Government has made changes to, or clarifications of, certain regulatory requirements.

The MHRA has, for this scenario, consulted on, and published, further guidance on how medicines, medical devices and clinical trials will be regulated. Following the consultation, three statutory instruments, covering the regulation of human medicines, medical devices and clinical trials were considered and approved by Parliament in February and March 2019. This legislation will take effect on "exit day" in the event of no deal. In August 2018, the Government also published a dedicated technical notice on the unilateral recognition of batch testing of medicines, if there is no deal. Both the guidance and the technical notice were made available in our Written Ministerial Statement to the House of Commons on 25th February.

National Supply and Disruption Response

As per arrangements put in place for March, the Department will also be operating a National Supply and Disruption Response (NSDR) unit. The contact details for the NSDR remain active and arrangements are in place to increase the capacity in this unit to support resolution of supply disruption incidents, should they arise. Full details of arrangements for alerting us to any anticipated disruption in supply across the UK will be issued closer to exit date.

Measures specific to medicines

Strengthening the processes and resources used to deal with medicines shortages

The Department's Medicine Supply Team has well established procedures to deal with medicine shortages and works closely with MHRA, the pharmaceutical industry, NHS England, the Devolved Administrations and others operating in the supply chain to help prevent shortages and to ensure that the risks to patients are minimised when they do arise.

Medicines suppliers should continue to use existing medicines reporting arrangements and alert the Department's Medicine Supply Team of any supply issues at the earliest point possible, so the Team can undertake a risk assessment and implement a management plan where required to help mitigate any potential impacts affecting patients. Guidance about the information that should be reported to the Medicine Supply Team and how to report can be found at the following link: <https://www.gov.uk/government/publications/reporting-requirements-for-medicine-shortages-and-discontinuations>.

In addition to the normal medicine shortage management route, the Department has put in place legislation to enable Ministers to issue serious shortage protocols that, where appropriate, enables community pharmacists to supply against a protocol i.e. to issue a substitute medication instead of the medication indicated on the prescription without going back to the prescriber first.

Procuring extra warehouse space

To ensure sufficient space to store stockpiled medicines ahead of a possible 29th March no-deal EU exit, my Department agreed contracts for additional warehouse space, including ambient, refrigerated and controlled drug storage. We will continue to provide warehousing capacity and will keep industry updated on how they can access this additional storage in advance of 31st October.

Moving forward together

The multi-layered approach set out above is similar to the package of measures put in place in advance of 29th March and remains essential to help ensure the continuation of medicines and medical supplies in the event of exiting the EU without a deal.

We will continue to ask health and social care service providers to avoid local stockpiling over and above business as usual ahead of 31st October as it is unnecessary and could cause shortages in other areas, which could put patient care at risk. Nor do patients need to personally stockpile medicines.

We have reflected on the planning and approach we took in advance of 29th March. While we were prepared for the event of exiting the EU without a deal, there are elements of the planning we believe we can improve in advance of 31st October. We are committed to sharing information and guidance with you at the earliest possibility to enable you to plan properly but also to ensuring that we minimise the number, length and complexity of requests for information we send to you.

To that end, in addition to ensuring that all future written updates on our EU exit planning are as clear and timely as possible, the Department will also invite you to regular supplier webinars to provide you with further information and guidance and to answer your questions. These will cover, for example, further details on the rationale for the six-week stockpiling ask in light of the latest border assumptions and how, together, government and suppliers can maximise trader readiness for the potential new customs requirements.

I hope this information is useful and provides direction to inform your own preparedness planning and arrangements. I continue to be extremely grateful for your engagement and cooperation.

Yours sincerely,



Steve Oldfield
Chief Commercial Officer

Trust Board 18 July 2019	
Patient Story – Experiences of EPIC Submitted on behalf of Alison Robertson, Chief Nurse Author: Emma James, Involvement and Engagement Officer	Paper No: Attachment L
Aims / summary <p>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 for the Trust Board. They also go to the Quality, Safety, Experience and Assurance Committee. Each story includes information on actions which were taken to improve aspects of a service, if applicable. Stories which are selected represent a range of families' experiences across a variety of wards and service areas across the divisions, ensuring that the experience of families are captured.</p> <p>The story to be shared on 18 July has been pre-recorded and details the views of three parents of inpatients at GOSH during EPIC implementation in April 2019. This was recorded a few weeks after 'go-live' and outlines the parents' experiences of communication about EPIC, challenges and benefits of the new system.</p> <p>The story highlights four key issues</p> <ol style="list-style-type: none"> 1. The parents we spoke to were aware that EPIC was coming having seen the posters and countdown clock. However, there was a mixed understanding of how EPIC would work and how families can access information via MyGOSH. 2. The parents found that the new system means that staff are able to answer any questions without having to check other systems or go away and come back. 3. The parents all experienced delays when EPIC went live particularly with medication which was often hours late. However, they all commented that this has improved. 4. The parents felt that staff were stressed and that implementation was challenging. They commented that further training may have been beneficial and that some staff were unable to sign families up to MyGOSH. 	
Action required from the meeting Review and comment	
Contribution to the delivery of NHS / Trust strategies and plans <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 Behaviours work • Quality Strategy 	

Financial implications None
Who needs to be told about any decision
Who is responsible for implementing the proposals / project and anticipated timescales Emma James – Involvement and Engagement Officer
Who is accountable for the implementation of the proposal / project Claire Williams – Interim Head of Patient Experience and Engagement
Author and date Emma James – Involvement and Engagement Officer – July 2019

Trust Board 18 July 2019	
EPR Programme Update Submitted by: Helen Vigne – Head of EPR Programme R Collins – Director of Transformation	Paper No: Attachment O EPR Programme Update
	For Information
<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.</p> <p>Summary</p> <p>The EPR Programme is currently in the planned ‘Stabilisation’ phase following the go-live on 19th April 2019. The Epic system has been successfully adopted across the organisation, but there are areas where the introduction of the new system has led to greater challenges for staff, as well as there being evidence that some individuals are coping better than others (at a service or specialty level) with the changes in process required to achieve optimum use of the system.</p> <p>Key areas of focus during stabilisation</p> <p>Some of the key areas of focus for the EPR and Trust operational / clinical teams since go-live have been Pharmacy, Radiology (and more specifically Interventional Radiology (IR)) and the prompt completion of discharge documentation and clinic letters / Referral to Treatment (RTT) status.</p> <p><u>Pharmacy</u></p> <p>There have been a number of different ‘Epic’ issues impacting the pharmacy team which in many cases have resulted in it taking longer to complete certain tasks and / or requiring additional validation. The EPR team, working closely with the Chief Pharmacist, directorate General Manager and members of the leadership team within pharmacy have established a prioritised plan for resolving the outstanding issues. This is tracked weekly with the team and additional input has been sought from Epic. University College London (UCL), which went live with Epic three weeks before GOS, has reported similar issues and there is a combined approach to design changes to the core software to better support U.K. prescribing and stock management workflows.</p> <p><u>Radiology</u></p> <p>The radiology department has identified a number of issues which have impacted the efficiency of the radiologists when reporting and undertaking multi-disciplinary team (MDT) meetings. ‘Upstream’ workflow errors by staff requesting imaging are affecting the team’s ability to record activity against the correct episode of care for the patient and it often takes considerable time to investigate and resolve the specific cause of issues. Whilst the Epic requesting, scheduling and reporting systems are all integrated within the single patient record, there are changes to the software which would alleviate some of the issues and these are being explored by the Epic team.</p> <p><u>Use of Epic data</u></p> <p>The Epic EPR system provides excellent visibility of patient safety metrics and the status of tasks within a workflow. These dashboards and reports are now being utilised more systematically by medical, nursing and operational leaders to identify trends as well as ‘deep dive’ to individual patient level. As the Trust moves forward with using the system, less time will be taken up resolving larger issues, allowing time to target support for individual users / groups. At executive / senior management level, the Epic system is starting to provide greater visibility of key safety and quality data which can be used to assess (and take action on) overall Trust performance.</p>	

EPR team support

Since go-live, the EPR team has been prioritising resolution of issues raised by users. The volume and level of complexity of issues across the different application teams has varied, and the EPR leadership team has been working with Epic to ensure additional supplier resource is brought in to support key areas. The team continues to balance resolution of issues with engagement with / direct support for end users, including:

- 'An Epic day of help' – on 27th June the EPR team, supported by members of the information and data assurance team, the PMO and other Trust staff, spent the day across all clinical and administrative areas. The team wore the pink jackets that were used over the go-live period; this was to remind end users that the team was still there to support them, and to see at first hand some of the issues and successes
- Support team – a 24*7 support team has been established, made up of staff who provide the training to our end users. This is in addition to the ICT help desk and provides direct help to end users as well as providing a focus for logging issues with the Epic application
- Our change team has continued to focus on visiting teams within the hospital to assist with some of the core administrative issues being experienced, and more broadly, members of the EPR team continue to attend specialty and departmental team meetings to gain a better understanding of the issues being reported
- There are twice weekly 'drop-in' sessions for admin and outpatient teams, a weekly 'personalisation session open to all staff (to help staff to tailor the system to their specific needs) and a session focussing on our Allied Health Professional (AHP) teams
- The Clinical & Operational Adoption Group, chaired by the Acting Chief Operating Officer, continues to meet fortnightly to prioritise issues and develop strategies to resolve high impact issues

Epic post live review

During week commencing 3rd June a team from Epic, together with our EPR analysts visited multiple operational and clinical areas to witness how the system was being used. This provide key information to help to prioritise changes within the system as well as areas which would benefit from additional education and support. All staff were also requested to complete a questionnaire which sought to understand how users were feeling about different elements of the system. This data will act as a baseline for subsequent post-live visits (the next scheduled for September 2019) to ensure that changes being made are resulting in the required improvement, particularly in terms of staff experience.

GE Finnamore have conducted their final external assurance review (1st and 2nd July). Following receipt of their report the team will evaluate any recommendations and provide responses through the existing governance fora.

Planning for Optimisation

Whilst the focus in the three months post go-live has been on stabilising the system, resolving issues and improving adoption / data quality, the EPR team has also reviewed the functional content of the latest software releases from Epic. The team will configure the system throughout the summer with testing, training (as required) and go-live planned for September 2019. In many instances, software enhancements within the upgrade will address some of the more complex issues currently being experienced by staff, but further software changes will still need to be specified for longer term improvements.

Trust Board 18th July 2019	
Children's Cancer Centre (CCC) Update	Paper No: Attachment M
Submitted by: Matthew Shaw – CEO Matthew Tulley – Development Director	
Aims / summary: <p>The updates the Board on progress with developing the CCC and aims to get agreement on a number of actions to be completed prior to submitting the final OBC in September.</p> <p>Following the meeting of the hospital and charity Boards in May the revised CCC scheme has continued to be developed. A key requirement from the Boards was the development of an ambitious vision for our cancer services to provide a context for the CCC investment. The paper describes this vision the creation of which has been a collaboration between the hospital and charity following engagement with many members of the clinical and research communities.</p> <p>The paper goes on to detail progress made in completing the Outline Business Case for the CCC, the work still to be done and sets out a proposal for engaging with Board members prior to the final OBC being submitted to the Board in September. The paper also describes the CCC project governance structure which has been agreed between the hospital and charity.</p>	
Action required from the meeting <p>The Board is asked to:</p> <ol style="list-style-type: none"> 1) Comment and approve the vision 2) Note current status and work to completed for the OBC 3) Comment on and agree the engagement process 4) Comment and approve the recommendation on funding that will be presented to the Board in September 5) Note the governance arrangements. 	
Contribution to the delivery of NHS Foundation Trust strategies and plans <p>The proposed investment contributes to all elements of the GOSH strategy</p>	
Financial implications <p>None at present. The Board will be asked to approve £8m.</p>	
Who needs to be told about any decision? <p>GOSHCC NHSE/I John Sisk & son.</p>	
Who is responsible for implementing the proposals / project and anticipated timescales? <p>Matthew Tulley – Development Director</p>	
Who is accountable for the implementation of the proposal / project? <p>Matthew Shaw – CEO</p>	

The Children's Cancer Centre

Purpose of the paper

Following the successful meeting between the Boards of the Hospital and the Charity which in principle approved the proposal for the Children's Cancer Centre work recommenced to update the Outline Business Case. It was agreed progress in the developing the OBC would be presented in July with the final OBC being submitted in September. The plan is to fully recommence design work for the CCC in October.

The Board to Board also agreed that the Hospital and Charity would work together to clearly articulate the vision of cancer services at GOSH. The team has worked with a number of clinicians to develop this vision and within this overall context articulate the purpose of the Children's Cancer Centre.

The purpose of this paper is the following:

- 1) To present the vision for cancer services at GOSH;
- 2) To provide the Board with a clear status update of each section of the OBC;
- 3) To clearly identify the areas still under development and the work required to complete the relevant sections;
- 4) To propose an approach for further development of the OBC and engagement with the Board prior to the formal September submission of the final OBC;
- 5) To agree the outcomes that will be requested at the September meeting of the Trust Board;
- 6) Provide details on the proposed governance structure.

Children's Cancer Centre – The Strategic Case

The Children's Cancer Centre at Great Ormond Street Hospital will be a national resource for children with rare and difficult-to-treat cancers. The complete vision document, co-produced by the hospital and charity, is at Appendix 1.

The vision of the Centre will be to improve outcomes for children through holistic, personalised and coordinated care across the child's entire cancer journey.

The Centre will be the physical embodiment of this aspiration and will provide inspiring and flexible spaces that can respond to the rapidly changing nature of cancer care and the research landscape. The Centre will facilitate the accelerated adoption of new innovations and models of care.

The Strategic Vision, the full version of the document is attached as an appendix, describes the service GOSH will offer to patients and their families and careers in the future. We understand the impact of a cancer diagnosis on the child and also on a wider circle of family and friends. The vision describes a service which is

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personalized using the latest advances in gene and cell therapy. It is holistic, considering and responding to all aspects of the diagnosis and treatment and their impact on physical and emotional well-being.

The vision will link our research, digital and education plans. The future cancer services will make the most of investments such as the Genomics Laboratory Hub, proton beam therapy and investment in research. Coherently linking investment in people, research and technology with the new Children's Cancer Centre creates a national resource supporting our ability to deliver holistic care, ground breaking research and allowing our patients to fulfill their potential.

In summary the CCC vision paints a picture of the cancer services of the future. It identifies a number of areas and work streams we need to focus on to deliver this vision and within this ambitious context how the CCC creates the inspiring spaces to help support our service ambitions.

Current status of the draft OBC

The OBC is structured using the standard HM Treasury five case business case model template. The structure and headings are based on recent examples of cases that have been reviewed and approved by NHSE/I.

The five sections in the model are:

- i) Strategy – why are we doing this and how does it fit with wider NHS and government policy.
- ii) Economic case – this is the options appraisal
- iii) Commercial case – is there a market for the project, ie. how will it be delivered
- iv) Financial case – impact on affordability
- v) Management case – how will the project be managed and delivered

Sections of the standard template are formulaic and to a certain extent restrictive. To counter balance this the Hospital and Charity co-authored Vision Statement captures the real ambition of the of cancer services at GOSH and how the investment in the Children's Cancer Centre supports the delivery of this vision. The vision statement will be a separate section of the business case, essentially an introduction, and we will need to ensure relevant sections are woven into the strategy section and form the main content of the executive summary.

The following status report of how far each section of the OBC has developed.

Strategy Section

The draft of this section is largely complete subject to comments. The section describes the policy context within which the investment proposal has been developed. The quality case for the investment provides the evidence supporting the value and purpose of creating the right environments to provide care and to support families, careers and our staff. The demand and capacity modeling has

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been updated which shows how the CCC supports both or future development of cancer services and frees up provision within the hospital for general growth.

Economic Section

The narrative in this section is a continuation of the options appraisal developed in the Strategic Outline Case. Three options have been progressed to be compared. The appraisal is in two parts a) qualitative and b) financial.

The qualitative appraisal of the options is complete. A multi-disciplinary team has reviewed and scored options and this work is presented in the OBC.

The quantitative analysis is work in progress. Guidance states that 30 and 60 year economic models are produced to financially evaluate the options. The work will be completed in July and August.

Commercial Section

This section is substantially complete. The procurement method selected, identifying a design team with contractor through the RIBA competitions process, has significantly satisfied the requirements of this section which traditionally asks what is the procurement approach and whether there is a market for the proposition?

The main area to be developed prior to September is the conversation between the Hospital and Charity regarding the land status of the CCC development site. The decant plan also requires further development as the funding for delivering the decant plan is an essential element of the September OBC approval.

Financial Case

This section is under development. The finance model has been created and the team are now fully focused on updating the financial model to demonstrate the financial impact of the investment. This section will require the greatest engagement with the Trust Board over the next eight weeks.

Management Case

This section is substantially complete. The management approach and structure is presented following detailed engagement between the Hospital and Charity. We have included the proposed governance structure at Appendix 2.

Work in progress and to be completed prior to September

The following is a list of work to be completed ordered by chapter:

Chapter	Work in progress	Engagement
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Strategy section	Incorporate vision document to reflect the overall ambition for the development of cancer services at GOSH.	Clinical teams Charity
Economic section	Complete quantitative evaluation.	OBC group
Commercial section	Agree land strategy. Define decant plan and procurement approach	GOSHCC Senior clinical team
Finance section	Update of LTFM is key to delivering this section. Initial workforce plan.	OBC group Finance team Workforce Estates FIC
Management case	Confirm structure with GOSHCC and develop ToRs for each group	Further review with GOSHCC FIC PAD

Development of the OBC and engagement with the Trust Board

It is important we engage with the Trust Board and Charity Trustees over the next few weeks to get feedback on the OBC and ensure the document presented in September contains all the required information in sufficient detail to support approval of the project. There is a proposal around engagement and we will facilitate whatever approach, tailored to individuals as necessary, required to support the delivery of a robust business case.

Sections of the business case will be circulated to Trust Board members and Trustees late July for review and comments. Individual/group briefings will be arranged for anyone who would find this helpful. The intent is to organize a workshop to discuss the final draft of the OBC in early September ahead of the Trust Board meeting on 18th September. The workshop will primarily address the finance section but also cover the other chapters of the OBC.

Over this period the finance section requires the most focus. There will be an update on the revision of the LTFM at the July meeting of FIC. Noted above it is planned to hold a workshop in early September to get final comments/agreement on the LTFM. FIC members may wish to discuss further engagement on 25th July.

We welcome comments on the planned engagement and suggestions to enhance the process.

Approvals process and outcome for September

The CCC programme has been revised to reflect the changes to the scope in terms of size, functional content and budget. The key programme constraints in terms of delivering the CCC are design, gaining planning approval and delivery of the decant works.

The revised programme is based on the OBC being approved by the Trust Board and Trustees in September and signing the design agreement and recommencing the design process with Sisk and BDP in October. In parallel with the CCC design development we need to deliver the Frontage Building decant works to handover the site for construction in Mid-2022.

To deliver this programme the funding approvals required in September are £16m for the CCC design development costs and £25m for the decant works. The funding principles agreed between the Boards would see GOSH contribute £8m to the design costs during the PCSA period.

The section below details our engagement with NHSE/I and the advice on third party approvals. It is important to be clear that the timetable described above is dependent on funding being released following Trust Board and Trustee approvals but prior to NHSE/I approval. The programme will extend if funding for the design and decant works becomes dependent on NHSE/I approval. The implications and consequences of this are being calculated.

Third party approvals

Following engagement with the NHSE/I capital team we have received further guidance on the external approvals process. As the proposed investment is now charitably funded with minimal impact on CDEL they have confirmed that DHSC and Treasury review and approval is not required. DHSC has requested NHSE/I keep them apprised of position as any changes to the current funding assumptions may require DHSA approval of the OBC and FBC.

The OBC and FBC do require review and approval from NHSE/I themselves. The format and timescales to undertake these reviews will now be discussed with our regional team but will follow Trust Board approval in September. Given the funding package for the project it is likely at this stage this will be a “light touch” review and approval but could still take 12-16 weeks.

Project Governance

The Trust and Charity are moving forward with the CCC scheme in partnership. There is a symbiotic relationship where success is mutually delivered and beneficial. There is agreement that an open, honest and transparent partnership is the approach that provides the best conditions for success.

The governance arrangements need to reflect the spirit of partnership at the same time as respecting the statutory responsibilities and accountabilities of the

organisations. The project management arrangements provide clear lines of accountability and responsibility as well as the provision of information and reporting. The Trust and Charity agree that whilst there are individual governance arrangements that cannot be delegated or superseded that effectively this is a joint endeavour.

The Trust and Charity agree that the project must demonstrate value for money and there is a shared objective to ensure that resources are managed efficiently and effectively to deliver the desired benefits. The parties equally have a shared incentive to ensure costs are appropriately managed maximizing the overall impact of Charity funding.

The CEOs group has been meeting regularly since February to guide the development of the revised CCC. This has worked well. The group has discussed governance arrangements to take the project forward. The proposed governance structure is shown at Appendix 2. Some key principles reflecting responsibility and accountability:

- A revised CCC Project Board is being established which will be jointly chaired by the GOSH and GOSHCC CEOs. GOSH CEO will be the Senior Responsible Officer (SRO) for the CCC project.
- Day to day delivery of the CCC is the responsibility of the GOSH Development Director reporting to the CCC project board and working within the principles and parameters set by the Project Board.
- The Project Board reports to the Trust Board and Charity Trustees (and also board sub-committees – FIC and PAD).
- The project will be subject to Gateway Reviews using the Cabinet Office Gateway Review process. It is assumed the Charity will commission an independent monitoring team.
- Proposal for three groups reporting into the Project Board.
- Business case delivery group – Chaired by Chief Nurse (Alison Robertson).
- CCC Project Team - Chaired by GOSH Development Director. There are a number of sub-groups reporting into the CCC project team.
- Fundraising panel – Charity to confirm lead.

There will be joint representation, as appropriate and desired, at all of these groups.

Conclusions and recommendations

Significant progress has been made developing and documenting the vision for the Children's Cancer Centre which provides a roadmap for delivering a world class service based on clinical care, research and teaching locally, nationally and internationally. The vision sets the capital investment within this context and

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demonstrates how the CCC will support our ambitious proposals for the development of cancer services at GOSH.

The OBC development is progressing well. The focus over the next six weeks will be completion of the financial sections. We are also undertaking refinement of the clinical brief, functional content and costings to provide robust assurance for the Boards ahead of the funding commitments we are seeking in September.

We have outlined the next stages of the approvals process. We are seeking approval of the OBC by the Trust Board and Board of Trustees in September and following this approval the funding to commence the CCC design work and the 4A decant works. We recognize this will be prior to approval from NHSE/I but is necessary to support the proposed project timetable.

Finally appropriate governance arrangements have been agreed between the hospital and charity.

Recommendations:

The Board is asked to:

- 1) Comment on the vision for cancer services at GOSH and confirm this strategic context provides the justification for the investment.
- 2) Note the progress made with the CCC OBC and the current position regarding the further work required.
- 3) Confirm the engagement planned to September is appropriate and whether the Board would wish or require any additional engagement prior to the submission of the OBC in September.
- 4) Note and confirm the approvals that the Trust Board will be asked to make in September for the funding for the design and decant works in noting this is prior to NHSE/I approval of the OBC.
- 5) Confirm the governance arrangements.

Enclosure

Appendix 1. Children's Cancer Centre – Strategic Case

Appendix 2. CCC project structure

Appendix 1

**GREAT ORMOND STREET HOSPITAL
CHILDREN'S CANCER CENTRE
STRATEGIC CASE**

**A partnership between Great Ormond Street Hospital and
Great Ormond Street Hospital Charity**

AMBITION

The Children's Cancer Centre at Great Ormond Street Hospital will be a national resource for children with rare and difficult-to-treat cancers.

The vision of the centre will be to improve outcomes for children through holistic, personalised and coordinated care, across the child's entire cancer journey.

The centre will be the physical embodiment of this aspiration and will provide inspiring and flexible spaces that can respond to the rapidly changing nature of cancer care and the research landscape. Facilitating accelerated adoption of new innovations and models of care.

STRATEGIC SUMMARY

A cancer diagnosis is instantly life changing. When a child is diagnosed with cancer, it has a big effect on them, and it is often the most difficult journey that they and their families must face. The routine of daily life changes and is replaced by frequent hospital visits and in many cases hospital stays, sometimes for up to 18 months. The time away from home may also mean time away from family, siblings, friends and school. This combined with the effects and side-effects of treatment, as well as worry about the impact of their diagnosis on their family, can affect a child's confidence and self-esteem. This can limit the ability of the child to lead an ordinary life and fulfil their potential.

Around 1,600 new cases of childhood cancer are diagnosed each year in the UK, which equates to about four children every day. As a result of investment in research and treatment, survival has increased dramatically, and four out of five children can now be successfully treated. Fifty years ago, 75 percent of children diagnosed with cancer died and today more than 75 percent survive. However, cancer remains the most common cause of death in the UK in children aged 5-14 years and around 250 children lose their lives to cancer every year. Great Ormond Street Hospital (GOSH) sees the most rare and difficult-to-treat childhood cancers and is often a place of last resort for these children.

The short- and long-term side-effects of treatment remain high for this group of children and can affect things such as mental health, sociability, education and fertility. There is an urgent need for more innovative and gentler treatments, especially as the overall number of children surviving cancer in childhood is increasing. This is now becoming a reality as a result of unparalleled advances in the understanding of the basic biology behind the disease, genomics and big data and digital technologies. These advances are making the potential for medicine limitless, and we are now in a position to develop a new paradigm based on a personalised precision medicine approach.

We are on the cusp of a revolution and from 2019, all children with cancer will be offered whole genome sequencing to enable more comprehensive and precise diagnosis. This will start to make personalised precision medicine a reality by allowing us to build a map for each individual child that will determine the best approach to treatment and the likely trajectory of their disease. This will offer hope of cure and a lifetime without treatment or worry of the disease returning. Especially with the explosion of gene and cell therapies and other advanced therapeutics that can now be used to treat diseases such as cancer. The CAR-T cell breakthrough, pioneered here at GOSH, exemplifies this (see breakout box).

How we look after children with cancer is therefore changing and this paradigm-shift will only be realised through seamless and coordinated care across the patient's entire cancer pathway, whether they are at home, in their local care community, at GOSH, or transitioning to adult or other services. Therefore, partnership at every level is integral, and GOSH is committed to playing a leading role in delivering the vision outlined in the NHS 10 year plan, which commits to develop and implement networked care to improve outcomes for children and

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young people with cancer, simplifying pathways and transitions between services and ensuring every patient has access to specialist expertise.

Improving outcomes for cancer is a major priority for the UK and paediatric cancer is assuming increasing importance. The timing is right to invest in a new Children's Cancer Centre at Great Ormond Street Hospital, creating a national resource for children with rare and difficult-to-treat cancers. There is no other place currently in the UK where the vision of the centre – to improve outcomes for children through holistic, personalised and coordinated care across the child's entire cancer journey – can be realised. This is for a number of reasons, including: the cohort of patients; the range of paediatric services including intensive care under one roof; the partnership with UCL and UCLH, including the investment in proton beam therapy; the investment in cancer research and research infrastructure such as the Genomics Laboratory Hub hosted at GOSH; our investment in digital technologies that will soon make GOSH one of the most digitally advanced hospital in the world; and GOSH's influence on national cancer committees and boards.

However, our cancer accommodation and co-dependent facilities are outdated and, in many cases, not fit-for-purpose for a modern hospital and the new innovations coming on stream. They are also fragmented at a time when the lines between in, out, day and ambulatory care services are becoming increasingly blurred. We currently see cancer patients, predominantly day cases with some overnight stays, in our oldest accommodation. In addition, we provide some of our most complex and sensitive services, oncology and neo-natal and paediatric intensive care, in facilities that will be 30 years old when the Children's Cancer Centre opens. The standard of accommodation does not meet best practice, and some of our sickest patients, undergoing chemotherapy, are treated in Safari Ward in the 1930's Southwood Building. The new Children's Cancer Centre will co-locate services in a nurturing environment and facilitate new models of care, improving clinical quality.

A true comprehensive cancer centre requires co-location of other hospital services and facilities and the Children's Cancer Centre will see our pharmacy facilities, critical for the delivery of modern cancer medication upgraded as the current facilities are cramped and not fit for purpose. In addition, there will be further investment in imaging, specifically PET-MR; and education through the relocation of the hospital school to a more prominent location, demonstrating the value we place in education as part of child's development. Finally, the Children's Cancer Centre will also provide a new front entrance for the hospital. It will create an appropriate, confident and outward physical representation of our value, our brand and place in the world.

In addition to investment in new facilities, there will be continued and sustained investment in cancer research and other cancer related programmes and initiatives that are integral to realising our vision and ensuring that the centre is a national and global resource.

Attachment M

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CAR-T therapies and Yuvan's story

CAR-T therapies are part of a new generation of personalised therapies that have been pioneered at GOSH for the treatment of acute lymphoblastic leukaemia (ALL). This cutting-edge therapy involves harnessing a type of immune system cells called T-cells to fight cancer.

Cricket fan and Lego enthusiast Yuvan was diagnosed with leukaemia in 2014 when he was six years old. His parents Sapna and Vinay say: "When Yuvan was diagnosed it was the most heart-breaking news we had ever received. We tried to stay hopeful as they say leukaemia in children has 90% cure rate, but sadly, his illness relapsed." ALL affects around 600 people per year, most of whom are children. Although treatments have improved steadily, approximately 10% of patients still relapse. Unfortunately, the standard treatments were not successful in treating Yuvan, so last year he underwent a bone marrow transplant. But, in October, he relapsed again.

In November, GOSH, along with two other UK hospitals, announced it would be one of the first hospitals to offer a treatment called Kymriah to NHS patients. Kymriah is a type of CAR-T therapy which modifies a patient's immune system cells, to attack cancer cells. This treatment has been tested in clinical trials in the US where it has been shown that approximately 50–62% of patients survive without leukaemia for 12 months or more.

Dr Sara Ghorashian, Consultant in Paediatric Haematology at GOSH and Yuvan's doctor says: "We are so pleased to be able to offer patients like Yuvan another chance to be cured. While it will be some time before the outcome of this powerful new therapy is known, the treatment has shown very promising results in clinical trials and we are hopeful that it will help". His parents Sapna and Vinay say: "This new therapy is our last hope. We are so glad that we at least have this new option. If he had relapsed a year ago it would have been a different story." Yuvan spent a lot of his time in hospital playing with Lego and drawing portraits of his nurses and doctors. He said: "I really hope I get better soon so I can visit Lego House in Denmark. I love Lego and am building a big model Bugatti while I'm in hospital."

While it will be some time before the results of his treatment are known, Yuvan has now finished the treatment and is back at home with his family. He finished building his Bugatti and has already started his next Lego project. Yuvan is eager to get back to school and see his friends, but he's still very vulnerable to infection. Sapna and Vinay are incredibly happy to have their boy home and are spending as much time as they can together as a family.



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Patient population

The hospital has some of the largest cohorts of rare disease patients anywhere in the world, providing it with an unparalleled opportunity to study these diseases and make a step-change. GOSH is the largest children's cancer unit in the UK, receiving between 300 – 400 new referrals each year, and has one of the largest cohorts of cancer patients in the world. GOSH sees the most rare and difficult-to-treat cancers. In particular, high risk brain cancers (which account for about 25%), chemotherapy resistant leukaemias (which account for about 20%), and relapsed solid tumours (which account for about 30%). The 5-year survival rate for the more difficult-to-treat childhood cancers is only about 40-50% (compared with 80-90% for those that are considered 'easier' to treat).

Widest range of specialist health services

The Hospital is the only exclusively specialist children's hospital in the UK. Most of the children cared for by GOSH are referred from other hospitals throughout the UK and overseas, more than half of the patients come from outside London. There are 63 different clinical specialties at GOSH; the UK's widest range of specialist health services for children on one site. GOSH also hosts 19 highly specialised national services. Importantly, many children need the help of different specialist teams, and this is very much the case for cancer patients because of their increasing medical complexity. This makes GOSH one of a few, if not the only, place in the UK that has the full range of specialties under-one-roof, including intensive care and BMT, needed to treat children with cancer.

As a regional, highly specialised, tertiary and quaternary referral centre, children and their families travel long distances for treatment and care at GOSH. GOSH's cancer clinicians provide care in partnership with secondary children's centres. Under these shared care arrangements, GOSH provides specialist care and most of the chemotherapy whilst the child's local hospital provides day to day care including home care, manages emergency events such as febrile neutropaenia and offers symptom control. The cancer service at GOSH sees children up to approximately age 13, at which point they are currently transferred to the service at University College Hospital.

It is important to recognise that not all children that come to GOSH to be treated for cancer survive. These children and families are supported through the Louis Dundas Centre for Children's Palliative Care (the LDC), whose mission is to reduce suffering for children with life-limiting or life-threatening conditions and for the lives of their families. The LDC is a joint initiative between GOSH and UCL GOS Institute of Child Health (ICH), bringing together academic research, education and clinical care in children's palliative care. Children's palliative and end of life care is also an important priority for the NHS. Over the next five years

NHS England will increase its contribution by match-funding clinical commissioning groups (CCGs) who commit to increase their investment in local children's palliative and end of life care services including children's hospices. This should more than double the NHS support, from £11 million up to a combined total of £25 million a year by 2023/24.

Proton beam therapy at UCLH

Two NHS centres will provide high energy proton beam therapy in the UK, The Christie NHS Foundation Trust (Manchester) which opened in 2018 and University College London Hospital (UCLH) NHS Foundation Trust which is due to open in Summer 2020. Up to 750 people will be treated at the proton beam therapy centre each year at UCLH. Proton beam therapy (PBT) is a type of radiotherapy that uses a beam of high energy protons, rather than high energy x-rays to treat specific types of cancer. A dose of high energy protons can be precisely targeted at a tumour, minimising the damage to surrounding healthy tissues and vital organs, thus reducing long-term effects associated with irradiating healthy tissues, such as problems with growth, IQ, development through puberty, hormone deficiencies, fertility, as well as an increased risk of the development of a second cancer. Proton beam is particularly suitable for complex childhood cancers and other hard to treat cancers, especially where the cancer is close to a critical part of the body such as the spinal cord.

London North Genomic Laboratory Hub

As part of NHS England's (NHSE) strategy to establish a national genomics medicine service, building on the 100,000 Genomes Project, which will ensure the NHS fully benefits from advances in genomics, NHSE has commissioned 7 genomic laboratory hubs (GLHs) as part of a national network. GOSH will host the London North GLH, which is a partnership between a number of Trusts across North London. Testing will focus on rare diseases, cancer and infectious diseases and from 2019 all paediatric cancer is moving to whole genome sequencing. No other national health system in the world is introducing sequencing in such a centralised way. Hosting the GLH will make as an even more attractive place for genomics research, as a result of improved capacity and capability.

Research

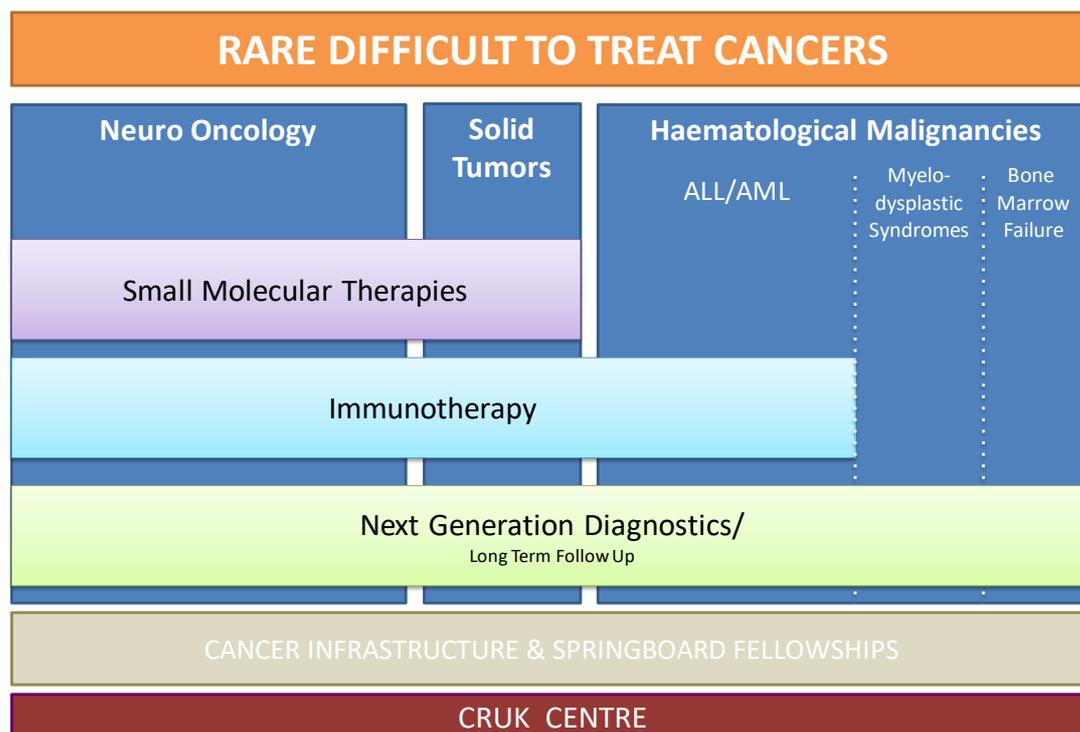
The partnership between the hospital, UCL Institute of Child Health and wider UCL, including the Crick, creates the right conditions for extraordinary problem-solving and offers an unrivalled opportunity to tackle some of the challenges faced by children with cancer. The hospital and Institute together are one of the few places in the world where truly translational paediatric research can be undertaken, and together they form the largest concentration of paediatric research expertise outside of North America. The quality of the research output has been demonstrated through bibliometric analyses that consistently put GOSH/ICH in the top three children's hospitals in the world for citation impact.

Attachment M

The environment for research at GOSH is supported by excellent local and national infrastructure. GOSH hosts the only National Institute of Health Research (NIHR) Biomedical Research Centre (BRC) in the UK focusing on paediatric research. The funding supports basic scientific discoveries made in laboratories to be translated into 'first in man' or 'first in child' clinical studies. The Zayed Centre for Research into Rare Disease in Children will be dedicated to a greater understanding of the genetic basis of rare childhood diseases, and house one of the largest GMP facilities in an academic and healthcare setting in Europe that will increase capacity to develop and offer gene and cell therapies for a large number of inherited and acquired conditions, including cancers. The hospital will also soon become one of the most advanced digital hospitals in the world through investment in the Digital Research, Informatics and Virtual Environments (DRIVE) unit. DRIVE will capitalise on the investment in the new Electronic Patient Record system and utilise the power of big data to improve patient care at GOSH and beyond, from wearable technology that can detect tiny changes in a patients vital signs, to advanced home monitoring devices which enable more sick children to be treated at home.

Research at GOSH and ICH has also received a major boost as a result of the GOSH Charity Research Strategy. The strategy was developed in collaboration with the paediatric research community and outlines a plan to create a step-change in child health research. The ambition of the strategy is 'to put the child and the adult they will become at the centre by focusing on delivering personalised medicine for children with rare and complex conditions', and during the 5-year period of the strategy, direct research commitments towards rare and complex diseases are likely to exceed £50m.

A campus-wide paediatric cancer strategy was agreed (see figure below) as part of the GOSH Charity Research Strategy, with a focus on improving survival and long-term outcomes for children with rare and difficult to treat cancers. This is a strategic initiative between GOSH, UCL's Great Ormond Street Institute of Child Health (GOS ICH), UCL's Cancer Institute and Great Ormond Street Hospital Charity. These organisations came together with a commitment to make a ~£7m strategic investment in cancer expertise to build capacity and leadership and enhance clinical trial activity. The initial tranche of funding has gone towards the establishment of two new professorial positions in neuro-oncology and malignant haematology. These appointments at UCL's Institute of Child Health will work in close collaboration with the UCL Cancer Institute and have clinical responsibilities at GOSH. Additional funding is earmarked in the next iteration of the strategy, including further investment in clinical academic leadership.



Partnership and leverage are key investment principles for the strategy, and collaborations with other charities, such as Cancer Research UK, as well as industry and other partners, will continue to be developed as a priority. This will include an evolving partnership with the Wellcome Sanger Institute around single cell sequencing of rare disease cohorts, including cancer. This partnership will aim to create a 'super highway' between GOSH and the Sanger Institute, capitalising on the incredible rare disease patient population at GOSH and the sequencing power of the Sanger, to develop new insights and scientific thinking.

Holistic care and support

The families who come to GOSH are incredibly resilient, but a little support can go a long way. GOSH Charity funds programmes and services that ease some of the stress on children and families during their stay at the hospital. There's increasing evidence that this holistic approach to care — offering support beyond medical care — can help children recover more quickly, avoid traumatic experiences, and reduce the risk of associated mental health problems now and in the future.

This support includes programmes and services such as the: Play Team, that use distraction and other techniques to reduce anxiety; GOSH Arts; the Citizens Advice Bureau; the Social Work team; spiritual support; patient parties; family assistance vouchers; and accommodation for patients and families who need to be near the hospital. These added value programmes improve the experience for families, making a difficult time that bit easier and we will continue to work with families to tailor the support that is provided.

WHAT FACILITIES ARE NEEDED TO DELIVER A COMPREHENSIVE CHILDREN'S CANCER CENTRE AT GREAT ORMOND STREET HOSPITAL?

There is increasing evidence of the benefit of improved environments across the spectrum of hospital care. It has been shown that improved physical settings can be an important tool in making hospitals safer, more healing, and better place to work. For many families and this is especially the case for cancer, stays at GOSH can be months and a nurturing homely and child-friendly environment is therefore important in reducing stress and promoting wellbeing, for both patients and families.

The new Children's Cancer Centre will be the physical embodiment of our cancer vision, providing inspiring and flexible spaces that can respond to the rapidly changing nature of cancer care and the research landscape. This will facilitate accelerated adoption of new innovations and models of care, ultimately improving clinical outcomes. The building will also provide a new front entrance for the hospital, which currently can be difficult to find on your first appointment. The new front entrance will give GOSH a greater sense of identity and be a more welcoming experience for all who come to the hospital, creating an entrance that draws you in and provides immediate comfort and reassurance.

Flexible and co-located clinical care pathways

The Children's Cancer Centre will provide the most integrated pathway of care possible, improving the experience for families. The centre will improve flow across inpatient, day care, outpatient and ambulatory care facilities, which will also create staffing and other efficiencies across the entire multi-disciplinary team (MDT). Flexible and adaptable spaces are vital to facilitate this model of care, especially in the rapidly changing cancer care and research landscape. In this fast-moving environment, flexibility and adaptability will also encourage new and less traditional/outmoded ways of working.

It is difficult to predict what cancer care will look like in 10 years' time, so the building needs to be able to adapt flexibly to new models of care, which may include an increased reliance on tele-medicine, greater care at home and in the community perhaps linked to the incorporation of wearable sensors transmitting data to GOSH in real time, as well as changes to the age that children transition to adult services. Furthermore, the configuration of rooms may need to change from low intensity to high intensity or from a room with beds to one with chemotherapy chairs for adolescent patients.

Finally, as the time approaches for children to leave the hospital, step-down accommodation is important for successfully transitioning children back to home and their local community. Especially as around 50% of GOSH's inpatients come from outside of London. The patient hotel, supported by the charity, has enabled GOSH to change its model of care. The building combines short stay accommodation to facilitate children and families coming in for day treatment with long term accommodation for families of children with complex needs who

benefit from learning skills in a homely environment before taking their child home.

Research Hospital

The hospital is transitioning from a hospital which undertakes research to a 'Research Hospital'. This means that every child and family referred to the Hospital will have an opportunity to participate in research and where research occurs throughout the hospital irrespective of where the children and families are physically located. This is particularly important for cancer, where almost every child is either on a clinical trial or other research protocol, meaning that children have access to the very latest treatments. The hospital also has the highest trial recruitment for paediatrics and therefore in the new Children's Cancer Centre, the intention is that every bed will be considered a research bed, and there will be no differentiation between the two. This approach will also continue to be complemented by the National Institute for Health Research (NIHR) Great Ormond Street Hospital (GOSH) Clinical Research Facility (CRF), which provides specialist day care accommodation for children and young people taking part in clinical research studies.

As part of our Research Hospital strategy we are also considering introducing integrated diagnostic Laboratory Medicine Platforms for advanced sample processing. This will enable faster and more accurate diagnosis and the development of new techniques that were previously not possible. GOSH can offer a unique diagnostic testing repertoire because of the collective knowledge and expertise under one roof. However, the current model, while successful, encourages silos of working and does not facilitate sharing of information, results, processes, techniques and resources. It also limits collaboration and potential for future services and does not support the research hospital vision. Although this facility will not be in the centre, its development will improve the speed to diagnosis for cancer and other rare diseases seen at GOSH.

Pharmacy – Children's Medicines Centre

Pharmacy is at the heart of the hospital and integral to all aspects of care and treatment. The pharmacy at the hospital operates at the highest level and is unlike an ordinary pharmacy due to the sophistication of care; the research and clinical trials that are undertaken across the Trust (there are 7-8 clinical trial pharmacists alone); the technology; as well as the acuity of the patients.

The pharmacy comprises three areas: 1) the dispensary; 2) the production facility, for things such as cytotoxic reagents (chemotherapy) and Total Parenteral Nutrition (TPN); and 3) the GMP facility, for the production of clinical grade gene and cell therapies, which will be accommodated in the Zayed Centre for Research into Rare Disease in Children. However, current facilities are fragmented, cramped and not fit for purpose and demand is exceeding capacity, especially with the increasing number of clinical trials. The layout of the pharmacy means an increased risk of errors.

The new Children's Cancer Centre will see our pharmacy facilities upgraded and co-located, excluding the GMP. It will see the creation of the Children's Medicines Centre, which in partnership with UCL, will create an internationally leading academic pharmacy programme. This research programme will develop and test new formulations and methods of drug delivery. This could lead to improved drug compliance and therefore ultimately improved outcomes for children.

Medical Imaging

Imaging technology is a critical part of cancer diagnosis and prognosis, including response to treatment. New techniques allow visualisation with more detail and clarity than ever before. The Trust has invested significantly in imaging over the last 5 years, with support from the charity. Including but not exclusively, the Turtle Imaging Suite with a state-of-the-art MRI and CT scanner, new SPECT-CT and Cardiac Catheter Lab, intraoperative MRI (iMRI), as well as upgrades of existing MR scanners. These advances have dramatically improved image quality, led to faster and more accurate diagnoses and faster scans have reduced the need for anaesthetic, as well as waiting times. Importantly, when it comes to CT, radiation exposure has been reduced to by up to 50%, making scans much safer.

However, further capacity is required, and a PET-MR will be a part of the Children's Cancer Centre, providing even more sophisticated imaging modalities on site that are essential for cancer diagnosis. Currently PET-MR is accessed at UCLH, however, only one slot is available per week and this could therefore compromise treatment through delay or if children are too sick to be transferred.

Hospital School

Education is arguably the next most important thing for children after health. The new Children's Cancer Centre will provide a flagship school for the whole hospital, a clear demonstration of the value that GOSH places on education and the interactions that come through learning. The school is also psychologically important for children and their families, helping to maintain a sense of normality away from the clinical environment and preparing children for a life beyond the hospital.

The school will offer fully accessible schoolrooms – a space where patients do not need to be taken back to the ward for toilet breaks. There will also be dedicated space for short, simple medical procedures allowing patients longer periods of uninterrupted learning, and private spaces for patients taking GCSE's or A levels during their stay.

The new building will aim to also offer a safe space for immune compromised children (such as cancer patients) to learn. This will be facilitated through improved air handling that will enable vulnerable children to be schooled there. Hence, this will allow patients who are currently taught one-to-one at the bedside for limited periods of time, greater access to teaching and resources. It is also hoped that with new ways of treating cancer, children are likely to be less

sick and therefore potentially able to benefit from the school if it is nearby. Ultimately, the support structure of the school, will not only help children make academic progress but also in improve their health and wellbeing.

Respite spaces for patients, families and health care professionals

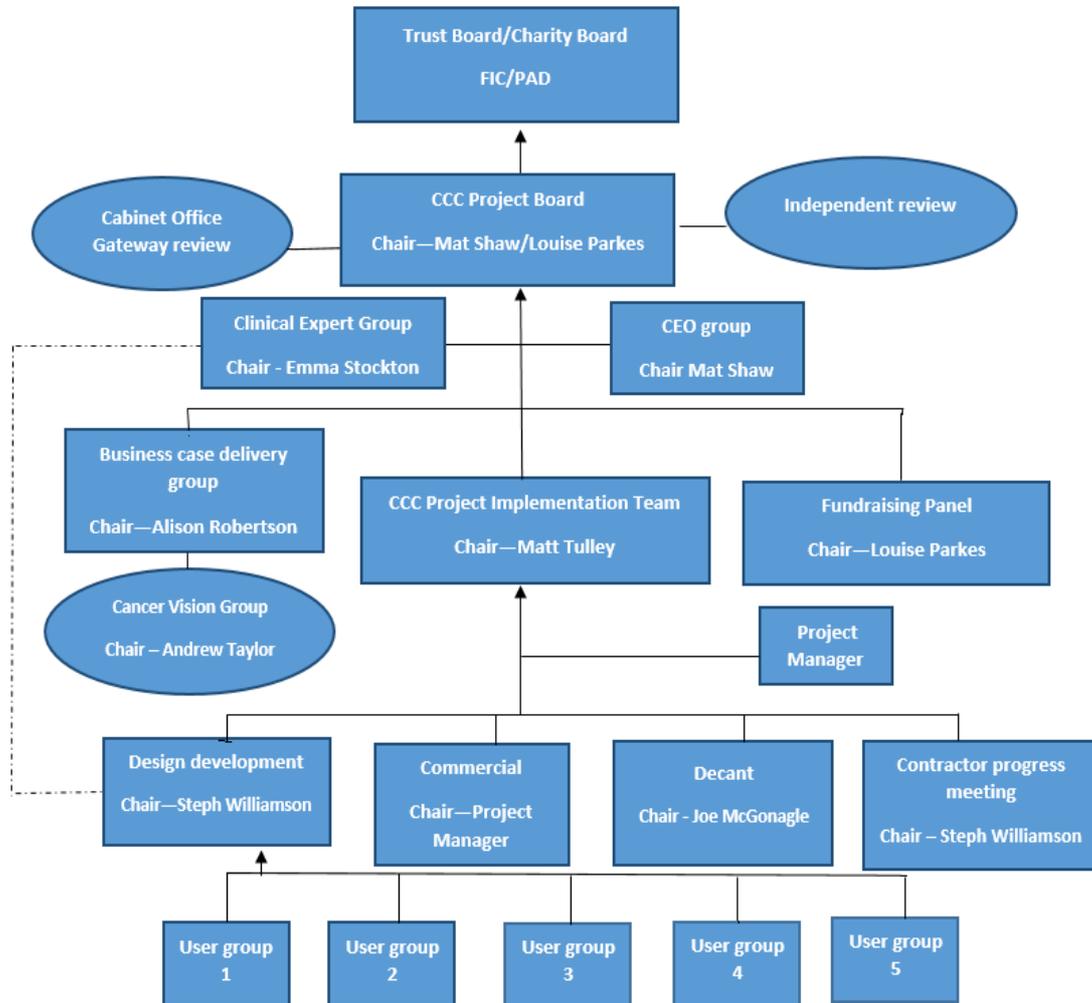
Respite spaces will form an important part of the hospital, promoting wellbeing. This will include play areas for younger children, relaxation areas for older children, spaces for parents to rest, as well as quiet areas for staff to have a break and meet as an MDT. Consideration will also be given to introducing a dedicated chef on the ward for the children. Children with cancer have cravings, get hungry at different times and their palate generally changes. A chef will make a huge difference to the mental and physical wellbeing of these children, helping to support their recovery.

CONCLUSION

The Children's Cancer Centre has the potential to impact children's health nationally and internationally and make a lasting and tangible impact on cancer outcomes and the delivery of personalised medicine for children with rare and difficult-to-treat cancers. Advances in medicine can be truly life changing and replace fear with hope and improve quality of life for children and their families. We have had some exceptional successes, but there is a lot more that we can offer these children, and this is the focus that keeps us moving. Ultimately, in keeping with our mission, we hope that our vision and investment in cancer will mean that more children will be able to fulfil their potential. We enter this next phase with huge optimism and excitement. It's a big and ambitious challenge but we are starting from strong foundations and children are relying on us.

Appendix 2

CCC Project structure



GREAT ORMOND STREET HOSPITAL

CHILDREN'S CANCER CENTRE

STRATEGIC CASE

**A partnership between Great Ormond Street Hospital and
Great Ormond Street Hospital Charity**

AMBITION

The Children's Cancer Centre at Great Ormond Street Hospital will be a national resource for children with rare and difficult-to-treat cancers.

The vision of the centre will be to improve outcomes for children through holistic, personalised and coordinated care, across the child's entire cancer journey.

The centre will be the physical embodiment of this aspiration and will provide inspiring and flexible spaces that can respond to the rapidly changing nature of cancer care and the research landscape. Facilitating accelerated adoption of new innovations and models of care.

STRATEGIC SUMMARY

A cancer diagnosis is instantly life changing. When a child is diagnosed with cancer, it has a big effect on them, and it is often the most difficult journey that they and their families must face. The routine of daily life changes and is replaced by frequent hospital visits and in many cases hospital stays, sometimes for up to 18 months. The time away from home may also mean time away from family, siblings, friends and school. This combined with the effects and side-effects of treatment, as well as worry about the impact of their diagnosis on their family, can affect a child's confidence and self-esteem. This can limit the ability of the child to lead an ordinary life and fulfil their potential.

Around 1,600 new cases of childhood cancer are diagnosed each year in the UK, which equates to about four children every day. As a result of investment in research and treatment, survival has increased dramatically, and four out of five children can now be successfully treated. Fifty years ago, 75 percent of children diagnosed with cancer died and today more than 75 percent survive. However, cancer remains the most common cause of death in the UK in children aged 5-14 years and around 250 children lose their lives to cancer every year. Great Ormond Street Hospital (GOSH) sees the most rare and difficult-to-treat childhood cancers and is often a place of last resort for these children.

The short- and long-term side-effects of treatment remain high for this group of children and can affect things such as mental health, sociability, education and fertility. There is an urgent need for more innovative and gentler treatments, especially as the overall number of children surviving cancer in childhood is increasing. This is now becoming a reality as a result of unparalleled advances in the understanding of the basic biology behind the disease, genomics and big data and digital technologies. These advances are making the potential for medicine limitless, and we are now in a position to develop a new paradigm based on a personalised precision medicine approach.

We are on the cusp of a revolution and from 2019, all children with cancer will be offered whole genome sequencing to enable more comprehensive and precise diagnosis. This will start to make personalised precision medicine a reality by allowing us to build a map for each individual child that will determine the best approach to treatment and the likely trajectory of their disease. This will offer hope of cure and a lifetime without treatment or worry of the disease returning. Especially with the explosion of gene and cell therapies and other advanced therapeutics that can now be used to treat diseases such as cancer. The CAR-T cell breakthrough, pioneered here at GOSH, exemplifies this (see breakout box).

How we look after children with cancer is therefore changing and this paradigm-shift will only be realised through seamless and coordinated care across the patient's entire cancer pathway, whether they are at home, in their local care community, at GOSH, or transitioning to adult or other services. Therefore, partnership at every level is integral, and GOSH is committed to playing a leading role in delivering the vision outlined in the NHS 10 year plan, which commits to develop and implement networked care to improve outcomes for children and young people with cancer, simplifying pathways and transitions between services and ensuring every patient has access to specialist expertise.

Improving outcomes for cancer is a major priority for the UK and paediatric cancer is assuming increasing importance. The timing is right to invest in a new Children's Cancer Centre at Great Ormond Street Hospital, creating a national resource for children with rare

and difficult-to-treat cancers. There is no other place currently in the UK where the vision of the centre – to improve outcomes for children through holistic, personalised and coordinated care across the child’s entire cancer journey – can be realised. This is for a number of reasons, including: the cohort of patients; the range of paediatric services including intensive care under one roof; the partnership with UCL and UCLH, including the investment in proton beam therapy; the investment in cancer research and research infrastructure such as the Genomics Laboratory Hub hosted at GOSH; our investment in digital technologies that will soon make GOSH one of the most digitally advanced hospital in the world; and GOSH’s influence on national cancer committees and boards.

However, our cancer accommodation and co-dependent facilities are outdated and, in many cases, not fit-for-purpose for a modern hospital and the new innovations coming on stream. They are also fragmented at a time when the lines between in, out, day and ambulatory care services are becoming increasingly blurred. We currently see cancer patients, predominantly day cases with some overnight stays, in our oldest accommodation. In addition, we provide some of our most complex and sensitive services, oncology and neonatal and paediatric intensive care, in facilities that will be 30 years old when the Children’s Cancer Centre opens. The standard of accommodation does not meet best practice, and some of our sickest patients, undergoing chemotherapy, are treated in Safari Ward in the 1930’s Southwood Building. The new Children’s Cancer Centre will co-locate services in a nurturing environment and facilitate new models of care, improving clinical quality.

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CAR-T therapies and Yuvan's story

CAR-T therapies are part of a new generation of personalised therapies that have been pioneered at GOSH for the treatment of acute lymphoblastic leukaemia (ALL). This cutting-edge therapy involves harnessing a type of immune system cells called T-cells to fight cancer.

Cricket fan and Lego enthusiast Yuvan was diagnosed with leukaemia in 2014 when he was six years old. His parents Sapna and Vinay say: "When Yuvan was diagnosed it was the most heart-breaking news we had ever received. We tried to stay hopeful as they say leukaemia in children has 90% cure rate, but sadly, his illness relapsed." ALL affects around 600 people per year, most of whom are children. Although treatments have improved steadily, approximately 10% of patients still relapse. Unfortunately, the standard treatments were not successful in treating Yuvan, so last year he underwent a bone marrow transplant. But, in October, he relapsed again.

In November, GOSH, along with two other UK hospitals, announced it would be one of the first hospitals to offer a treatment called Kymriah to NHS patients. Kymriah is a type of CAR-T therapy which modifies a patient's immune system cells, to attack cancer cells. This treatment has been tested in clinical trials in the US where it has been shown that approximately 50–62% of patients survive without leukaemia for 12 months or more.

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While it will be some time before the results of his treatment are known, Yuvan has now finished the treatment and is back at home with his family. He finished building his Bugatti and has already started his next Lego project. Yuvan is eager to get back to school and see his friends, but he's still very vulnerable to infection. Sapna and Vinay are incredibly happy to have their boy home and are spending as much time as they can together as a family.



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The hospital has some of the largest cohorts of rare disease patients anywhere in the world, providing it with an unparalleled opportunity to study these diseases and make a step-change. GOSH is the largest children's cancer unit in the UK, receiving between 300 – 400 new referrals each year, and has one of the largest cohorts of cancer patients in the world. GOSH sees the most rare and difficult-to-treat cancers. In particular, high risk brain cancers (which account for about 25%), chemotherapy resistant leukaemias (which account for about 20%), and relapsed solid tumours (which account for about 30%). The 5-year survival rate for the more difficult-to-treat childhood cancers is only about 40-50% (compared with 80-90% for those that are considered 'easier' to treat).

Widest range of specialist health services

The Hospital is the only exclusively specialist children's hospital in the UK. Most of the children cared for by GOSH are referred from other hospitals throughout the UK and overseas, more than half of the patients come from outside London. There are 63 different clinical specialties at GOSH; the UK's widest range of specialist health services for children on one site. GOSH also hosts 19 highly specialised national services. Importantly, many children need the help of different specialist teams, and this is very much the case for cancer patients because of their increasing medical complexity. This makes GOSH one of a few, if not the only, place in the UK that has the full range of specialties under-one-roof, including intensive care and BMT, needed to treat children with cancer.

As a regional, highly specialised, tertiary and quaternary referral centre, children and their families travel long distances for treatment and care at GOSH. GOSH's cancer clinicians provide care in partnership with secondary children's centres. Under these shared care arrangements, GOSH provides specialist care and most of the chemotherapy whilst the child's local hospital provides day to day care including home care, manages emergency events such as febrile neutropaenia and offers symptom control. The cancer service at GOSH sees children up to approximately age 13, at which point they are currently transferred to the service at University College Hospital.

It is important to recognise that not all children that come to GOSH to be treated for cancer survive. These children and families are supported through the Louis Dundas Centre for Children's Palliative Care (the LDC), whose mission is to reduce suffering for children with life-limiting or life-threatening conditions and for the lives of their families. The LDC is a joint initiative between GOSH and UCL GOS Institute of Child Health (ICH), bringing together academic research, education and clinical care in children's palliative care. Children's palliative and end of life care is also an important priority for the NHS. Over the next five years NHS England will increase its contribution by match-funding clinical commissioning groups (CCGs) who commit to increase their investment in local children's palliative and end

of life care services including children's hospices. This should more than double the NHS support, from £11 million up to a combined total of £25 million a year by 2023/24.

Proton beam therapy at UCLH

Two NHS centres will provide high energy proton beam therapy in the UK, The Christie NHS Foundation Trust (Manchester) which opened in 2018 and University College London Hospital (UCLH) NHS Foundation Trust which is due to open in Summer 2020. Up to 750 people will be treated at the proton beam therapy centre each year at UCLH. Proton beam therapy (PBT) is a type of radiotherapy that uses a beam of high energy protons, rather than high energy x-rays to treat specific types of cancer. A dose of high energy protons can be precisely targeted at a tumour, minimising the damage to surrounding healthy tissues and vital organs, thus reducing long-term effects associated with irradiating healthy tissues, such as problems with growth, IQ, development through puberty, hormone deficiencies, fertility, as well as an increased risk of the development of a second cancer. Proton beam is particularly suitable for complex childhood cancers and other hard to treat cancers, especially where the cancer is close to a critical part of the body such as the spinal cord.

London North Genomic Laboratory Hub

As part of NHS England's (NHSE) strategy to establish a national genomics medicine service, building on the 100,000 Genomes Project, which will ensure the NHS fully benefits from advances in genomics, NHSE has commissioned 7 genomic laboratory hubs (GLHs) as part of a national network. GOSH will host the London North GLH, which is a partnership between a number of Trusts across North London. Testing will focus on rare diseases, cancer and infectious diseases and from 2019 all paediatric cancer is moving to whole genome sequencing. No other national health system in the world is introducing sequencing in such a centralised way. Hosting the GLH will make as an even more attractive place for genomics research, as a result of improved capacity and capability.

Research

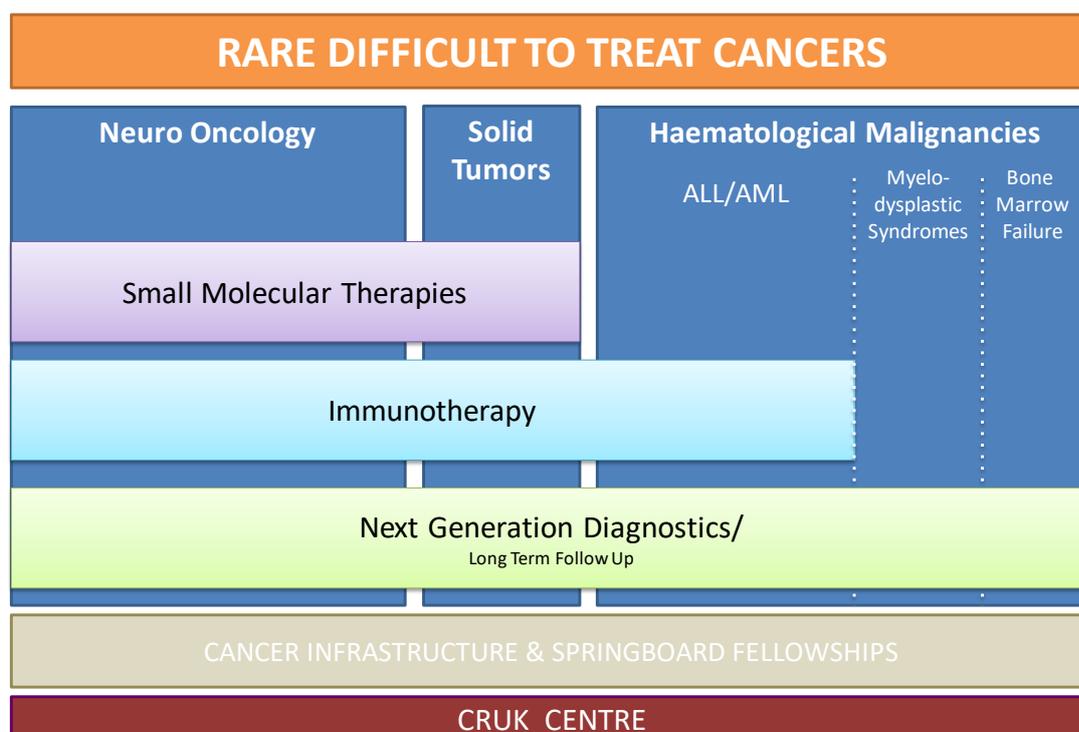
The partnership between the hospital, UCL Institute of Child Health and wider UCL, including the Crick, creates the right conditions for extraordinary problem-solving and offers an unrivalled opportunity to tackle some of the challenges faced by children with cancer. The hospital and Institute together are one of the few places in the world where truly translational paediatric research can be undertaken, and together they form the largest concentration of paediatric research expertise outside of North America. The quality of the research output has been demonstrated through bibliometric analyses that consistently put GOSH/ICH in the top three children's hospitals in the world for citation impact.

The environment for research at GOSH is supported by excellent local and national infrastructure. GOSH hosts the only National Institute of Health Research (NIHR) Biomedical Research Centre (BRC) in the UK focusing on paediatric research. The funding supports basic scientific discoveries made in laboratories to be translated into 'first in man' or 'first in child' clinical studies. The Zayed Centre for Research into Rare Disease in Children will be dedicated to a greater understanding of the genetic basis of rare childhood diseases, and house one of the largest GMP facilities in an academic and healthcare setting in Europe that will increase capacity to develop and offer gene and cell therapies for a large number of inherited and acquired conditions, including cancers. The hospital will also soon become one of the most advanced digital hospitals in the world through investment in the Digital

Research, Informatics and Virtual Environments (DRIVE) unit. DRIVE will capitalise on the investment in the new Electronic Patient Record system and utilise the power of big data to improve patient care at GOSH and beyond, from wearable technology that can detect tiny changes in a patients vital signs, to advanced home monitoring devices which enable more sick children to be treated at home.

Research at GOSH and ICH has also received a major boost as a result of the GOSH Charity Research Strategy. The strategy was developed in collaboration with the paediatric research community and outlines a plan to create a step-change in child health research. The ambition of the strategy is 'to put the child and the adult they will become at the centre by focusing on delivering personalised medicine for children with rare and complex conditions', and during the 5-year period of the strategy, direct research commitments towards rare and complex diseases are likely to exceed £50m.

A campus-wide paediatric cancer strategy was agreed (see figure below) as part of the GOSH Charity Research Strategy, with a focus on improving survival and long-term outcomes for children with rare and difficult to treat cancers. This is a strategic initiative between GOSH, UCL's Great Ormond Street Institute of Child Health (GOS ICH), UCL's Cancer Institute and Great Ormond Street Hospital Charity. These organisations came together with a commitment to make a ~£7m strategic investment in cancer expertise to build capacity and leadership and enhance clinical trial activity. The initial tranche of funding has gone towards the establishment of two new professorial positions in neuro-oncology and malignant haematology. These appointments at UCL's Institute of Child Health will work in close collaboration with the UCL Cancer Institute and have clinical responsibilities at GOSH. Additional funding is earmarked in the next iteration of the strategy, including further investment in clinical academic leadership.



Partnership and leverage are key investment principles for the strategy, and collaborations with other charities, such as Cancer Research UK, as well as industry and other partners, will continue to be developed as a priority. This will include an evolving partnership with the Wellcome Sanger Institute around single cell sequencing of rare disease cohorts, including cancer. This partnership will aim to create a 'super highway' between GOSH and the Sanger Institute, capitalising on the incredible rare disease patient population at GOSH and the sequencing power of the Sanger, to develop new insights and scientific thinking.

Holistic care and support

The families who come to GOSH are incredibly resilient, but a little support can go a long way. GOSH Charity funds programmes and services that ease some of the stress on children and families during their stay at the hospital. There's increasing evidence that this holistic approach to care — offering support beyond medical care — can help children recover more quickly, avoid traumatic experiences, and reduce the risk of associated mental health problems now and in the future.

This support includes programmes and services such as the: Play Team, that use distraction and other techniques to reduce anxiety; GOSH Arts; the Citizens Advice Bureau; the Social Work team; spiritual support; patient parties; family assistance vouchers; and accommodation for patients and families who need to be near the hospital. These added value programmes improve the experience for families, making a difficult time that bit easier and we will continue to work with families to tailor the support that is provided.

WHAT FACILITIES ARE NEEDED TO DELIVER A COMPREHENSIVE CHILDREN'S CANCER CENTRE AT GREAT ORMOND STREET HOSPITAL?

There is increasing evidence of the benefit of improved environments across the spectrum of hospital care. It has been shown that improved physical settings can be an important tool in making hospitals safer, more healing, and better place to work. For many families and this is especially the case for cancer, stays at GOSH can be months and a nurturing homely and child-friendly environment is therefore important in reducing stress and promoting wellbeing, for both patients and families.

The new Children's Cancer Centre will be the physical embodiment of our cancer vision, providing inspiring and flexible spaces that can respond to the rapidly changing nature of cancer care and the research landscape. This will facilitate accelerated adoption of new innovations and models of care, ultimately improving clinical outcomes. The building will also provide a new front entrance for the hospital, which currently can be difficult to find on your first appointment. The new front entrance will give GOSH a greater sense of identity and be a more welcoming experience for all who come to the hospital, creating an entrance that draws you in and provides immediate comfort and re-assurance.

Flexible and co-located clinical care pathways

The Children's Cancer Centre will provide the most integrated pathway of care possible, improving the experience for families. The centre will improve flow across inpatient, day care, outpatient and ambulatory care facilities, which will also create staffing and other efficiencies across the entire multi-disciplinary team (MDT). Flexible and adaptable spaces are vital to facilitate this model of care, especially in the rapidly changing cancer care and research landscape. In this fast-moving environment, flexibility and adaptability will also encourage new and less traditional/outmoded ways of working.

It is difficult to predict what cancer care will look like in 10 years' time, so the building needs to be able to adapt flexibly to new models of care, which may include an increased reliance on tele-medicine, greater care at home and in the community perhaps linked to the incorporation of wearable sensors transmitting data to GOSH in real time, as well as changes to the age that children transition to adult services. Furthermore, the configuration of rooms may need to change from low intensity to high intensity or from a room with beds to one with chemotherapy chairs for adolescent patients.

Finally, as the time approaches for children to leave the hospital, step-down accommodation is important for successfully transitioning children back to home and their local community. Especially as around 50% of GOSH's inpatients come from outside of London. The patient hotel, supported by the charity, has enabled GOSH to change its model of care. The building combines short stay accommodation to facilitate children and families coming in for day treatment with long term accommodation for families of children with complex needs who benefit from learning skills in a homely environment before taking their child home.

Research Hospital

The hospital is transitioning from a hospital which undertakes research to a 'Research Hospital'. This means that every child and family referred to the Hospital will have an

opportunity to participate in research and where research occurs throughout the hospital irrespective of where the children and families are physically located. This is particularly important for cancer, where almost every child is either on a clinical trial or other research protocol, meaning that children have access to the very latest treatments. The hospital also has the highest trial recruitment for paediatrics and therefore in the new Children's Cancer Centre, the intention is that every bed will be considered a research bed, and there will be no differentiation between the two. This approach will also continue to be complemented by the National Institute for Health Research (NIHR) Great Ormond Street Hospital (GOSH) Clinical Research Facility (CRF), which provides specialist day care accommodation for children and young people taking part in clinical research studies.

As part of our Research Hospital strategy we are also considering introducing integrated diagnostic Laboratory Medicine Platforms for advanced sample processing. This will enable faster and more accurate diagnosis and the development of new techniques that were previously not possible. GOSH can offer a unique diagnostic testing repertoire because of the collective knowledge and expertise under one roof. However, the current model, while successful, encourages silos of working and does not facilitate sharing of information, results, processes, techniques and resources. It also limits collaboration and potential for future services and does not support the research hospital vision. Although this facility will not be in the centre, its development will improve the speed to diagnosis for cancer and other rare diseases seen at GOSH.

Pharmacy – Children's Medicines Centre

Pharmacy is at the heart of the hospital and integral to all aspects of care and treatment. The pharmacy at the hospital operates at the highest level and is unlike an ordinary pharmacy due to the sophistication of care; the research and clinical trials that are undertaken across the Trust (there are 7-8 clinical trial pharmacists alone); the technology; as well as the acuity of the patients.

The pharmacy comprises three areas: 1) the dispensary; 2) the production facility, for things such as cytotoxic reagents (chemotherapy) and Total Parenteral Nutrition (TPN); and 3) the GMP facility, for the production of clinical grade gene and cell therapies, which will be accommodated in the Zayed Centre for Research into Rare Disease in Children. However, current facilities are fragmented, cramped and not fit for purpose and demand is exceeding capacity, especially with the increasing number of clinical trials. The layout of the pharmacy means an increased risk of errors.

The new Children's Cancer Centre will see our pharmacy facilities upgraded and co-located, excluding the GMP. It will see the creation of the Children's Medicines Centre, which in partnership with UCL, will create an internationally leading academic pharmacy programme. This research programme will develop and test new formulations and methods of drug delivery. This could lead to improved drug compliance and therefore ultimately improved outcomes for children.

Medical Imaging

Imaging technology is a critical part of cancer diagnosis and prognosis, including response to treatment. New techniques allow visualisation with more detail and clarity than ever before. The Trust has invested significantly in imaging over the last 5 years, with support from the

charity. Including but not exclusively, the Turtle Imaging Suite with a state-of-the-art MRI and CT scanner, new SPECT-CT and Cardiac Catheter Lab, intraoperative MRI (iMRI), as well as upgrades of existing MR scanners. These advances have dramatically improved image quality, led to faster and more accurate diagnoses and faster scans have reduced the need for anaesthetic, as well as waiting times. Importantly, when it comes to CT, radiation exposure has been reduced to by up to 50%, making scans much safer.

However, further capacity is required, and a PET-MR will be a part of the Children's Cancer Centre, providing even more sophisticated imaging modalities on site that are essential for cancer diagnosis. Currently PET-MR is accessed at UCLH, however, only one slot is available per week and this could therefore compromise treatment through delay or if children are too sick to be transferred.

Hospital School

Education is arguably the next most important thing for children after health. The new Children's Cancer Centre will provide a flagship school for the whole hospital, a clear demonstration of the value that GOSH places on education and the interactions that come through learning. The school is also psychologically important for children and their families, helping to maintain a sense of normality away from the clinical environment and preparing children for a life beyond the hospital.

The school will offer fully accessible schoolrooms – a space where patients do not need to be taken back to the ward for toilet breaks. There will also be dedicated space for short, simple medical procedures allowing patients longer periods of uninterrupted learning, and private spaces for patients taking GCSE's or A levels during their stay.

The new building will aim to also offer a safe space for immune compromised children (such as cancer patients) to learn. This will be facilitated through improved air handling that will enable vulnerable children to be schooled there. Hence, this will allow patients who are currently taught one-to-one at the bedside for limited periods of time, greater access to teaching and resources. It is also hoped that with new ways of treating cancer, children are likely to be less sick and therefore potentially able to benefit from the school if it is nearby. Ultimately, the support structure of the school, will not only help children make academic progress but also in improve their health and wellbeing.

Respite spaces for patients, families and health care professionals

Respite spaces will form an important part of the hospital, promoting wellbeing. This will include play areas for younger children, relaxation areas for older children, spaces for parents to rest, as well as quiet areas for staff to have a break and meet as an MDT. Consideration will also be given to introducing a dedicated chef on the ward for the children. Children with cancer have cravings, get hungry at different times and their palate generally changes. A chef will make a huge difference to the mental and physical wellbeing of these children, helping to support their recovery.

CONCLUSION

The Children's Cancer Centre has the potential to impact children's health nationally and internationally and make a lasting and tangible impact on cancer outcomes and the delivery of personalised medicine for children with rare and difficult-to-treat cancers. Advances in medicine can be truly life changing and replace fear with hope and improve quality of life for children and their families. We have had some exceptional successes, but there is a lot more that we can offer these children, and this is the focus that keeps us moving. Ultimately, in keeping with our mission, we hope that our vision and investment in cancer will mean that more children will be able to fulfil their potential. We enter this next phase with huge optimism and excitement. It's a big and ambitious challenge but we are starting from strong foundations and children are relying on us.

<p>Trust Board 18 July 2019</p>	
<p>GOSH Learning Academy: Charity Grants Case</p> <p>Submitted by: Lynn Shields – Director of Education</p>	<p>Paper No: Attachment N</p> <p><i>A Case for the GOSH Learning Academy – V2.0</i></p>
<p>Aims / summary</p> <p><i>From coversheet submission to GOSH Children’s Charity (GOSHCC) Grants Committee drafted in collaboration with GOSHCC Grants Director:</i></p> <p><i>Education is the third pillar of Great Ormond Street Hospital’s core mission, alongside research and care. To date, education has not received the same level of focus and attention as other areas, despite it being a high priority for the Trust. Education supports the creation of a positive culture by attracting and retaining talented people and providing them with the skills and capabilities needed to deliver excellent care. It was therefore agreed by GOSH Charity as part of the Hospital Priorities Steering Group that education, and the creation of a ‘GOSH Learning Academy’ (GLA), should be prioritised for charitable funding over the next 5 years.</i></p> <p>Following Trust process the GLA case was reviewed by Trust Board, Finance & Investment Committee, and the Executive Management Team, while also receiving strong support from the Charity’s Grants Committee when they reviewed the Outline Business Case at their meeting in October 2018.</p> <p>The Full Grants Case, developed in partnership with GOSHCC, has been presented to the Charity Grants Committee on the 25 June. The case sets out the vision, ambition and rationale for the establishment of the GOSH Learning Academy and the impact that it will have for the hospital and the children that it sees and treats.</p> <p><i>The Grants Case outlines a 5-year strategy for education. Training and development with a break and review at year 3. This breakpoint is an opportunity to review progress and impact whilst determining the release of further funding for the final 2 years. Importantly, it is also an opportunity to consider space requirements and implications, because it would not be possible to achieve further scale-up in the final 2 years and beyond without additional capacity in terms of space. In the first 3 years, we have requested a total commitment of £14,719 million to pump prime and invest in the GLA. The request for funding is for a mixture of revenue posts to support the scaling up of the current education offering, as well as funding for the direct costs of education e.g. apprentices etc. If successful, investment will commence in September 2019 with significantly less funding utilised in Year 1.</i></p> <p><i>Overall, GOSH Trust Board and GOSH Charity view the GOSH Learning Academy as an exciting and important opportunity that has the potential to make a real difference to the children that the hospital sees and treats, through investment in the people who care for them and more broadly. It is also an essential component part of the hospital’s overall strategy and future vision.</i></p>	
<p>Action required from the meeting</p> <ul style="list-style-type: none"> • For information and update pending GOSHCC Board decision on 16 July 	
<p>Contribution to the delivery of NHS Foundation Trust strategies and plans</p> <ul style="list-style-type: none"> • Aligned to the GOSH Strategy: <i>Fulfilling Our Potential</i> through the approved <i>GOSH Education and Training Strategy</i> 	

Financial implications

- Application for GOSHCC funding for the first three years of the GLA in a commitment of £14,719 with further 2 year commitment pending review in Year 3

Who needs to be told about any decision?

- People and Education Assurance Committee
- Finance and Investment Committee
- Executive Management Team

Who is responsible for implementing the proposals / project and anticipated timescales?

- Lynn Shields – Director of Education

Who is accountable for the implementation of the proposal / project?

- Executive Lead: Alison Robertson – Chief Nurse
- Proposal Lead: Lynn Shields – Director of Education



Great Ormond Street
Hospital for Children
NHS Foundation Trust



A CASE FOR THE

GOSH LEARNING ACADEMY

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1. DOCUMENT DETAILS

PROJECT TITLE	A Case for the GOSH Learning Academy
PROPOSED START DATE	September 2019
DURATION OF FUNDS	3 – 5 years
EXECUTIVE SPONSORS	Alison Robertson, Chief Nurse Caroline Anderson, Director of HR & OD Helen Jameson, Chief Finance Officer Sanjiv Sharma, Medical Director
DATE	17 May 2019
VERSION	2.0
STATUS	Approved for submission to GOSHCC Grants Committee
LEAD APPLICANT	Lynn Shields, Director of Education
CO-APPLICANTS	James Scott, Head of Strategy and Planning Joanna Weeks, Associate Director of Workforce Development Sean Baxter, Finance Partner Simon Blackburn, Co-deputy Medical Director for Medical and Dental Education Matthew Tulley, Director of Built Environment

2. INTRODUCTION

This case has been drafted at the request of the Great Ormond Street Hospital NHS Foundation Trust. It provides justification for the GOSH Learning Academy (GLA) over the next five years.

This follows Trust Board approval of relevant documents including:

- *GOSH Learning Academy: Education and Training Strategy* ([Appendix 1](#))
- *GOSH Leadership Strategy* ([Appendix 2](#))
- *GOSH Learning Academy: Strategic Plan* ([Appendix 3](#))

3. AMBITION

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.

Education and training provided to our staff remains pivotal to the experience of our patients. The children and young people attending Great Ormond Street Hospital are cared for by our entire multi-professional workforce—it is our role to ensure that our people have the knowledge, skills, and capabilities to provide the exceptional care that our patients require.

Every stage of the patient journey on any given day is influenced by the education and training provided to our workforce, whether this be the communication skills of the medical secretary organising their visit, the multi-professional team caring for them, the leadership skills of our corporate and operational teams, or the administrator planning their transport home. Each stage of this journey includes a host of practices performed by staff that must be underpinned by excellent training to ensure our children and young people are cared for in the most effective and efficient way possible

Education and training is fundamental for all NHS institutions providing services to patients and families, but we aim to have a voice in paediatric healthcare which reaches far beyond our mandatory obligations as an NHS provider. GOSH aims to be 'Always Expert', and the development of the GOSH Learning Academy (GLA) would ensure its place at the forefront of expertise in tertiary and quaternary care for children and young people. Our ambition is to truly be recognised as a learning organisation; to provide a *GOSH Learning Academy Prospectus* nationally and internationally which is recognised as offering world-class paediatric healthcare education and training; so that GOSH is known as an exemplary choice not just for patient care, but for anyone seeking to attain the knowledge, skills, and capabilities to provide specialist and highly-specialist healthcare to children and young people.

4. INTERNAL LANDSCAPE

There is a large body of evidence that directly relates successful education and learning programmes with improved patient care.¹²³⁴⁵ In 2017, GOSH reported 12 Serious Incidents (SI), two Never Events, 4,964 PALS cases, and paid out more than £14 million in claims due to damages. We benchmark comparably to other similar organisations, but we recognise we have much we can and should improve. The evidence-base indicates education and training is one of the critical methods by which to improve care for our children and young people and prevent adverse patient outcomes.

The education and training of dentists, doctors, midwives, nurses, pharmacists, and other health-care professionals has long been the foundation of safe, high quality health care.

World Health Organization

In the wake of national concerns around patient safety, the first and over-riding recommendation of the Berwick Report (National Advisory Group on the Safety of Patients in England, 2013) was for,

"... [the NHS] to become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end."

The report concludes,

"The most powerful foundation for advancing patient safety in the NHS lies much more in its potential to be a learning organisation, than in the top down mechanistic imposition of rules, incentives and regulations."

Being a learning organisation is not simple, and GOSH has some catching up to do. Commitment to learning requires the acknowledgement that education and training underpins the patient experience and the willingness of the entire organisation to make this a priority for development and investment. Moreover, healthcare is a safety critical industry that "requires an education and training system in which safety and quality are central" (General Medical Council and Medical Schools Council, 2015). "A better educated workforce was associated with fewer deaths, with every 10% increase in nurses with degrees associated with a 7% reduction in death rates." (Bazian, 2014)

At GOSH, we care for patients with very complex needs. "Coping with the complexity of clinical practice requires not just competency but capability, the ability throughout one's career to adapt to change, generate new knowledge and continuously improve performance." (Tomlinson, 2015) In such a complex environment, it is especially crucial to recognise the intrinsic link education and training has with patient care. World-renowned organisations known for exemplary care rightly prioritise education and training, because they recognise its vital place in positive patient outcomes. We aim for GOSH to be in this space.

¹ General Medical Council and Medical Schools Council. (2015). *First, do no harm: Enhancing patient safety teaching in undergraduate medical education*. Manchester: General Medical Council | Medical Schools Council.

² Kirkman, M. A., Sevdalis, N., Arora, S., Baker, P., Vincent, C., & Ahmed, M. (2015). The outcomes of recent patient safety education interventions for trainee physicians and medical students: a systematic review. *BMJ Open*.

³ Tomlinson, J. (2015). Using clinical supervision to improve the quality and safety of patient care: a response to Berwick and Francis. *BMC Medical Education*.

⁴ Bazian. (2014, February 26). *Patients 'are safer with better-educated nurses'*. Retrieved from Behind the Headlines: <https://www.nhs.uk/news/medical-practice/patients-are-safer-with-better-educated-nurses/#where-did-the-story-come-from>

⁵ World Health Organization. (2011). *WHO patient safety curriculum guide: multi-professional edition*. Geneva: World Health Organization.

5. EXTERNAL LANDSCAPE

Education and training is seen as a crucial for all Trusts in the NHS, and it has been linked to providing excellent and safe services as well as new models of care (Department of Health, 2014) and is the area of focus for governing bodies such as NHS Health Education England (HEE). Further evidence suggests education and training as a key driver in recruitment and retention (NHS Employers, 2018). For these reasons, education and training is a significant factor in NHS future planning:

- *The NHS Long Term Plan* (NHS England, 2019) – Following years of austerity, the Government announced additional funding for the NHS alongside a 10-year plan which includes reforms to care and access and the development of a workforce to meet these changes. In recognition of the evidence confirming the impact education and training has on high-quality patient care, it forms one of the primary focuses of this plan.
- *Developing People – Improving Care* (NHS Improvement, 2016) – This national framework builds on evidence which indicates that high-performing health and care systems with exemplary education and training provisions ensure excellent leadership capabilities, therefore ensuring those systems “improve population health, patient care, and value for money.”
- *The Topol Review* (Topol, 2019) – This recently published paper challenges us with a vision of an imminent and rapidly progressive technology-enhanced NHS. This will alter the roles and functions of clinical staff in healthcare who will need additional skills to be effective in this environment. We will require a robust and contemporary education and training provision to prepare, adapt, and flourish in this digital world.

However, the Trust, and education and training specifically, face a number of challenges:

- Since 2014, there has been a year-on-year reduction in NHS HEE funding.
- The UK’s departure from the European Union will have an unknown impact on recruitment and retention—a key issue for the NHS and GOSH.
- Potential effect of immigration rule changes and pay not in line with inflation.

Other external factors and potential threats include:

- *Enhancing Training and Support for Learners* (Health Education England, 2018) describes a need to enhance the working lives of training doctors through access to high-quality learning or experiences
- NHS HEE’s mandate to widen participation into healthcare with new roles and approaches (e.g. clinical apprenticeships, nursing associates, and post-graduate apprenticeships)
- The Royal College of Paediatrics and Child Health (RCPCH) estimates at least 752 WTE extra consultants are required to meet *Facing the Future* (Royal College of Paediatrics and Child Health, 2018) and specialised services standards.⁶
- In the *State of Child Health* (Royal College of Paediatrics and Child Health, 2019), the RCPCH describes that the number of applicants to paediatric training programmes who are European Economic Area (EEA) graduates has fallen by 58% in the past 2 years. This is echoed by the General Medical Council (GMC) in their document, *The state of medical education and practice in the UK* (General Medical Council, 2017), which notes that paediatric specialties have a high reliance on non-UK graduates (48%), but increasingly the UK is perceived as less attractive. This is on the background of a sharp fall in the number of applicants to medical training: there were unfilled places at medical school in the UK for the first time in 2018.
- There is an increasing expectation of healthcare professionals to have the professional capabilities to work flexibly and confidently across a range of care boundaries and locations, e.g. Sustainability and Transformation Partnerships (STPs). The reshaped paediatric curriculum (RCPCH Progress, 2018), which represents a movement towards capabilities rather than competencies, is a reflection of this new expectation.
- The bursary for undergraduate nursing has been discontinued. Up until 2017, the Department of Health and Social Care (DoH) provided a bursary to attract young people to the profession. Nursing students will now, however, pay full tuition, which has already had a significant negative impact on enrolment numbers and presents a severe risk to the nursing workforce of the future.
- London faces some of the greatest challenges around nursing shortages, with an estimated 1/3 of national vacancies. Collaboration between NHS England, NHS Improvement, and Health Education England have developed projects such as CapitalNurse to address this and bring about sustainable solutions to recruitment and retention issues; many of the drivers within these programmes focus on developing attractive education

⁶In order to deliver this we would need to attract 15% more paediatricians into training, yet recent applications for training posts in paediatrics fell by 27.5%.

and training provisions for the nursing workforce within London Trusts. (NHS England and NHS Improvement London, 2017)

This case acknowledges all of these challenges and aims to create a lean, collaborative education and training service with the necessary resources and facilities to overcome them by utilising best practices from comparable national and international institutions.

6. PARTNERSHIPS

Working closely with internal and external stakeholders is fundamental to the success of our priorities. Each area of education and training is strengthened and enhanced through strong links with other institutions, including Higher Education Institutes (universities), academic organisations (e.g. our preferred partner UCL Great Ormond Street Institute of Child Health), our Charity, and potential commercial partners, including international collaboration. The ability for education and training to flourish within an organisation and the wider community depends largely on its ability to utilise the resources it has at its disposal and capitalise on emerging opportunities. At GOSH, we are fortunate in having a wealth of specialist knowledge experts, and we have the opportunity to utilise this with our strong brand and reputation to enhance our established partnerships and develop new ones.

We are committed to continuing to work closely with the ICH (the UCL Great Ormond Street Institute of Child Health). This important strategic relationship will help us to be successful, while supporting the ICH's mission to *improve the health and well-being of children and the adults they will become, through research, education, and public engagement*. ICH are currently developing an Education Strategy, which will be integral to their refreshed Academic Strategy, and it is very timely for both organisations to align their strategies in this area. Working in collaboration will maximise opportunities to provide academic education through a cost-effective and accessible way, identifying new market opportunities, and creating high-quality teaching spaces.

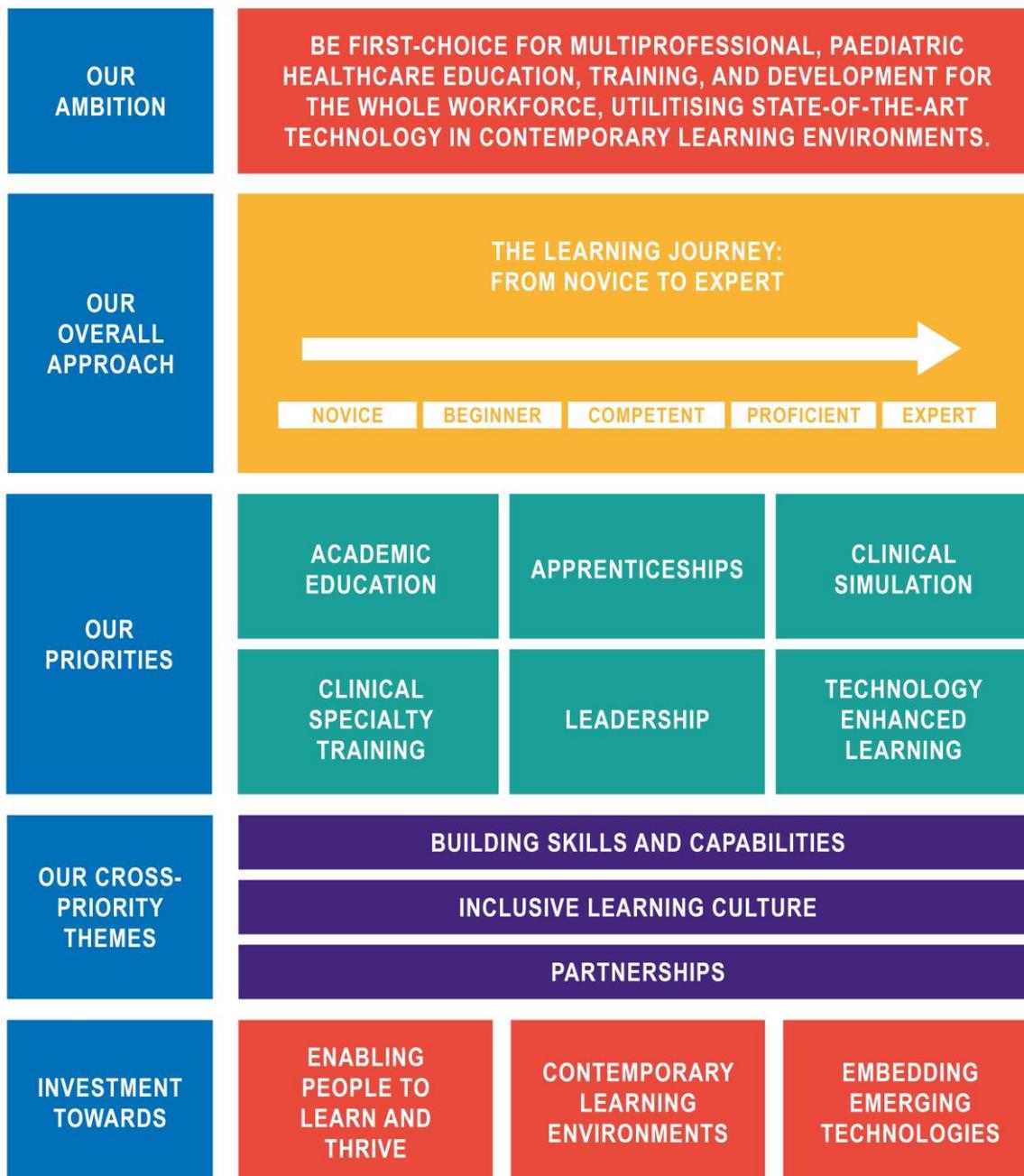
7. STRATEGIC AND OPERATIONAL RESPONSE

The challenges faced by the organisation internally and externally warrant robust a strategic and operational response. These have been addressed through the *GOSH Learning Academy: Education and Training Strategy* and its Strategic Framework and Operating Model. ([Appendix 1](#))

7.1 STRATEGIC RESPONSE

In response to imminent challenges and the publishing of the Trust Strategy, *Fulfilling Our Potential*, the *GOSH Learning Academy: Education and Training Strategy* was developed with internal and external stakeholders to deliver the Trust's strategic priorities relating to education and training over the next five years. This document includes a Strategic Framework which describes how the GLA vision will be implemented in practice. It illustrates and further details our ambition, overall approach, priorities, cross-priority themes, and areas for investment:

Figure 1



This framework will underpin all activity within the GLA over the next five years, heavily informing the *GOSH Learning Academy: Operational Plan* currently in development, and ensuring investment is cost-effective and directly contributes to the delivery of our ambition.

7.2 OPERATIONAL RESPONSE

The current operating model for education and training at GOSH is not fit-for-purpose. Five departments are divided across three directorates, accountable to three different Executive Directors, and focus on delivery to different staff groups. This is counterintuitive and reinforces siloed working.

For example, in the same model as similar organisations (e.g. Birmingham Women’s and Children’s and Evelina London Children’s Hospital), central education and training would be restructured into one Education and Training Directorate, providing multi-professional, quality-assured education and training to the entire clinical and non-clinical workforce together with our local partnerships with our clinical directorates.

The current and future states are presented below:

Figure 2

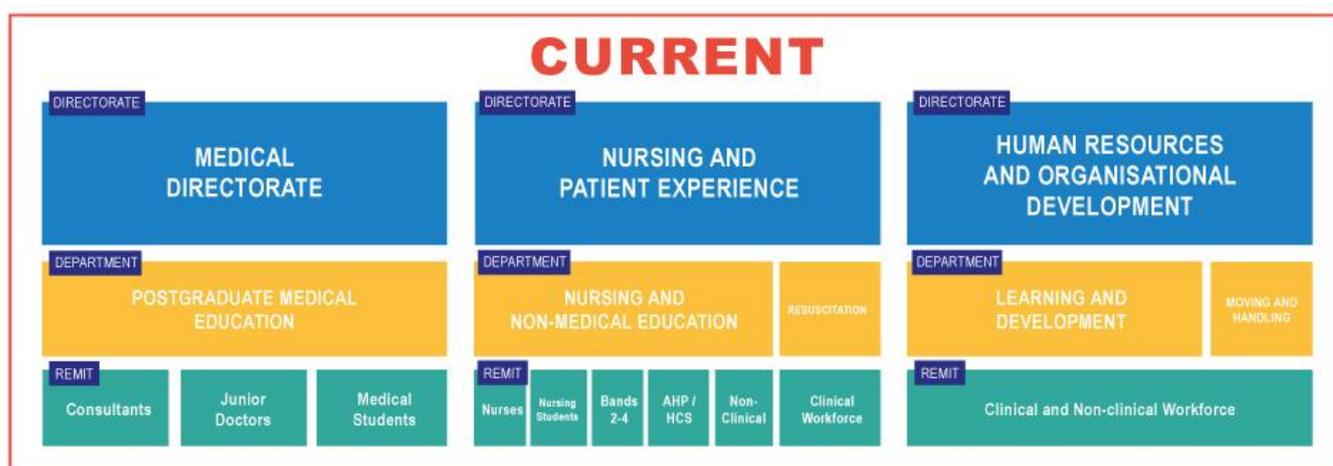


Figure 3



This model provides a contemporary, lean, collaborative structure through which we can address our Business Objectives in the most productive and efficient method possible.

8. BUSINESS OBJECTIVES

To deliver our ambition, Business Objectives have been established in the *GOSH Learning Academy: Strategic Plan* and are across three horizons: core objectives, emerging opportunities, and new directions. ([Appendix 3](#)) The level of financial investment will determine which objectives will be achievable and are further detailed in the [Options Appraisal](#).

Figure 4

 <p>HORIZON 1</p> <p>Core objectives, most closely aligned to current education and training</p>	Deliver mandatory obligations, standards, contracts, etc.
	Delivery current education and training
	Continue to strengthen relationships and partnerships
	Ensure financial stability
 <p>HORIZON 2</p> <p>Emerging opportunities, building on current education and training</p>	Establish a single operating directorate
	Bring education and training in line with best practice
	Establish Learning Academy brand
 <p>HORIZON 3</p> <p>Taking education and training in new directions</p>	Establish Learning Academy facilities
	Embed emerging technologies
	Explore international commercial and partnership opportunities

9. OPTIONS APPRAISAL

A number of options have been explored to support the success of the GLA and its Business Objectives over the next 5 years. An analysis indicates the preferred and most cost-effective option is to seek investment from our partner the GOSH Children's Charity (GOSHCC) to enable our people to learn and thrive, to embed emerging technologies, to develop and build the Learning Academy service, and acquire contemporary learning environments through redeveloping existing Trust space or leasing from one of our partners. An appraisal of each option against the GLA Business Objectives is detailed below.

Figure 5

OPTIONS APPRAISAL		OPTION 1 CURRENT OFFER	OPTION 2 • INVESTMENT IN SERVICE • NO CAPITAL INVESTMENT IN FACILITIES DEVELOPMENT	OPTION 3 • INVESTMENT IN SERVICE • REVIEW AT END OF YEAR 3 FOR FURTHER INVESTMENT IN SERVICE AND CAPITAL INVESTMENT IN FACILITIES DEVELOPMENT
 HORIZON 1	Deliver mandatory obligations, standards, contracts, etc.	✓	✓	✓
	Deliver current education and training	✓	✓	✓
	Continue to strengthen relationships and partnerships	✗	✓	✓
	Ensure financial stability	✗	✓	✓
 HORIZON 2	Establish a single operating directorate	✓	✓	✓
	Bring education and training in line with best practice	✗	✓	✓
	Establish Learning Academy brand	✗	✓	✓
 HORIZON 3	Establish Learning Academy facilities	✗	✗	✓
	Embed emerging technologies	✗	✗	✓
	Explore international commercial and partnership opportunities	✗	✓	✓

9.1 OPTION 1

CURRENT OFFER

Within the current financial climate, GOSH education and training programmes have continued to improve and expand to address clinical needs, integrate contemporary methods, and keep pace of new technologies. We strive to ensure our service provides the education and training necessary for staff to deliver the Trust Strategy and consistently demonstrate the Trust Values. However, we now find ourselves in a position of limited potential due to funding constraints. We are able to provide an education and training service that, while covering core obligations as a specialist NHS care provider, is unable to keep abreast of new technology, clinical need, and unable to explore broader opportunities.

The current financial model is sourced from the following annual revenues:

Table 1

SOURCE	ANNUAL
GOSH	£ 15,200,000
GOSH Children's Charity	£ 250,000
NHS Health Education England (HEE) Education Support	£ 3,350,000
NHS Health Education England (HEE) Salary Support	£ 4,850,000
Commercial Income	£ 310,000

Currently NHS HEE provides a significant component of annual revenue towards education, training, and development for the Trust. This is delivered through the Learning and Development Agreement (LDA) and is mainly comprised of salary support for trainees working within the Trust and tariffs owed to the Trust for educating trainees on student placements. A smaller portion is available for Nursing, Allied Health, and Healthcare Science Workforce Development and Continued Professional Development (CPD). The Trust has successfully explored unique models for utilising this ever-shrinking source of funding, e.g. franchised modules with universities, partnerships with Trusts in the STP, etc. to ensure a stable education provision for our people. A smaller portion of funding can be attained through additional bids submitted to HEE throughout the financial year, dependent on priorities identified by HEE and DoH. The GLA works actively to attain bid funding for these projects as an additional source of revenue.

The Trust invests significantly in both its educators within the clinical directorates as well as its corporate education teams. This investment is sufficient to maintain the status quo and ensure safe practice. The education teams have ensured this investment is used as efficiently as possible to establish value for money in what is an increasingly difficult financial climate.

Our Charity in recent years has established annual revenue streams for CPD for nursing and non-medical staff groups (in response to reductions from HEE sources) as well as funding for staff sabbaticals and staff usage of the ICH Library.

Education and training services within the Trust are stable but are unable to develop further to deliver our ambition outlined within the Trust's *Education and Training Strategy*. Without additional significant investment, the service will struggle significantly in the coming years, losing any foothold in the paediatric healthcare education market being explored by other Trusts, risking damage to the organisation's brand and reputation.

9.2 OPTION 2

- **INVESTMENT IN LEARNING ACADEMY SERVICE**
- **NO CAPITAL INVESTMENT IN LEARNING ACADEMY FACILITIES DEVELOPMENT**

The GLA would be able to deliver a significant number of its Business Objectives with immediate investment in its services. This step-up in funding would allow for the services to deliver above and beyond what are its core responsibilities within the Trust. With the necessary investment in services, the Learning Academy vision can begin to explore our ambition *to be the first-choice for multi-professional paediatric healthcare education, training, and development for the whole workforce.*

This option would establish a new financial model over the next three to five years supported by the GOSHCC investment totalling £20.3 million over five years:

Table 2

SOURCE	ANNUAL
GOSH	£ 15,400,000 ⁷
GOSH Children's Charity	£ 4,500,000⁸
NHS Health Education England (HEE) Education Support	£ 3,350,000
NHS Health Education England (HEE) Salary Support	£ 4,850,000
Commercial Income	£ 490 - 660,000

With an increased annual investment of approximately £4.25 million, the Trust would be able to establish a provision across our six education and training priorities to ensure the development of a world-class provision which goes above and beyond the core, mandatory needs of the Trust and the NHS.⁹

It must be noted, however, that there is a definitive ceiling which the GLA would reach without further investment in necessary facilities development. Areas such as Clinical Simulation, a key driver for improving patient safety, will rely heavily on contemporary learning spaces being made available. Its expansion and the ability to integrate modern, technology-enhanced methods throughout other priorities is severely impacted by the inadequate spaces within the Trust precinct which are currently available to education and training. The overall *GLA Prospectus* would be further constrained, as the Trust is reaching or has already exceeded its space capacity courses and sessions. This further will affect the GLA's national and international offer, as a world-class education service must have an appropriate, fit-for-purpose venue to host education and training if it hopes to establish and maintain its brand and reputation.

9.3 OPTION 3

- **INVESTMENT IN LEARNING ACADEMY SERVICE**
- **REVIEW AT END OF YEAR 3 FOR FURTHER SERVICE INVESTMENT AND CAPITAL INVESTMENT IN LEARNING ACADEMY FACILITIES DEVELOPMENT**

This option is preferred. This plan includes investment in the Learning Academy service over the next three years and a pause at the end of Year 3 to review further service investment and capital investment in facilities development. It is recognised that through this option, the GLA would be able to fulfil all horizons of Business Objectives and fully deliver on our ambition.

Two factors must be considered:

- **Facilities development requires the appropriate level of services at its foundation.** – While it is acknowledged that our ambition is contingent on contemporary learning environments and that current space is inadequate to deliver this, a new, state-of-the-art building would be of little worth if a state-of-the-art service

⁷ Includes 1% inflation.

⁸ Average annual revenue provided over first three years.

⁹ This is explored in detail within the [Step-Change Analysis](#).

was not developed beneath it—it would be analogous to an art gallery which contains no paintings. Furthermore, acknowledging the immediate challenges internally and externally the Trust faces, it is imperative that the enhancement of our education and training offer within GOSH commences without delay.

- **The preferred option for facilities development has yet to be determined.** – Space remains a challenging area for all areas of the Trust due to the Trust’s location within central London. Buying new space may not be the most cost-effective way forward when considering the Trust’s overall development Masterplan. Redeveloping existing space within the Trust footprint or leasing space from our partners may be a preferred investment yielding better value. This has yet to be determined, however.

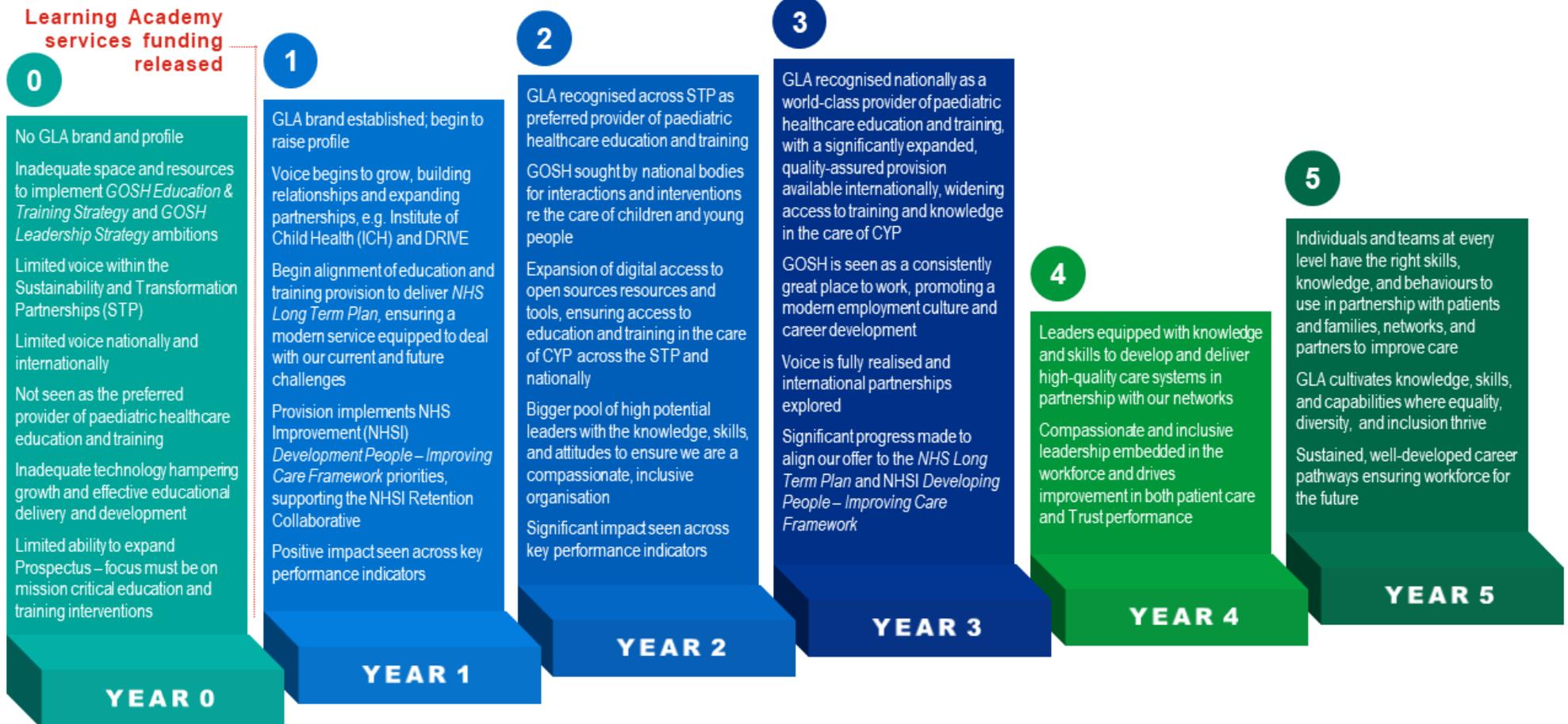
By the end of Year 3, the GLA service and *GLA Prospectus* would be fully developed, primed, and prepared to make best use of newly developed spaces to ensure a world-class provision by 2022/23. A transformative step-change analysis has been performed to illustrate the expected benefits of Options 2 and 3 over the next five years within the following [Step-Change Analysis](#) and [Finance Case](#).

10. STEP-CHANGE ANALYSIS

Below is the expected transformative step-change over the next five years for Options 2 and Options 3 (preferred) detailed in section [Options Appraisal](#). A full Step-Change Analysis for each Strategic Framework priority is available in [Appendix 4](#).

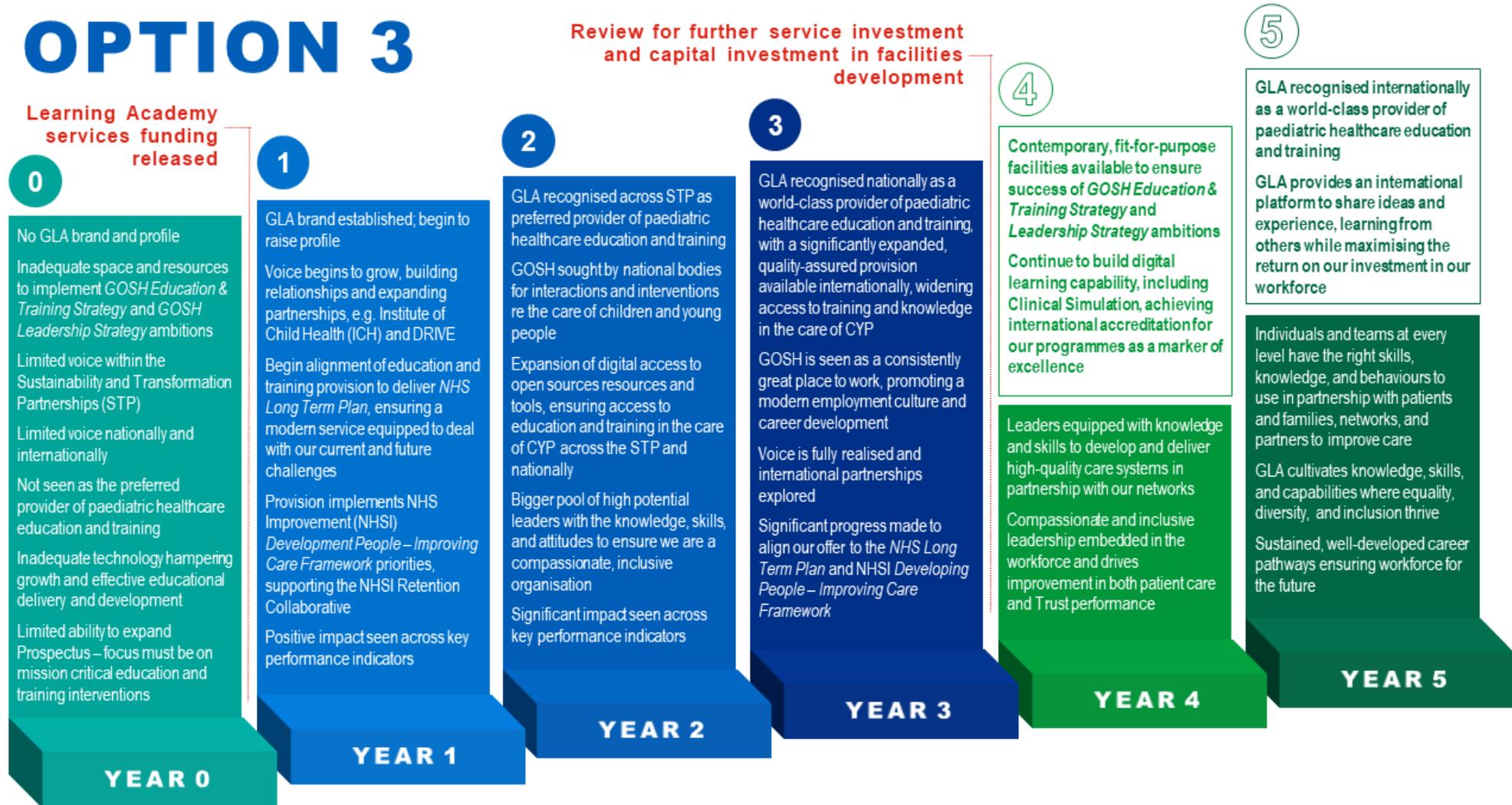
Figure 6

OPTION 2



There is a definitive ceiling of deliverable benefits from the GLA without needed investment in contemporary space and facilities. As noted, these are most impactful on our ability to establish an international reputation, increase the *GLA Prospectus*, and embed emerging technology and clinical simulation.

Figure 7



11. FINANCE CASE

The financial model below has been structured around the preferred Option 3 identified within the [Options Appraisal](#) with an Education Finance Summary included within [Appendix 5](#).

In Phase 1 (Years 1-3), revenue of approximately £ 14,000,000 would be dedicated to areas of investment against each priority within the Strategic Framework, with further investment in services and capital investment in facilities development to reviewed at the end of Year 3.

Investment through Option 3 commences in September 2019 with significantly less revenue utilised in Year 1, recognising that effectively implementing investment in equipment and technology will be contingent on the expansion of the GLA service provision within this year. Once the GLA service has been fully established, funding will increase significantly in Years 2-3.

Case will be reviewed at the end of Year 3 to assess further service investment and capital investment in facilities development. This does not preclude the possibility of earlier funding release dependent on market availability and arising opportunities.



Table 3: Cash Flow Model

OPTION 3

	YEAR 1	YEAR 2	YEAR 3	TOTAL		YEAR 4	YEAR 5	TOTAL	GRAND TOTAL		ON-GOING REVENUE
	£'000's	£'000's	£'000's	£'000's		£'000's	£'000's	£'000's	£'000's		£'000's
STRATEGIC PRIORITIES											
Academic Education	£255	£304	£353	£912	REVIEW	£368	£382	£750	£1,662	COMMITMENT END	£200
Apprenticeships	£493	£1,713	£1,916	£4,121		£1,435	£819	£2,254	£6,376		£0
Clinical Simulation	£209	£260	£261	£731		£408	£412	£820	£1,551		£437
Clinical Specialty Training	£759	£1,019	£1,021	£2,799		£1,023	£1,025	£2,048	£4,847		£137
Leadership	£671	£733	£787	£2,191		£589	£591	£1,180	£3,370		£0
Technology Enhanced Learning	£489	£759	£463	£1,711		£415	£419	£833	£2,544		£242
TOTAL	£2,876	£4,788	£4,801	£12,465			£4,237	£3,648	£7,885		£20,350

Table 4: Commitment Model

OPTION 3	PHASE 1 (YEAR 1)	PHASE 2 (YEAR 4)	GRAND TOTAL	PHASE 3 (ON-GOING REVENUE)
ACADEMIC EDUCATION				
Candidate Numbers	1,050	950	2,000	
Education Funding (£'000's)	£252	£228	£480	£10
Education Support (£'000's)	£660	£522	£1,182	£190
Education Support (WTE)	5.00	5.00	5.00	4.00
TOTAL	£912	£750	£1,662	£200
APPRENTICESHIPS				
Apprentice Numbers	55	0	55	
Education Funding (£'000's)	£5,566	£0	£5,566	£0
Education Support (£'000's)	£810	£0	£810	£0
Education Support (WTE)	3.20	0.00	3.20	0.00
TOTAL	£6,376	£0	£6,376	£0
CLINICAL SIMULATION				
Candidate Hours	49,500	60,000	109,500	
Education Funding (£'000's)	£400	£0	£400	£21
Education Support (£'000's)	£331	£820	£1,151	£416
Education Support (WTE)	1.40	6.90	6.90	6.90
TOTAL	£731	£820	£1,551	£437
CLINICAL SPECIALTY TRAINING				
Candidate Numbers	1,200	900	2,100	
Education Funding (£'000's)	£2,280	£1,645	£3,925	£7
Education Support (£'000's)	£519	£403	£922	£130
Education Support (WTE)	2.80	2.80	2.80	1.80
TOTAL	£2,799	£2,048	£4,847	£137
LEADERSHIP				
Candidate Numbers (Internal)	900	1,000	1,900	
Education Funding (£'000's)	£1,800	£800	£2,600	£0
Education Support (£'000's)	£391	£380	£770	£0
Education Support (WTE)	3.00	3.00	3.00	0.00
TOTAL	£2,191	£1,180	£3,370	£0
TECHNOLOGY ENHANCED LEARNING				
Candidate Numbers (Online)	40	200	240	
Education Funding (£'000's)	£570	£20	£590	£12
Education Support (£'000's)	£1,141	£813	£1,954	£231
Education Support (WTE)	7.20	6.20	7.20	3.20
TOTAL	£1,711	£833	£2,544	£242
EDUCATION FUNDING TOTAL (£'000's)	£10,868	£2,693	£13,561	£48
EDUCATION SUPPORT TOTAL (£'000's)	£3,851	£2,938	£6,790	£968
EDUCATION SUPPORT TOTAL (WTE)	22.60	23.90	28.10¹⁰	15.90
GRAND TOTAL	£14,719	£5,631	£20,350	£1,016

¹⁰ A total of 28.10 WTE posts will have funding committed fixed-term throughout Phases 1 and 2. This is larger than the sum of Phase 1 and 2 due to roles ending and new roles commencing at the beginning of Phase 2.

11.1 FINANCE CASE

Funding over the five-year period is explored further against each priority below.

11.1.1 ACADEMIC EDUCATION

The consistent delivery of high quality, compassionate, exceptional care is underpinned by the provision of continued professional development that provides staff with the skills and capabilities to ensure “the right person, with the right skills, are in the right place at the right time.” (Cummings) Investment through academic education will considerably expand our Academic Education portfolio within the *GLA Prospectus*, funding the development of new specialist modules and increasing intakes of currently over-subscribed modules, increasing availability to larger numbers of internal and external candidates and disseminating specialist knowledge nationally and internationally. By the end of Year 3, the GLA aims to be facilitating a total of 18 specialist academic modules and 2 postgraduate awards. This will cement GOSH’s reputation as the place of choice to work and learn, improving recruitment and retention of workforce, as well as establishing the Trust as the leading provider of paediatric postgraduate healthcare education within Greater London and the UK.

By the end of Year 3, this financial commitment will have enabled up to 1,050 clinical healthcare professionals to access academic education within their specialties while working towards a Masters level award annually. This has a dual benefit of increasing competency and improving recruitment and retention. Contemporary modelling around workforce recognises that high-potential candidates choose organisations with premium offers for continued professional development, academia being a priority within this.

The investment will also enable our partners, regionally and nationally, to access specialist and highly-specialist knowledge and training through the GLA Academic Education Portfolio. Internal staff have the immediate benefit of access to knowledge which improves patient care within the organisation, and external programmes would empower local teams to care for children in their local environment, improving patient flow and the quality of care patients receive once after leaving the Trust precinct.

In order to deliver these commitments, there is a requested investment in the support beneath the academic provision development. The success of the expansion of the Academic Education Portfolio will be reviewed at Year 3 to accurately assess impact and sustainability.

11.1.2 APPRENTICESHIPS

A significant number of clinical apprenticeships will be funded over the five-year period, these include but are not limited to:

- 20 Undergraduate Nursing
- 20 Nursing Associates
- 10 Allied Health Professionals
- 5 Advanced Clinical Practitioners

This commitment will allow GOSH to keep pace with the national healthcare agenda and trail-blaze in piloting new national workforce models in collaboration with NHS England and NHS HEE. In addition to supporting the clinical apprentices, there is investment to provide the educational support required to ensure high quality-assured placements.

This proposed model delivers staff who have spent their entire training working hand-in-hand with our clinical experts, in our clinical environments, ensuring a workforce that not only have excellent skills and capabilities but who also share our values and drive to provide excellent, high-quality care to children and young people.

We will establish world-class programmes and a recruitment platform to attract and retain new apprentices, ensuring our workforce of the future and widening access to career pathways for our workforce. Some clinical apprenticeships are recently approved, hence the increased funding provided in Years 2-3 for programme commencements. Programmes are of varying length from two to four years, and release of investment accounts for completing cohorts and our continuing commitment.

During this pilot phase, GOSH will be able to assess if this model is sustainable for the future. All completing apprentices will be recruited into substantive registered roles, however we will have the opportunity to review these programmes for future delivery. For this reason, the Educational Support team established to support these programmes will continue contingent on the outcome of programme review.

11.1.3 CLINICAL SIMULATION

Of all GLA priorities, clinical simulation faces the greatest limit to expansion due to space constraints. GOSH is a national and international provider of specialist paediatric services and our portfolio of specialist simulation courses should mirror this unique role and responsibility.

Within Years 1-3, the funding commitment will be invested in equipment and the expansion of the provision within the currently available space, beginning to bridge the gap between ourselves and our competitors. This commitment will begin to expand in-situ (on-the-ward) training as well as longer, in-depth courses and programmes, while integrating multi-professional teaching, and expanding the clinical simulation component across all other priorities. By building skills and knowledge while raising awareness of human factors and patient safety, we will integrate the 'Learning From' national agenda into GOSH as we work towards becoming a learning organisation.

During the initial three-year commitment, we will begin to market our simulation offer which will be underpinned by cutting edge technology and innovation to generate a sustainable income to cover increased revenue costs. For this reason, the expansion in the simulation team, akin to other educational support, will be through secondment and fixed-term only while we build this portfolio.

Should capital investment be released and contemporary learning environments established after the three-year commitment, clinical simulation will be able to provide substantial expansion in all simulation programmes, embedding emerging technologies such as augmented reality (AR), virtual reality (VR), and haptics environments in Years 4-5, driving the reach towards our highest business objectives and ongoing sustainability. This will allow for a substantial increase in education and training outputs for simulation across all metrics.

11.1.4 CLINICAL SPECIALTY TRAINING

To ensure our workforce has the highest level of skills and capabilities, both a *GOSHCC Non-medical and Medical Charity Scholarship Award* will be established. This will see a significant expansion of our specialty training uptake by our clinical workforce, both building competency within the Trust by exposing staff to knowledge nationally and internationally and contributing to wider dissemination of our specialist knowledge in the care of children and young people.

Within the Trust, the GLA service will significantly expand its own currently modest clinical specialty training offer and provision, ensuring complex skills and capabilities in each specialty are more widely available, staff are at the forefront of practice, and we are delivering levels of care above and beyond core NHS responsibilities. As research progresses, technology enhances, and treatment methods improve, this offer must expand in order to guarantee our staff are continually learning within their specialties for them to deliver safe, confident, and compassionate practice which integrates the cutting edge of clinical care.

The initial three-year commitment to support this priority will ensure the build of a Clinical Speciality Training Portfolio within the *GLA Prospectus* that would attract commissioning through HEE for NHS trusts and bodies requiring programmes of education and training in caring for paediatric patients with complex conditions. Funding generated through increased access for our partners would support subsequent revenue costs to support this vital area of work.

11.1.5 LEADERSHIP

The CQC Inspection Framework acknowledges that you cannot have a high-performing organisation that is not well-led. (Care Quality Commission, 2019) The Leadership offer within the *GLA Prospectus* will increase and improve significantly from Years 1-5 with vital investment in the leadership development infrastructure. This will deliver the development of new leadership programmes and expansion of existing curriculums that historically have been limited in application.

The ambitions detailed within the *GOSH Leadership Strategy* will begin to come to fruition with substantially more multi-professional courses on offer, reaching far further than our core responsibilities to regulatory bodies. Services will be funded within this time period to build and develop the programmes to create sustainable, personalised leadership development programmes within GOSH across all strata of the workforce. This will ensure the delivery of

the *GOSH Leadership Strategy* ambition across its priorities, including individual leadership development, team leadership development, system leadership, talent management, staff wellbeing, and senior leadership team development.

This investment will drive innovation and creativity within the Trust, creating an inclusive learning culture, and improving our partnerships across our systems locally, nationally, and internationally.

11.1.6 TECHNOLOGY ENHANCED LEARNING

With the acknowledgement that technology currently and will continue to drive improvements in healthcare education, Years 1-2 will see a capital investment in a new Virtual Learning Environment (VLE) and the establishment of a Digital Learning Team to ensure its successful build and delivery. This will allow the entire *GLA Prospectus* across all strategic priorities to deliver cutting edge e-learning and disseminate this to external healthcare professionals nationally and internationally.

The population of content and expansion of the system will continue to be seen over Years 3-5 with the aim to create sustainable delivery methods and content creation for the future, positioning GOSH as a leader in this area. This investment will allow for greater collaboration with DRIVE and other industry partners, allowing the GLA to develop and implement new education technology, particularly virtual and augmented reality (VR and AR). Potential facilities development would work in tandem with the uptake of these technologies within newly developed clinical simulation spaces and contemporary learning environments.

11.2 SUSTAINABILITY CASE

It would be pragmatic to recognise that current NHS financial resources are not sufficient to ensure the success of the *GOSH Education and Training Strategy* and its long-term sustainability. Outcomes will be contingent on successful investment attained through the presented case herein and the opportunity to build a sustainable income model to ensure continued delivery in the future.

Within the case, there is an initial investment in the GLA services build and growth to ensure future success. At the end of this five-year grant commitment, the on-going revenue costs to ensure delivery of a similar standard equate to approx. £1,000,000 per annum.

The case outlined below includes annual proposed targets towards achieving financial stability and illustrates a journey towards a sustainable GLA service to ensure the retention of improvements and expansions. We propose that any income that exceeds internal revenue requirements and cost savings targets within the first five years would delay or replace investment received through the charity grant.

It should be noted that within the Educational Support required to reach our ambition, all posts will be recruited to as secondments or fixed-term appointments from outside the NHS, allowing for flexibility of recruitment, ensuring revenue is not permanently committed, and allowing termination of roles if required. By offering secondments into the GLA team, we will promote careers in education within GOSH, developing and increasing education and training delivery across the Trust and further ensuring future sustainability. The initial five-year investment commitment from the charity will focus entirely on non-recurrently pump-priming these services for future sustainability.

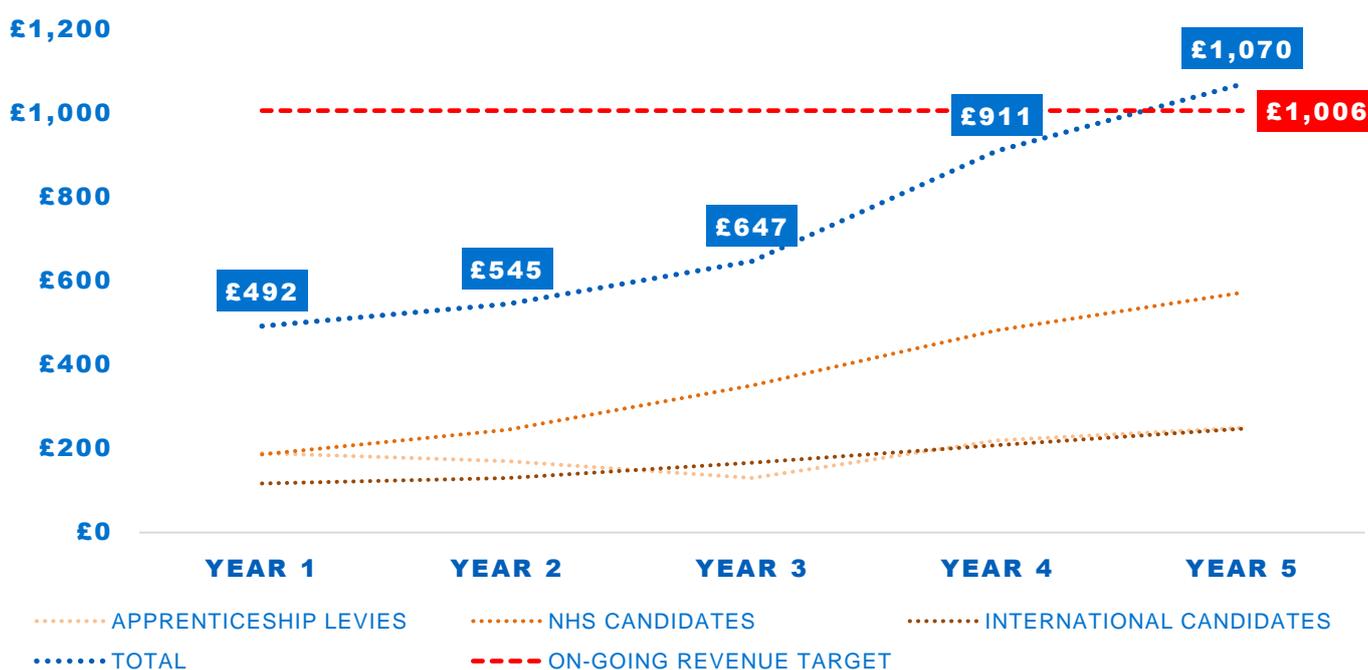
Sustainability needs to be built through a diverse set of income streams to ensure opportunities are realised. This will include opening up the ability to access government and NHS funding in the future that is currently a missed opportunity as well as offering value for money courses to the rest of the NHS and its workforce—which will reduce their requirement for local investment in equipment and staffing whilst ensuring high quality training and education.

The pricing strategy within the Sustainability Case focus is based on margins from already established programmes at current, competitive market prices. New programmes in development are priced lower than comparable institutions nationally and internationally to ensure these can be successfully marketed.

Table 5

	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5
	£'000's	£'000's	£'000's	£'000's	£'000's
INCOME SOURCE					
Apprenticeship Levies	£189	£170	£130	£220	£250
NHS Candidates	£186	£245	£351	£482	£572
International Candidates	£117	£130	£166	£208	£248
TOTAL	£492	£545	£647	£911	£1,070

Table 6



11.2.1 INCOME STREAMS

11.2.1.1 Academic Education

The planned increase in the *GLA Academic Education Portfolio* through specialist module developments, increased intakes, and an improved marketed offer will correlate with an increase in commercial income from external candidates.

Previous financial modelling around costs to internal staff has not appropriately considered overheads to education and training services to facilitate these modules and is currently under revision, terms subject to agreement at internal assurance committees.

11.2.1.2 Apprenticeships: Placements (NHS HEE)

NHS Health Education England in recent years has provided bespoke funding for implementation of new apprenticeship roles. This modelling includes funding currently available for the Nursing Associate Apprenticeship roles within this proposal. However, depending on HEE priorities, additional funding support for other roles and continued current funding arrangements are confidently expected but not assumed in current conservative modelling.

11.2.1.3 Apprenticeships: Supporting Provider

GOSH currently pays c£1m per annum in Apprentice Levy—however to date it has only been able to access a limited amount of these funds as to do so you need to be an established education provider. Additional income secured

through achieving this accreditation is included within the model in the later years, as the charity investment in the programme would enable the trust to establish these courses.

GOSH is already an established Supporting Provider for the Healthcare Support Worker Apprenticeship and validation for Supporting Provider status for Advanced Clinical Practice Apprentices and Leadership/Management Apprentices is currently being assessed. These programmes would yield a dependable source of revenue from both internal and external candidates via both the Trusts internal apprenticeship levy and other organisations levy payments.

11.2.1.4 Courses

Akin to the Academic Education Portfolio, with a substantial expansion of the overall GLA education and training offer, there will be an expected increase in revenues from external NHS candidates, modelled against demand assessment of sessions, courses, study days, and programmes from external candidates. These would be funded by a mixture of individual candidates, HEE and other NHS organisations, in line with current practices across the NHS. The further integration of technology enhanced learning and clinical simulation will establish an attractive offer to external healthcare professionals across the STP where organisations are looking to network to avoid duplication in expertise—to minimise the investment required for the highest quality of training recognising some funds would need to flow between organisations to support the ongoing running costs. These offerings could also be attractive both nationally, and, in the future, internationally.

11.2.1.5 International Fellowships

In-roads have already been established in the offer of international fellowships. Though explored previously for Medical staff, Nursing and Non-medical fellowships have previously not been considered. With the establishment of the GLA, GOSH will be in a space to establish world-class fellowships to market internationally. Interest abroad has been scoped and has a high potential for commercial revenues exceeding conservative figures within the sustainability model.

11.2.1.6 International Placements

Akin to international fellowships, placements for both undergraduate medical and nursing students will see significant expansion. The ability to have an established GLA service working in partnership with placements in clinical areas improves our ability to attract international students.

11.2.1.7 Virtual Learning Environment

The Virtual Learning Environment (VLE) has the multi-faceted ability to create more readily accessible education while establishing sustainable commercial revenues with vastly reduced overheads in comparison to other work-streams. Modelling presented conservatively estimates online course developments coming online, with pricing benchmarked below well-established international competitors. Beyond the traditional course format, other areas such as webinars are currently being scoped and therefore not included within this case.

12. RISK ANALYSIS

It is imperative that risks to the overall success of the GOSH Learning Academy case be identified and planned mitigations put in place, regardless of the level of investment attained.

RISK	MITIGATION
<p>HEE funding reductions – Health Education England has faced year-on-year reductions in direct funding to Trusts. This heavily affects funds such as Workforce Development, which were historically much higher. There have also been reductions in tariffs provided for student placements due to changes in Market Forces Factor (MFF). Discontinuation of the student nursing bursary has precipitated a national decline in enrolments, correlating with a decrease in placements and tariff income for trusts.</p>	<ul style="list-style-type: none"> • Franchised academic module portfolio – Numerous postgraduate academic modules have been brought in-house, reducing the costs for the Trust by 75%. This will expand further as a result of this case. • Become a recognised provider of specialist children’s education and training on the HEE commissioning portal to increase reach nationally and access indirect funds available to Trusts. • HEE bids – Monies now become available throughout the financial year for bespoke funding for HEE identified priority areas and projects. All bids are actively explored for potential GOSH delivery and, if successful, help to mitigate reductions in funding from traditional, recurrent streams. • Increased Higher Education Institute (HEI) partnerships – To mitigate reductions in student nursing placement tariff, partnerships with universities has increased to maintain enrolment levels on GOSH placements. Placement weeks at GOSH remain at the same level prior to removal of the student nursing bursary.
<p>Trust infrastructure – The Trust is grappling with many projects surrounding mission critical clinical and ICT services within the forthcoming financial years, e.g. Electronic Patient Records (EPR) and the GOSH Children’s Cancer Centre. The ability for the Trust to provide project support and embed necessary technology to ensure the success of the GLA faces risk.</p>	<ul style="list-style-type: none"> • People and Education Assurance Committee – The effects of this risk on GLA business objectives will be reported and reviewed quarterly and actions identified for mitigation. • ICT Project Board – The GLA is working in partnership with the ICT directorate to ensure risks are identified and mitigation plans are put in place. The <i>GLA Operational Plan</i> will be contingent on this on-going work, especially around Clinical Simulation and Technology Enhanced Learning.
<p>Seconded posts – There is an inherent risk to quality of candidate and turnover of staff if posts throughout the timescale of the project are required as secondments only.</p>	<ul style="list-style-type: none"> • We will aim to identify the strongest candidates through talent management both internally and working in partnership within the STP.
<p>Space and facilities – With limited available space and outdated facilities within the Trust precinct, success of business objectives face risk. The ability to enhance and expand education and training is contingent on contemporary learning environments being available. There will be a ceiling for the GLA offer without improvement and expansion of space.</p>	<ul style="list-style-type: none"> • People and Education Assurance Committee – The effects of this risk on GLA business objectives will be reported and reviewed quarterly and actions identified for mitigation. • Charity Grants Committee – A review in 2022/23 of further investment and investment in space and facilities.

13. OUTCOMES AND MEASURES

One of the key considerations in the case for the GLA is to ensure we are utilising contemporary, data-driven measures (i.e. metrics, key performance indicators, etc.) to appraise the success of outcomes within the business objectives.

MEASURE	TOOL
Fill Rate – uptake and attendance of courses with the GLA Prospectus by both internal and external candidates	Learning Management System (LMS)
Candidate Hours – (Hours x Candidates) preferred measure of overall education and training activity	Learning Management System (LMS)
Evaluation – review and feedback of GLA Prospectus content and delivery of education and training by both internal and external candidates	GOSH digital evaluation platform (currently Survey Monkey is preferred provider)
Staff Survey – review of staff’s evaluation of overall availability and quality education and training	GOSH Staff Survey
Recruitment and retention rates	GOSH Workforce data
Exit interviews	GOSH Workforce data
Care Quality Commission (CQC) Assessment	Care Quality Commission (CQC) Report
NHS England/Improvement (NHSE/I) Assessment	NHS England/Improvement (NHSE/I) Annual Quality Report

14. QUALITY AND ASSURANCE

In order to ensure regular monitoring and quality assurance, the GLA will develop easily accessible and reliable reporting systems (i.e. dashboards, etc.) to report outcomes and measures and allow comprehensive oversight by our direct assurance bodies. This includes monthly reporting from the GLA Implementation Steering Group to the GLA Programme Board, which subsequently provides quarterly reporting to the GOSH People and Education Assurance Committee, the GOSHCC Grants Committee, GOSH Finance and Investment Committee, Executive Management Team and GOSH Trust Board. ([Appendix 6](#))

In order to ensure external oversight and value for money, the GLA Programme Board will be established to review overall project status and investment. A nominated member from the GOSHCC Grants Committee will be a participating member of this board.

The newly established *GOSH Children’s Charity Scholarship Awards* will be overseen within an established committee by senior GOSH Education and Training leads as well as a nominated member of GOSHCC. A bi-annual application and approval process will be established for these awards and activity will be reported to the GLA Programme Board as well as the aforementioned internal assurance bodies.

15. APPENDICES

15.1 APPENDIX 1



Appendix 1 - GOSH
Learning Academy -

15.2 APPENDIX 2



Appendix 2 - GOSH
Leadership Strategy.

15.3 APPENDIX 3



Appendix 3 - GOSH
Learning Academy -

15.4 APPENDIX 4



Appendix 4 - Step
Change Analysis.pdf

15.5 APPENDIX 5



Appendix 5 -
Education Finance S

15.6 APPENDIX 6



Appendix 6 - GLA
Governance and Rej

16. REFERENCES

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Trust Board 18th July 2019	
Gastroenterology Review Update	Paper No: Attachment P
Submitted by: Sanjiv Sharma, Medical Director	
Aims / summary This report provides: <ul style="list-style-type: none"> • an update on the progress the hospital has made in implementing the actions arising from the 2017 RCPCH review of Gastroenterology Services • highlights a decision by the ICO in May 2019 requiring the hospital to release the first draft of the 2017 RCPCH report • Notes that during preparation for the release of the first draft of the 2017 RCPCH report, it was noted that an incomplete version of the final report was shared with the Board in March 2018. The final version of the report is included with these papers for completeness. 	
Action required from the meeting <ul style="list-style-type: none"> • Note the progress made against the action plan • Note the copy of the 2017 RCPCH final report, and details of differences between the copy previously provided to the Board 	
Contribution to the delivery of NHS Foundation Trust strategies and plans Delivering of Safe, High Quality Care	
Financial implications None known currently	
Who needs to be told about any decision? Sanjiv Sharma, Medical Director	
Who is responsible for implementing the proposals / project and anticipated timescales? Senior Management Team for Body, Bone and Mind Patient Safety and Outcomes Committee	
Who is accountable for the implementation of the proposal / project? Sanjiv Sharma, Medical Director	

Royal College of Paediatrics and Child Health Review of Gastroenterology Services Update Paper July 2019

1. Context and Background

In 2015, the Royal College of Paediatrics and Child Health (RCPCH) undertook a review of the Gastroenterology Services at GOSH as part of the invited review process.

As agreed, and in line with the recommendations of the first report, a second review was undertaken by the RCPCH in July 2017 to assess progress. The report was completed in December 2017 and an update was provided to the Trust Board in March 2018.

There were multiple FOI requests associated with the RCPCH review during 2017, in addition to significant media attention linked to a television programme which aired in April 2018.

2. ICO Decision

One of the FOI requests sought disclosure of the first draft of the 2017 report. The hospital had denied the request at the initial and internal review stage. The requestor referred the matter to the Information Commissioner's Office (ICO). On the 2nd May 2019 the ICO issued a decision notice requiring the hospital to release the first draft of the 2017 report under the FOI process. This was completed on the 5th June 2019 in line with the ICO specifications.

3. Disclosure issues identified

As part of the process of preparing for the disclosure of the first draft report, it was identified that the copy of the RCPCH final report 2017 which was shared with the Board in the public session in March 2018 did not include all of the appendices. Five of the seven appendices, and reference to them in the main body of the report, had been removed:

- Appendix 2 Contributors to the review
- Appendix 3 Standards and Reference Documents
- Appendix 4 Information provided to the Review Team
- Appendix 6 Summary of Survey Responses
- Appendix 7 Progress against Recommendations

It was identified that the same version of the final report (i.e. without appendices) was also shared with our regulators. The issue was immediately highlighted to the Executive Management Team in June 2019 who agreed a plan for stakeholder

engagement which aligns with our commitment to greater openness and transparency with internal and external stakeholders including:

- Meetings with internal stakeholders including the wider Gastroenterology Team, Safeguarding Team and Patient Experience Team
- Report to Trust Board
- Discussions with external stakeholders including the RCPCH, CQC and NHS E/I

In the absence of reference to the removal of the appendices in the cover sheet that accompanied the report, and the fact that many of the leadership team have since changed, it has not been possible to establish the rationale for this decision.

In the interests of transparency, the full report with all appendices is included with this report, as well as an update on the progress of actions to address the report's recommendations.

4. Gastroenterology Action Plan Update

The updated gastroenterology service action plan (updated July 2019) is appended to this report for the Board's assurance. This has also been shared and discussed at the hospital's Patient Safety and Outcome Committee (PSOC), who are now receiving monthly updates on progress going forward. The following highlights are brought to the Board's attention:

- Progress has been made against all 26 recommendations
- 4 actions are noted to be complete
- 9 actions have 'ongoing' timescales
- 2 action deadlines are 'TBC' as we are awaiting a deadline being agreed by NHS E
- 1 recommended action relating to transition of care is covered as part of the Trust wide transition project
- Original timescales have been exceeded for 10 actions particularly those which have related to job planning and recruitment, but progress is being made, and the updates are included.
- Overdue actions requiring further attention and are being monitored through PSOC:
 - Consideration of whether there should be a further clinical review (A5)
 - Increase medical support for intestinal failure team (B6)
 - Strengthen the pathways and links with the local units for support for children with feeding tubes (C3)
 - Roles and responsibilities for management of patients on non-gastro wards (General Paediatrics and Gastroenterology) (C4)

Appendix 1 - Action Plan for Discussion and Development with Gastroenterology Team
RCPCH gastroenterology service review – January 2018

RCPCH Recommendation		Response	Led By	Reporting to (governance/group)	Due date	Position as of July 2019
A Leadership, strategy and external focus						
A1	Appoint a respected NHS based external clinical leader to the post of senior clinical lead – equivalent to a chair – in gastroenterology to develop the service, working together with other units on London-wide GI network collaboration	This recommendation, rather than being unilaterally considered by GOSH, must be agreed jointly with partner organisations , the way forward being developed within the context of networked service models overseen and signed off by commissioners. The Trust has invested in developing and appointing a clinical leader for gastroenterology from its existing team. It has focused particularly on achieving high and sustained standards of service delivery and judged that investment in clinical leadership of the service was an essential enabler for this. The Trust does not consider that appointing a Chair for the service at the current time is appropriate given such a post is likely to be primarily academic. The Trust is, however, very supportive of proposals to develop closer and more collaborative networks, and would be keen to participate in a London-wide collaboration. It would not be appropriate for this to be GOSH-led, except where particular sub-specialty expertise is required but the Trust would be very happy to work with those responsible for setting up such networks.	NHS England Directorate Chief of service to agree next steps with Med Director for NHS England Specialised Services Commissioning	NHS England	complete	Completed Oct 2017
A2	GOSH should become part of this London network to equally contribute to the care of the regional population alongside other GI units. In addition, GOSH may wish to also agree on their unique focus and to ensure appropriate communications between GOSH and all hospitals in this network	Agreed and should be developed with partners and led by commissioners as described above. GOSH fully supports strengthening of such arrangements and would wish to play a full part in a London wide gastroenterology network, focusing on working together to provide the services that enable children across London – and nationally - to fulfil their potential. This would include potentially taking on additional tertiary work as long as that is supported by adequate resource and capacity. The Trust is keen to work with network colleagues, led by specialised commissioners, to achieve this aim.	NHS England Directorate Chief of Service to agree next steps with Med Director for NHS England Specialised Services Commissioning	NHS England	On going	<ul style="list-style-type: none"> • On going conversations with North Thames Paediatric Gastro Teams to strengthen collaborate working, agree pt pathways and protocols • Last meeting 10th May 19 • GOSH based Network manager appointed - Victoria Salter • joint leads NT gastro network appointed – Mark Ferman RFH - Warren Hyer – C & W & DGH • NHSE To conform next meeting date

Appendix 1 - Action Plan for Discussion and Development with Gastroenterology Team
RCPCCH gastroenterology service review – January 2018

RCPCCH Recommendation		Response	Led By	Reporting to (governance/group)	Due date	Position as of July 2019
A3	As commitment to the proportion of its catchment from Greater London, working alongside other paediatric gastroenterology units, GOSH should agree and publish a defined specialist geographically based catchment area alongside its national specialisms. This would encourage development of stronger relationships, better networking, with provision of services close to patients' homes	Agreed and should be developed with partners and led by commissioners as described above. GOSH fully supports this proposal and is keen to work with commissioners and neighbouring units to agree how to define and organise the network to achieve these aims. Although we recognise that geographically based catchment areas would work well for some sub-specialist work, it is the opinion of GOSH that working alongside provider units that meet an appropriate standard of care and agreed referral guidelines is critical to the success of a managed network.	NHS England Directorate Chief of Service to agree next steps with Med Director for NHS England Specialised Services Commissioning	NHS England	tbc	As above
A4	Review the acceptance criteria, pre and post clinic MDT and job plans carefully to enable greater throughput of patients without compromising governance or increasing risk	Agreed. This work is underway , with a review of acceptance criteria complete, pre and post clinic MDTs now established and work continuing on job planning to reinforce delivery of a safe, sustainable and secure service.	Clinical Lead for Gastroenterology	Divisional Management Team	April 2018	<ul style="list-style-type: none"> • Consultant Job plans completed 2019 • CNS & Medical Staff restructure & recruitment in progress • Review acceptance Criteria still in place, will change in line with network strategy. • Post clinic MDT to continue for the foreseeable future to agree pt plans
A5	There should be a further clinical review of the service and approach to cases 12 months after the lifting of referral restrictions	GOSH fully supports the need for continued review and learning, and considers this must be part of 'business as usual' . The Trust has already undertaken a significant journey with this service and is now working to embed sustainable high quality care; it will therefore deliver this objective through its improved internal governance processes, which are externally scrutinised. It will consider the requirement for further clinical review if that process and scrutiny suggests there is such a need.	Divisional Director of Operations	Operational Performance and Delivery Group	April 2019	<ul style="list-style-type: none"> • Review referral criteria still in place • AG Directorate Chief of Service to discuss with COO & CEO, future plans for service to be re-assessed
B Management and governance						

Appendix 1 - Action Plan for Discussion and Development with Gastroenterology Team
RCPCCH gastroenterology service review – January 2018

RCPCCH Recommendation		Response	Led By	Reporting to (governance/group)	Due date	Position as of July 2019
B1	Clinical management should satisfy the Board that an investigation of historical gastroenterology cases has been completed in full, specifically the care of all children on long term interventions without a clear validated diagnosis	Complete. GOSH has kept the Board regularly informed of progress on this work and this action has been completed. Additional assurance about all patients currently within the service will be provided from a newly-launched database now rolled out, which will enable the Trust to identify and review care and outcomes of all children treated by the department.	Clinical Lead for Gastroenterology	Divisional Management Team	Complete	
B2	There should be a demonstrated climate of openness in addressing concerns raised by staff to provide assurance that appropriate action and candour has been exercised	Agreed and ongoing. The Trust has appointed seven Freedom to Speak Up Ambassadors and is committed to ensuring openness and candour are embedded across all of its services including gastroenterology. Regular staff surveys and feedback will be used to determine success in this area.	Clinical Lead for Gastroenterology	Divisional Management Team	Ongoing	<ul style="list-style-type: none"> • Complex pts MDT in place • Sub-speciality MDTs in place • Trust survey circulated to all staff • Speak up for Safety programme & training in place at GOSH • Duty of Candour training in progress • HR led gastro staff survey /pulse check to be implemented
B3	Take steps to ensure there is stability of clinical and operational management to embed the positive developments	Ongoing. The Trust has taken, and continues to deliver, a considerable organisational development programme with particular focus on the development and improvement of clinical and operational leadership and management, embedding mutual trust and support and ensuring clear and robust oversight of its service delivery.	Clinical Lead for Gastroenterology	Divisional Management Team	complete	<ul style="list-style-type: none"> • Operational, Nursing and Medical leadership in place with consistency over the last 18 months
B4	Ensure a UK peer network is involved with development and agreement of guidelines, perhaps through BSPGHAN, not just international partners	Agreed and ongoing. There is a limit to UK only peer networks for some of these services, as there are no UK peers who provide some of the more specialised gastroenterology services available at GOSH. For that reason, the Trust relies upon international expertise and is currently engaged in such peer reviews and networks, including representation at the highest level on ESPGHAN and BSPGHAN. For IBD and nutrition the guidelines have been peer-reviewed by two external paediatric gastroenterologists.	Clinical Lead for Gastroenterology	Divisional Management Team	Ongoing	<ul style="list-style-type: none"> • 2019 - Service Lead & Gastro Pharmacist reviewing all drug protocols/SOPs • Subspecialty Leads reviewing all protocols amending in line with new guideline changes etc • GOSH SOPs to be peer reviewed through North Thames Paediatric Gastro network

Appendix 1 - Action Plan for Discussion and Development with Gastroenterology Team
RCPCH gastroenterology service review – January 2018

RCPCH Recommendation		Response	Led By	Reporting to (governance/group)	Due date	Position as of July 2019
						<ul style="list-style-type: none"> Pathway outlines with DGHs to be managed through North Thames Paediatric Gastro network
B5	Finalise job plans, including weekend ward presence, appoint to permanent positions and consider additional recruitment to provide cross-cover and manage activity	Agreed and ongoing. This is something the Trust does for all consultants (not just gastroenterology). Appropriate consultant 24/7 cover is already provided for the service, with consultant ward rounds undertaken on Saturdays and clear consultant on-call arrangements to support the on-site registrar on Sundays. Every emergency admission to the Trust is reviewed for how long they wait for consultant opinion, and the gastroenterology service has not been raised as an area of concern from those reviews.	Clinical Lead for Gastroenterology/ Directorate Chief of service	Medical Director	April 2018	<ul style="list-style-type: none"> Consultant job plans Completed May 2019 Job plans updated and realigned to service demand & pt needs. Recruitment plans in progress – <ul style="list-style-type: none"> Locum post advertised. 2 x Permanent JDs with Medical Director for sign off
B6	Increase medical support for the intestinal failure team	Agreed and to be considered as part of the broader London-wide system noted above. Business case under development.	Clinical Lead for Gastroenterology	Divisional Management Team	September 2018	<ul style="list-style-type: none"> Outstanding – Trust PN service requires business case to improve overall provision. investment in Gastro PN Consultant & MDT staff needed Business case in progress
B7	Prioritise improvement of the ward environment as a matter of urgency and involve ward staff in discussions about relocation	Complete. Initial moved has happened. The service has already been decanted from its original unsatisfactory Rainforest location and will shortly be moving again to new state of the art facilities. Ward staff have been fully involved in ongoing discussions throughout the relocation plans and will continue to remain involved.	Clinical Lead for Gastroenterology	Divisional Management Team	Complete	IP Ward moved August 2018
B8	Consider appointment of a nursing practice educator	The Trust is committed to effective and appropriate levels of practice educator support (for all of its services)	Directorate chief Nurse	Divisional Management Team	April 2018	<ul style="list-style-type: none"> Completed - Person appointed 2018 July re-advertising – previous advert unsuccessful

Appendix 1 - Action Plan for Discussion and Development with Gastroenterology Team
RCPCCH gastroenterology service review – January 2018

RCPCCH Recommendation		Response	Led By	Reporting to (governance/group)	Due date	Position as of July 2019
B9	Strengthen links with and feedback from the pharmacy team within the overall governance reporting arrangements	Agreed. The team will take forward this recommendation and ensure it has excellent working arrangements with the pharmacy team. This recommendation will also be taken forward through the existing programme to review the Trust's pharmacy service.	Chief Pharmacist/ Clinical Lead for Gastroenterology	Divisional Management Team	July 2018	<ul style="list-style-type: none"> 1.0wte pharmacist works within Gastro Team. Attends governance & MDT meetings Currently reviewing all Gastro Drug protocols /SOPs with Gastro Clinical Lead As finalised submission to monthly pharmacy DTC
C Safeguarding and patient centred care						
C1	Maintain current safeguards, governance and QI programmes and consider rolling out the benefits and principles of PNB and ICN across the service	Agreed and ongoing. The Trust is taking this forward through the ICN database which enables international benchmarking (see also the answer to recommendation B1 above). The service also partakes in the broader ongoing safeguards, governance and QI approach overseen by the patient experience team	Clinical Lead for Gastroenterology	Quality Improvement Committee	Ongoing	<ul style="list-style-type: none"> Meetings managed within Governance TOR framework, referrals, Complex MDTs etc. New Trust EPR – EPIC in place April 2019 My GOSH pt portal in place Continued close working with safeguarding and social work teams Continued ICN benchmarking
C2	Involve a named general paediatrician in the referrals meeting and any gastroenterology subspecialty case with a perplexing presentation including current cases where a child has a significant disability after receiving treatment or investigations without a proven cause	The Trust has taken steps to encourage the role of general paediatricians within the service including, for example, allergy, complex care, and the dysmotility pathway. GOSH is keen to invest in development of general paediatricians with specialist interests to support the gastroenterology service as well as the needs (including repatriation) of patients requiring complex care.	Clinical Lead for General Paediatrics/ Clinical Lead for Gastroenterology	Divisional Management Team	July 2018	<ul style="list-style-type: none"> Referral meeting done as MDT with Lead Nurse & Consultant team +/- operational manager Safeguarding representation at complex MDT & relevant case conferences General Paediatrician allocated to attend relevant Gastro MDTs through their job plans
C3	Strengthen the pathway and links with local units for support for children with feeding tubes	Agreed. GOSH has invested in additional Interventional Radiology and agrees there is need for a clearer pathway to be developed jointly between IR, Gastroenterology and local	Clinical Leads for Radiology, Surgery and Gastroenterology	Divisional Management Team	July 2018	Not gastro specific issue –IR & SNAPS Working group established, GI bleeding SOP and service specific

Appendix 1 - Action Plan for Discussion and Development with Gastroenterology Team
RCPCCH gastroenterology service review – January 2018

RCPCCH Recommendation		Response	Led By	Reporting to (governance/group)	Due date	Position as of July 2019
		units, for children who have been repatriated with complex needs requiring long term feeding tubes.				pathways being discussed & collated to establish protocol
C4	Clarify the responsibilities between gastroenterology and general paediatrics for patients on non-gastro wards	Agreed. The Interim Medical Director will take responsibility for taking forward this recommendation with the general paediatrics service.	Medical Director	Divisional Management Team	March 2018	Not Gastro specific action - General Paeds Imke Meyer-Parsonson arranging July meeting with Gastro Service Lead
C5	Continue the rollout of the Transition improvement project to gastroenterology. Pathways should be patient based rather than be clinician's choice and require better networking. The design of such a programme should involve young people and include a suite of communications materials suitable for patients, parents and families	Agreed and ongoing. The Trust has an existing Transitional Care Policy with a project addressing these points is being overseen by a dedicated transitional care lead within the QI team.	Transition Improvement Manager/Clinical Lead for Gastroenterology	Quality Improvement Committee	September 2018	n/a
C6	Invest in building sufficient clinical psychology input to meet identified demand and increase mental health screening/support	Agreed. A business case for a new psychologist has been approved with the post-holder starting in January 2018. An additional business case for further psychology input into gastroenterology is currently under development, as well as care pathways specifically addressing the inclusion of psychological and other CAMHS support.	Clinical Lead for Psychology/ Clinical Lead for Gastroenterology	Divisional Management Team	September 2018	<ul style="list-style-type: none"> Provision Improved since review 1wte Psychologist working within Gastro Team. 2nd person fixed term 1 yr recruitment in progress. estimated start date of November 2019
C7	Plan realistically to ensure the appropriate number of beds so that children with 'perplexing presentations' can be admitted, observed and managed cohesively with general paediatrics local paediatric teams and safeguarding where necessary	Agreed and ongoing – the Trust's gastroenterology service is committed to ensuring that it has the right capacity to enable it to offer specialist investigation, advice and support, including support to clinical networks aiming to ensure patients are cared for as close to home as possible and appropriate (see recommendation A3).	Divisional Management Team	Operational Performance and Delivery Group	Ongoing	<ul style="list-style-type: none"> 25% increase in bed base -2 extra gastro IP beds opened end of 2018. One IP bed ring fenced for perplexing pts. July – due to Nursing levels & unreliable Bank staff, 2 extra beds closed Nursing staff to be fully established Oct 2019

Appendix 1 - Action Plan for Discussion and Development with Gastroenterology Team
RCPCH gastroenterology service review – January 2018

RCPCH Recommendation		Response	Led By	Reporting to (governance/group)	Due date	Position as of July 2019
C8	Ensure the effectiveness of complex cases MDT to encourage the lead clinician to discuss cases in a forum with other GI consultants, general paediatrician, safeguarding lead (where appropriate), nursing staff and clinical psychologists. All staff should be empowered to contribute	Agreed and ongoing. The team has put much focus on ensuring that these meetings are happening regularly and functioning well as part of ongoing work to develop an open culture and give staff the freedom to speak up. Much positive feedback has been received on the progress that has been made and the Trust will follow up with an internal survey to see how people are finding the new arrangements, and obtain their views on what more we could do to encourage and embed an open culture.	Clinical Lead for Gastroenterology	Divisional Management Team	Ongoing	<ul style="list-style-type: none"> Gastro MDT, General Paediatrician & CAMHS present at complex case meetings +/- Safe guarding lead MDT staff survey planned via HR to assess willingness to be open and raise concerns
C9	Ensure continued support to the safeguarding programme with all clinical staff in gastroenterology safeguarding trained to Level 3	Agreed and complete. These are the current requirements already operating within the service.	Clinical Lead for Gastroenterology	Divisional Management Team	Complete	
C10	Consider developing leaflets and web guides for patient and parents to support and improve their experience of using the service	Agreed. Listening event has been held and work on guides is under way.	Clinical Lead for Gastroenterology	Divisional Management Team	July 2018	<ul style="list-style-type: none"> Patient listening event 2017 Patient GIU aftercare leaflets reviewed and updated 2018 IP Ward listening event for staff & patients March 2019 PN patient listening event date TBC IBD patient listening event May 2019
C11	Develop a proactive programme of quality improvement and engagement with management and other specialist teams. The team should aim to develop clear service pathways and build a QI/safety dashboard across the London GI Network	GOSH fully supports the suggestion that this should be done on a London-wide/network basis and would be keen to participate in such a proposal. The Trust would be happy to work with those responsible for establishing the network to achieve this. The team are committed to the NHS monitoring process for highly specialised services, take part in the annual review process led by NHS England and have started the process of JAG review, newly in place for paediatrics and comprising of an annual process of independent assessment against national standards for endoscopy. The team also engages actively with the Trust's QI initiatives, including – for	NHS England Medical Director to agree next steps with Med Director for NHS England Specialised Services Commissioning	NHS England	tbc	<ul style="list-style-type: none"> Mid-flow JAG accreditation for endoscopy service – covering governance and QI July – GOSH submission & readiness ahead of other Paed Units. Unable to be assessed until other units catch up. ? October 2019 North Thames Network to discuss as part of the service improvement plans –

Appendix 1 - Action Plan for Discussion and Development with Gastroenterology Team
RCPCH gastroenterology service review – January 2018

RCPCH Recommendation		Response	Led By	Reporting to (governance/group)	Due date	Position as of July 2019
		example - focus currently being given to work to support the transition to adult services.				
C1 2	Continue to improve liaison and understanding between the gastroenterology consultants and social care team	Agreed and ongoing.	Social Care Team Lead/Clinical Lead for Gastroenterology	Divisional Management Team	Ongoing	<ul style="list-style-type: none"> Team Included in complex MDT & ward rounds and relevant pt case discussions

RCPCH Invited Reviews Programme

Follow-Up Review

Great Ormond Street Hospital NHS Foundation Trust
Gastroenterology Service

Visit date July 2017
Final report December 2017

RCPCH

Royal College of
Paediatrics and Child Health

Leading the way in Children's Health

RCPCH Invited Reviews Programme
December 2017

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Royal College of Paediatrics and Child Health
5-11 Theobalds Road
London WC1X 8SH
Tel: 0207 092 6000
Email: enquiries@rcpch.ac.uk
Web: www.rcpch.ac.uk

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Note 1: Our review has not looked specifically at clinical outcomes or individual case management. Our recommendations and the plans for network and governance development should facilitate systemic improvements in these areas.

Note 2: This report reflects the evidence and interviews considered by the Review team during the visit in June and July 2017. We acknowledge that in the time taken to agree the final report the Trust has made progress but the report stands as a 'snapshot' of the position in July 2017

Executive Summary

This review report examines progress against the recommendations of the RCPCH Invited Review of gastroenterology service at Great Ormond Street Hospital in 2015. It provides a fresh view of the current service with recommendations that encourage sustainable, achievable and integrated service provision for children and young people with gastroenterological conditions.

The review team recognises that the gastroenterology service had faced a difficult period following the 2015 review. The service had significantly reduced activity whilst investigations were carried out including a detailed programme of case review and a thorough overhaul of administration and governance systems.

By the end of 2016 the service was considered by the Trust to be in a positive position and the RCPCH was approached in spring 2017 to carry out a follow up review. The review team comprised two experienced paediatricians and a lay reviewer supported by an RCPCH manager. Terms of reference were agreed and the team interviewed almost 100 people and examined a similar number of documents to the 2015 review

The review team found very good senior clinical and operational leadership which needs to be sustained and embedded. There have been significant improvements in administration of patient communications and clinic organisation and a suite of new governance meetings and reporting pathways which ensure that any new referrals are appropriately investigated and diagnosed in conjunction with their local referring paediatrician. The consultants were working better as a team and engaging more with multidisciplinary colleagues, particularly the more recently appointed and locum consultants.

Many of the consultants and other staff were embracing the new ways of working. There had been significant investment in nursing, and improved involvement of multidisciplinary colleagues including psychology and dietetics. Strong nursing leadership on the wards and investigations unit was embedding the governance and quality programme with improved morale and a clear career structure for staff.

However, the new approach has not been universally accepted by all gastroenterology consultants and some remained sceptical about the need for change. Some concerns were expressed that the Trust and team had not yet fully learned from the consequences of the 2015 review, when further detailed case review work was required urgently to ensure all children were on appropriate care plans. Whilst the original report had been shared with regulators and commissioners, who had monitored the action planning and progress of the Trust against the recommendations, some staff working in the service had not seen it and told the review team that they were not yet confident that their concerns could be raised and responded to in a climate of openness.

Further encouragement is needed for the gastroenterologists to fully embrace external peer review. Some consultants see their service as only 'quaternary' or highly specialised and are selective about accepting their fair share of specialist ('tertiary') referrals in the London catchment; this approach has been supported by the Trust and specialist service commissioners during the period since the initial review report but the continued limitation is causing friction with other providers. It is important going forward that specialist services and the specialist commissioners work closely together with clarity about expertise and referral pathways across London and the South East.

The service is currently working at around half of its previous activity and needs to step back up to manage a similar workload to peer units. There are some efficiency savings which could be made to achieve this and subsequently some investment in staffing and robust job planning may be needed to ensure that the gains made in governance and safety are embedded and continue with the changeover of the Medical Director. We would recommend involvement in a networked Quality Improvement programme and/or appointment of an externally-facing senior clinical leader – equivalent to a Chair or professorship appointed by the NHS with an interest in translational research-- to support the development of a strong gastroenterology network in London.

The full report sets out the findings which are wide ranging but reflect the impact of the 2015 report and the extent of turnaround that has been achieved. There has been good progress in dealing with the immediate issues of concern and implementing practical systems but the next stage is ensuring this culture remains embedded to focus on the best interests of the child.

Safeguarding systems and processes have improved since the previous review with strengthening of the safeguarding team, improved focus on training and reporting and better links with patients' local children's services. The appointment in February 2017 of a respected, experienced Named Doctor will enable this improvement to continue.

Involvement of families and management of transition are areas which still require improvement but again the Trust is aware of this and striving to bring the gastroenterology service to the standards of other teams in the Trust and other gastroenterology centres. There is a wide selection of material and support readily available for these schemes and no reason not to move forward more swiftly with this to build healthy trusting relationships with families and other units.

In summary, the Trust is making good progress on the significant transformation identified as necessary in the 2015 report but now needs to broaden its activity to play a full part in the regional network. There are some areas of very good practice, but there is still more to do to complete the assurance process, embed the change of culture and restore the confidence of peers and families that the service has truly turned around.

1 Introduction

1.1 Since the RCPCH's review of GOSH Gastroenterology services in summer 2015 the review team maintained contact with the Medical Director at the Trust, as the detailed recommendations from the review were implemented. The actions taken by the Trust as a result of the review involved significant change to internal team function and staff roles as well as investment in new governance systems and restrictions on referrals until the concerns raised by the review had been dealt with.

1.2 Two years on the Trust formally invited the RCPCH to return and review progress against the recommendations, and provide a fresh steer as to what was needed to embed sustainable change and build a service that was confident and respected as part of a wider gastroenterology network. GOSH has an extremely strong reputation for managing the most complex paediatric conditions and there was ambition that the gastroenterology service could be safely restored to fulfil its role as a specialist level provider with world-class expertise in some aspects of its care.

2 Terms of reference

The terms of reference for the review were agreed by the leadership team at the Trust and the gastroenterology team as follows:

“The RCPCH will conduct a follow up review of the paediatric gastroenterology service at GOSH focusing specifically on:

- a) What progress has been made against the recommendations from 2015 in terms of
 - Leadership and management
 - Concerns arising from MDT work
 - Strategic positioning and external referral pathways
 - Safeguarding
 - Communications and administrative support
 - Clinical activity and job planning
 - Governance, guidelines and audit
 - Training and supervision
 - Patient and family Involvement?
- b) Are the current protocols, pathways and guidelines fit for purpose and working effectively?
- c) Are there any areas of notable practice or achievement?
- d) The priorities and strategy for development of the service.”

3 Background and Context

The current service

3.1 The gastroenterology service at GOSH is managed as three divisions, each hosting one NHS England Highly Specialised Service as well as managing specialist referrals from other centres and limited referrals from other departments within GOSH. The conditions managed by each unit are:

- Neuro-Gastroenterology and Motility Unit (Drs Borelli, Lindley, Thapar and a locum) Chronic Intestinal Pseudo-obstruction (CIPO NHS England HSS); Refractory / intractable Constipation; Cyclic Vomiting Syndrome (CVS); Gastro-oesophageal reflux disease, Oesophageal Motility Disorders (Achalasia, Oesophageal atresia etc.); Gastric motility disorders (gastroparesis); Feeding and eating disorders (working closely with feeding team and Mildred Creak Unit and Functional Gastrointestinal Disorders
- GI Mucosal Immunology (Drs Kiparissi, Shah and two locums) Inflammatory Bowel Disease (IBD) early and late onset, (Crohn's Disease, Ulcerative Colitis, unclassified), Coeliac disease, Eosinophilic Oesophagitis, Immunodeficiency, Autoimmune GI diseases, Epidermolysis Bullosa.
- Nutrition and Intestinal Rehabilitation (Drs Koeglmeier and Hill) Congenital Diarrhoea (Tufting Enteropathy, Micro-villous atrophy, etc.), Short gut with intestinal failure, Faltering growth, Intestinal failure assessment, Shwachman-Diamond Syndrome, Acute and chronic pancreatitis.

3.2 There are seven permanent consultants, and three locum appointments pending a decision on the future configuration of the service. There are ten 'middle grade' doctors working as clinical fellows or registrars. Two matrons (who also cover other areas), 9.5 clinical nurse specialists (an increase since 2015) a ward sister and 6.5 Band 7 nurses / nurse practitioners complete the senior clinical team.

3.3 Day case attendees and elective/non-elective admissions for less than 5 days are admitted to Kingfisher ward which has 10 inpatient beds (3 assigned to gastroenterology patients) and 6 day case beds and closes at weekends. Inpatients staying for longer are accommodated in the 8-bedded Rainforest ward which is not fit for purpose and at the time of the visit there remained uncertainty as to the plan for relocation.

Actions since the previous review – see Appendix 7

3.4 Completion of the RCPCH's review in July 2015 coincided with the appointment of a new medical director at the Trust. On 20th July, the RCPCH raised immediate concerns about, some aspects of the service which were followed up in a letter dated 22nd July. These concerns related to allegations of

- Over investigation of some children
- Over diagnosis of certain conditions without consistent criteria or thresholds

- Poor flow of safeguarding and contextual information from local clinicians and children's services
- A concern about how patients are selected for research projects.

3.5 The letter recommended that “*a swift but thorough review is undertaken of the diagnosis and management of 40 of the children currently being treated for eosinophilic colitis to determine whether the overall best interests of the child are being met, and if not devise a strategy for resolution. This review should be completed within three to six months and depending upon the findings of the first 40, more cases may need to be examined*”.

3.6 The Trust responded swiftly to this notification and advised the RCPCH on 24th July that from Monday 27th July all new referrals to the service were to be reviewed by an intake multidisciplinary team (MDT), all procedures were to be agreed in advance against written justification, the cohort of 40 cases for review was being established and consensus –based diagnostic criteria and guidelines for investigation and treatment were to be developed.

3.7 The full review report was sent to the Trust in draft on 7th August and, following receipt of factual accuracy comments, in its final form on 4th September 2015. It defined the external review caseload to “*children without IBD on immune-modulation; enteral feeds and elemental diets*” and made 24 further recommendations which are included in Appendix 6.

3.8 During autumn 2015 the Medical Director established the expert panel to conduct the external casenote review, comprising four consultant paediatric gastroenterologists and a consultant allergist. Initial attempts to convene international experts delayed establishment of the panel and the original suggestion of an independent lay chair was not implemented. A list of 40 cases was drawn up for review selected from those who had specifically received any of the following interventions:

1. Exclusion or elimination diet; 2. Presence of gastrostomy or use of NG/J tube; 3. Steroids; 4. Other immune suppressants (eg MMF, azathioprine) or monoclonal antibody treatments. Once established with terms of reference in November 2015 the panel carried out a rapid casenote review and agreed that fourteen of the first 18 cases gave the panel significant cause for concern over the diagnosis and treatment regime. This was formally reported to the Medical Director in December 2015, recommending a more detailed expert review of these same cases including histology, plus a wider clinical review of patients across the service. The panel's report and recommendations were presented in January 2016.

3.9 From January 2016 major restrictions were put on referrals into the service, including significant reduction in endoscopy work, and other specialist centres were asked to increase their activity ‘on a temporary basis’ to accommodate these referrals

and also conduct follow up reviews of some of the existing GOSH patients. This course of action was agreed with NHS England. An investigation was carried out and there were changes to the management team and a major overhaul of governance, procedures, administration and safeguarding arrangements in line with the recommendations of the RCPCH report, with fortnightly meetings of a task and finish group chaired by the Medical Director.

3.10 The Trust Board was kept fully apprised of the findings and recommendations of the review and the progress being made to address them.

3.11 In parallel with these changes, in March 2016, 42 patients were identified within the gastroenterology service on immunosuppression and/or steroid therapy without another comorbidity or diagnostic rationale. These patients were re-examined by independent expert paediatric gastroenterologists together with the remaining 24 cases in the initial sample. Where appropriate the patient was seen and changes to treatment regime discussed. In line with the panel's recommendations, independent assessment of treatment plans in clinic were undertaken for a sample 20% of gastroenterology patients and two consultant gastroenterologists were seconded into the Trust for three days a week during 2016 to assist with assessing these patients in clinic. Their care was discussed with the GOSH gastroenterologist and where appropriate their treatment regime was amended and and/or they were discharged them to the care of their local service. This was completed by June 2016. For each patient a summary was completed and scored using the NPSA harm definition and the Trust Risk Matrix: "Has harm been done?", "What is the risk of harm?" and "Likelihood of harm"

3.12 The Care Quality Commission (CQC) was involved at an early stage and supported the sampling review of 20% of all gastroenterology patients. In total the Trust estimated that care and treatment of around 300 patients was reviewed. During 2016 the CQC held fortnightly meetings with the Trust but these reduced as the Trust demonstrated more secure governance systems. There was joint oversight with NHS England and NHS Improvement but this moved to operational oversight by the end of 2016. Slide sets presented to the September 2016 Members Council and January 2017 Senior Management team were shared with the RCPCH Review Team but they did not see a formal report for the completion of this process.

3.13 The Specialist Commissioning team at NHS London was made aware of the review and agreed to the changes in referrals and other steps being taken by the Trust to address the concerns raised by the RCPCH. NHS Improvement was also updated.

3.14 By December 2016 the Trust considered it had made significant progress in addressing the clinical concerns raised by the RCPCH and wrote to a number of stakeholders, including specialist centres who had taken its referrals, commissioners, RCPCH and the CQC summarising the concerns and action taken. A summary

statement was posted on the Trust website which set out the steps that had been taken, and included the commitment to invite the RCPCH to conduct a follow up review.

3.15 Both the detailed and the summary statements from the Trust contained the phrase: “the review did not find evidence of long term consequences of over investigation or overtreatment”. This, the review team were told, was justified by the Trust from consideration of the cases examined in detail and review of the statements made by the visiting consultants in response to the questions set out in 3.11. There was recognition by the Trust that for some children there had been lost school days, side effects and disruption.

3.16 Some staff in the Trust, and some clinicians in other specialist centres who had not been fully apprised about the process, inferred that this ‘no consequences’ statement had arisen from the RCPCH 2015 review report since most staff had not seen it. Those who expressed concern felt the statement may not have taken into account other patients still undergoing similar treatment for many years whose care had not been reviewed, nor the psychosocial impact on patients who had been on treatments for many years.

3.17 Formal communication with the families whose children’s care was being reviewed by the team at GOSH was carefully planned, and NHSE was involved in this planning. Following the initial casenote review, families were told the conclusions drawn about their child’s care. The letters explained that the child’s care was being reviewed as part of ongoing quality approach and that as a result in some cases changes needed to be made to the treatment regime. The wording used aligned with that on the Trust website and was sent to stakeholders and referring units. In December 2016, the Divisional Director wrote to all children and young people whose care had been reviewed and their parent/carer explaining that the review was complete and that further actions were being addressed including the request for external review.

3.18 The Medical Director left the Trust in December 2016 and Dr David Hicks, a respected former medical director who had been appointed earlier in 2016 to assist with the service overhaul, took over in an interim role and formalised the arrangements for the RCPCH to revisit the service.

4 The Review Process

4.1. The review team comprised three of the four members who conducted the previous review and details are included in Appendix 1. The team's gastroenterology expert had retired so was replaced by a BSPGHAN Council member who had contributed to the development of the recent 2017 joint standards.

4.2 Members of the review team attended a helpful pre-visit meeting with the Interim Medical Director, Deputy Chief Executive and other colleagues in May 2017. There was agreement that this review should be as open as possible and involve all those who contributed previously (if still in post) as well as others who are new to working with the service. A range of documentation was provided to the team before and during the review period and information requested was provided, where available, swiftly and without hesitation.

4.3. The review was conducted over five individual days to maximise the availability of the review team. The visit programme was put together by the Trust and alongside this the RCPCH made contact with other stakeholders and arranged for written submissions or telephone or face-to-face interviews with one or more members of the team. In all 94 individuals contributed to the review.

4.4 A survey seeking the views of patients and families was made available through the Trust and relevant social media and a member of the review team attended an engagement morning for patients and families on 15th July 2017. The survey generated just 18 responses which was surprisingly low. The RCPCH uses surveys on its reviews to provide an opportunity for patients and families to contribute their views. However it is more important to assess how a service is itself gathering and acting upon the views of patients and families and this is considered in section 5.9.

4.5 Throughout the review the Interim Medical Director and staff across the service have been helpful, open and accommodating and the review team did not feel there was any restriction on access to information. Those contributing from outside the Trust have been open and honest in their opinions and almost all those who participated had noticed an improvement in the service and were keen to continue to work with the Trust to embed the changes.

5 Findings

The findings from the review have been grouped under the headings of the terms of reference.

5.1 Leadership and management

5.1.1 Most of those interviewed recognised that it had been a very difficult two years for the gastroenterology service; particularly for the consultants who had undergone investigation but also for nursing and other staff who recognised that treatments they had been administering may have been inappropriate. The impact of the changes to the service had been far-reaching in some teams whilst others had seen little change beyond temporary disruption. Some of the external experts who agreed to support the Trust through casenote reviews and taking referrals had found the team unwelcoming and the process and communications unsatisfactory.

5.1.2 At Trust Board level the arrival of the new Medical Director in July 2015, alongside a new Chief Nurse catalysed the change, enabling the Trust to start to tackle longstanding concerns raised by the RCPCH and others about the service. An interim general manager was appointed for a year in February 2016 who gained respect and ensured the casenote review work was delivered and documented systematically. Actions were completed and clear policies began development. A new Divisional Director and replacement General Manager alongside the appointment of a new clinical lead from within the team has enabled swift and positive change in the governance systems, referral pathways, administration of clinics and communication with patients and families.

5.1.3 Although improved processes and systems are now in place there were still some concerns expressed that more time is needed, with clear and confident leadership to tackle deep-seated attitudes amongst some of the consultants.

5.1.4 A consistent theme amongst almost all staff interviewed, was frustration at the absence of clear communication from senior management about the 2015 RCPCH review report and how and why the changes during 2016 were implemented. Whilst the Board, CQC, commissioners and external reviewers had seen the report it had not been shared with the consultants, even in summary form and there was much unhelpful speculation and frustration at the report's content and the reason for the imposition of changes by the Trust management. Staff received a brief announcement just before Christmas 2015 explaining that as a consequence of the RCPCH report, activity would be significantly restricted but there was too little information for them to understand and plan for the consequences or advise families what was happening. Some of the staff interviewed had inferred a lack of trust and a sense of isolation from the Board and senior management, which could have been mitigated through greater visibility, briefings

and a programme of organisational development to build and retain trust and recognise the efforts of those working with and within the service.

5.1.5 Whilst staff felt it was important to share their frustrations at how the process had been handled, in order that lessons could be learned, most interviewees did recognise, with hindsight, that the events of 2016 had been necessary and helpful in the longer term. They appeared to understand that given there were personnel issues to deal with, it had been important to be careful with information, sure-footed in managing potential trigger points, particularly around media interest, and to maintain control to make the service safe as swiftly as possible. They recognised the positive medical and operational leadership of the Trust, division and service and were hopeful that the 2017 RCPCH review would trigger sustainable restoration of an open, fully functioning service. The General Manager is well respected and has built a good level of trust. The Interim Medical Director is well respected and has provided a positive influence on the team but is scheduled to leave in December; the Divisional Director is highly respected and has a clear vision of how to manage the consultant team and encourage the best from the service and important that the new Medical Director engages swiftly to maintain the confidence of the team and its stakeholders.

Recommendation: Take steps to ensure there is stability of clinical and operational management to embed the positive developments

5.1.6 Amongst the consultants there is a more positive approach to service delivery and governance systems. Following case reviews all consultants underwent individual and team coaching sessions to address the issues highlighted in the previous review and build greater interpersonal and team-working skills. This has had some impact although several interviewees were concerned that the changes made around multidisciplinary working, consistent protocols and peer review may not be sustained once the service gets busier so continued management vigilance to ensure the new processes are embedded is important.

5.1.7 Whilst the clinical lead has worked hard to bring the team together, support the governance changes and develop, with colleagues, a shared vision for the service, there is an opportunity to establish the service more formally as a centre of excellence, building momentum and respect externally amongst specialist and research colleagues. By creating an NHS based senior clinical leadership post in gastroenterology, high calibre applicants would be attracted to the opportunity to develop and influence the clinical service. This was a recommendation in the 2015 review. The right appointee would bring gravitas, credentials, excellent networking capability and constructive challenge to lead and develop the GOSH team further in regional, national and international circles. Strategically GOSH being based in London has a responsibility to equitably contribute alongside other paediatric GI units to the care of children in the region. They should encourage greater external collaboration and peer engagement

amongst the consultant team to develop and demonstrate excellence alongside providing opportunities for critical challenge and enhanced research capability.

Recommendation – Appoint a respected NHS based external clinical leader to the post of senior clinical lead - equivalent to a chair - in gastroenterology to develop the service, working together with other units on London-wide GI network collaboration (see also section 5.8 about networks)

Recommendation - GOSH should become part of this London network to equally contribute to the care of the regional population alongside other GI units. In addition, GOSH may wish to also agree on their unique focus and to ensure appropriate communications between GOSH and all hospitals in this network

5.1.8 Other teams in the Trust have risen to the challenge and continued to support families and the gastroenterology team, recognising that they have been undergoing significant difficulties. Surgeons have seen a more systematic approach to pathways but are concerned that the systems may have become 'over bureaucratic' and inefficient, with little cross-department representation at team meetings.

5.1.9 The dietetics team were very enthusiastic about the changes since the 2015 review, with much greater MDT involvement in clinics, development of protocols and pathways and rigorous follow up of children following exclusion diets. However, there is more to do to embed the changes and ensure that children with complex needs always receive appropriate observation, management and review.

5.1.10 Nursing leadership within gastroenterology has improved significantly with a new matron and ward sisters/nurse practitioner on the wards and investigations unit. Staff turnover has reduced, morale is good, staff have defined career pathways and speak positively about the service outside the Trust. Stronger links have been forged with mental health staff so ward nurses feel better equipped to manage and support complex families.

5.2 Concerns arising from MDT work

5.2.1 The 2015 RCPCH report recognised the intention of the complex cases MDT to identify and review the care of patients with challenging presentations, where there may be a more functional / psychological / factitious cause to symptoms and treatment may need to be revised. This was chaired by a consultant child psychologist, but the 2015 report commented that it was not being robustly supported to work as swiftly and effectively as it should. Since the review the complex case MDT had increased its activity and attendance, and the review team were told of a database of complex cases numbering around 180 of which 70% were perplexing presentations. The chair retired late in 2016; the new chair was reported to be well-respected and the meetings are continuing to work effectively with increasing engagement of most of the consultants.

The local paediatrician for a child whose case is under review is usually invited to telephone in and provide context to the discussions, and the Named Doctor for safeguarding also attends when her diary permits.

5.2.2 Despite the improvement and changes to functioning of the complex case MDT, there remain concerns amongst some staff that whilst the process continues to improve it is insufficiently effective or thorough at the moment. They told the review team that a higher proportion of children may benefit from reduced or delayed intervention where the indicators of disease are unclear, but that even as clinicians they did not feel confident to raise concerns. They explained that in some areas they still perceived a culture that suppressed challenge from colleagues which made them fearful of speaking out. The published phrase stating, “no evidence of long term consequences” as referenced in 3.15-3.16 further exacerbated their concerns although the Trust had received approval from NHS England for all communications. Several indicated that there appeared not to have been any organisational learning or remorse from the situation or focus on actually what happened to those children and families.

5.2.3 These continuing concerns need to be tackled systematically and transparently by the Trust so that all staff understand the process for raising concerns and feel confident that these will be properly investigated and, most importantly, responded to genuinely and honestly with due care and support for the families involved. Specific cases brought to the attention of the RCPCH team were raised swiftly with the Medical Director in July and the review team has been advised that the matter is being addressed.

5.2.4 Under the 2016-7 NHS Contract all Trusts were required to appoint a “Freedom to Speak Up Guardian” to support whistleblowing and reporting of concerns. GOSH appointed seven FTSU Ambassadors across a diversity of job roles to ensure they were approachable. The team meet regularly, are engaged in an ongoing development programme supported by the Human Resources and Organisational Development department and link with the National Guardian’s office. The initiative is being reviewed but was reported to be working well.

Recommendation – Clinical management should satisfy the Board that an investigation of historical gastroenterology cases has been completed in full, specifically the care of all children on long term interventions without a clear validated diagnosis.

Recommendation - There should be a demonstrated climate of openness in addressing concerns raised by staff to provide assurance that appropriate action and candour has been exercised.

Recommendation - There should be a further clinical review of the service and approach to cases 12 months after the lifting of referral restrictions

5.2.5 The review team recognises the challenges faced by clinicians and families in discussing changes of treatment or discharge from the service, particularly when families have become familiar with one consultant and the service at GOSH. The two consultants seconded into the service in 2016, as well as gastroenterologists in other specialist units were expected skilfully to manage an unenviable task in explaining to patients and families why the changes had been made and helping them to adapt to a different care plan.

Recommendation - Ensure the effectiveness of complex cases MDT to encourage the lead clinician to discuss cases in a forum with other GI consultants, general paediatrician¹, safeguarding lead (when appropriate), nursing staff and clinical psychologists. All staff should be empowered to contribute.

5.2.6 Every clinic is now preceded and followed by an MDT which reviews the cases and agrees the clinical management. This shared decision-making improves patient safety, provides a teaching and learning opportunity and reassures patients that there is more than one clinician advising on their care. This assurance and consistency of approach has been welcomed by almost all staff involved. There are some consultants who find it burdensome and others noted the additional clinical and administrative time required for reporting and uploading all discussions to casenotes. The universal MDT approach still needs to be fully embedded but will also need to be risk assessed and streamlined so it is sustainable and remains effective once the service has opened up to a wider range of referrals. As a minimum, there must be the consultant on take and the lead consultant for the clinic.

Nuclear Medicine and diagnostics

5.2.7 The 2015 report highlighted poor communications between the gastroenterologists and the diagnostic team, with inadequate information for and about patients, a lack of clarity over the purpose and need for some investigations and concerns that children were being over-investigated. The pre-procedure information about patients available to the diagnostic team was reported to have improved, but the review team was told that sometimes patients are still being referred with insufficient justification or checks, or requests for procedures that are unusual, which generates tension between the teams. Regular meetings between the teams should be facilitated to address these concerns and ensure that all procedures are carefully considered in terms of the best interests of each child with a climate of equality and discussion.

Gastroenterology Investigations Unit (GIU)

5.2.8 Following the review there has been a transformation in the GIU and endoscopy service. Activity had dropped significantly; each referral requires detailed supporting information and is now robustly assessed by an MDT to identify where symptoms may be functional. A bid for replacement of the endoscopy stack was successful with the new

¹ Section 5.5 on safeguarding explores the role of the general paediatricians

equipment coming into use at the time of the visit. This investment in the service has been much welcomed and improved morale in the unit as well as significantly reducing risk; the previous stack was not fully compatible with the Trust’s information systems. Nurses are receptive to doing more investigations and an in house specialist training course is being established

5.2.9 Children and families are much better prepared for the diagnostic procedures in the GIU than two years ago, when communications and administration was very poor and staff felt unsupported. There is reasonably good information on the Trust website and patient leaflets and a newly appointed staff member will focus on pre-admission arrangements and further improve communication and patient/family experience. The nursing leadership has been strengthened, including the recent appointment of a nurse practitioner which has improved morale and reduced turnover.

5.3 Clinical activity and job planning

5.3.1 Following the restriction on accepting referrals, total activity has dropped significantly (Fig 1) yet the consultant staffing numbers remain unchanged, enabling much more time to be spent on MDTs and governance activity. However even with reduced referrals from July 2015 and further reductions six months later the department only succeeded in meeting the 18 week RTT targets in December 2016. It has since remained compliant.

Activity (Source = Qlikview)	2014/15	2015/16*	2016/17	Commissioned 17/18
Outpatient - New	902	1,237	207	263
Outpatient - Follow-Up	2,395	3,922	2,934	2,646
<i>Total Outpatient</i>	<i>3,297</i>	<i>5,159</i>	<i>3,141</i>	<i>2,909</i>
Outpatient (Telephone)	1,762	389	617	594
Day Case	1,319	1,344	881	725
Elective	1,190	961	859	840
Non-Elective	41	50	77	46

Fig 1 Gastroenterology Activity *Whilst additional consultants were seeing extra patients

5.3.2 There is a referral MDT every Monday morning which all consultants are expected to attend. The MDT was reported to work well with good agreement.

5.3.3 The criteria for accepting referrals were finalised in May 2017 and include all referrals from other specialist centres, plus selective referrals from secondary care in a district general hospital (DGH), and limited in-Trust referrals. These criteria are too limited; they were imposed in 2015-6 when the service was being reviewed and some staff were not available for a period. Now the review is complete and all are working again it is important that the service ‘steps up’ to deliver at least as efficiently as peer units contributing effectively to paediatric GI care in the region.

5.3.4 The general manager for gastroenterology had drafted a comprehensive service position statement as a basis for future planning, which included a demand and capacity analysis and assessment of the administrative and clerical workforce restructure. It reflected that the current workload is unsustainable in the long term which is also the view of the specialist commissioner given the increased pressure on other units which previously referred to GOSH. Of course, families who have been waiting a considerable time for their appointment and travelled a long way for it expect plenty of time with the doctor or others at the hospital but this is inefficient use of medical time.

5.3.5 The review team concur that the service should be able to see 6-8 patients per clinic including appropriate MDT review. With nursing backup and efficient administration this should be feasible and is more in line with other specialist services nationally.

Recommendation - Review the acceptance criteria, pre-and post clinic MDT, and job plans carefully to enable greater throughput of patients without compromising governance or increasing risk

Nutrition/intestinal failure

5.3.6 The nutrition service/intestinal failure was reported to be very stretched with two consultants and three nurse specialists with up to 52 inpatients on PN across up to ten wards in the hospital. They struggle to meet the RCPCH/BSPGHAN standards that every child on PN should be seen weekly and have seen reduction in clinical fellow support since 2015, which impinges on the consultant job plans. The issue is on the Risk Register and the team are seeking an additional consultant post to enable cover for leave and sickness.

5.3.7 It is suggested that a review of patients on PN is conducted to ensure that all are requiring the intervention, and comparison with network and European standards as conducted in 2015 may again provide useful benchmarks. However the current situation is unsustainable and there is a realistic case for increased senior medical cover.

Recommendation – Increase medical support for the intestinal failure team

5.3.8 Concerns were also raised to the review team from regional centres about the local management of children with feeding tubes. A typical cited example is of children with displaced Jejunal tubes, with no clear pathway with regards to point of referral or contact in GOSH to replace these tubes. Presently these referrals may be accepted by either the surgical or gastroenterological teams, partly depending on which unit may have a bed.

Recommendation – Strengthen the pathway and links with local units for support for children with feeding tubes

Managing patient diets

5.3.9 Given the cohort of families that are referred to the department seeking advice, the oversight and management of exclusion diets needs to be robust. The review team heard reports that some children had been kept on strict dietary regimes for over 6 months without review and others had been recommended exclusions even before a first appointment, which may not have been necessary and could have affected self-esteem and quality of life. It was reported to have been in some cases hard to reintroduce foods even following inpatient stays, as compliance at home can be patchy.

5.3.10 Although there is a fortnightly steering group for allergy, and the dietitians have a higher profile within the MDT, there is no currently paediatric allergy consultant in the Trust.

5.3.11 Whilst the review team was told there are now better explanations about special diets and improved expectation management, including written diet sheets, just two consultants sign off multiple exclusion diets which can cause delays. Clarity is required about what allergy service should be offered and its governance, and there is scope for the general paediatricians to have greater involvement.

Rotas, ward rounds and team working

5.3.12 There has been considerable progress made in rostering and visibility of the consultants. Job plans have been drafted by the clinical lead and general manager but have not been agreed yet pending the recommendations of this review and any consequent changes to service activity.

5.3.13 Nine of the consultants cover a fortnight on 'take' including availability on-call overnight and at weekends. Although this technically risks breaching the Working Time Regulations² in terms of compensatory rest for periods on call in the hospital the workload is not acute or excessive (there is of course no emergency department) and all consultants are content with the arrangement, in effect working seven weeks a year on-call.

5.3.14 The on-take doctors conduct a ward round at least daily and sometimes twice, and others were reported to be more visible on the ward seeing their patients and liaising with the nursing staff on Wednesdays and Fridays. Following the Monday morning referral MDT there is a Grand Round at which each inpatient is presented by their consultant to the consultant on-take for the week. Although there were still reports of the on-take consultant changing the management plan of an inpatient there was a greater tendency to discuss the approach with the child's consultant and the increased profile of the specialist nurses has improved consistency of care and involvement of patients and parents in understanding why changes were being made.

² Statutory requirements adopted in the UK based on the European Working Time Directive limiting the number of hours spent on site at work. <https://www.gov.uk/maximum-weekly-working-hours/overview>

5.3.15 Team working amongst the consultants was reported to have improved and some have risen very well to the challenge of new opportunities since the 2015 review. All have undertaken four team-coaching sessions to assist this, but teamworking remains relatively fragile and continued vigilance around behaviours and attitudes by the General Manager and Strategy/research lead is likely to be required for some time yet. It was suggested that further teambuilding work would be helpful and as we suggest elsewhere, the appointment of a senior clinical leader to the department could provide that. There is more to do to fully involve other disciplines; although the consultants have begun to engage better with managers, nurses and dietitians through multidisciplinary teams, others such as pharmacists struggle to be heard. (see Section 5.10.8). The paediatric gastroenterology team has three divisions and it is important for these units to not only communicate and work cohesively together but also to come across as a unified paediatric GI team when working with other specialities and hospitals.

5.3.16 There were still no scheduled weekend ward rounds despite the service accommodating extremely sick children. The consultants were reported to often 'pop in' and see their patients or catch up on paperwork, but the surgeons would not involve them for post-surgery review at a weekend. The review team support the BSPGHAN/RCPCH standards that specialist advice should be available round-the-clock and children should not be in hospital for any longer than absolutely necessary. Development of an efficient seven-day service, as happens in paediatric services around the country will increase throughput and make best use of limited inpatient beds.

Recommendation – Finalise job plans, including weekend ward presence, appoint to permanent positions and consider additional recruitment to provide cross-cover and manage activity.

Outliers

5.3.17 Whilst most patients are accommodated on Rainforest and Kingfisher wards, the gastroenterology and nutrition team also visits those recovering from surgery or receiving parenteral nutrition but under a different department. There was some confusion as to which doctors have overall responsibility and the role of the gastroenterology team and general paediatricians which needs to be addressed.

Recommendation - Clarify the responsibilities between gastroenterology and general paediatrics for patients on non-gastro wards

Ward environment

5.3.18 All interviewees agreed that although nursing leadership and culture had improved, the physical environment on Rainforest Ward remained at the time of the visit wholly unfit for purpose. There have been numerous reports and business cases highlighting insufficient cubicles, toilets and space resulting in excessive waits for admission, high numbers of complaints, inappropriate outliers and concern about patient

safety. This has also been highlighted by the CQC and despite the construction of new ward space elsewhere in the Trust there was still no definitive plan. This is unacceptable.

5.3.19 At the time of the visit relocation had been proposed to Sky ward once the space has been vacated by other specialties which would enable the three locations in which the team works to be closer together, but there were concerns about privacy and dignity for adolescents. Many staff expressed anxiety that the new ward space may need to be shared with metabolic and endocrine teams due to risk of 'patient overflow' and other risks to patients. Some expressed concerns that the nursing approach is very different and considerable training and team building would be required in such an arrangement, but the senior nurses did not consider that to be significant or insurmountable.

5.3.20 The plans still offer insufficient beds to manage patients needing stabilisation of long term nutrition needs; they cannot be accommodated on Rainforest, making their care inefficient and potentially delaying discharge. Some patients requiring long term observation or two-week pre-transplant assessment before transferring to King's cannot be accommodated to meet the timescale required for the procedure.

5.3.21 Neither the ward sister nor Matron appeared to have been consulted over the practical requirements of a new ward. Their involvement at an early stage is important when planning use of space and practical operation, alongside the benefits of proximity of the three clinical services (inpatients, day-case and endoscopy).

Recommendation – Prioritise improvement of the ward environment as a matter of urgency and involve ward staff in discussions about relocation.

5.3.22 If a move is not approved then the service will need to further restrict those referrals that can be accepted. This is not feasible given the pressure on other services and the continued presence of a full complement of paediatric gastroenterologists so it is essential that a move to an appropriate location is expedited.

Recommendation - Plan realistically to ensure the appropriate number of beds so that children with “perplexing presentations” can be admitted, observed and managed, cohesively with general paediatrics, local paediatric teams and safeguarding where necessary.

Mental health CAMHS and psychological support

5.3.23 There is increased awareness, through the MDT and the clinical lead of the importance of psychological input to the gastroenterology service. In November 2016 a band 8b Clinical Psychologist was appointed on a two year fixed term 0.8 wte contract in order to embed psychology within the gastroenterology service. A clinical fellow from the gastroenterology team has been allocated one session a week to link with the feeding team resulting in swift resolution of queries, and much improved pathways for children moving between the services. The clinical fellow and administration team have in recent

months built much more effective communication channels with the child's local paediatrician and CAMHS service to smooth referrals between the specialist teams, and discharge to integrated local care.

5.3.24 Whilst there have been significant improvements in the approach to children presenting with complex conditions, including advising parents that a psychologist will be present at the initial MDT, and earlier involvement in review, some consultants were reported to focus on medical investigations before considering functional /psychological causes for symptoms. The review team was told of inconsistency and confusion over who is responsible for a child, once physical investigations have been completed and no clear diagnosis made. This appeared to be a deep-seated view and requires firm and consistent challenge to recognise 'normality' and a more holistic approach to the child and family. Other clinical specialties at GOSH have moved much further forward with this approach for which psychology is well embedded, delivering improved health outcomes. A psychologist should attend every gastroenterology referral assessment meeting and psychosocial assessment should be completed for every patient for whom surgery is proposed.

5.3.25 A business case has been drafted for provision of universal mental health screening as a CQUIN³ for all children and young people with long term conditions at their first appointment in four specialties, including gastroenterology. However there remains insufficient capacity in the CAMHS team (0.8WTE, 8b Clinical Psychologist fixed term to November 2018) to support the gastroenterology team properly. A business case for two additional Band 7 roles and permanency for the psychologist is awaiting approval.

Recommendation - Invest in building sufficient clinical psychology input to meet identified demand and increase mental health screening /support.

5.4 Communications and administrative support

5.4.1 Since the 2015 review there has been improved leadership and investment in administration systems and personnel, which has reduced turnover and improved morale. A skill-mix review resulted in some posts being regraded to provide a clearer career progression, and each department having a similar administrative support structure. The medical secretaries have clear processes for managing and responding to contacts from families, arranging call-back on telephone calls and monitoring letter turnaround times. Appointment letters were increasingly being sent on time with better templates for patient letters, discharge notes and other notifications. There is a single departmental number for queries, with a rota for taking enquiries enabling the others to concentrate on other duties.

³ [Commissioning for Quality and Innovation](#) – Indicators which enables release of funding.

5.4.2 A monthly performance dashboard is prepared by the clinical service lead and general manager to ensure administrative improvements remain a priority for support. In May the gastroenterology RAG meeting noted a plan to address the issues that had been raised around discharge summaries.

5.4.3 Communication within the gastroenterology team was reported to be better – there is less changing of patient regimes when on take and grand round care plans seem to last the week more frequently.

5.5 Safeguarding

5.5.1 There has been good progress in addressing the arrangements for safeguarding across the Trust since 2015. The RCPCH had previously expressed serious concerns about the isolation of the safeguarding (social work) team from the problems in gastroenterology, and the frequent absence on admission of any local data on the child and family in terms of safeguarding or fabricated or induced illness (FII) issues. These issues had been identified in a serious case review in 2013 and a number of changes have been made including the appointment in February 2017 of an experienced Named Doctor for child protection to the General Paediatric team which has been widely welcomed as a further positive step.

5.5.2 The safeguarding annual report 2016-7 also highlights the strengthening of the safeguarding nursing team, development of social work function and increased involvement of staff in child protection conferences as well as plans for updating the safeguarding policy and improving safeguarding training quality and compliance. Following an internal report in response to the Lampard Report prepared by the interim named doctor in 2015-6, a review was commissioned from an external expert in March-April 2017 following the arrival of the new Named Doctor. The report recognised that progress had been made and provided a number of helpful recommendations.

Recommendation - Ensure continued support for the safeguarding programme with all clinical staff in gastroenterology safeguarding trained to Level 3

5.5.3 The 2017 review team was told of patients requiring extensive psychological therapy who had undergone many years of invasive treatment thought to have been based on functional or fabricated symptoms. Although the families may have accessed several teams, the Trust is moving towards a culture of systematic, sustained organisational learning from these cases and proactive case review for others in similar situations. Some staff remain unconvinced that this is embedded. Such cases are complex and may require involvement of many clinicians and agencies to ensure that case reviews are thorough and complete and those patients and their families are supported through the process.

Social work team

5.5.4 As a result of the previous reviews the social work team has been strengthened and started to link more closely with local units. The social work team can provide a range of therapeutic support to families, helping them cope with the challenges of a sick child and also exploring issues that may relate to functional problems or psychological need. Some staff were concerned that some of the doctors feel that involving social care may be stigmatising for a family, although work is under way to improve MDT working and level 3 face to face training is delivered by members of the social work team. Work continues to strengthen these relationships with a new training programme to help clinicians communicate with families about managing functional illness where there is no physiological reason for a child's symptoms.

Recommendation - Continue to improve liaison and understanding between the gastroenterology consultants and the social care team.

General paediatrics

5.5.5 The role of the general paediatricians in supporting the gastroenterology service is undervalued and should have a higher profile. General paediatricians can bring objectivity to complex and perplexing cases, particularly motility patients awaiting surgery where it is important that all possible child protection issues or alternate treatments are considered carefully. They should be fully integrated within the department to advise on 'normality' of cases, liaise effectively with local referring clinicians and provide an experienced opinion around safeguarding concerns.

5.5.6 Currently the general paediatricians cover many specialties, offering continuity of advice and support for families navigating several teams within GOSH including surgery, TPN and gastroenterology. They also have an important role in the international and private patients division, ensuring that the principles of the Trust are upheld for these families and the restrictions on accepted referrals and approaches to treatment are consistent with the NHS work carried out in the Trust. They do not of course have oversight of the approach to patients and families who choose private investigations, diagnosis and treatment in other centres but these services are registered with the CQC.

5.5.7 The general paediatricians have worked hard since the 2015 review to identify those children whose diagnosis and treatment may have been inappropriate in order to move them more towards 'normality' where possible, reducing interventions and tackling psychosocial issues. They reported that whilst there have been massive improvements in safety and protecting children from harm they do not use the escalation process to raise or discuss cases of concern, learn from findings and focus on making the child better.

5.5.8 It is essential that a general paediatrician provides regular input to the referrals meeting and complex MDT, that they take lead responsibility for patients as part of the MDT and it is suggested that they have access to observation and rehabilitation beds.

These could be used for children recovering from major surgery, requiring observation before diagnosis or those with a residual disability.

Recommendation – Involve a named general paediatrician in the referrals meeting and any gastroenterology subspecialty case with a perplexing presentation, including current cases where a child has a significant disability after receiving treatment or investigations, without a proven cause.

5.6 Governance, guidelines and audit

5.6.1 The improvements to governance and administrative processes since the 2015 review have been positive and were remarked upon by several interviewees. During 2016 the Medical Director chaired a fortnightly Improvement Group meeting to address the report's recommendations.

5.6.2 Since November 2016, with a new general manager and completion of the case reviews, these meetings have migrated to a more sustainable structure and the following have been introduced:

- Monthly Report showing activity, incidents, risks, feedback, finance, various KPIs
- Monthly Risk Action Group with multi-disciplinary representation
- Fortnightly Quality Improvement Group that include the following work-streams
 - Improving Outpatient Clinics
 - Improving Communications
 - Improving Pathways for procedures in the GIU
- Weekly Consultants Meeting
- Monthly Administration & Clerical Team Meeting
- Weekly PTL and planning meeting to assess capacity for GIU admissions
- Quarterly Guidelines and Protocols Review Meeting (from July 2017)

5.6.3 This is a strong system, with good feedback about how the Risk Action Group, chaired by the Clinical Lead supported by the Divisional Director and General Manager with cross-service medical and nursing attendance is driving improvements such as the GIU Stack replacement. Some concerns were raised that a 'spike' in medication errors was not on the risk register but the systems have been refined with routine double-checking. The review team heard that nurses raise issues more readily with doctors and incidents are more formally approached and dealt with in a more open way.

5.6.4 Some of these new work streams are in their early stages, driven by the general manager and will need continued support, encouragement and review to maintain commitment and demonstrate sustainable impact amongst the consultant team. This is particularly important should there be any changes to the management team, and/or if the activity increases in line with the recommendations of this report.

IBD service

5.6.5 This service operates under an international benchmarking collaborative 'Improve Care Now' or ICN which has had pre and post clinic peer review and outcome measures for many years. The department has continued to accept all new referrals aged under 6 years from specialist centres, although referrals for older children have been restricted since late 2015 and are sent elsewhere. The team was reported to have made good progress with the MDT, virtual IBD clinics, regular ward rounds and improved governance with plans for an improved patient database for specialist clinics and a swifter pathway enabling more patients to be seen. The team is apparently keen to increase its networking with peers in this relatively limited field, and they are planning an open day for DGH paediatricians and the development of shared guidelines with local settings. Guidance for the diagnosis and management of eosinophilic disease are being developed through the European Society for Paediatric Gastroenterology, Hepatology and Nutrition, (ESPGHAN).

5.6.6 The IBD unit also subscribes to Patient Knows Best scheme (PNB), a UK-social enterprise-developed patient-controlled online medical records system and tool to help patients better manage their care. GOSH is one of the first UK hospitals to use the scheme and reported positive benefits.

5.6.7 The review team did not examine these schemes in detail but recognise the importance of quality improvement and benchmarking, the enthusiasm of the IBD team and the Trust's international reputation. It is of note that although the service was reported to be respected, it is very selective about the age range covered and few interviewees outside the IBD team mentioned the schemes or the international status of the service, and evidence of Quality Improvement initiatives outside IBD was slim. Many interviewees reflected that a priority should be establishing a stronger presence and benchmarking within UK gastroenterology peer networks but there is scope to use the learning from these schemes in other divisions and indeed departments in the Trust.

Recommendation - Maintain current safeguards, governance and QI programmes and consider rolling out the benefits and principles of PNB and ICN across the service

Patient experience and quality

5.6.8 There are three Assistant Chief Nurses responsible for workforce, patient experience and quality.

5.6.9 The service was proud of the reduction in complaints to zero since January 2017 from 2-3 per month during 2015, which comprised around 15% of overall complaints in the Trust. In the year to April 2016 there were 152 informal comments/concerns, with most of the negative ones being about the Rainforest ward environment. However, it is

important to acknowledge that the activity has dropped by around half in the period so a proportionate reduction in complaints is to be expected.

5.6.10 The number of reported incidents fell between June and November 2016 but since then has increased – probably reflecting increased reporting - then plateaued as they are being dealt with, peaking at 33 per month in April 2017. There were no serious incidents reported to NHSE between June 2016 and May 2017; of the comments analysed resulted in minor or no harm but 91% were patient safety and 9% were health and safety issues. The multidisciplinary Risk Action Group monitors and acts on incidents which is good practice.

5.7 Training and supervision

5.7.1 Within the Trust the last 18 months has seen a strengthened process to allocation and support for trainees, with refreshed College Tutor roles linking with Divisional Educational leads and better join-up between departments. The Trust has begun to run College membership training courses and exams and has a positive feel about future developments of teaching and training.

5.7.2 The Medical Director temporarily suspended its training posts in November 2015 but the Trust has indicated to the Head of School that they would like to accept them from September 2017. One grid trainee and two SHO posts will be established in the context of a department that is now better furnished with juniors to contribute to the overall out of hours rota. It is important that the new posts are suitably attractive in terms of experience and innovation as recruitment in the past has previously been difficult. Most of the non-consultants working in the department (and Trust) are clinical fellows including international graduates.

5.7.3 The GMC report and other intelligence indicated that junior doctors previously experienced few opportunities to participate in practical procedures – the Trust now has a simulator facility but this is under-utilised and could be better co-ordinated.

5.7.4 Not all the consultants had been enthusiastic teachers which was surprising to hear for a team that considers itself to be offering “quaternary care”. Consultant attendance at the educational meeting can be poor but the College Tutor plans to improve that. There were however no concerns about the consultants’ competence. Trainees reported that much of their learning had been from peers, and they were sometimes asked themselves to teach beyond the scope that they were comfortable with.

5.7.5 It is important if the Tier 1 trainees are returned to the department that they are offered protected time for training. The College Tutor was willing to support the reintegration of trainees if the issues above can be sustainably improved.

5.7.6 For Clinical Fellows there has been considerable improvement since 2015, with more time for teaching and learning with the reduced activity and introduction of the pre- and post-clinic MDTs. Some come from overseas with no gastroenterology experience so can struggle a little initially. The timing of the Grand Round after the complex MDT means some registrars find it difficult to attend the first meeting but they see patients regularly and discuss with colleagues. The teaching afternoons are appreciated and feedback about those consultants who regularly attend was very positive.

5.7.7 Consultant compliance with appraisal is monitored. All appeared to be up to date.

5.7.8 There has been considerable improvement in career opportunities for nurses within the gastroenterology service with the increased profile of the clinical nurse specialists, but there is still no nursing practice educator. It is a priority for teaching to include a more structured approach to manage total parenteral nutrition (TPN) and double-checking prescriptions so patients can leave hospital sooner.

Recommendation - Consider appointment of a nursing practice educator

5.8 Strategic positioning and external referral pathways

5.8.1 Following the 2015 review a restriction was placed on new referrals which was still in place when the review team revisited. The lead consultant and a colleague had developed a positive and clear strategy for the future of the service which concentrated on development of the highly specialised work and providing opportunities for specialist consultants from other units to conduct joint clinics at GOSH. Whilst it is logical and straightforward, the strategy perhaps underestimates the capability of the service. It does not recognise the expertise that has over several years developed in other centres from which the GOSH team may themselves learn. Most of the work commissioned from GOSH is relatively routine specialist work and the three 'highly specialist' elements are very low volume.

5.8.2 Relationships with other specialist providers were mixed; whilst individual consultants worked well with external teams (Luton and Dunstable and UCLH were specifically mentioned) there was continued unease about poor communications from GOSH management and lack of recognition from both GOSH and the NHS England commissioners that the 'temporary' redirection of referrals had placed considerable strain on other teams. Seven specialist providers were asked to support GOSH on a short term basis in November 2015 when the service closed to new referrals as investigations were in progress. During 2016 only selective referrals from other specialist centres were accepted. In December 2016, GOSH wrote to all units explaining that their internal investigations were complete and that they were asking the RCPCH to revisit but without providing further information about outcomes or anticipated timescales for completion and resumption of normal services. This resulted in increasing frustration at other units which were facing pressure on waiting lists, frustrated families and additional cost which

was not covered by the payable tariff, which had been proportionately withdrawn from GOSH

5.8.3 The review team was told that this whole process had been ‘utter chaos’ with no details about pathways and protocols, alternative specialist centres being overwhelmed and unable to offer shared care to DGH referrers. The consultants were unable to advise as they were not driving the process. There were concerns that children and families were unsupported and confused and that GOSH was perceived to be practising ‘defensive medicine’ with the consultants becoming too afraid to practise and being ‘micromanaged’. There were concerns about patients who had missed several appointments due to the confusion and a lack of clarity and communication from commissioners as to how these patients and the ongoing situation should be managed.

5.8.4 During the course of the review team’s visits a joint letter was sent to the London Specialist Commissioner from seven specialist units requesting urgent intervention to rebalance the patient flows and require GOSH accepting more specialist referrals. The letter highlighted the implications for patients of the reduced activity at GOSH, which included long waiting lists to be seen at other centres and no attempt by GOSH or the Commissioners over the 18 months of restrictions to proactively liaise with the specialist centres and plan the capacity required to manage the additional workload. The specialist commissioner had confirmed that he was awaiting confirmation from the MD at GOSH that the service was fit to restore activity.

5.8.5 Across London there has over recent years been an expansion in provision of specialist gastroenterology with many expert services developing their own preferred catchment areas and building enviable reputations. The RCPCH 2013 census⁴ showed a considerably greater proportion of specialists in London (there are 25 paediatric GI consultants for a population of 8-9 million where Department of Health guidance suggests 1 per million. See Fig 1 overleaf.

5.8.6 Although proud of its three small highly specialised elements of its services the GOSH team is not providing leadership to other units and the struggle to appoint to permanent posts whilst the review was ongoing stimulates questions about how these services are provided. There is no formal network or opportunity for co-ordinated referral pathways and peer support between specialist units for development of highly specialised expertise and mutual teaching and learning. There appeared to be no formal monitoring of outcomes or quality of the highly specialised (and expensive) services nor whether they offer the NHS value for money as provided.

⁴ RCPCH 2013 census – specialist services.

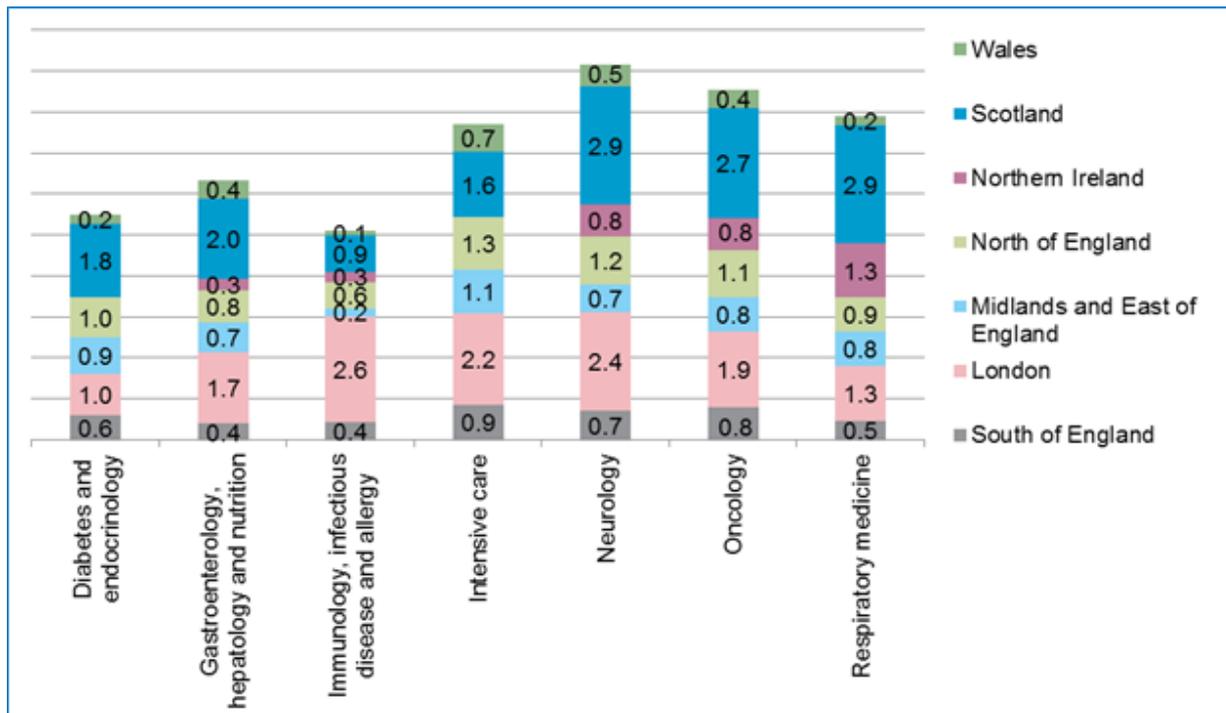


Fig 1 Ratio of headcount of where specialty consultants are based to 100,000 children aged 0-15 for the largest seven subspecialties (excluding neonatal medicine and community child health) by UK region.

5.8.7 The Specialist Commissioning team are minded to establish a London network for specialist paediatric gastroenterology services and there is a role for GOSH (or indeed another unit) to take the lead on establishing and administering the network, developing agreed pathways of care and quality indicators. It is important that GOSH plays a full part in that network, managing a specialised service as well as the small elements of highly specialised work, learning from others and restoring relationships following the problems outlined above.

Recommendation – As commitment to the proportion of its catchment from Greater London, working alongside other paediatric gastroenterology units, GOSH should agree and publish a defined specialist geographically based catchment area alongside its national specialisms. This would encourage development of stronger relationships, better networking with provision of services close to patients’ homes.

Recommendation: Develop a proactive programme of quality Improvement and engagement with management and other specialist teams. The team should aim to develop clear service pathways and build a QI/safety dashboard across the London GI Network.

5.9 Patient and family involvement (see also 5.6.8)

5.9.1 This is an area where there is scope for more proactive activity, partially due to the focus necessarily having been on ensuring the service is operating safely and dealing with those families who have longstanding concerns. It was reassuring that the number of complaints has dramatically fallen in recent months in response to improved administration processes and better communication between the clinicians.

5.9.2 Although there is scope and aspiration amongst some of the clinicians to improve engagement with families several do not see this as a priority and were cautious about the RCPCH team seeking patient input. There was mention of an engagement event some years previously that had gone badly and alongside previously high levels of complaints this appears to have restricted the approach of the consultant team to seeking feedback. However the Friends and Family test is operating in the Trust with monthly feedback and a 'you said, we did' noticeboard and there are opportunities for engagement work being developed elsewhere in the Trust to be proactively developed within the gastroenterology service including patient reported outcome (PROM) or experience (PREM) measures.

5.9.3 Families whose child(ren)'s care had been reviewed during 2016 had been invited to talk to the PALS service if they had concerns or questions about the care and treatment of their child. They and their children were invited to an engagement event which was very effectively facilitated by an external agency in July 2017. Disappointingly there were several no-shows but those that attended provided a rich source of material and feedback from which the service can build an engagement strategy for all children and families as well as an action plan to resolve the concerns raised. Given these were generally families with considerable experience of the service it was a good place to start, but the review team noted that some of these families whose child's medication had been appropriately decreased expressed discontent at the intervention.

5.9.4 Feedback received by the review team (Appendix 6) indicated that many parents were not satisfied with the communication from the Trust following the 2015 report, and complaints continue around the lack of family-focus and integration when organising appointments. Many families still don't know what the situation is for their child. The listening event provided a clear message that although things appear to be improving, more must be done to build confidence amongst the families and listen meaningfully to, and act upon their concerns and suggestions.

5.9.5 Across the wider Trust the level of engagement of parents and families was reported to vary between teams. The hospital has a Young People's Forum to support involvement of Children and Young People who are or have been patients in their care and service planning. Individual departments have developed other schemes and tools and the gastroenterology team could learn techniques from colleagues. The 'Patient

Knows Best' scheme (see 5.6.6) helping individual IBD patients manage their condition was a good model and its principles could be extended to other divisions

5.9.6 In practical terms there were complaints about the lack of parent facilities on Rainforest ward and children on special diets being sent from the catering team foods they were not allowed. Involvement of parent groups in designing information leaflets /webpages and perhaps representation on risk or guidelines groups would begin to demonstrate a desire to listen and respond to the views of patients and families. The RCPCH “&Us” team can provide sources of advice and assistance in establishing such schemes.

5.9.7 The RCPCH was keen to hear from any patients or families who wished to share their views with the review team and a short qualitative online survey was prepared and distributed through the ward (leaflets and posters), via Facebook social media groups and face to face contact at the engagement event. Eighteen responses were received, almost all heard of the survey through social media despite leaflets and posters being provided by the RCPCH to put on the wards. Responses are summarised in appendix 6 for taking on board in the 'you said-we did' notice board format along with the open event conclusions to continue the formal programme of engagement and involvement.

Recommendation - Consider developing leaflets and web guides for patients and parents to support and improve their experience of using the service.

5.10 Protocols pathways and guidelines

5.10.1 Since the review a considerable number of internal guidelines and protocols have been redrafted and there was positive feedback from multidisciplinary colleagues that that the approach to care was more consistent and relationships had improved under the new clinical lead. All consultants were now reported to work within the guidelines and the MDT arrangement supports that. Some pathways are still required such as GI Food Allergy, (see 5.10.11) led by dietetics but the guidelines group is in place to oversee that.

5.10.2 International and private patient activity carried out at GOSH was also reported to be compliant with the guidelines used for NHS patients.

5.10.3 Guidelines will be drafted and reviewed in future through the quarterly guidelines and protocols meeting, approved by the Trust-wide multidisciplinary Guidelines and Protocols Approvals Committee (GAPAC). The terms of reference for this gastroenterology group mention international links but not liaison with other specialist services within a network; it is important to share learning amongst peers particularly where presentations are rare or complex, and to be sure the protocol enables clinicians to “recognise normal”. Including this element in the approval cycle will enable the service to better serve patients and external peers through clear agreed pathways.

Recommendation – Ensure a UK peer network is involved with development and agreement of guidelines, perhaps through BSPGHAN, not just international partners.

5.10.4 The tendency for local DGH's to refer complex families to GOSH for a second opinion when a local DGH is capable of managing the case had reduced since the 2015 restrictions on referrals. Consequently, more patients were reported to be being managed confidently by the 'local' paediatrician, which can result in improved school attendance, social relationships and a sense of normality. All guidelines and protocols should be based upon this close to home principle, with commissioner support. For example, 2-week observations currently based on Rainforest and some diagnostic tests may be possible in local units prior to admission with properly supported local staff. This is already being explored by the IBD team and benefits the patients and frees ward space at GOSH.

Compliance with national standards

5.10.5 The RCPCH/BSPGHAN standards published in 2017 provide nine criteria which apply to all gastroenterology units, and one of the consultants was on the advisory group. The service is striving to comply with them all but needs additional resource to meet standards

Standard		Compliance
1	Work in a network	Not yet. See recommendation
2	Access to advice/transfer 24/7	Advice possible 9-5, Phone response 24/7t. No beds for transfers
3	Transition policies and pathways	Patchy. See below
4	Endoscopy facilities and emergencies	Not compliant for emergencies – Business case for an interventional endoscopist
5	Specialist service IBD	Compliant
6	Specialist diets need paediatrician and MDT	All have named consultant but not necessarily a paediatrician – no regular round
7	Inpatient PN are reviewed weekly by consultant led MDT	Risk – not compliant due to insufficient clinical staff. See recommendation
8	Home PN patients have a dedicated team	Compliant
9	The service has links to a hepatology specialist centre	Compliant – linked to King's

Adolescence and Transition

5.10.6 Transition arrangements for gastroenterology patients were reported to be patchy in practice although the Trust is in year 2 of a three-year improvement project for transition with a bespoke CQUIN and priority in the Quality Account. There is a good relationship with University College London Hospitals (UCLH) for IBD patients but the links for PN are less assured, and the transition arrangements outlined to the review

team appeared to lack flexibility, being based on the medical relationships rather than patient choice. The motility service is relatively new so some patients are only just approaching transition and it was not clear what plans are in place. Concerns were expressed that UCLH would not take new patients under 18 years and GOSH policy at the time of the visit was reported to be transition at 16 so this needs to be addressed.

5.10.7 At the time of the visit the webpage outlining the transition process was out of date but this has been improved with helpful information and a video. The Trust has a Clinical Nurse Specialist for adolescent patients but some staff were unaware of her role within gastroenterology and identified a need for exploration with gastroenterology patients issues around transition and any psychosocial concerns, as well as practical discussion about sexual health and pregnancy.

Recommendation- Continue the roll out of the Transition improvement project to gastroenterology. Pathways should be patient based rather than be clinician's choice and require better networking. The design of such a programme should involve young people and include a suite of communications materials suitable for patients, parents and families.

Pharmacy

5.10.8 The relationships between the gastro team and the pharmacy department still had room for improvement. The pharmacists work with a range of teams across the Trust providing advice on new drugs, checking and administering prescriptions and supporting the treatment of patients alongside the medical team. In particular, they support patients on Parenteral Nutrition (PN) who number 45-50 inpatients and around 50 at home which is one of the highest levels in the UK.

5.10.9 The pharmacists are keen to work more closely with the consultants but consider the importance of their service in the MDT is not respected by the consultants– in marked contrast to the engagement of other teams. For example, gastro consultants do not provide input to the development of new protocols, sending a junior doctor who is unable to contribute sufficiently. Consultants refuse to sign prescriptions immediately without full consideration. Although there are regular meetings between the gastro consultants and the pharmacists, agreements made at the meeting were reported not to be followed through. A protocol is needed about joint working with pharmacy and accountability and governance arrangements, perhaps nominating a liaison clinician in each team

Recommendation – Strengthen links with and feedback from the pharmacy team within the overall governance reporting arrangements

5.11 Are there any areas of notable practice or achievement?

5.11.1 A number of positive actions and good practice are covered throughout the sections above but are drawn together in this section to recognise progress since 2015 and encourage further work going forward. For example

- Investment in clinical leadership
- Positive, engaged general management with informed, useful monthly dashboards.
- Improved ward leadership and better links to mental health expertise.
- A systematic governance and reporting structure although this needs to be embedded.
- A comprehensive set of guidelines agreed and monitored.
- Better equipped endoscopy suite with reduced turnover and improved morale.
- Administration – managing telephone calls and response times
- The rapid response service for medication review which was reported to have made big changes to children's' quality of life.
- Positive attitudes in the IBD service– engaging outside the Trust, PNB and ICN
- Development of the Risk Action Group – resulting in tight governance and action.
- Much greater involvement of dietetics.
- Improved clinical nursing leadership and confidence to speak out

5.12 The priorities and strategy for development of the service.

This is covered in the sections above and the recommendations for the service.

6 Recommendations

We recommend sharing this report with the GI team who have contributed to the review process and the full report or a summary should be shared more widely amongst contributors to demonstrate transparency.

Leadership, Strategy and external focus

Appoint a respected NHS based external clinical leader to the post of senior clinical lead - equivalent to a chair - in gastroenterology to develop the service, working together with other units on London-wide GI network collaboration. (5.1)

GOSH should become part of this London network to equally contribute to the care of the regional population alongside other GI units. In addition, GOSH may wish to also agree on their unique focus and to ensure appropriate communications between GOSH and all hospitals in this network. (5.1)

As commitment to the proportion of its catchment from Greater London, working alongside other paediatric gastroenterology units, GOSH should agree and publish a defined specialist geographically based catchment area alongside its national specialisms. This would encourage development of stronger relationships, better networking with provision of services close to patients' homes. (5.8)

Review the acceptance criteria, pre-and post clinic MDT and job plans carefully to enable greater throughput of patients without compromising governance or increasing risk (5.3)

There should be a further clinical review of the service and approach to cases 12 months after the lifting of referral restrictions. (5.2)

Management and Governance

Clinical Management should satisfy the Board that an investigation of historical gastroenterology cases has been completed in full, specifically the care of all children on long term interventions without a clear validated diagnosis. (5.2)

There should be a demonstrated climate of openness in addressing concerns raised by staff to provide assurance that appropriate action and candour has been exercised. (5.2)

Take steps to ensure there is stability of clinical and operational management to embed the positive developments. (5.1)

Ensure a UK peer network is involved with development and agreement of guidelines, perhaps through BSPGHAN, not just international partners. (5.10)

Finalise job plans, including weekend ward presence, appoint to permanent positions and consider additional recruitment to provide cross-cover and manage activity. (5.3)

Increase medical support for the intestinal failure team. (5.3)

Prioritise improvement of the ward environment as a matter of urgency and involve ward staff in discussions about relocation. (5.3)

Consider appointment of a nursing practice educator. (5.7)

Strengthen links with and feedback from the pharmacy team within the overall governance reporting arrangements. (5.10)

Safeguarding and Patient centred care

Maintain current safeguards, governance and QI programmes and consider rolling out the benefits and principles of PNB and ICN across the service. (5.6)

Involve a named general paediatrician in the referrals meeting and any gastroenterology subspecialty case with a perplexing presentation including current cases where a child has a significant disability after receiving treatment or investigations without a proven cause. (5.5)

Strengthen the pathway and links with local units for support for children with feeding tubes. (5.3)

Clarify the responsibilities between gastroenterology and general paediatrics for patients on non-gastro wards. (5.3)

Continue the roll out of the Transition improvement project to gastroenterology. Pathways should be patient based rather than be clinician's choice and require better networking. The design of such a programme should involve young people and include a suite of communications materials suitable for patients, parents and families. (5.10)

Invest in building sufficient clinical psychology input to meet identified demand and increase mental health screening /support. (5.3)

Plan realistically to ensure the appropriate number of beds so that children with "perplexing presentations" can be admitted, observed and managed cohesively with general paediatrics local paediatric teams and safeguarding where necessary. (5.3)

Ensure the effectiveness of complex cases MDT to encourage the lead clinician to discuss cases in a forum with other GI consultants, general paediatrician, safeguarding

lead (when appropriate), nursing staff and clinical psychologists. All staff should be empowered to contribute. (5.2)

Ensure continued support to the safeguarding programme with all clinical staff in gastroenterology safeguarding trained to Level 3. (5.5)

Consider developing leaflets and web guides for patients and parents to support and improve their experience of using the service. (5.9)

Develop a proactive programme of quality Improvement and engagement with management and other specialist teams. The team should aim to develop clear service pathways and build a QI/safety dashboard across the London GI Network. (5.8)

Continue to improve liaison and understanding between the gastroenterology consultants and the social care team. (5.5)

Appendix 1 The Review team

Dr David Shortland MD FRCP FRCPCH DCH has been a paediatrician for 25-years in Poole, Dorset, including ten years as neonatal lead and twelve as clinical director. David was the lead clinician for the rebuild of the paediatric department in 2005 and currently leads on Clinical Quality for the paediatric department.

Following five years as member, then Chair, of the Clinical Directors Special Interest Group, in 2006 David was elected as the National Workforce Officer for the RCPCH leading the 2007 national workforce census and designing a cohort study of trainees to provide a clearer understanding of the current and future workforce, helping to define how the role of paediatricians can evolve to provide consultant delivered care and hence safe and sustainable services. David was elected Vice President (Health Services) in 2009 and played a central role in developing strategy for Child Health Services in the United Kingdom supporting paediatricians through the challenges of radical reform to the health service, working time legislation and service re-design. During David's five years in post he developed a national template for the resident paediatrician and was lead author for "Facing the Future". This document defined 10 quality standards for acute paediatric services and is widely quoted as a template for good practice. David led a national audit of these standards in 2013 and currently chairs a steering group extending the standards approach to care outside hospitals. Since 2014 David has been clinical adviser to the RCPCH Invited Reviews programme and has led a number of high profile reconfiguration, individual and service reviews.

Dr Nadeem Ahmad Afzal MBBS, MRCP, MRCPCH, MD is an Expert Adviser for the NICE Centre for Guidelines and has recently served as Honorary Secretary of the British Society of Paediatric Gastroenterology Hepatology and Nutrition (BSPGHAN). Dr Afzal is a Consultant in Paediatric Gastroenterology, Hepatology and Nutrition at University Hospital Southampton. As Honorary Senior Clinical Lecturer at Southampton University he runs an active research programme. Dr Afzal has established paediatric hepatology services at University Hospital Southampton, is the paediatric endoscopy lead and helps to run the Wessex Paediatric Gastroenterology Network. Dr Afzal is an Invited lecturer to the MSc in paediatric gastroenterology at Barts, London and MSc in Allergy in Southampton University. Dr Afzal has served as Editor in Chief for World Journal of Gastrointestinal Endoscopy and has contributed to the gastroenterology section of the RCPCH Paediatric Care Online.

Claire McLaughlan is an independent consultant and former Associate Director of the National Clinical Assessment Service with a particular interest in the remediation, reskilling and rehabilitation of healthcare professionals. As a former registered (intensive care) nurse, educationalist and non-practising barrister Claire developed the NCAS Back on Track services for dentists, doctors and pharmacists in difficulty. Over the last 10 years Claire has worked with over three hundred organisations and practitioners to 'make a difference' before irreparable damage was done to patients and the public,

practitioners, and organisations. Before joining NCAS Claire was Head of Fitness to Practise at the Nursing and Midwifery Council.

Sue Eardley joined RCPCH as Head of Health Policy in January 2011 and established the Invited Reviews programme for the College, conducting over 70 reviews in five years. An engineer by training, Sue spent 13 years as a non-executive and then Chairman of an acute Trust in London, alongside a range of voluntary activities including national and local involvement in maternity services and the NHS Confederation. Sue led groups contributing to the Maternity NSF and chaired her local MSLC for four years. Before joining the RCPCH Sue spent six years full time leading the maternity and children strategy team at the Healthcare Commission and then Care Quality Commission, overseeing strategy, design and delivery of all inspections and reviews in England of maternity, child health and safeguarding.

Appendix 2 Contributors to the review

The following post holders/staff groups / representatives were interviewed as part of the review

Senior team

Medical Director
Chief Nurse
Deputy Chief Nurse
Divisional Assistant Chief Nurse
General Manger
Deputy Chief Executive#
Head of Communications
Deputy Director of Operations
Divisional Director

Medical staff

Anaesthetics and Surgery
Histopathology
Clinical Psychology
General Paediatrics
Immunology
Gastroenterology consultants
Clinical Fellows,
Junior doctors
Radiology and nuclear medicine
Locum gastroenterologists
Safeguarding
Undergraduate training
Palliative Medicine

Other staff

PALS, Risk and Complaints
Dietetics
Endoscopy
Feeding
Safeguarding
Management and Administration
Ward Sisters/ Matrons
Pharmacy
Clinical Nurse Specialists:

External representatives from

Southampton University hospital
Southend
Luton and Dunstable Hospital
UCLH
Royal Free Hospital
Alder Hey Children's
Birmingham Children's
Newcastle Hospitals
Cambridge University Hospitals
Barts Health
Kings College Hospital London
Specialist Commissioning, NHS London
Care Quality Commission

Appendix 3 Standards and reference documents

The following standards are referenced in the review

[Quality Standards for Paediatric gastroenterology, Hepatology and Nutrition](#)

RCPCH /BSPGHAN January 2017

[Transition from Children's to adults' services for young people](#)

NICE guidance NG43

[Transition from children's to adults' services](#)

NICE QS140 to NICE Transition

[MHPS – Handling concerns about a practitioner](#)

NCAS June 2012

Appendix 4 Information provided to the review team

Documents were provided by the Trust relating to the following areas and where further documents were requested these were provided swiftly.

- Report from expert panel
- Various update/progress reports from 2016 – flash reports and SMT update
- Template letters sent to parents and patients whose cases were reviewed
- Gastro team strategy for the future
- Business cases for new ward, psychology staff, endoscopy stack,
- Minutes of divisional board meetings
- Correspondence from Addenbrookes outlining pressure on activity
- Improvement group minutes 2016
- Monthly specialty review reports
- Guidelines and protocols committee ToR and list of current guidelines
- Quality Improvement group tor
- Risk register, incident reports, complaints summary and F&F test results
- Safeguarding policy, 2015-6 annual report, 2016 external report
- Appraisal and PDR policy and sample forms
- Risk management strategy and ToR and minutes of RAG meeting

Appendix 5 – List of Abbreviations

BSPGHAN – British Society for paediatric gastroenterology, hepatology and Nutrition
CAMHS – Child and Adolescent Mental Health Services
CQC – Care Quality Commission
CQUIN – Commissioning for Quality and Innovation
DGH – District General Hospital
GI – Gastro Intestinal
GIU – Gastro Intestinal Unit
GOSH – Great Ormond Street Hospital for Children
HEE – Health Education England
IBD – Irritable Bowel Disease
ICN – Improve Care Now scheme
MHPS – Maintaining High Professional Standards
MDT – Multi Disciplinary team
NHSE- HSS - NHS England Highly Specialised Services
NICE – National Institute for Health and Care Excellence
(P)ICU – (Paediatric) Intensive Care Unit
QI – Quality Improvement
RCPCH – Royal College of Paediatrics and Child Health
TPN /PN - Total parenteral nutrition
UCLH – University College London Hospitals.

Appendix 6 – Summary of survey responses.

A total of 17 parent carers and one patient (aged 14) responded to the online questionnaire. All the children and young people had been under the service for over 18 months, and sixteen for over four years.

Eight had been seen within the last 3 months, and nine had not had contact for over 6 months. Eleven had been under mucosal immunology, five neurogastroenterology and two nutrition and gastrointestinal failure. All who sent their contact details have been acknowledged.

Positive Comments - what was good?

Mucosal Immunology (11 responses)

- Good appointment. Shocked to find out that out Dr x left the trust and that has been the reason why we have been seen by different doctors. Not really good when one needs continuation of care
- Dr x has been amazing for us and a real expert in his field.(x 2 responses)
- Things have greatly improved within the IBD department. There is follow up before the appointments as well as after. The Dietetics team can be a bit more prompt in their action points after the clinic appointments but otherwise, the Nurses who attend the clinic follow up on everything that is discussed.
- I like my dr and the nurse specialists and the pkb system
- Staff in all areas are superb (x 2 responses)
- Always had a very positive experience with all staff. Patients Know Best service provides an invaluable secure contact point with the department (x 2 responses)
- The doctor my daughter saw was much friendlier than those she has seen in recent visits. She spoke in a manner that meant we felt as though we were believed! My daughter felt at ease and the doctor spoke knowledgeably about what was disgusted xxx

Neurogastroenterology / Nutrition and Intestinal Failure (7 responses)

- Great levels of specialism and medical equipment which have brought me further to a diagnosis
- We now get appointment letters well in advance (however these have been cancelled).

- The last time we were on Kingfisher ward they were helpful and efficient. Mr x is always helpful and speaks directly to my daughter and is happy to explain things and repeat things where needed. We see Dr x at an outreach clinic at our local hospital and appointments are hard to get often waiting over a year.
- Dr x and the kingfisher nurses (x2 responses)

Negative – What could be better?

Mucosal Immunology

- Sadly nothing [was good] as for the past 2 years there has been no service for our children.
- We recently asked to be discharged due to the poor care from Dr x whilst Dr x was on leave. He was very rude about my children and said there was nothing wrong with them, when clearly biopsies and test proved otherwise.
- Better admin would be good as it is shockingly bad and better joined up working putting the child first
- Acknowledge and treat Eosinophilic Disorders / Gut allergy using international guidelines. Be honest and open, Carry out your duty of care as a quaternary hospital do not turn the clock back on 15 years of speciality knowledge by playing it safe and discarding your patients. Listen to patients and parents if you support them and believe in them they will be your biggest advocates. Work with patient advocacy groups/ charities, government and scientists etc in a positive manor. It is the only way forward see the USA example www.rarediseasesnetwork.org
- Don't continue to abandon these complex children and their families, doing nothing is "doing harm". Lead the way for the UK, be the best that you can, do what it says on the tin "the child first and always"
- Better contact between appointments, less cancelled and rescheduled appointments, easier contact within the department to reschedule appointments at convenient times.
- A shiny new ward or better administration are pointless without a doctor that can treat your child, acknowledge their symptoms and discuss a condition that had been diagnosed at GOSH.
- Easier contact with the consultant/doctor is required in between appointments

- Listen to children and parents. Better Admin support.
- We were not informed why we were moved to another hospital and another consultant when we contacted GOSH they had limited records of our attendance over the 8 years our son was a patient
- access to test results
- Communication between team members and other professionals outside the in house team. Facilities on gastro ward are poor for patient. As a gastro ward the food sent is of poor standard and is often not labelled correctly and for gastro patients this is important
- If the clinics are in the afternoon and they, invariably, over-run, can the hospital arrange for the blood test departments to be open for longer than 5 pm as it is very inconvenient for parents to bring their sick children to hospital for specific blood tests. Even if there is one person on duty after 5 pm, people would not mind waiting, but it becomes very difficult to come the next day again.
- Better admin support. More openness in changes and consistency

Neurogastroenterology / Nutrition and Intestinal Failure

- Nothing good about Gastro at gosh, impossible to get appointments, no one to call with problems, wards terrible, you get told one thing at appointments but the review letter says completely different information
- Putting patients first. Stop trying to off load the blame for the recent poor review onto parents. Start LISTENING to parents, stop making assumptions, stop putting "diagnoses" on research papers which haven't been given, communicate with local healthcare (God forbid..... GOSH are known as "God's Own Service" here because of their self-inflated opinion) and offer appropriate support to patients they previously claimed to care about instead of rubbishing past diagnoses to get themselves out of a sticky situation. Also - never get clinic letters typed in India again, apart from the time lag a year's worth of ours went to Australia!
- Also stop the internal private referrals. We were even asked if we wanted to travel to Belgium for oesophageal manometry if we could pay and told how easy it was. Private and NHS gets meshed together and the children are the biggest losers with parents purely the victims of consultants desire to further their research and/or free up waiting list space.

- Very little! [has improved] Clearly GOSH cannot get rid of EGID patients fast enough. Care has always been haphazard with clinic letter errors, delayed clinic letters, dangerous overdose prescriptions local pharmacy picked up and even merging of one child's notes with another of the same name from the same town who was one day older.... However previously we felt GOSH cared, even though in practical terms it meant keeping your wits about you as errors were common, potentially life changing and continuity of care non-existent. Dr x was fantastic and left the kids in a good place, however Dr x supported local FII referral (happening to a LOT of GOSH EGID patients) and we've now been discharged. Appalling service, no care and the child last or never. I wouldn't recommend GOSH to anyone even if it was a last resort and am so pleased we are out of there. Never ever going back. Children were previously also under Rheumatology, Surgery, Immunology, Dietetics (no input from them, just a name to receive letters, hopeless) and Dentistry. All other departments were excellent. Gastro are in a league of their own!!!
- As a 14 year old, I think communication between the doctors and adolescents needs to improve. Also brighter, cleaner gastro wards with more private rooms for teenagers.
- Better contact and support
- There seems to be a total 'washing of hands' of EGID at GOSH. During our last appointment the focus was solely on motility, even the letter received afterwards stated 'previous eosinophilic infiltration'. My son is on several medications a day to help his EGID and nobody has reviewed them in nearly two years. We need continuation of care of EGID.
- Poor communication, poor decision making, always leaving things to see how they are in x months

- Communication and following up

Other comments

- We were invited to the listening event. I was a founder member (by invitation) of the GOSH Gastro Parent Network which was rapidly dissolved when the consultants felt it wasn't endorsing their poor practice. Frankly I wouldn't waste the time, travel and childcare cost or effort travelling down to any future event but seized the opportunity to complete this survey. I've run online support forums for gastro parents for years, I'm a parent of 20 years and have been dealing with gastro issues myself all my life. Dr x was very keen for my help and input when it suited but we've been left high and dry with absolutely no tertiary, secondary or primary care now. Disgusting. We never sought a diagnosis of EGID - indeed we challenged it with respect of two children as there was not evidence, but were reasonably happy with the care - to be dropped as inconvenient is appalling.

Appendix 7 Progress record against recommendations

Leadership and Vision

2015 Recommendation	Progress evidence
<p>a) Create a chair in gastroenterology post Engage a respected gastroenterology leader as a Professor/ Chair with sufficient management time to support and manage the consultant team and lead implementation of the recommendations below.</p>	<p>This has not been addressed although attempts were made in 2015 to identify an individual. We feel the climate has changed and there may be a candidate with the appropriate skills and availability.</p>
<p>b) Address immediate concerns arising from complex gastroenterology MDT work, including initiation of an expert independent UK peer review of children without IBD on immune-modulation; enteral feeds and elemental diets with an action plan for each case completed by end 2015</p>	<p>This has been completed; some further assurance work is suggested in the report.</p>
<p>c) Agree and articulate a clear vision for gastroenterology at GOSH, including</p> <ul style="list-style-type: none"> • Development of a network with tertiary centre colleagues to support peer review, consider joint clinics and improve dialogue about pathways, diagnosis and management of complex cases. 	<p>A strategy has been produced by the clinical lead which is an excellent start. Further work to develop networks and peer working, incorporating some of the suggestions in the report would be helpful and if a Professor/Chair is appointed across the London Network this will further strengthen the plan.</p>
<ul style="list-style-type: none"> • Exploring the potential to focus on quaternary work delivering highly specialised care to a high standard and diverting routine secondary/tertiary work such as DGH outreach to other tertiary providers to reduce pressure on the service. 	<p>This was successful whilst the concerns raised in the 2015 report were dealt with. However it is important to take back the specialist portfolio to enable a sense of ‘normality’ and reduce waiting times for children and young people within the system</p>
<ul style="list-style-type: none"> • Considering, in partnership with other tertiary providers, what level of tertiary and investigative work should remain at GOSH to provide second opinion, peer review, parenteral nutrition and training experience to support the quaternary functions. 	<p>This conversation needs to be had with specialist providers and commissioners. Unfortunately, the corporate communications between units has not been constructive over the last 2 years</p>
<h3>Management</h3>	
<p>d) Complete the proposed directorate restructuring to align the gastroenterology team managerially with</p>	<p>Directorate restructuring has been completed successfully with new</p>

<p>interdependent medical teams. This includes immunology, metabolic medicine and infectious diseases⁵, so the Infection Cancer and Immunity (ICI) team would be the most appropriate fit, alongside dermatology and rheumatology.</p>	<p>General Manager and Divisional Director in place.</p>
<p>e) Conduct an urgent review of safeguarding arrangements in the service and wider Trust to ensure that local information and context about each child/family is securely notified to all who should be aware. Specific issues to address include:</p> <ul style="list-style-type: none"> • Accurate and diligent completion of ROBOT forms – these must include all pertinent information available about the child with a mechanism for adding further information that becomes available. 	<p>We are aware that two such reviews have been undertaken and it is essential that the Trust implements those recommendations and strengthen safeguarding arrangements for the future</p> <p>Not checked but no concerns arose during the review</p>
<ul style="list-style-type: none"> • Instigate a process of communication with referring clinicians and their organisations to ensure clear ‘health dialogue’ where there may be any safeguarding concerns 	<p>Considerable improvement with local paediatricians involved in complex MDT where possible.</p>
<ul style="list-style-type: none"> • Examine the culture of safeguarding in the wider Trust to provide assurance that staff are skilled in identifying and confident in communicating any concerns about the safety and welfare of children and young people in the care of GOSH. 	<p>New Named Doctor is moving this area forward, but still some way to go to be confident that all issues are picked up swiftly</p>
<p>f) Address communications concerns through developing clear and agreed standards of communication and behaviour, with clarity about decision making and dissemination processes. Develop a mechanism to monitor, respond and provide support if standards are not met by individuals or collectively</p>	<p>There is strong governance and administrative process with behaviour issues being dealt with swiftly and effectively and monthly performance reporting.</p>
<p>g) Strengthen administrative support for the team, reviewing in detail the communications and ‘paper trail’ of patients with those who administer it. Identify and mitigate any risks or inefficiencies including monitoring and enforcing compliance with elements of the process.</p>	<p>As above, more work is required to fully embed the processes.</p>

⁵ See Department of Health Framework of Critical Interdependencies 2008

<p>h) Redesign the external referral pathway – immediately and then in line with (c) above, Review the guidance about referral criteria, template forms and letters to clarify expectations for families and local clinicians, building on comments received on the current approach.</p>	<p>The restrictions on referrals provided an opportunity to consider this. A guideline group has been established to design and document pathways and this needs to involve secondary care paediatricians.</p>
<p>Give advice on which is the most appropriate tertiary gastroenterology team to seek advice from instead.</p>	<p>This should evolve with development of a London Network of gastroenterology units</p>
<p>Monitor discharge arrangements and audit follow-up requests to ensure patients are discharged to local services wherever appropriate</p>	<p>We did not review casenotes but an exercise to this end was conducted in 2016 and the MDT should pick up those who should be seen locally.</p>
<p>Support this with a clear communications plan building on complaint information</p>	<p>We have not seen this.</p>
<p>Clinical activity and Job Planning</p>	
<p>i) Review rotas and clinical attendance to meet current and planned activity and ensure that job plans reflect actual duties (and vice versa). This should include:</p> <ul style="list-style-type: none"> • Consultant of the Week - scheduled ward rounds, attendance and absence of other clinical work. The care plan for long-stay or 'complex' patients must always be determined by their lead consultant 	<p>Job plans have been drafted but not completed. See recommendation</p> <p>Positive action has been taken to reduce instances of the Consultant of the week changing care plans.</p>
<ul style="list-style-type: none"> • Weekend consultant ward rounds should be instigated 	<p>Not yet but consultants respond to clinical calls. recommendation repeated</p>
<ul style="list-style-type: none"> • Availability of specialist gastroenterology advice out of hours including immediate access to a specialist registrar or consultant. An audit or monitoring of specialist demand out of hours may assist in defining the requirement. 	<p>The service is unchanged from the 2015 review but some of the consultants do respond more quickly.</p>
<p>Review of consultants' contracts to reflect the issues raised in this report and require attendance on site for core activities</p>	<p>Included in Job Plans</p>
<p>j) Increase the involvement of clinical psychologists in the pathway where functional disorders are</p>	<p>Some progress but a business case is pending for greater coverage through 2</p>

<p>suspected and audit impact on outcomes. Providing this input to families early in their contact with the Trust can demonstrably improve the quality of experience and speed discharge where either functional problems exist or the long journey to diagnosis has put additional strain on the child or family</p>	<p>x Band 7 support.</p>
<p>k) Review the training and engagement of Clinical Fellows to ensure their training is appropriate and seek feedback from their placements.</p>	<p>Some improvement given the reduce pressure of work but more opportunities could be made.</p>
<p>l) Review and clarify the activity and role of the general paediatricians to provide capacity for them to triage all internal /inpatient referrals and take a lead, co-ordinating medical role for patients with complex, multi-specialty conditions.</p>	<p>Some progress but insufficient capacity to cover more work at the moment</p>
<p>Governance</p>	
<p>m) Establish a regular governance performance work stream and meeting with mandatory clinical attendance and programme of work to include:</p> <ul style="list-style-type: none"> • agreement of key service indicators (e.g. acceptable and achievable waiting times, standards for communication and responding to enquiries) 	<p>There has been a marked improvement in governance arrangements and a monthly report covers these topics.</p>
<ul style="list-style-type: none"> • A dashboard of performance, including the above, developed by and with clinicians 	<p>Done, always could do with review to seek new data</p>
<ul style="list-style-type: none"> • Strengthened input to management of concerns, complaints and incidents, including trends and 'you said we did' information 	<p>Gastroenterology risk assessment group and other structures to bring this data closer to the consultants.</p>
<ul style="list-style-type: none"> • Development of peer review, service audit and risk management 	<p>MDTs before and after clinic provide helpful review</p>
<ul style="list-style-type: none"> • Action planning as a result of the above 	<p>Plans were shared during 2016 and now completed.</p>
<p>n) Ensure ward staff have appropriate training and supervision for managing children and families with mental health needs. This may be a Trust-wide issue that affects other teams as well.</p>	<p>Improved cover as Matron also covers the mental health wards and there is good liaison between the teams</p>
<p>o) Initiate a divisional programme of Quality Improvement, perhaps through senior nurses or clinical fellows with clear objectives and</p>	<p>Not yet evidenced</p>

demonstrable outcomes. RCPCH can support this through courses and learning packages. ,	
p) Refresh the protocols and guidelines about which and when interventions are necessary to which all consultants adhere unless there are clear recorded grounds for deviation. More rigorous adherence to such guidelines, with preview and audit of cases could significantly reduce the pressure on the endoscopy service, improve throughput for those patients who do need it and speed up diagnosis care for those who do not.	Guidelines and protocols have been developed and a formal group established for ongoing refinement and refresh.
Patient Involvement	
q) Ensure all patients are assigned specialist nurses who can provide a 'first point of call' for families.	There has been an increase in CNS availability and involvement and they are consulted more by families and doctors.
r) Establish a user group for children young people and families who can advise on communication issues, support other parents and provide positive input to service development.	Not yet established. A morning workshop session took place on 15 th July but this needs to be incorporated into the service.
s) Develop web-based information for children young people and families who use the service which explain what to expect when referred to the service.	Not seen, The website provides plenty of information but is aimed at parents.
Environment	
t) Address longstanding environmental issues and relocate/refurbish Rainforest Ward to provide a more suitable facility - involving families and staff in design,	Little change. Continued recommendation.

Trust Board 18th July 2019	
Integrated Quality and Performance Report June 2019 – reporting on May data	Paper No: Attachment R
<p>Submitted by: Sanjiv Sharma, Medical Director Alison Robertson, Chief Nurse Andrew Taylor, Acting Chief Operating Officer</p>	
<p>Aims / summary The Integrated Quality and Performance Report (IQPR) 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>It identifies key areas for improvement in terms of quality and performance including</p> <ul style="list-style-type: none"> • Low rate of timely incident closures (slide 4, 7& 13) • Decrease in WHO Checklist Compliance particularly in areas outside theatres (slide 5 & 7) • Decline in FFT Performance (slide 7, 16, 21 & 22) • Discharge Summary performance (slide 29) • Mandatory training compliance at staff group/directorate level (slide 7 & 32) <p>As this report has already been reviewed at PSOC and QSEAC, the Quality Focus slide (3) has been updated on 12/07/2019 to reflect the outcome of discussions and the plans agreed through those fora.</p> <p>The WHO checklist performance data (which had originally triggered concerns re: decline in performance) has been updated in the dashboards at slide 7 to include the up to date accurate data which has now been produced following data quality queries in a variety of Trust meetings.</p>	
<p>Action required from the meeting Committee members to note and agree on actions where necessary</p>	
<p>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.</p>	
<p>Financial implications For indicators that have a contractual consequence there could be financial implications for under-delivery</p>	
<p>Who needs to be told about any decision? Where appropriate and applicable: Internal stakeholders, NHS Improvement and NHS England Special Services Commissioners</p>	
<p>Who is responsible for implementing the proposals / project and anticipated timescales? Each Domain / Section has a nominated Executive Lead</p>	
<p>Who is accountable for the implementation of the proposal / project? As above</p>	

Integrated Quality & Performance Report June 2019

(Reporting on May 2019 data)

Sanjiv Sharma

Medical Director

Alison Robertson

Chief Nurse

Andrew Taylor

Acting Chief
Operating Office

Data correct as of: 3rd July 2019
Report updated on 12th July 2019
following July PSOC and QSEAC to offer
additional information to the Board

The child first and always



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Performing well
 Room for improvement
 Significant improvement required

 Data not previously requested/available
 Parameter not needed/not agreed
 * Potential data quality issues post EPIC. Caution to be taken in interpretation.

Direction of trend from previous month

June 2019 – Quality Focus

- Updated following PSOC and QSEAC

Rate of timely incident closures
(Slide 4, 7, 13)

- Incident closure rates have improved slightly in May (52%) but it's acknowledged that significant improvement is still required.
- There has been significant improvement in June and July for key areas including Heart and Lung and Brain.
- Following discussion at PSOC in July, recovery plans were requested from each directorate which will be reviewed at the Deputy Chiefs of Service meeting in July 2019.
- The directorate recovery plans will be supplemented with a central patient safety team implementation plan to ensure that all closures are quality assured.

Decrease in WHO Checklist Compliance *
(Slide 5 & 7)

- The initial data produced for the performance reports from EPIC highlighted a significant decline in WHO performance (80% overall), particularly in non-theatre areas. (60%)
- Following discussion at Divisional Performance meetings, PSOC & QSEAC the data was reviewed further, and the data quality issues have resolved.
- The updated performance figures have been amended in this report to provide the Board with assurance regarding safety performance in our theatre and interventional areas.
- Performance in June 2019 for the non-theatre areas is now also >98%.

Decline in Friends & Family Test Performance *
(Slide 7, 16, 21 & 22)

- We had anticipated a decline in response rate for FFT in the months following EPIC implementation while staff adjusted to the new system and ways of working.
- The response rate is higher than anticipated but still below the 25% threshold.
- Potential data quality issues with the denominator data (number of discharges) have been identified as the hospital adapts to the new system. The patient Experience Team are working with the Performance Team to understand and fix the problems.
- We suspect that the data quality issues will not significantly impact the overall hospital response rate, but it is impacting our departmental response rate data.

Discharge Summary Performance *
(Slide 29)

- Performance continues to fluctuate with May 2019 seeing 45.27% of discharge summaries being sent within 24 hours, which is a decline from April (56.38%).
- The Trust is currently undertaking a full data investigation and deep-dive to understand the impact of EPIC.
- Directorates have raised concerns regarding the information pulled into the discharge summary, the clinical workflow, identification of summaries in progress or not started and the flagging of whether a patient requires a discharge summary.
- We are providing further training and support to the clinicians who need to complete discharge summaries. This includes the training of our Service Managers and Directorate Leads to support staff with the completion of this task and appropriate data quality checks.
- Working groups have been initiated to focus on specific challenges experienced by services and ensure resolutions are agreed and transacted.
- Compliance for this standard is currently forecast by December 2019.

Mandatory Training Compliance
(Slide 7 and 32)

- The overall stat-man training for the hospital is performing well at 92%.
- However, we know that this overall figure masks underperformance in some key areas including safeguarding and resuscitation at directorate and professional group level.
- In July 2019 the CEO sent a message to all staff urging a focus on ensuring that our statutory and mandatory training rates were up to date
- The Medical Director and Chiefs of Service are identifying and communicating with individual consultants
- The Workforce Development team are reviewing capacity for Resuscitation & Safeguarding training to ensure that adequate spaces are available.
- Training rates are being monitored at Directorate Performance Review meetings.

* There are a number of metrics on the dashboards in the report which are marked with a red asterisk. This is to draw to your attention to data which is being reported in a different way temporarily post EPIC, or which may be subject to a data quality query. Please exercise caution in interpretation.



Duty of Candour compliance data demonstrates that performing well at having the initial duty of candour discussions with patients (100% of cases in April and May). There is really encouraging progress in sending the duty of candour letters, we are not yet meeting the 10 working day target routinely (40% for May 2019). Training in the new hospital Duty of Candour process was launched in June 2019, so we anticipate that this will help to support more timely completion of letters. Next month's report will also include compliance data on stage 3 of the process (sharing the outcome of our investigation with patients and families).

High risk monthly review performance has improved to 70% in May 2019 (from 56% in April). The Patient Safety Team will work closely with the RAGS to support improvement through in June. Directorate level data on risk review compliance will also be considered at the Directorate Performance Meetings from August 2019.

We have seen a positive improvement in the numbers of policies which are currently in date and available to staff. 67% of policies are in date for May 2019 compared to 58% in April 2019. There are 2 approval meetings scheduled for July and 1 being scheduled for August with a focus on high risk policies.

There are 6 open red complaint actions which link to one complex case. The action plan has been revised post EPIC (as planned), and will be presented to the July Closing the Loop meeting. Our lessons learned audit focussed on an SI from 2017 regarding a cardiorespiratory arrest secondary to aspiration of water from a ventilator tubing circuit. It found good evidence that we had implemented the key actions and a further refinement of the process has been recommended to ensure that there is clear evidence of training records in the department.

FOI performance with responses within timescale remain high (90% for May, which is slightly down from 94% in April) and there have been no requests for internal review or referrals to the ICO.

Email SARS performance for dealing with requests within timescales remains at 0%. One request was completed in May 2019, but not within timescale. It included the disclosure of 399 pages of emails.

Legal SARS performance has deteriorated significantly in April and May following introduction of EPIC. While the reported completion figure for May is 78%, there were 23 requests outstanding at the end of the month compared to 2 in April and 0 in May. The issues with data retrieval have been escalated to the EPIC team and a meeting has been organised with the CCIO to agree a plan to address these issues. An update on this plan will be provided in next month's report.

We have commissioned a new Trust Wide Quality Improvement Project to help improve the safety of urethral catheterisation. This aims to reduce harm associated with catheterisation, and will be rolled out Trust wide.

Quality and Safety Overview

The Trust is seeing an increase in the percentage of incidents closed within timeframe however there is much more work to do to bring performance to the expected level. It is expected that Incidents that are reported on the Datix system are reviewed, investigated and closed within 45 working days. As of May 2019 we have only managed to achieve that in 52% of incidents closed. The IPP directorate have rolled out a weekly Datix Review Group led by a Consultant and the Nursing Education team, supported by the Q&S team, which identified 3 key learning points and ensures that the incidents are reviewed.

WHO checklist performance appears to have declined significantly following the introduction of EPIC. It had been anticipated that the system would support staff to complete and document the checks at the appropriate times during the procedure, however this has not materialised in all cases, but this is believed to be a training issue in theatres rather than a risk that the checklist is not being completed. In areas outside theatres, more work is being done to support clear pathways for completing the WHO checklist appropriately in addition to training on the EPIC system. This performance is being kept under very close review via the fortnightly Executive CQC meetings. (Comment added 12.7.2019: Data checks following circulation of this report have confirmed a much higher performance and the report has been amended at slide 3 and 7 to reflect this.)

There are currently 335 open risks on the risk register which includes risks identified by Clinical teams, Corporate teams and Trust wide risks. In line with the Risk Management Strategy risks should be reviewed according to their grade (4 weeks for high, 8 weeks for medium and 12 weeks for low) currently the Trust is operating at 70-80% compliant with those timeframes. The Patient Safety team continue to support the Clinical Directorate's to ensure that the risks are reviewed and that the Datix system is updated to reflect the updated action.

The Quality Improvement team are working with the Pharmacy team and clinical directorates to improve the pathways for Controlled Drugs management and Total Parental Nutrition (TPN). The QI team are working with their colleagues in Clinical Audit and Patient Safety to identify other key work streams of Medication safety, a further update will be provided in the next IQR.

May saw the launch of the Quality Rounds, which is a peer to peer review of the clinical areas against the CQC's Key Lines of Enquiry (KLOE's). Over 50 volunteers were trained and took part in the rounds which has highlighted many areas of good and outstanding practice that is being shared with others and areas which we could do better. These include testing of electrical equipment and decontamination. The next Quality Round is planned for July 2019.

The Speaking up for Safety training programme has been rolled out Trust wide with a positive uptake on training dates.

Emerging risks in Patient Safety

Pharmacy Safety

- An MHRA inspection in May 2019 has highlighted significant areas for improvement in our manufacturing processes, including delays with our quality managements system processes. There is a recovery plan in place which has been shared with the MHRA and other regulators, and is being closely supervised by the Chief Pharmacist, General Manager and Quality and Head of Special Projects for Quality and Safety. The BAF risk is being updated accordingly.
- The Pharmacy department is also experiencing challenges in workload and workflow post the introduction of EPIC. This had led at times to reduced ward presence of pharmacists.

Follow up appointments

- During the EPIC launch we reduced activity across the Trust and this has continued longer than anticipated in some areas post Epic Go Live. This has had an impact on patients being seen in a timely manner, although there have been no reports of harm caused. The patient safety concern raised via the risk action groups is that patients are not being seen for outpatient follow up within specific pathway timeframes post-operatively. A review of the scale of the problem, including an evaluation of the impact on patients will be undertaken.

Line access

- There have been a number of incidents reported around line management (inclusive of but not limited to central and peripheral lines) in May. This includes delays in lines being removed, delays in lines being inserted, and concerns around management of infected lines. The backlogs for line removal for haem-onc patients has been addressed through waiting list initiatives in May and June. However, the underlying causes contributing to these backlogs, which include, but are not limited to capacity in IR, which is a known risk in the organisation. The risk is being escalated to a Trust wide Risk which will be discussed at Operational Board to agree a clear action plan for addressing this issue at a hospital level.

Hospital Quality Performance – June 2019 (May Data)

Are our patients receiving safe, harm-free care?

	Parameters	Mar 19	April 19	May 2019
Patient Safety Incident Reporting *	R<60 A 61-70 G>70	62.8	480	582
Incident Closure Rate (% of incidents closed in 45 working days)	R 0-64%A>65-75% G>76-100%	45.9%	47%	52%
No of incidents closed	Trending	564	341	624
Average days to close (2018 - 2019 incidents)	R ->50, A - <50 G - <45	63.7	87	70
Medication Incidents (% of total PSI)	TBC	32.4%	21.9%	24.6%
WHO Checklist (overall) *	R<98% G>98-100%	94.5%	88.9%	98.5%
WHO Checklist (Theatres) *	R<98% G>98-100%		95.98%	99.2%
WHO Checklist(non-theatres)*	R<98% G>98-100%		80.3%	97.3%
Near Miss reports (% of incidents reported)	R <8%, A 8-9%, G>10%	6%	8%	9.1%
Serious Incidents	R >1, A -1 G – 0	0	2	1
Overdue SI	R >1, A -1, G – 0	1	1	1
Safety Alerts overdue	R- >1 G - 0	3	2	2
Safeguarding Children's Reviews	New	0	0	0
	Open and ongoing	6	6	6
Safeguarding Adults Board Reviews	New	0	0	0
	Open and ongoing	1	1	1

Are we delivering effective, evidence based care?

	Target	Mar 19	April 19	May 2019
Specialty Led Clinical Audits on Track	R 0- 69%, A>60-75% G>75-100%	86%	81%	82%
Number of completed specialty led clinical audits per year	Aim =100 p.a G= YTD total at month end is on target	131	10	24
NICE guidance overdue for assessment of relevance	R=1+, G=0	0	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%	100%	100%	100%

Are our patients having a good experience of care?

	Parameters	Mar 19	April 19	May 2019
Friends and Family Test Recommend rate (Inpatient) *	G – 95+, A- 90-94, R<90	96.5%	96%	96%
Friends and Family Test Recommend rate (Outpatient) *	G – 95+, A- 90-94,R<90	94.1%	91%	91%
Friends and Family Test - response rate (Inpatient) *	25%	25.8%	17%	22%
PALS*	N/A	165	135	182
Complaints*	N/A	7	7	9
Red Complaints (%total complaints YTD)	R>12% A- 10-12% G- <10%	7%	8%	9%
Re-opened complaints (% of total complaints YTD)	R>12% A- 10-12% G- <10%	13%	14%	12%

Are our People Ready to Deliver High Quality Care?

	Parameters	Mar 19	Apr 19	May 19
Mandatory Training Compliance	R<80%,A-80-90% G>90%	93%	92%	92%
PDR	R<80%,A-80-90% G>90%	85%	84%	80.6%
Appraisal Compliance (Consultant)	R<80%,A-80-90% G>90%	86%	87%	84%
Safeguarding Children Level 3 Training compliance	R<80%,A-80-90% G>90%	85%	82%	77%
Safeguarding Adults L1 Training Compliance	R<80%,A-80-90% G>90%	92%	92%	91%
Sickness Rate	R -3+ G- <3%	2.5%	2.4%	2.4%
Turnover - Voluntary	R>14% G<14%	14.8%	14.7%	15.2%
Vacancy Rate – Contractual	R- >10% G- <10%	-0.15%	8.2%	8.5%
Vacancy rate - Nursing		3.4%	7.2%	0.5%
Bank Spend		5.8%	4.4%	4.6%
Agency Spend	R>2% G<2%	1%	0.9%	0.59%

Well Led Dashboard

Is our culture right for delivering high quality care?

	Target	Feb 2019	March 2019	April 2019	May 2019
High Risk Review (% reviewed within date)	R<80, A 81-90% G>90%	71%	68.5%	55.7%	70%
Serious Incident Actions (number of actions overdue)	R- >2 A- 1-2 G- 0	Data collection will start for April data		TBC	TBC
Red Complaints Action Plan Completion (no of actions overdue)	R- >2 A- 1-2 G- 0	2	9	6	6
Duty of Candour Cases	N/A	N/A		6	5
Duty of Candour Conversation (Stage 1)	R<75% A 75-90% G>90%	N/A		100%	100%
Duty of Candour Letter (Stage 2)	R<75% A 75-90% G>90%	N/A		83%	60%
Duty of Candour – compliance with 10 days		N/A		50%	40%
Policies (% in date)	R 0- 79%, A>80% G>90%	56%	58%	58%	67%
Fit and Proper Person Test Compliance (self assessment)	R - <90% A 90-99% G – 100%	100%	100%	100%	100%
Actions for Staff survey within timescale	TBC	N/A	N/A	N/A	N/A
Quality Improvement Led Projects – Trust Wide	Volume monitoring	3	3	3	4
Quality Improvement registered Projects – Local	Volume monitoring	7	8	7	9
Freedom to speak up cases	Volume monitoring	8	8	6	7
HR Whistleblowing - New	Volume monitoring	0	0	0	0
HR whistleblowing - Ongoing	open cases	1	1	1	1
New Bullying and Harassment Cases (reported to HR)	Volume	0	2	1	0
	12 month rolling	New Metric	New Metric	New Metric	9

Are we managing our data?

	Target	March 2019	April 2019	May 2019
FOI requests	Volume	47	56	49
FOI % responded to within timescale	R- <65% A – 65-80% G- >80%	95%	94%	90%
FOI - Number requiring internal review	R>1 A=1 G=0	1	0	0
FOI Number referred to ICO	G=0 R=1+	0	0	0
Information Governance Incidents	volume	14	11	13
IG incidents reported to ICO	volume	0	0	0
SARS (Medical Record) Requests		108	90	106
SARS (Medical Record) processed with 30 days	R- <65% A – 65-80% G- >80%	100%	97.8 %	99%
SARS (Email) Requests	volume	1	1	0
SARS (Email) Requests released	volume	2	2	1
SARS (Email) Requests released within 90 days	R- <65% A – 65-80% G- >80%	0%	0%	0%
SARS (Email) in progress	volume	6	5	4
SARS (Legal) Requests	volume	55	78	65
SARS (Legal) Compliance	R- <65% A – 65-80% G- >80%	93%	36%	78.5%

Always



Welcoming Helpful Expert One Team

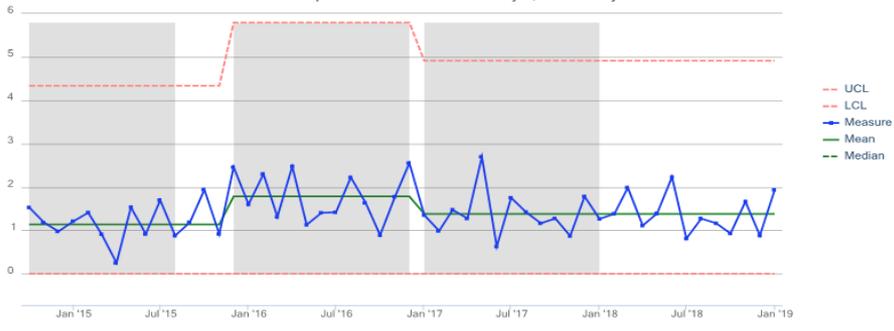
Are we delivering effective and responsive care for patients to ensure they have the best possible outcomes?

Responsive Hospital Metrics		Mar-19	Apr-19	May-19	Effective & Productivity Hospital Metrics		Mar-19	Apr-19	May-19
Diagnostics: patient waiting <6 weeks	R<99% G -99-100%	97.48% ↓	90.79% ↓	90.51% ↓	Discharge summary 24 hours	R<100% G=100%	79.00% ↓	56.38% ↓	45.27% ↓
Cancer 31 day: referral to first treatment	R<85% G 85%-100%	100% →	100% →	100% →	Clinic Letter– 7 working days		36.25% ↑	66.0% ↑	
Cancer 31 day: Decision to treat to First Treatment	R<96% G 96-100%	100% →	100% →	100% →	Clinic Letter– 14 working days		68.29% ↑	92.06% ↑	
Cancer 31 day: Decision to treat to subsequent treatment - surgery	R<94% G94-100%	100% →	100% →	100% →	Was Not Brought (DNA) rate		8.45% ↑	7.28% ↓	8.67% ↑
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%	66.80% ↑	Data under review	
Cancer 62 day: Consultant upgrade of urgency of a referral to first treatment	-	100% →	100% →	100% →	Theatre Utilisation – Outside Theatres	R<77% G>77%	54.30% ↓		
Theatre Cancellation for non-clinical reason	-	52 ↑	Data under review		Trust Beds	Bed Occupancy	79.10%	Data under review	
Last minute non-clinical hospital cancelled operations - breach of 28 day standard	R 1+ G=0	7 ↓			Avg. Ward beds closed	35	32		
Urgent operations cancelled for a second time.	R 1+ G=0	0 →	0 →	0 →	ICU Beds Closed	6	5	0 ↓	
Same day/day before hospital cancelled outpatients appointments	-	1.28% ↑	1.25% ↓	1.01% ↓	Refused Admissions	Cardiac	6	4	2 ↓
RTT Incomplete pathways (national reporting)	92%	92.24% ↑	90.07% ↓	88.25% ↓	PICU/NICU	14	3	9 ↑	
RTT number of incomplete pathways <18 weeks	-	6430 ↑	6683 ↑	6503 ↓	PICU Delayed Discharge	Internal 8-24 hours	3	2	2 →
RTT number of incomplete pathways >18 weeks	-	541 ↓	737 ↑	866 ↑	Internal 24h +	13	4	3 ↓	
RTT Incomplete pathways >52 weeks Validated	R - >0, G=0	4 ↑	5 ↑	6 ↑	External 8-24 hr	4	2	0 ↓	
RTT incomplete pathways >40 weeks validated	R - >0, G=0	28 ↑	31 ↑	35 ↑	External 24h+	7	7	3 ↓	
Number of unknown RTT clock starts – Internal Ref	-	0	0	0	Total 8-24h	7	4	2 ↓	
Number of unknown RTT clock starts – External Ref	-	231	465	521	Total 24h +	20	11	6 ↓	
RTT: Total number of incomplete pathways known/unknown - <18 weeks	-	6656 ↑	6587 ↑	7016 ↑	PICU Emergency Readmission <48h	-	1	1	1 →
RTT: Total number of incomplete pathways known/unknown - >18 weeks	-	546 ↑	547 ↑	869 ↑	Daycase Discharges	In Month	2,322	2,249	1,938 ↓
					YTD	28,667	2,249	4,187 ↑	
					Overnight Discharges	In Month	1,440	1,010	1,519 ↑
					YTD	16,707	1,010	2,529 ↑	
					Critical Care Beddays	In Month	972	836	1,170 ↑
					YTD	11,720	836	2,006 ↑	
					Bed Days >100 days	No of Patients	17	2	7 ↑
					No of Beddays	3,131	203	1,095 ↑	
					Outpatient attendances (All)	In Month	21,678	16,809	19,156 ↑
					YTD	266,187	16,809	35,965 ↑	

Do we deliver harm free care to our patients?

CVL Infections

GOSH-acquired CVL infections for every 1,000 line days



*updated chart not yet available pending rebuild of Quality Dashboards post EPIC

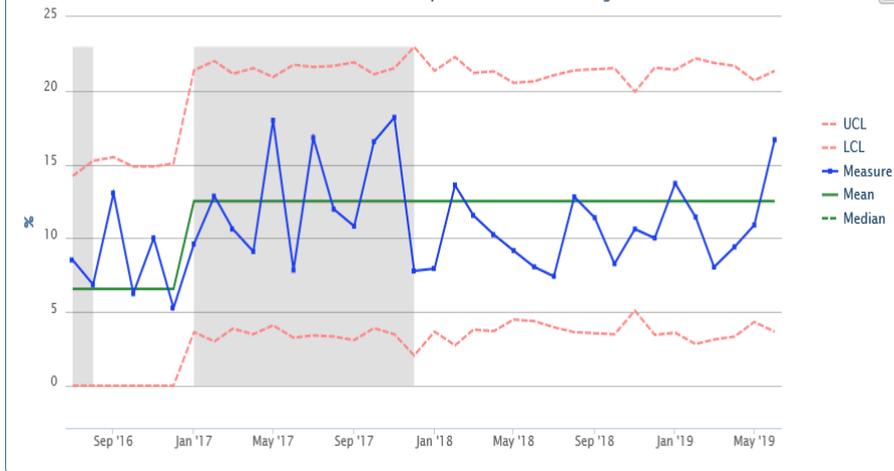
		Jan	Feb	March	April	May
Central Venous Line infections (per 1000 bed days)	Mean - 1.6	2.1	2.5	3.2	0.9	2.8

Infection Control Metrics

Care Outcome Metric	Parameters	Feb 2019	Mar 2019	April 2019	May 2019
Bacteraemias (mandatory reporting – MRSA, MSSA, Ecoll, Pseudomas Klebsiella)	In Month	7	5	5	9
	YTD	82	87	5	14
C Difficile cases - Total	In month	1	1	0	1
	YTD	6	7	0	1
C difficile due to lapses (Considered Trust Assigned but awaiting confirmation from NHS E)	In Month	1	0	0	1
	YTD	6	6	0	1

Medication incidents causing harm

% of Medication Incidents Reported via Datix Causing Harm



		Feb 19	Mar 19	Apr 19	May 19
% of reported medication incidents causing harm	Mean-12.5%	14%	9%	11%	17%

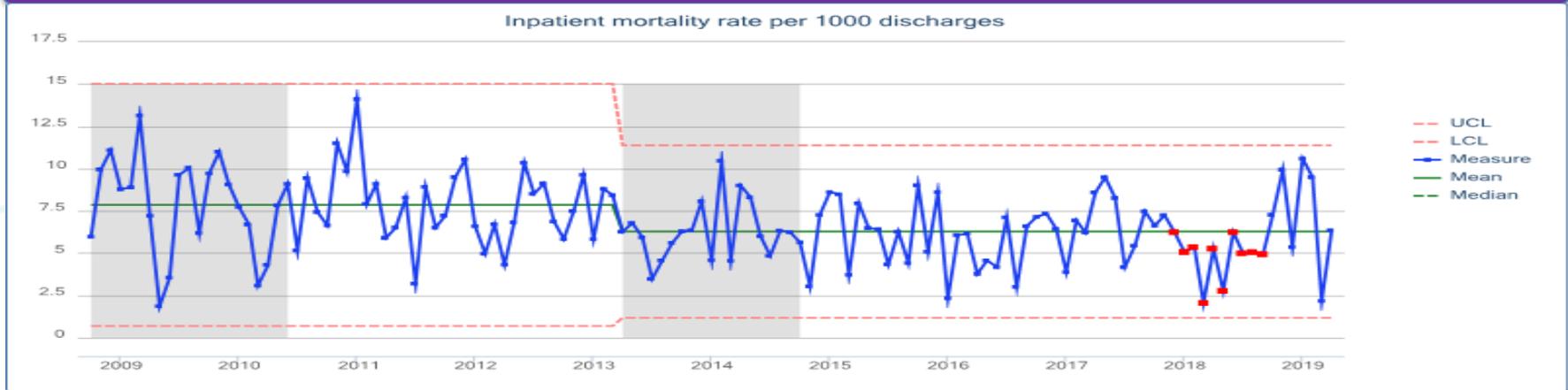
Pressure Ulcers

Number of Hospital Acquired Pressure Ulcers Reported (Category 2+)



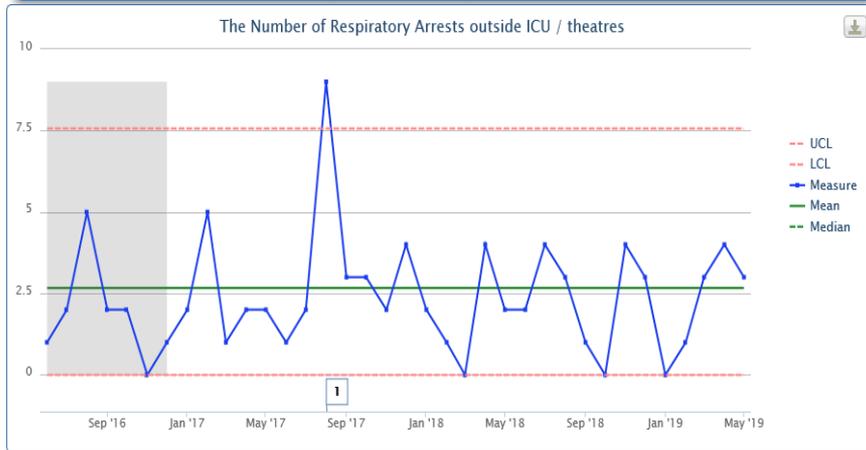
		Feb	March	April	May
Hospital Acquired Pressure Ulcer (2+)	R – 12+, A 6-11 G =0-5	2	7	3	4

Inpatient mortality

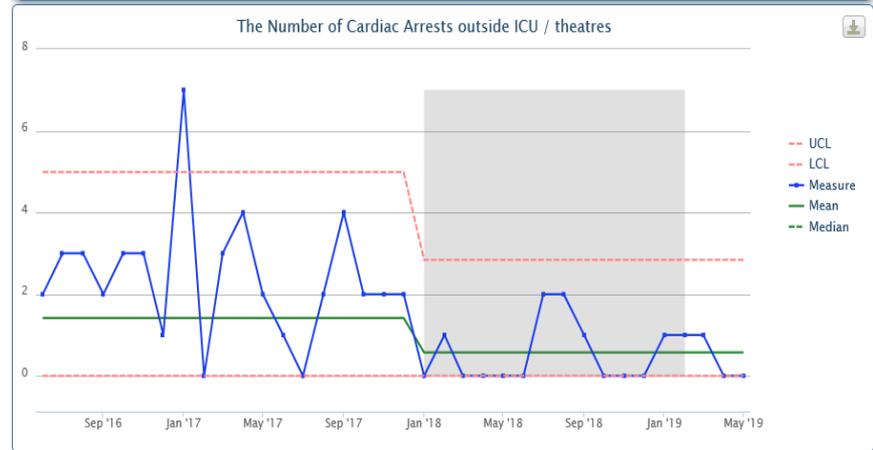


*updated mortality data not yet available pending update of Quality Dashboards post EPIC

Respiratory Arrests



Cardiac Arrests



The dashboards for respiratory arrest and cardiac arrest show volume this month, rather than rate, while we rebuild the quality dashboards Post EPIC

Lessons Learned audit June 2019 - Cardiorespiratory arrest secondary to aspiration of water from a ventilator tubing circuit

Background

As part of our governance and learning culture it is important that there we check our implementation of action and learning from past incidents, to identify if we have “closed the loop”. A summary of SIs reported to PSOC from 2018 onwards 2018/19 have been reviewed by the Head of Special Projects for Quality and Safety and Clinical Audit Manager to identify actions where assurance about implementation would benefit from audit.

The incident

This audit looks at an SI that occurred in 2017 on NICU

Cardiorespiratory arrest secondary to aspiration of water from a ventilator tubing circuit

A neonate suffered a cardiorespiratory arrest following aspiration of excess water that had accumulated in the ventilator tubing circuit of the Fabian Optiflow model VN500.

Learning identified to be audited

“The majority of ventilators in use on the unit have an auto fill function for the humidification systems. Staff on the unit are more familiar with the autofill function than a manual fill option .Whilst there is a written warning to staff on the Optiflow ventilator reminding them of the manual fill humidifier, after it was first employed this was removed. Thus no alert was visible to staff using the Fabian Optiflow on subsequent shifts “

“The ventilator technicians offer ventilator training to all staff on induction. There is no attendance record or certificate and completion of training and so it is not possible to determine who has received training nor what this entailed.”

Audit findings

Implemented

The Clinical Audit Manager reviewed this . On the 3rd May there were three patients on Optiflow on NICU . Confirmed with the Senior ITU Support Technician that there are no manual fill chambers in use in the trust.

Requires implementation

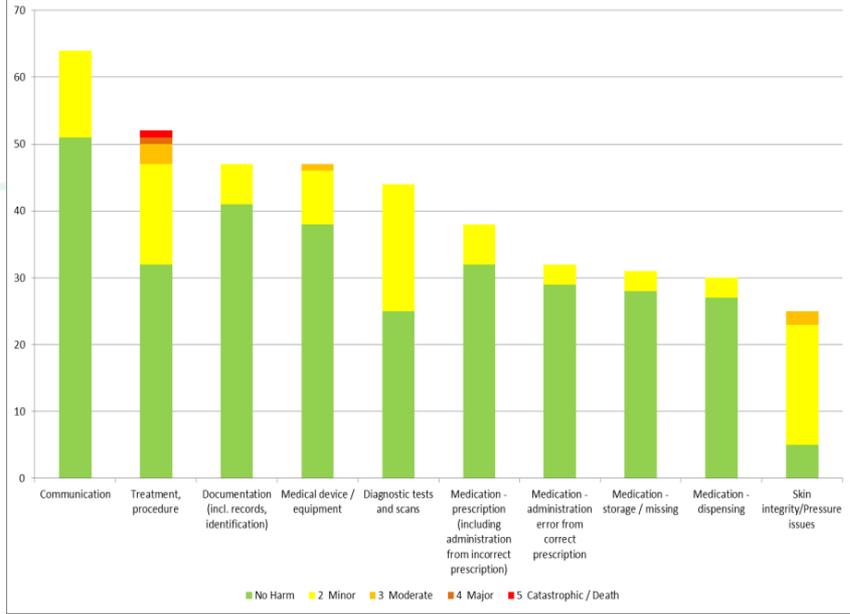
Confirmed with the Matron that staff are signed off as competent and records of competency are kept with the staff. Competencies for ventilation are done throughout the first 6 months and it is signed in the Nurse’s own competency book. An improvement would be a system to evidence who has had training outside of individual records

Action agreed by PICU/NICU Matron and Head of Nursing for the Directorate

Action	Action Lead	Date to be completed	Date to check this has happened
Records of all ventilator training given on induction to be recorded on the PICU local drive	Deborah Lees	Central records of these 6 month competencies will now be kept going forward	October 2019

Patient Safety incidents (reported on Datix)

Incidents by Category and Severity



Medication prescription and administration errors were high in May, which is a known historically annual trend as many new doctor contracts start at this time. The other high point for these errors historically has been November. However what is interesting is that the focus of these errors has shifted. Whereas previously prescription errors were often due to unfamiliarity with local guidelines, currently the errors are largely down to in-built problems with EPIC, and with training on the new system. This suggests that long term EPIC's safety measures may help mitigate against this trend.

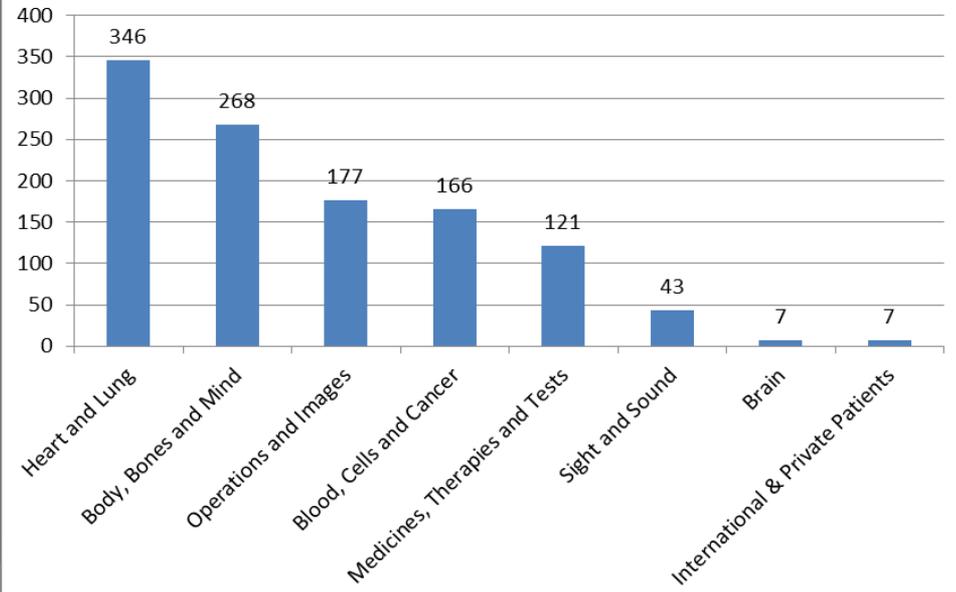
Controlled drug storage and management was another issue which was frequently reported in May. Common issues are wrong storage of patient's own medication, poor documentation and medication losses due accidental spillage. The plan to do a major trust-wide review of controlled drugs may also be acting to raise awareness around best practice in storage and encouraging reporting.

Investigations for incidents should be completed within 45 days for investigation, unless they are a Serious Incident (SI) in which case the timeframe is 60 days. For most incidents this is well within the timeframe an investigation will take.

On review, we found that many incident investigations had taken place but the results had not been uploaded onto DATIX. The Patient Safety team are always happy to meet with staff to review and close incidents, and this can be done on a regular basis to support timely closure.

In addition, many incidents are medical in nature, however comparatively few doctors use DATIX. It is important that as many doctors as possible sign up to review and manage incidents.

Incidents by Division older than 45 days



Recently Closed Patient Safety Alerts

NHS/PSA/W/2018/009: Risk of harm from inappropriate placement of pulse oximeter probes (December 2018)

NHS/PSA/RE/2018/004: Resources to support safer modification of food and drink (April 2019)

NHS/PSA/D/2019/001: Wrong selection of orthopaedic fracture fixation plates. (Feb 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: It has been challenging identifying a product appropriate for use with the patient cohort in the Trust. However, a product has now been identified which is being assessed for suitability in theatres and potential trial.

NHS/PSA/RE/2018/006: Resources to support safe and timely management of hyperkalaemia (Aug 2018). This alert was due to close in May, but there was a delay of a week in closing while we arranged a fix for the intranet listing of policies to avoid confusion. This alert has now been closed.

New and ongoing Patient Safety Alerts

NHS/PSA/RE/2019/002: **Assessment and management of babies who are accidentally dropped in hospital**

Update: The Trust is compliant with this alert as all steps are covered in the Patient Falls Policy. However it was decided to keep this open to explicitly include a section on carrying a child in the corridor, although this is not covered in the alert **Due:** Nov 2019

Patient Safety – Serious Incident Summary

New & Ongoing Serious Incidents				
Directorate	Ref	Due	Headline	Update
Heart & Lung	2019/8273	11/07/2019	Retained arterial line	Timeline being drafted
Operations and Images	2019/8826	17/07/2019	Retained surgical instrument (never event)	Report being drafted
Estates and Facilities	2019/10699	08/08/2019	Staff collapsed on Trust premises.	Timeline underway.
Brain	2019/11025	13/08/2019	Delay in diagnosing renal failure	Timeline underway
Body, bones and mind	2019/12525	30/08/19	Unnecessary removal of Hickman Line	Timeline underway

New Serious Incidents

2019/11025 – a patient attended GOSH with end-stage renal failure. Reviewing clinical notes from a previous visit 2 years ago, it was identified that some blood results may have indicated the early stages of renal failure. It is not clear whether the outcome would have been different had this been identified.

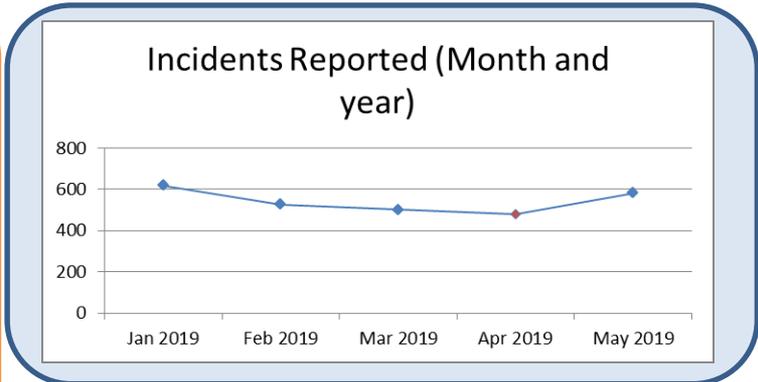
2019/12525 – a patient attended with a suspected line infection. Removal in IR was booked in advance, and the line was checked daily for cultures (all negative). However the procedure was not cancelled and the line was removed. This will mean an additional procedure in 6 weeks to replace the line.

Sharing Lessons Learned: SI 2018/24654

Situation: A patient had an elective cardiac catheter procedure for balloon dilation and implantation of a melody valve. During the procedure the conduit ruptured and the patient haemorrhaged and sadly died.

Analysis: The conduit had become calcified and brittle, and this is why it was more vulnerable to rupture.

Recommendations: This outcome was a known but unfortunate risk of the procedure. It has been referred to expert peer review to consider if there are any additional learning points for the team. No recommendations for change in practice have been identified to date.



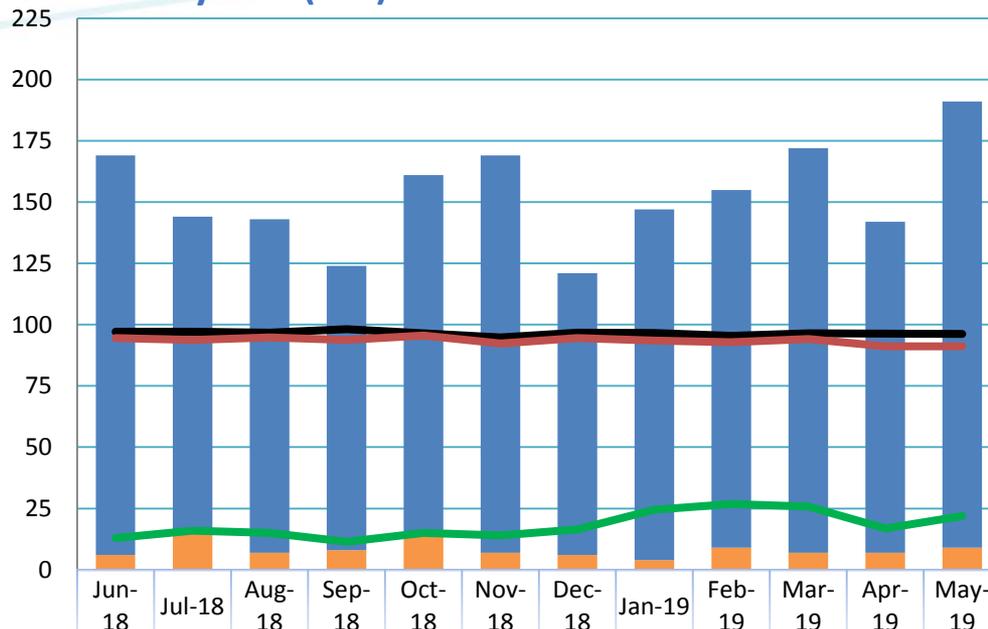
Always



Patient Experience Overview

Are we responding and improving?

Patients, families & carers can share feedback via PALS, Complaints & the Friends and Family Test (FFT).



PALS	163	129	136	116	146	162	115	143	146	165	135	182
Formal Complaints	6	15	7	8	15	7	6	4	9	7	7	9
FFT recommendation rate - Inpatients %	97	97	97	98	97	95	97	97	95	97	96	96
FFT recommendation rate - Outpatients %	95	94	95	94	96	92	95	94	93	94	91	91
FFT % response rate	13	16	15	11	15	14	17	25	27	26	17	22

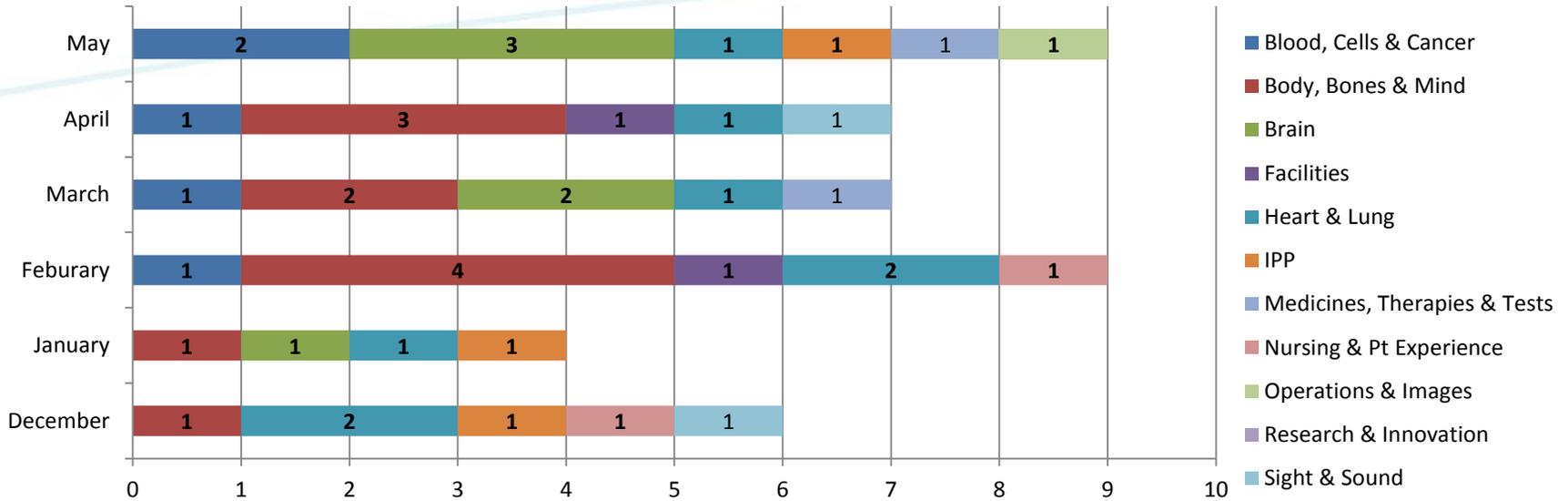
Integrated Patient Experience Commentary

The Patient Experience teams have been closely monitoring feedback following the EPIC implementation. While there has been an increase in Pals cases in May, there were no specific concerns about EPIC.

There was an increase in concerns about communication (particularly in Pals cases). It is hoped that these issues will be reduced as families communicate via MyGOSH.

The Trust FFT response rate has increased from 17% in April to 22% this month. While the inpatient recommendation rate is consistent with previous months, outpatients has dropped since April. However, positively outpatient FFT responses have increased significantly.

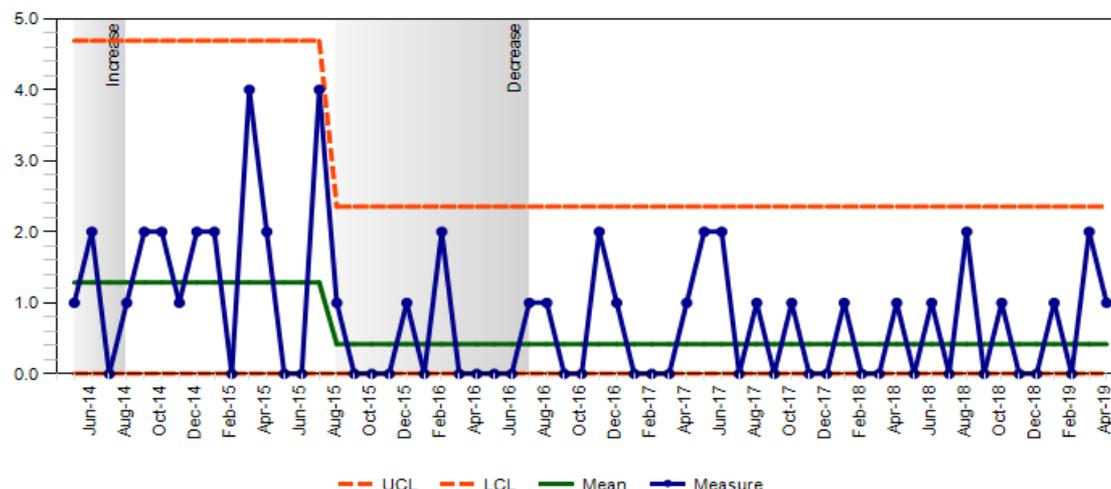
Complaints: Are we responding and improving?



There were 9 new complaints received in May 2019 which related to concerns about/ that:

- delays in obtaining genetic test results from the clinical team
- the behaviour and attitude of a clinician. These concerns were raised in three complaints and related to three different specialities
- delays with dispensing medication in pharmacy
- two medication errors
- the decision not to prescribe a specific drug
- a clinic appointment was conducted insensitively
- the accuracy of the information given in clinic and within the medical records

Red Complaints: Are we responding and improving?



No of new red complaints this financial year 2019/20:	2
New Red complaints opened in May 2019	1
No of re-opened red complaints this year 2019/20:	0
Open red complaints (new and reopened) as at 31/05/2019:	3

New red complaint

Ref	Opened Date	Report Due	Description of Complaint	Divisions Involved	Next Steps:
19/010	10/05/19	22/07/19	Parents are concerned that their child was not admitted to a specialist ward and therefore didn't receive the expert and urgent care required. They feel this led to permanent brain damage	IPP	Draft response has been received from the directorate and is with the complaints team for review

There are 6 Red Complaint actions which remain open. This is partly due to the fact that some actions are no longer appropriate or required within EPIC. The action plan will be updated to reflect changes in processes and procedures post-EPIC. The clinical audit team have completed an audit of the current actions and a new audit plan will be agreed following the revised action plan.

PALS – Are we responding and improving?

Cases – Month	05/18	04/19	05/19
Promptly resolved (24-48 hour resolution)	149	89	134
Complex cases (multiple questions, 48 hour+ resolution)	16	45	45
Escalated to formal complaints	0	2	2
Compliments about specialities	4	1	1
*Special cases (e.g. large volume of contact following media interest)	0	0	0
Total	171	137	182
Themes for the top five specialties			
Lack of communication (lack of communication with family, telephone calls not returned; incorrect information sent to families)	55	46	73
Admission/Discharge /Referrals (waiting times; advice on making a NHS/ IPP referral; cancellations; waiting times to hear about admissions; lack of communication with families, accommodation)	14	7	12
Staff attitude (rude staff, poor communication with parents, not listening to parents)	7	11	4
Outpatient (cancellation; failure to arrange appointment; poor communication, franking of letters)	40	36	45
Transport (eligibility, delay in providing transport, failure to provide transport)	10	4	7
Information* (GOSH information, Health information, care advice, advice NHS, access to medical records, incorrect records, missing records, support/listening)	29	30	34

There has been an increase of Pals cases this month. This reflects the end of a planned period of reduced patient activity as part of the EPIC implementation.

Pals continue to monitor cases relating to EPIC. However, this month there have been no specific concerns raised about EPIC.

The implementation of MyGOSH (and specifically the function to contact clinical teams directly) is expected to improve communication. However, this will take some time as staff get used to the new system and MyGOSH sign up rates increase.

In May there was a significant increase in concerns about communication. Primarily these relate to the Brain (n=27) and Body, Bones and Mind (n=15) directorates.

*Pals have added data relating to information requests in order to more accurately capture the top themes of concerns raised.



PALS – Are we responding and improving?

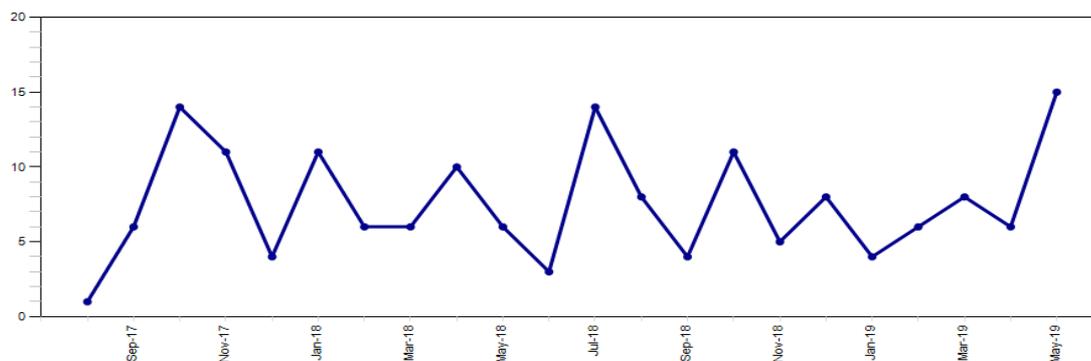
Top specialities - Month	05/18	04/19	05/19
Neurology	5	6	13
Cardiology	13	6	13
Outpatients	6	10	9
ENT	9	8	7
Gastroenterology	7	9	7

The main themes of **Neurology** cases related to communication (including concerns about delays in referrals, delayed test results, no responses to calls, explanation regarding a change in transport policy, how to raise questions about care following an appointment) as well as cancellations, accommodation provision and a request for a patient’s notes.

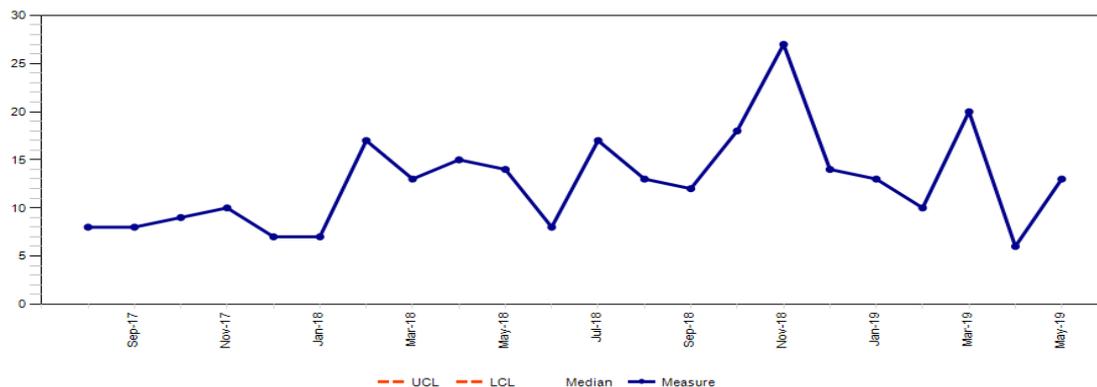
The Neurology team explained that many of these issues arose during a period of transition following EPR. Staff are being supported in their use of EPR and are continuing to promote MyGOSH.

Cardiology* cases in May also highlighted issues relating to communication. Specifically, delays in getting test results, unreturned phone calls and correspondence, delays in referrals and appointments, inadequate plans for a procedure, inadequate information about preparation for a procedure, and inaccurate information about a patient’s condition.

Neurology cases



Cardiology cases

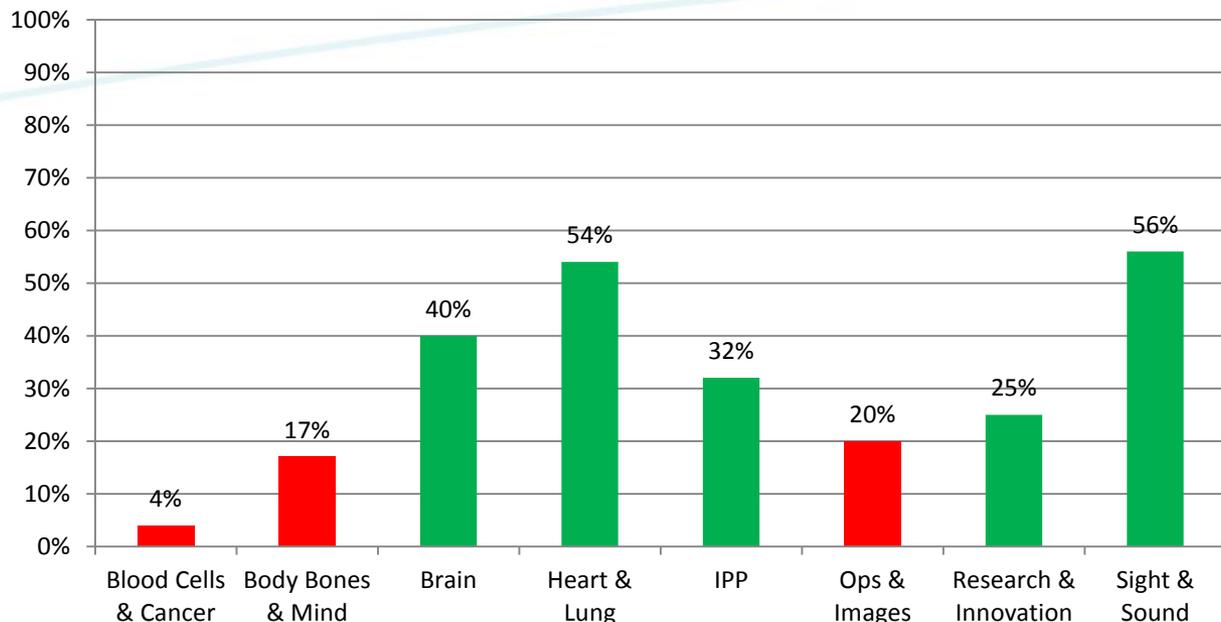


**Pals are liaising with Cardiology for feedback regarding the increased cases and to better understand any contributing factors as well as actions to address this.*



FFT: Are we responding and improving?

Directorate Response Rate



Following a reduction in the overall Trust FFT response rate in April (17%), this increased to 22% in May.

While the percentage to recommend score for inpatients has remained static at 96%, outpatients remains below target at 91%.

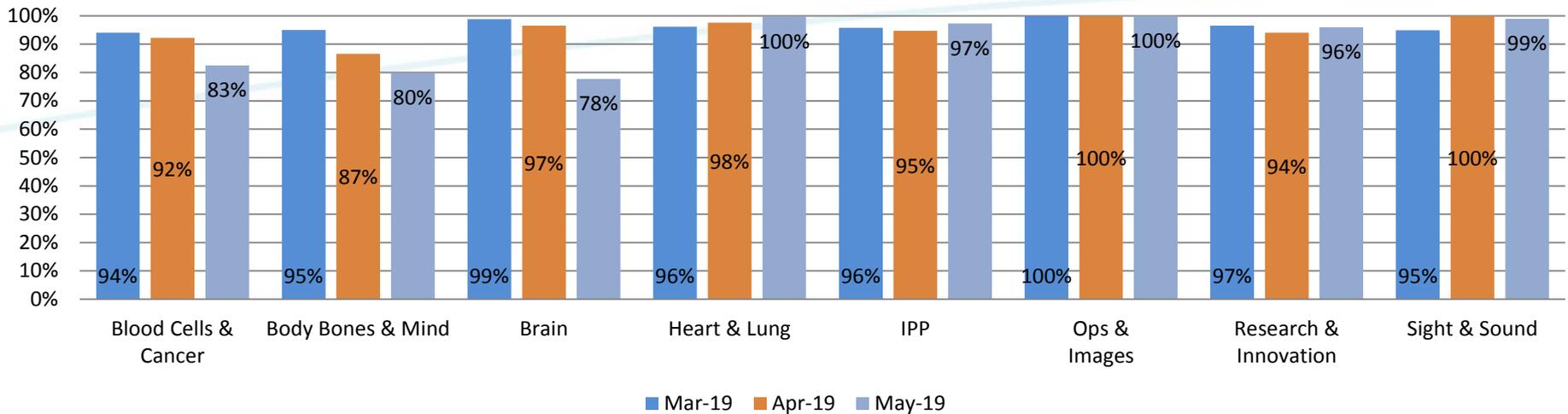
Five directorates met or exceeded the 25% Trust target for FFT responses in May.

There are some unresolved issues relating to discharge data from EPIC which has impacted FFT rates particularly at directorate level. Specifically, the Patient Experience team have identified discrepancies relating to incorrect discharges from theatres rather than ward areas which means that the above rates may be subject to marginal change. The Patient Experience team is working with EPR team to resolve these issues.

Additionally, changes since the EPIC implementation mean that some patients, previously booked as outpatients for procedures such as blood tests, are now recorded on EPIC as inpatient admissions. This is particularly relevant to Safari (part of the Blood Cells and Cancer directorate) and has contributed to the lower response rate.

FFT: Are we responding and improving?

Percentage to recommend



The inpatient recommendation rate overall was unchanged at 96%. However, at a directorate level, there were reductions in 4 of the eight directorates. In particular, the Patient Experience team are liaising with the Brain directorate and providing further data to aid analysis of the reasons for the reduced recommendation rate in May. This will be included in the June IQR.

	Inpatient Comments	Outpatient Comments	IPP Comments	Total Feedback	% with qualitative comments (All areas)
Mar 19	876	673	48	1597	81.3%
Apr 19	516	399	40	955	85.3%
May 19	667	701	51	1419	79.4%

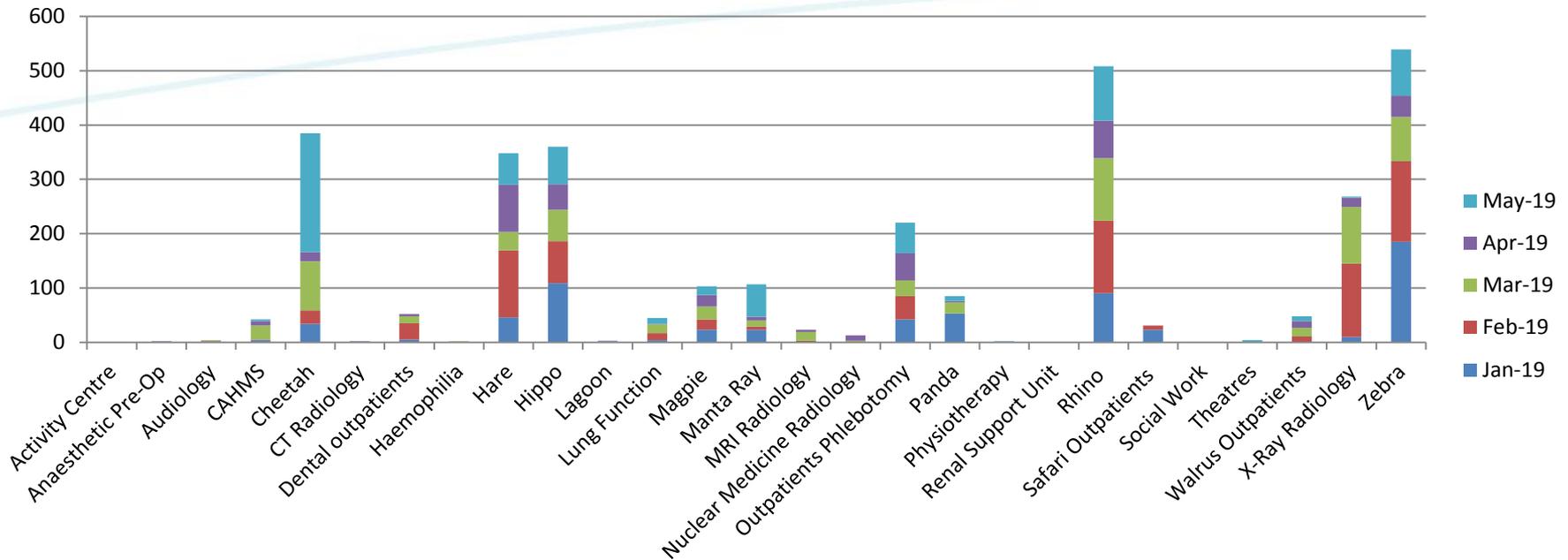
FFT comments from both inpatients and outpatients increased in May 2019. The percentage of qualitative comments remains high at 79%. There were many positive comments on how the staff made patients and families feel welcome and in very safe hands. Negative comments during May have been varied and include pharmacy delays, procedure delays and communication issues between teams and departments.

Always



FFT: Are we responding and improving?

FFT Outpatients



The above chart outlines the number of the FFT responses within Outpatients. There is currently no Trust or NHS target for outpatient FFT feedback.

As expected, the number of responses have increased this month (percentage increase =75%) after the significant drop in April during the Epic go live. This still remains lower than average monthly responses received during Q1 2019.

The majority of negative comments within outpatients relate to waiting times for appointments.

Qualitative Comments

Positive

"When we were first admitted to GOSH, we were gutted and only expected the worst. The staff have given us the most incredible support from being there for a shoulder to cry on to giving us the best clinical advice. We are so lucky as a nation to have people like you watching over us!" – Giraffe Ward

*"All staff are extremely friendly. The people at the front in yellow shirts who escort you are terrific and a great way to make patients feel welcome. **Hare Outpatients***

*"A very good experience from start to finish. All the staff were friendly and professional. Facilities are excellent" **Nightingale Ward***

*"Staff are fantastic! Nothing is too much trouble and there is lots to do for children. Lots to play with and pass the time. Fantastic facilities" **Outpatient Phlebotomy***

Feedback is shared with the teams concerned. All negative comments are followed up with the families (subject to contact details being available).

The child first and always

Negative

*"We visit weekly for a 3 hour drug infusion. We travel 2.5 hours each way leaving home at 6.30am to arrive for 9am. Each time the nurses complete their tests in order for the drug to be made up within an hour of arrival. Every time there is a delay in the pharmacy providing the drug. It is currently 3.15pm and we still haven't got the drug to start the infusion. As we need 24 hour checks post drug it is likely we will not be home until approx. 11pm tomorrow creating child care issues, not forgetting the fact that my son is exhausted and usually has school the next day. He takes two days to recover from the experience. As his mother, I am drained also. CRF is also a very boring place to be waiting hours upon hours despite a fantastic play therapist. My son should not have to go through this". **Somers Clinical Research Facility***

A meeting took place on 14th June with relevant staff from Somers CRF, Pharmacy and Civas (who prepare the medication).
An action plan has been implemented to improve the waiting time for clinical trial drugs produced in Civas.

Always

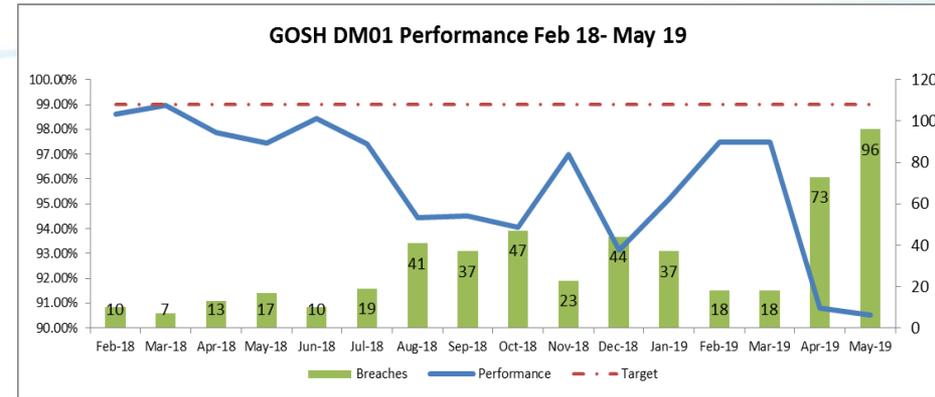




Responsive – Diagnostic Waiting Times

May 2019 Summary

- The Trust continues to underachieve against the 99% national standard, reporting 90.81% of patients waiting within 6 weeks for the 15 diagnostic modalities
- The number of reported breaches has significantly increased to 96 compared to April when we reported 73.
- This is a further significant decline in performance compared to 18/19 due to a combination of the planned activity slot reduction over EPIC Go-live (21 lists down in MRI approx. 60 patient slots), tolerance patients and trust processes.



Of the 96 breaches, 76 are attributable to modalities within Imaging and the remaining 20 relate to Gastroscopy, ECHOs, Electrophysiology, Cystoscopy and Audiology diagnostic tests.

The breaches fall into four distinct themes; 70 due to reduced planned activity slot availability and administrative teams unable to provide reasonable offers to patients, 6 due to lack of capacity, 10 Trust processes (clinician unavailability, delay on protocolling scans, no ward bed available, patient booked into a wrong scanner), and 10 tolerance patients- failed sedation, patient unfit for scan, list overrun, unable to cannulate, scanner breakdown, and unable to complete urgent patient was a priority.

The Trust has developed a recovery plan and trajectory, however, it should be acknowledged that returning to an acceptable level of breaches is expected to take a number of months due to continued reduction in activity in May, loss of the CT scanner for a week in May and the planned MRI upgrade programme. The current trajectory forecasts compliance by end of September 2019.

Cancer Wait Times

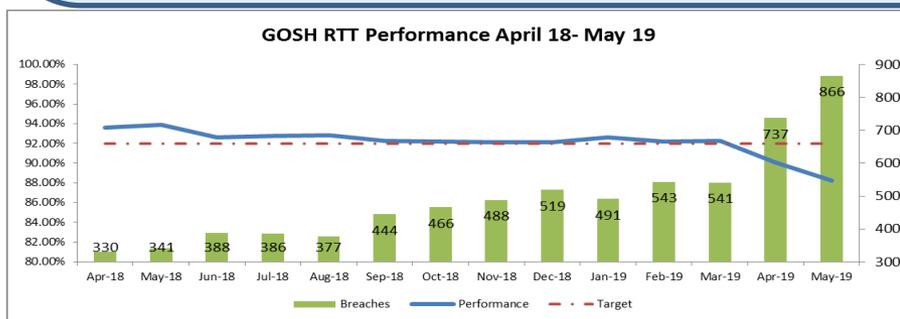
At the time of writing the report for the month of April 2019, no breaches against the cancer standards attributable to the Trust were reported, with performance being at 100%. Indicative performance for May projects compliance against all standards.



Responsive – Referral to Treatment

May 2019 Summary

- The Trust did not achieve the RTT 92% standard, submitting performance of 88.25%, with 866 patients waiting longer than 18 weeks. However, it was projected that a drop in performance due to EPIC Go-Live was to be expected due to the planned activity reduction. The Trust is currently reviewing all under achieving specialties and working with services to produce recovery plans and trajectories. Trust compliance against this standard is expected by March 2020
- As previously described 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).
- Two of the seven NHS directorates have met the 92% standard
- The number of patients waiting 40 weeks+ has increased to 35 patients in May from 31 in April



52 Week Waits:

The Trust reported 6 patients waiting over 52 weeks in May. One in ENT, four in Dental & Maxillofacial Surgery and one in SNAPS. One of the Dental patients was seen in June and was discharged, whilst the other 2 patients have TCIs in July and August (patient choice) and the third one needs joint surgery with MaxFax and is currently awaiting a TCI. The ENT patient is a complex case and procedure needs to be coordinated with the dental team. The SNAPS patient was also a delayed referral (initial referral was never received by GOSH) and when received went to Urology first and on triage was transferred to SNAPS. The patient has a TCI in July.

National Benchmarking:

For the month of April half of the patients on the Trusts incomplete PTL were waiting less than 7 weeks (nationally 7 weeks), and 92 out of every 100 patients were waiting less than 19 weeks (nationally 23 weeks) on a PTL size of 7,423 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 184 providers reporting against the standard (NHS Trusts only) 76 in April were delivering 92% or better. 16 providers reported 90-92%, 72 at 80-90% and 19 reported <80%. 1 provider did not report.

Nationally, GOSH is ranked as the 92nd best performing Trust out of 183 providers. In London, GOSH is the 16th best performing Trust out of 28 Providers reporting RTT performance.

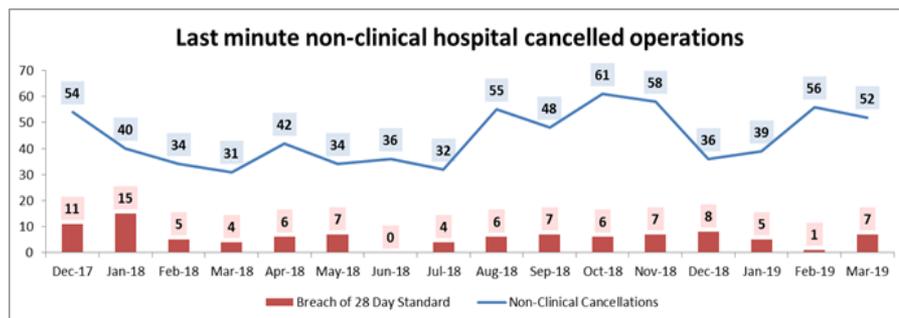
Responsive – Last minute non-clinical hospital cancelled operations (and associated 28 day breaches)

Last minute non-clinical hospital cancelled operations:

At the time of writing, both April and May data was not available. The data is currently being reviewed and will be available in August 2019 due to this being a quarterly national submission.

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 a second time.



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 did not meet the 97% standard with 95.99% of patients having valid data in May. This is a result of EPIC Go live and the Trust is confident the standard will be met in upcoming months as staff get more familiar with the new system.

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 a decrease in collating ethnicity for patients accessing mental health services, with 67.53% (-2.43%) in May having a valid ethnic code. This is continues to be addressed with operational teams via weekly monitoring, refreshed training and focused Data Assurance work. Capture of this data is now completed within the EPIC system.

Patients with a valid NHS Number

% of patients with a valid NHS Number Inpatients and Outpatients

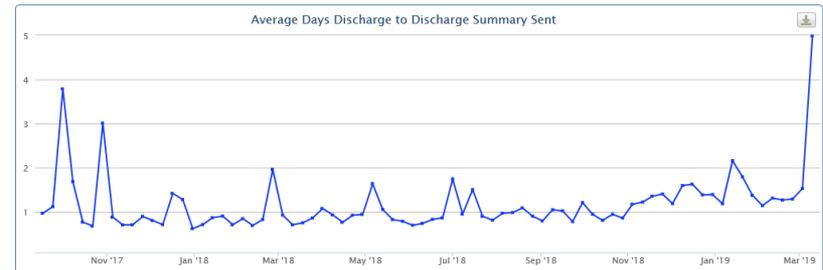
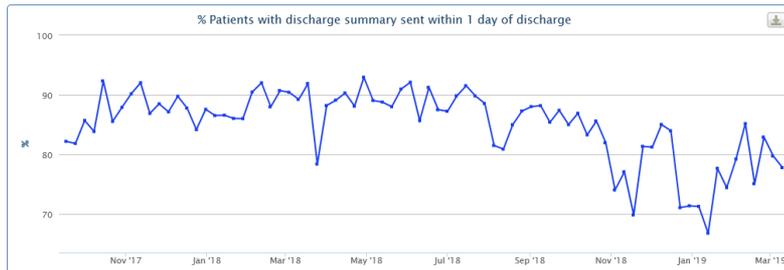
This indicator has been added the Dashboard for 2018/19 following agreement with NHSE the content of Schedule 4 of the NHS Contract.

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

May 2019 Summary

- Performance within this metric continues to fluctuate and be challenging to directorates with May 2019 seeing 45.27% of discharge summaries being sent within 24 hours, which is a decline from April performance (56.38%).
- The Trust is currently undertaking a full data investigation and deep-dive into this metric to understand the impact of EPIC. Directorates have raised concerns regarding the information pulled into the discharge summary, reviewing the clinical workflow, identification of summaries in progress or not started and the flagging of whether a patient requires a discharge summary.
- Working groups have been initiated to focus on specific challenges experienced by services and ensure resolutions are agreed and transacted.
- Compliance for this standard is currently forecast by December 2019.



Clinic Letter Turnaround Times

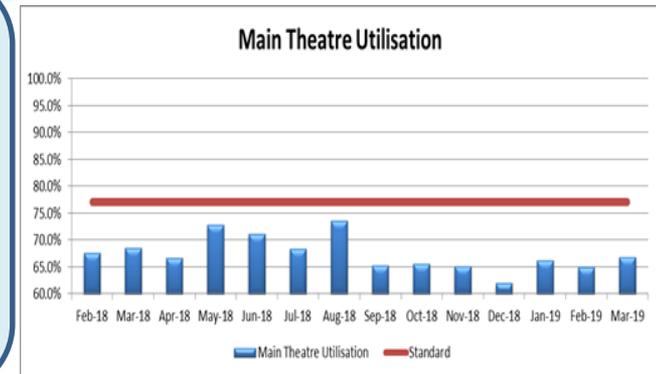
For April 2019 (as this indicator is reported a month in arrears), performance has significantly improved in relation to 14 day turnaround; 92.06% in April compared to 68.29% in March.

However, we will also be undertaking a deep dive into this metric to understand how the process in the EPIC system has impacted this process operationally; identifying where delays in the process reside within each specialty and implement actions. Some of the other actions to be taken include utilising the EPIC Report to monitor the volume of outstanding letters on a daily basis and target the area of delay, ensure clinic letter turnaround is part of monthly service reviews, extra admin time to work through the backlog of letters in specific areas and review the content and quality of the clinic letters.

Productivity – Theatre Utilisation

Theatre utilisation for April and May remains unavailable at the time of reporting. This is due to reporting the indicator data from EPIC continues to be validated and utilisation logic application understood and signed off.

Work continues on targeting fully utilising lists and addressing delays with clerking and consenting of patients. However, it is expected that theatre utilisation will be impacted as EPIC stabilises and throughput returns to normal levels.



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: At the time of reporting, bed occupancy was unavailable for the reporting period of April and May. This indicator and methodology is currently under-review as part of the statutory returns work being completed to support EPR implementation.

Bed closures: The average number of beds closed in May (32) remained consistent with the number of beds closed in April. The reasons for closures are linked to staffing. This was mainly due to Sky having an average of 8 beds closed and both Bumblebee and Hedgehog having 5 beds closed. NICU/PICU have experienced an average of 3 beds closed

Trust Activity

Trust activity: May activity for day case discharges are below the same reporting period for last year,. However outpatient attendances, critical care bed-days and overnight discharges are above the same reporting period last year. 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 the month of May, there were seven patients whose stay in hospital was over 100 days, accumulating 1,095 bed days in total.

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.

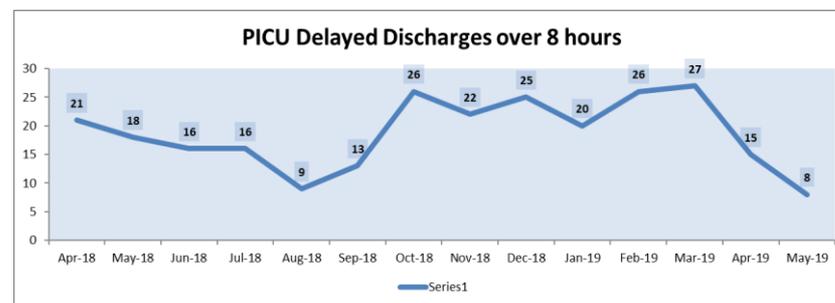
CATS PICU/NICU Refusals: The number of CATS referral refusals into PICU/NICU from other providers during May has increased to 9 from an April position of 3. The overall number of refusals for 2018-19 (189) were eight less than those in 2017-18 (197). During 2018-19 the Trust received 382 patients via 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

Quarter	GOSH PICU/NICU/CICU 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

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. May has seen eight patients delayed over 8 hours compared to 15 in April.



PICU Emergency Readmissions:

Readmissions back into PICU within 48 hours is one patient for the month of May, similar to April.

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Workforce Headlines

- **Contractual staff in post:** Substantive staff in post numbers in May were 4667 FTE which is a slight decrease from April (4609 FTE), however this is higher than the same month last year.
- **Unfilled vacancy rate:** The Trust vacancy rate for May increased to 8.53%, which while below target is well above the long term average. This is due to an increase in the budgeted establishment as well as a change to reporting of some unidentified Better Value costs. Trust vacancy rates have been below target since July 2017. The Nurse vacancy rate for May is 6.6% which is an increase from April (4.9%)
- **Turnover** is reported as voluntary turnover. Voluntary turnover increased to 15.2%, which is 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 17.9% which is slightly above 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 May 2019 was 0.9% of total paybill, which is below the local stretch target, and is also well below the same month last year (1.2%). 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. Bank % of paybill was 4.6%.
- **Statutory & Mandatory training compliance:** In May the compliance rate across the Trust was 92%, which is above the target however 2 Directorates (Heart & Lung & Body, Bones & Mind) reported below target. Across the Trust there are 8 topics below 90% including Information Governance where the target is 95%.
- **Sickness absence** remains at 2.5%, and remains below target, and below the London average figure of 2.8%. The 2019/20 target remains 3%.
- **Appraisal/PDR completion** The non-medical appraisal rate has fallen to 81% with most Directorates below target. Consultant appraisals have reduced to 84%.



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Trust KPI performance May 2019

Metric	Plan	May 2019	3m average	12m average
Voluntary Turnover	14%	15.2%	14.9%	14.7%
Sickness (12m)	3%	2.4%	2.4%	2.4%
Vacancy	10%	8.5%	5.5%	2.8%
Agency spend	2%	0.6%	0.8%	1.0%
PDR %	90%	81%	83%	83%
Consultant Appraisal %	90%	84%	83%	86%
Statutory & Mandatory training	90%	92%	92%	92%

Key:
■ Achieving Plan ■ Within 10% of Plan ■ Not achieving Plan

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Directorate (Clinical) KPI performance May 2019

Metric	Plan	Trust	Blood, Cells & Cancer	Body, Bones & Mind	Brain	Heart & Lung	Medicine, Therapies & Tests	Operations & Images	Sight & Sound	IPP
Voluntary Turnover	14%	15.2%	15.2%	13.9%	12.6%	15.2%	13.9%	11.8%	17.6%	24.1%
Sickness (12m)	3%	2.4%	2.0%	2.1%	2.3%	2.8%	1.9%	2.8%	3.3%	4.2%
Vacancy	10%	8.5%	-4.6%	4.2%	0.9%	4.4%	-5.4%	2.4%	6.2%	14.4%
Agency spend	2%	0.6%	0.1%	0.1%	0.0%	0.1%	0.4%	-0.3%	1.0%	0.0%
PDR %	90%	81%	85%	78%	90%	81%	81%	76%	90%	91%
Stat/Mand Training	90%	92%	92%	89%	93%	89%	92%	91%	92%	93%

Key:
■ Achieving Plan ■ Within 10% of Plan ■ Not achieving Plan

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Directorate (Corporate) KPI performance May 2019

Metric	Plan	Trust	Clinical Operations	Corporate Affairs	DPS	Finance	HR&OD	Medical Director	Nursing & Patient Experience	Research & Innovation
Voluntary Turnover	14%	15.2%	18.9%	14.6%	12.5%	13.1%	19.5%	19.0%	15.4%	32.2%
Sickness (12m)	3%	2.4%	1.2%	0.0%	2.8%	0.9%	4.0%	1.6%	1.3%	1.5%
Vacancy	10%	8.5%	34.5%	8.9%	24.0%	23.8%	6.1%	23.3%	-1.7%	-71.1%
Agency spend	2%	0.6%	0.6%	-0.0%	6.9%	8.6%	-10.2%	0.0%	0.0%	0.0%
PDR %	90%	81%	79%	79%	84%	93%	92%	86%	80%	75%
Stat/Mand Training	90%	92%	95%	93%	94%	100%	96%	92%	96%	96%

Key:
■ Achieving Plan
■ Within 10% of Plan
■ Not achieving Plan

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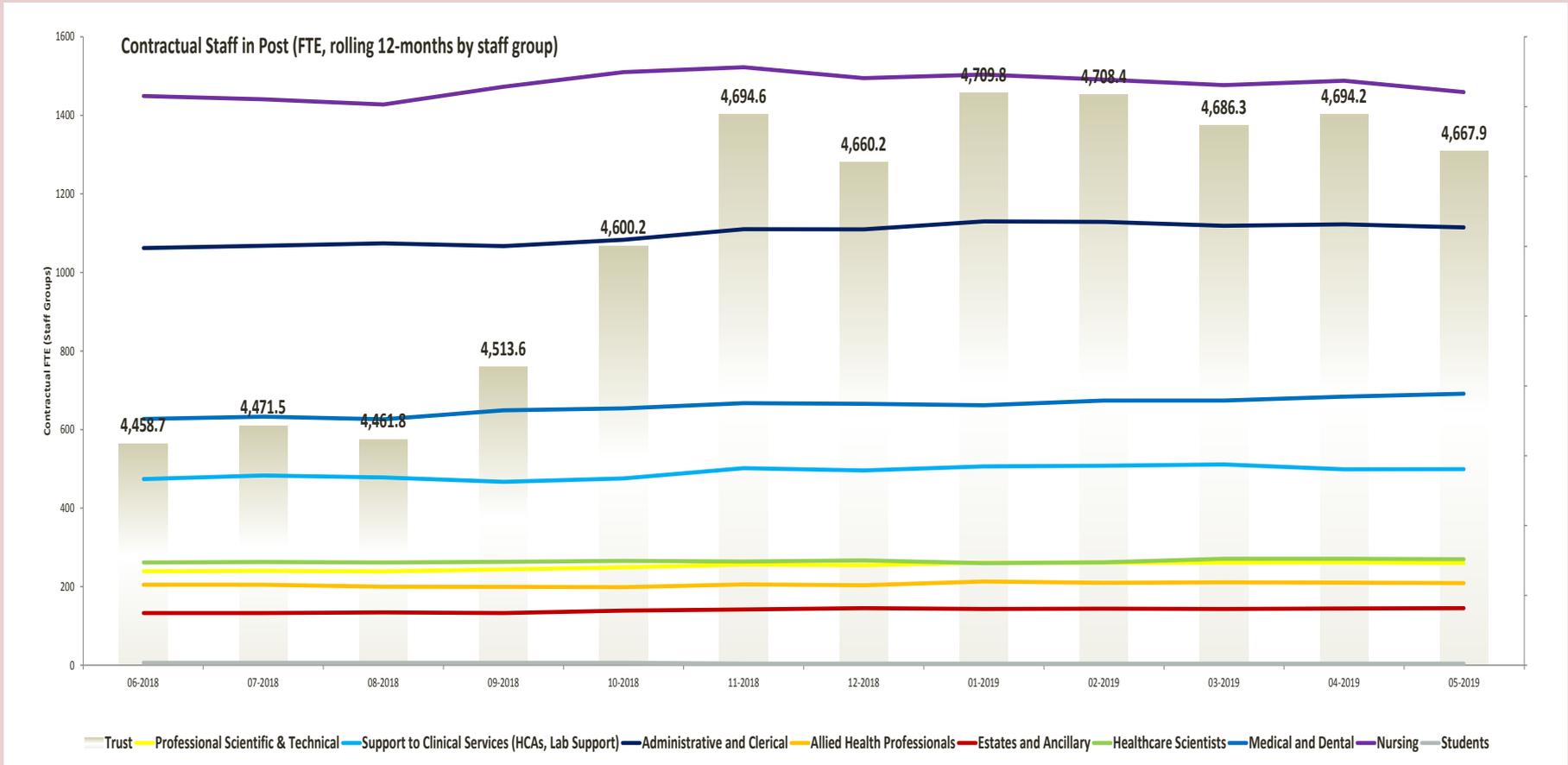


Welcoming Helpful Expert One Team



Are our people ready to deliver high quality care?

Substantive staff in post by staff group



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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.



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.

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. This helps capture and share learning and improvement, prevent duplication, and provides a platform to raise the profile of quality improvement.

Area of work	Project lead:
1 To reduce the number of unnecessary clotting samples in SNAPS	Sonia Basson, SNAPS SpR
2 To Improve the knowledge/ understanding for all new parents on the precautions and restrictions on Fox/ Robin from day one of their child's admission.	Robyn Newton (Ward sister) & Anna Sillett (Ward Sister)
3 Supporting the medication safety work stream of the Hospital Pharmacy Transformation Programme Board (HPTPB), by reviewing the management of Parenteral Nutrition (PN) at GOSH	Stephen Tomlin (Chief Pharmacist)
4 Supporting the implementation of Quality & Safety initiatives on Pelican ward	Carole Campbell (Ward Sister) & Emma Gilbert (Matron)
4 To improve and standardise the provision of Play at GOSH so that all children and young people receive the play support they require for their needs	Laura Walsh (Head of Play Services)
5 To implement Datix review rounds to improve the culture of learning from incident reporting in IPP	Deborah Zeitlan (Consultant General Paeds)
6 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)
7 Discharge summaries – IPP Revising the provision of DS in IPP following EPIC to enable standardised documentation with additional safety measures	Sian Pincott (DCOS IPP), Tariq Chaudry (Fellow)
8 Mobile App Development Project Develop a framework and process to oversee the development and implementation of Mobile Applications in the Trust	Louis Grandjean (ID Cons)
9 Improve handover quality and continuity of care for outlying patients in the cardiology service	Craig Laurence (Cardiac Fellow)

If you have any improvement work going on in your area that you wish to share or would like to seek QI support, contact the team to discuss further or complete the [Quality Improvement Project Notification Form](#) and submit this to Gosh.QI@gosh.nhs.uk.

For more information, visit the [QI intranet page](#) (search 'quality improvement')

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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



Body, Bones and Mind



Operations and Images



Sight and Sound

- Reduce unnecessary coagulation testing in SNAPS

- ZAPPP



Blood, Cells and Cancer



Heart and Lung



International and Private Patients



Medicines, Therapies and Tests

- Reducing IR delays & cancellations
- Patient/ Family information
- Pelican Q&S initiatives

- Datix review meeting
- Discharge Summaries

- Standardise the provision of play
- HPTPB – PN

Trust-wide projects

Reducing incidences of extravasation harm and repeated cannulation

Reducing rejected laboratory samples

Improving Transition

Improving safety of urethral catheterisation

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)

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Welcoming Helpful Expert One Team

**Trust Board
 18th July 2019**

Month 02 2019/20 Finance Report

Paper No: Attachment T

**Submitted by:
 Helen Jameson, Chief Finance Officer**

Attachment Finance Report M02

Key Points to take away

1. The Trust is required to achieve an overall control total. The Trust is behind its control total in Month 2 by £0.5m. None of the £1.0m reserve has been released into the position.
2. The Trust is behind its income target by £3.0m (excluding pass through) at Month 2. NHS Clinical Income that is not on block contract is behind plan by £0.4m. Private Patient income is also behind plan by £1.9m YTD due to lower levels of activity.
3. Pay is underspent YTD by £1.9m due to the number of vacancies across the Trust that are not being covered by bank or agency.
4. Non pay is £0.6m underspent year to date (excluding pass through). This predominantly relates to underspends on clinical supplies and drugs which are partially offset but non-delivery of non-pay better value schemes.
5. Cash is higher than plan by £6.3m (£48.0m against a plan of £41.7m) in part due to higher than planned receipts from NHSE. The capital programme is currently £4.1m behind plan due to slippage on estates and Equipment projects. Overall, overdue Trust IPP debt has increased to £37.2m from £36.9m in M01.

Introduction

This paper reports the Trust's Financial Position as at the end of May 2019 (Month 2). The Trust is required to achieve a breakeven control total (excluding PSF) for the year which is a decrease from 2018/19. This includes a Better Value program of £20m.

Year to date the Trust is currently reporting an adverse position to plan of £0.5m. The Trust recurrently delivered £0.4m YTD of the Better Value programme target (£1.5m) with the rest being covered by non-recurrent pay vacancies.

Financial Position – Summary Points

NHS & other clinical revenue (excluding pass through) is adverse to plan by £0.4m YTD. Most services are under a block contract arrangement so the underperformance is occurring on those services remaining on a cost and volume contract and is due to a combination of lower levels of activity and depth of coding.

Private patient income is behind plan by £1.9m as activity is below that expected, which may be in part due to Ramadan.

Non-clinical income is £0.8m behind plan YTD and £0.2m behind plan in month. £0.4m of this relates to the timing of spend on approved charity funded projects and £0.3m relates to the underperformance on work for other Trusts and commercial funding schemes across the

organisation.

Pay is underspent by £1.9m YTD. The key contributors to this underspend are the number of vacancies across the organisation that not currently being backfilled by agency and bank. The Trust is currently below the NHSI agency cost ceiling that it agrees as part of its annual plan and is forecasting to remain below this for the rest of the year.

Non-Pay expenditure (excluding pass through) is underspent by £0.6m YTD. This is driven by lower spend on clinical supplies and drugs which is driven by lower levels of activity post EPIC go live and the timing of charity projects. These underspends are partly offset by the under delivery of the non-pay element of the Better Value programme.

Financial Forecast – Summary Points

The Trust is forecasting to deliver plan.

Statement of Financial Position – Summary Points

Indicator	Comment																				
NHSI Financial Rating	The Trust overall metric score is a three which is in line with plan. Two of the five metric are being scored as a four. The score of four is due to the deficit position at the start of the year which was planned for and planned to improve throughout the year. The annual plan is for an overall score of one.																				
Cash	<table border="1"> <thead> <tr> <th>Variance/movement</th> <th>Cash variance vs plan YTD (£m)</th> </tr> </thead> <tbody> <tr> <td>EBITDA – lower than plan</td> <td>(0.5)</td> </tr> <tr> <td>Interest – higher than plan</td> <td>0.3</td> </tr> <tr> <td>Inventories – Lower than plan</td> <td>(0.1)</td> </tr> <tr> <td>Trade and Other Payables - higher than plan</td> <td>6.8</td> </tr> <tr> <td>Provisions – lower than plan</td> <td>(0.2)</td> </tr> <tr> <td>Other liabilities – lower than plan</td> <td>(1.4)</td> </tr> <tr> <td>Capital expenditure – lower than plan</td> <td>1.0</td> </tr> <tr> <td>Other</td> <td>0.4</td> </tr> <tr> <td>Cash variance to plan</td> <td>6.3</td> </tr> </tbody> </table>	Variance/movement	Cash variance vs plan YTD (£m)	EBITDA – lower than plan	(0.5)	Interest – higher than plan	0.3	Inventories – Lower than plan	(0.1)	Trade and Other Payables - higher than plan	6.8	Provisions – lower than plan	(0.2)	Other liabilities – lower than plan	(1.4)	Capital expenditure – lower than plan	1.0	Other	0.4	Cash variance to plan	6.3
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Other liabilities – lower than plan	(1.4)																				
Capital expenditure – lower than plan	1.0																				
Other	0.4																				
Cash variance to plan	6.3																				
NHS Debtor Days	NHS Debtor days in month are 12 days which is inline with the plan. This is because the majority of the Trust's NHS invoices by value relate to contractual monthly SLA payments which are settled on the 15th of each month.																				
IPP Debtor Days	IPP debtor days decreased from 243 to 232 days due to higher than average receipts from embassies.																				
Creditor Days	Creditor days increased in month from 30 to 32 days but is still in line with plan.																				
Inventory Days	Drug inventory days cannot be calculated as the value of the pharmacy inventory is not available. Non-Drug inventory days remained the same as M1 at 92 days.																				

Action required from the meeting

- To **note** the Month 2 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

If the Trust does not achieve its control total then it will not receive the PSF funding which is £0.6m for Q1 and £3.8m full year. The Control Total is back ended to with increased amounts each Quarter.

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 2 2019/20

Contents

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Non-Pay Summary	7
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Cash, Capital and Statement of Financial Position Summary	9

FINANCIAL PERFORMANCE

	In month			Year to date			Full Year Forecast	
	Plan	Actual	RAG	Plan	Actual	RAG	F'cst	RAG
INCOME <i>incl. passthrough</i>	£39.4m	£38.5m	●	£77.4m	£75.7m	●	£488.5m	●
PAY	£24.3m	£23.0m	●	£48.5m	£46.7m	●	£289.2m	●
NON-PAY <i>incl. passthrough</i>	£17.1m	£17.9m	●	£34.1m	£34.7m	●	£199.3m	●
CONTROL TOTAL <i>excl PSF</i>	(£2.0m)	(£2.4m)	●	(£5.2m)	(£5.7m)	●	£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 2, the Trust position is adverse to the planned control total (£0.5m). The Trust Income is behind plan YTD (£2.1m) due to activity levels and depth of coding. YTD pay costs are favourable to plan (£1.8m) due to the vacancies across the organisation not being covered by bank or agency staff. Non-pay is favourable to plan (£0.6m excl. passthrough) due to underspend relating to lower than planned activity. Below plan charitable income YTD (£0.4m) is offset by reduced pay and non pay expenditure due to timing of the projects expected to occur later in the year.

INCOME BREAKDOWN RELATED TO ACTIVITY

Income breakdown Year to Date	Plan (£m)	Actual (£m)	Var (£m)	RAG
NHS & Other Clinical Revenue	£46.2m	£45.8m	(£0.4m)	●
Pass Through	£9.8m	£11.1m	£1.3m	
Private Patient Revenue	£11.2m	£9.3m	(£1.9m)	●
Non-Clinical Revenue	£10.2m	£9.4m	(£0.8m)	●
Total Operating Revenue	£77.4m	£75.7m	(£1.7m)	●

RAG: on or favourable to plan = green, 0-5% adverse to plan = amber, 5%+ adverse to plan = red

AREAS OF NOTE:

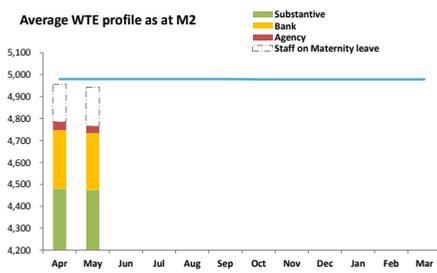
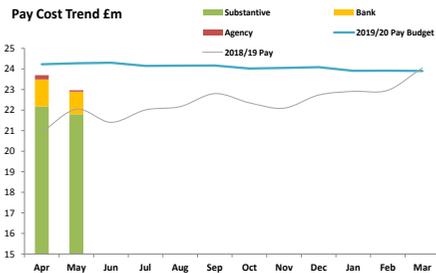
Operating revenue is adverse to plan (£3.4m excluding pass through) YTD. The Trust has entered into a block contract with NHSE and some of the CCGs for 2019/20; this is represented in the NHS income figures with the underperformance (£0.4m) arising from lower than planned levels of activity and depth of coding on those contracts that are not on block. Passthrough drugs remain on cost and volume and have over performed (£1.3m), offset by passthrough drug expenditure. Private patient income is below plan (£1.9m) due to lower levels of activity through the Ramadan period. Non-Clinical income underperformance (£1.2m) is due to lower levels of charitable contributions which will be achieved later in the year when expenditure is incurred.

PEOPLE

	M2 Plan Av. WTE	M2 Actual Av. WTE	Variance
PERMANENT	4,630.5	4,474.7	155.8
BANK	292.8	258.4	34.5
AGENCY	56.5	32.9	23.6
TOTAL	4,979.7	4,765.9	213.8

AREAS OF NOTE:

The pay costs have risen in absolute terms from last year due to the AfC pay award and one off non-consolidated AfC payments in M1. This is combined with increased costs associated with the Go live of EPIC which will reduce in future months. As part of Budget setting the establishment was reviewed and set in line with the Trust bed base. The WTE excludes 176.7 average contractual WTE's on maternity leave within the Trust. There are a number of vacancies across the Trust, and the plan set for bank and agency spend is currently below plan (and below the agency ceiling set by NHSI).

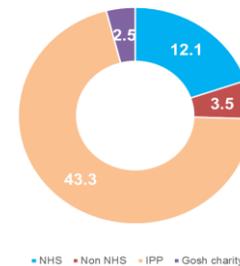


CASH, CAPITAL AND OTHER KPIS

Key metrics	Plan	Actual
Cash	£41.7m	£48.0m
IPP Debtor days	120	233
Creditor days	30	32
NHS Debtor days	30	12

Capital Programme	YTD Plan M2	YTD Actual M2	Full Year F'cst
Total Trust-funded	£4.6m	£3.6m	£21.8m
Total Donated	£9.5m	£6.5m	£46.7m
Grand Total	£14.1m	£10.0m	£68.6m

Net receivables breakdown (£m)



NHSI metrics	Plan M2	Actual M2
CAPITAL SERVICE COVER	4	4
LIQUIDITY	1	1
I&E MARGIN	4	4
VAR. FROM CONTROL TOTAL		3
AGENCY		1
TOTAL	3	3

AREAS OF NOTE:

- Cash held by the Trust is higher than plan by £6.3m of which £6.1m was received from NHS England ahead of plan.
- The capital programme is behind plan by £4.1m at M02 due to slippage on several Estates, and Equipment projects.
- IPP debtors days decreased in month from 243 days to 233 days largely as a result of higher than average receipts from Embassies
- Creditor days is increased slightly in month from 30 to 32 days.
- NHS debtor days remained the same as M01 at 12 days which is in line with plan.
- The NHSI metric for M2 is an overall value of 3 which is inline with the Trust plan. All metric are inline with plan with the exception of variance from control Total where the total is underperforming against the plan.

Annual Budget	Income & Expenditure	2019/20								Rating	Notes	2018/19 YTD Actual	CY vs PY			
		Month 2				Year to Date							YTD Variance	YTD Actual	Variance	
		Budget	Actual	Variance		Budget	Actual	Variance							(£m)	(£m)
(£m)		(£m)	(£m)	(£m)	%	(£m)	(£m)	(£m)	%		(£m)	(£m)	%			
296.47	NHS & Other Clinical Revenue	23.51	23.55	0.04	0.17%	46.23	45.83	(0.40)	(0.87%)	A	1	47.00	(1.17)	(2.49%)		
59.94	Pass Through	5.02	5.55	0.53	10.56%	9.79	11.09	1.30	13.28%			9.90	1.19	12.02%		
69.76	Private Patient Revenue	5.73	4.39	(1.34)	(23.39%)	11.19	9.34	(1.85)	(16.53%)	R	2	9.70	(0.36)	(3.71%)		
62.25	Non-Clinical Revenue	5.16	4.96	(0.20)	(3.87%)	10.16	9.39	(0.77)	(7.58%)	R	3	9.00	0.39	4.38%		
488.42	Total Operating Revenue	39.42	38.45	(0.97)	(2.46%)	77.37	75.65	(1.72)	(2.22%)	R		75.60	0.05	0.07%		
(272.88)	Permanent Staff	(22.65)	(21.80)	0.85	3.75%	(45.25)	(43.97)	1.28	2.83%			(39.70)	(4.27)	(10.76%)		
(3.48)	Agency Staff	(0.29)	(0.07)	0.22	75.86%	(0.58)	(0.27)	0.31	53.45%			(0.50)	0.23	46.00%		
(12.81)	Bank Staff	(1.34)	(1.10)	0.24	17.91%	(2.68)	(2.42)	0.26	9.70%			(2.70)		0%		
(289.17)	Total Employee Expenses	(24.28)	(22.97)	1.31	5.40%	(48.51)	(46.66)	1.85	3.81%	G	4	(42.90)	(3.76)	(8.76%)		
(13.80)	Drugs and Blood	(1.14)	(0.91)	0.23	20.18%	(2.24)	(1.77)	0.47	20.98%	G		(2.20)	0.43	19.55%		
(44.13)	Other Clinical Supplies	(3.80)	(3.46)	0.34	8.95%	(7.56)	(6.75)	0.81	10.71%	G		(7.30)	0.55	7.53%		
(62.50)	Other Expenses	(5.61)	(6.41)	(0.80)	(14.26%)	(11.42)	(12.06)	(0.64)	(5.60%)	R		(9.80)	(2.26)	(23.06%)		
(59.94)	Pass Through	(5.02)	(5.55)	(0.53)	(10.56%)	(9.79)	(11.09)	(1.30)	(13.28%)			(9.80)	(1.29)	(13.16%)		
(180.37)	Total Non-Pay Expenses	(15.57)	(16.33)	(0.76)	(4.88%)	(31.01)	(31.67)	(0.66)	(2.13%)	R	5	(29.10)	(2.57)	(8.83%)		
(469.54)	Total Expenses	(39.85)	(39.30)	0.55	1.38%	(79.52)	(78.33)	1.19	1.50%	G		(72.00)	(6.33)	(8.79%)		
18.88	EBITDA (exc Capital Donations)	(0.43)	(0.85)	(0.42)	(98.13%)	(2.15)	(2.68)	(0.53)	(24.70%)	R		3.60	(6.28)	(174.33%)		
(18.88)	Owned depreciation, interest and PDC	(1.53)	(1.52)	0.01	0.72%	(3.05)	(3.02)	0.03	1.15%		7	(2.58)	(0.44)	(16.98%)		
0.00	Control Total (exc. PSF)	(1.96)	(2.37)	(0.41)	(20.85%)	(5.20)	(5.69)	(0.49)	(9.52%)							
3.76	PSF	0.19	0.19	(0.38)	(200.00%)	0.38	0.38	(0.38)	(100.00%)							
0.00	Control total	(1.77)	(2.18)	(0.41)	(22.94%)	(4.82)	(5.31)	(0.49)	(10.18%)	R		1.02	(6.33)	(620.98%)		
(13.07)	Donated depreciation	(1.01)	(1.06)	(0.05)	(5.07%)	(2.01)	(2.02)	(0.01)	(0.75%)			(1.82)	(0.20)	(11.10%)		
(13.06)	Net (Deficit)/Surplus (exc Cap. Don. & Impairments)	(2.78)	(3.24)	(0.46)	(16.47%)	(6.83)	(7.34)	(0.51)	(7.41%)			(0.80)	(6.54)	(817.00%)		
(5.50)	Impairments	0.00	0.00	0.00	0.00%	0.00	0.00	0.00	0.00%			0.00	0.00	0%		
46.72	Capital Donations	5.60	2.36	(3.24)	(57.86%)	9.53	6.44	(3.09)	(32.42%)		6	3.40	3.04	89.41%		
28.16	Adjusted Net Result	2.82	(0.88)	(3.70)	(131.13%)	2.70	(0.90)	(3.60)	(133.19%)			2.60	(3.50)	(134.46%)		

Plan Annual	Directorates	2019/20								Rating
		Month				Year to Date				
		Budget	Actual	Var	Var %	Budget	Actual	Var	Var %	
(£m)		(£m)	(£m)	(£m)	%	(£m)	(£m)	(£m)	%	
(31.70)	Blood Cells & Cancer	(2.58)	(2.54)	0.04	1.55%	(5.27)	(5.14)	0.13	2.47%	G
(30.90)	Body Bones & Mind	(2.55)	(2.72)	(0.17)	(6.67%)	(5.14)	(5.16)	(0.02)	(0.39%)	G
(22.39)	Brain	(1.86)	(1.86)	0.00	0.00%	(3.71)	(3.76)	(0.05)	(1.35%)	G
(45.88)	Heart & Lung	(3.82)	(3.81)	0.01	0.26%	(7.71)	(7.68)	0.03	0.39%	G
(26.05)	Medicines Therapies & Tests	(2.16)	(1.94)	0.22	10.19%	(4.32)	(4.52)	(0.20)	(4.63%)	A
(32.74)	Operations & Images	(2.71)	(2.83)	(0.12)	(4.43%)	(5.43)	(5.60)	(0.17)	(3.13%)	A
(18.66)	Sight & Sound	(1.57)	(1.76)	(0.19)	(12.10%)	(3.10)	(3.28)	(0.18)	(5.81%)	R
25.01	International Private Patients	2.05	0.76	(1.29)	(62.93%)	3.96	2.55	(1.41)	(35.61%)	R
2.80	Research And Innovation	0.22	0.24	0.02	9.09%	0.45	0.48	0.03	6.67%	G
180.52	Corporate/Other	13.02	14.09	1.07	8.22%	25.07	26.41	1.34	5.35%	G
0.00	Control total	(1.96)	(2.37)	(0.41)	(20.92%)	(5.20)	(5.70)	(0.50)	(9.62%)	



Summary

- YTD the Trust is reporting an adverse position to the control total (£0.5m). Private patient income is below plan (£1.9m) while pay is underspent (£1.9m) and NHS activity not on a block is below plan (£0.4m). The Trust position includes PSF funding for months 1&2.

Notes

- NHS & other clinical revenue (excluding pass through) is adverse to plan YTD (£0.4m). This is driven by lower levels of activity across the organisation on non-block NHS income.
- Private Patient income has fallen in month and is behind plan YTD (£1.9m) due to lower than planned activity across a number of specialties and due to lower demand across the period of Ramadan.
- Non-clinical income is adverse to plan (£0.5m) due to timing of charity funded projects.
- Pay is favourable to plan (£1.9m) due to vacancies across the Trust. The Trust has a full year plan for agency (£3.5m) and Bank (£12.8m) staffing which is also underspent at Month 2.
- Non pay (excluding pass through) is underspent (£0.6m) YTD due to lower levels of activity across the organisation post EPIC go live and timing of charity funded projects.
- Income from capital donations is lower than plan YTD due to slippage in capital projects (£3.1m).

Organisation	Contract type	Annual plan £000s	Income plan £000's	Income actual £000's	Income variance £000's	RAG	YTD Variance
NHS England	Block	£274,248	£42,936	£42,936	£0	G	
	Pass through drugs	£51,747	£8,453	£9,806	£1,353	G	
	Cost & volume	£795	£118	(£196)	(£314)	A	
Total NHS England		£326,790	£51,507	£52,546	£1,039	G	
CCG contracts	Block	£13,010	£1,922	£1,922	£0	G	
	Cost & volume	£0	£0	£46	£46	G	
	Pass through	£3,828	£625	£448	(£177)	A	
Total CCG contracts		£16,838	£2,547	£2,416	(£131)	A	
CCG non contract activity	Cost & volume	£6,255	£958	£1,082	£124	G	
	Pass through	£1,218	£199	£120	(£79)	A	
Total NHS Clinical Income		£351,101	£55,211	£55,991	£953	G	
Non NHS	Cost & volume	£5,015	£760	£752	(£8)	G	
	Pass through drugs	£292	£48	£4	(£44)	G	
Private patients	Cost & volume	£69,759	£11,189	£9,337	(£1,852)	R	
TOTAL CLINICAL INCOME		£426,167	£67,208	£66,257	(£951)	R	

RAG Criteria:

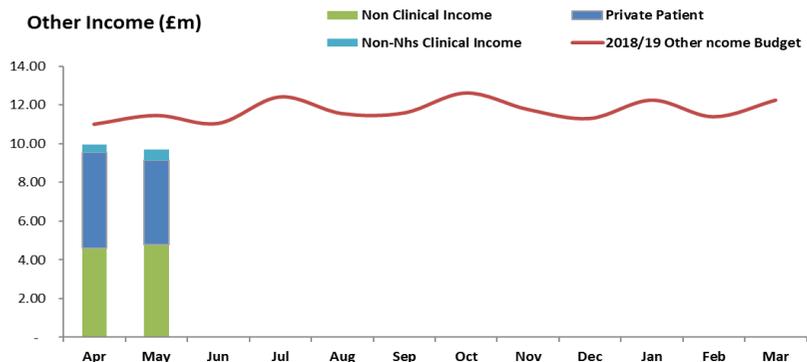
Green
Favourable
Variance to
plan
Amber Adverse
Variance to
plan (< 5%)
Red Adverse
Variance to
plan (> 5% or >
£0.5m)

Summary

- Block contracts for activity have been agreed with NHS England for specialised commissioning and are in the process of being agreed with contracted CCG's. This approach was adopted to mitigate the risk from the implementation of the new patient administration system, EPIC.
- Pass through income is being charged on a cost and volume basis for all commissioners except NHS England where drugs only are on a cost and volume basis. There can be significant variability in these categories and therefore a block was not seen as appropriate due to the potential risk.
- The key driver of the adverse variance of £951k is the under-performance of £1,852 for private patients that is largely due to reduced activity as a result of the implementation of EPIC and Ramadan.
- This adverse variance is offset by increased pass through drugs income for NHS England. This value is currently based on an estimate for May and may be subject to change when refreshed in June.

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	£5,731	£4,386	(£1,345)	£11,189	£9,337	(£1,852)	R	
Non NHS Clinical Income	£4,887	£378	£529	£151	£742	£925	£183	G	
Non-NHS Clinical Income	£74,646	£6,109	£4,915	(£1,194)	£11,931	£10,262	(£1,669)	R	
Education & Training	£8,005	£668	£626	(£42)	£1,286	£1,259	(£27)	G	
Research & Development	£26,282	£2,193	£2,099	(£94)	£4,366	£4,432	£66	G	
Non-Patient Services	£1,001	£83	£57	(£26)	£162	£88	(£74)	A	
Commercial	£1,609	£133	£109	(£24)	£260	£232	(£28)	G	
Charitable Contributions	£10,716	£877	£980	£103	£1,724	£1,336	(£388)	A	
Other Non-Clinical	£18,401	£1,397	£1,279	(£118)	£2,737	£2,419	(£318)	A	
Non Clinical Income	£66,014	£5,351	£5,150	(£201)	£10,535	£9,766	(£769)	R	



RAG Criteria:

Green Favourable YTD Variance
Amber Adverse YTD Variance (< 5%)
Red Adverse YTD Variance (> 5% or > £0.5m)

Summary

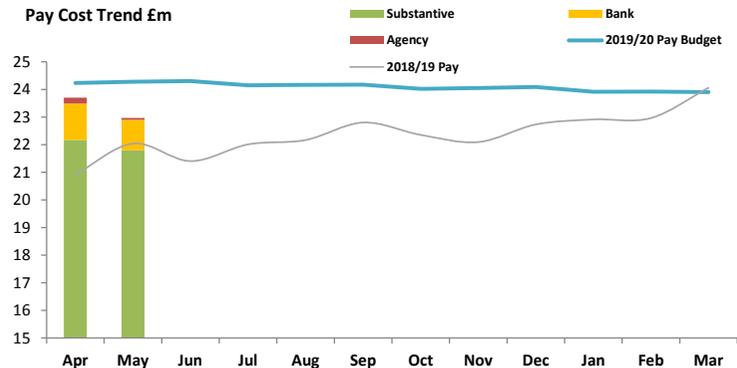
- Private patient income is adverse to plan YTD (£1.9m) due to lower than expected bed occupancy caused by referrals rates into the Trust. This is a further deterioration from Month 1 where this income was £0.5m lower than plan, bringing the YTD position to £1.9m adverse to plan.
- Charitable contributions are £0.4m adverse to plan due to timing of spend on approved projects.
- Other Non-Clinical income is adverse to plan YTD (£0.7m) due to underperformance on work for other Trusts and commercial funding schemes across the organisation.
- Project DRIVE is underperforming against its commercial income target (£0.2m).

Workforce Summary for the 2 months ending 31 May 2019

*WTE = **Worked WTE**, Worked hours of staff represented as WTE

£m including Perm, Bank and Agency	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)	9.9	1,214.2	48.7	8.4	1,131.9	44.8	1.4	82.3	0.7	0.8	G
Consultants	9.0	368.0	146.7	8.6	348.8	147.5	0.4	19.3	0.5	(0.0)	G
Estates & Ancillary Staff	0.8	146.8	33.4	0.7	129.2	33.5	0.1	17.6	0.1	(0.0)	G
Healthcare Assist & Supp	1.6	305.6	32.1	1.5	283.2	32.2	0.1	22.4	0.1	(0.0)	G
Junior Doctors	4.6	381.9	72.5	4.5	336.7	80.7	0.1	45.3	0.5	(0.5)	G
Nursing Staff	13.9	1,623.9	51.4	13.5	1,550.9	52.4	0.4	72.9	0.6	(0.3)	G
Other Staff	0.1	10.0	55.3	0.1	8.3	55.4	0.0	1.7	0.0	(0.0)	G
Scientific Therap Tech	8.5	948.4	53.6	8.8	944.0	55.8	(0.3)	4.4	0.0	(0.3)	A
Total substantive and bank staff costs	48.4	4,998.8	58.1	46.2	4,733.0	58.5	2.2	265.7	2.6	(0.3)	G
Agency	0.6	56.5	61.6	0.3	32.9	49.8	0.3	23.6	0.2	0.1	G
Total substantive, bank and agency cost	49.0	5,055.2	58.1	46.4	4,765.9	58.5	2.5	289.3	2.8	(0.3)	G
Reserve*	(0.5)	(75.5)	0.0	0.2	0.0	0.0	(0.7)	(75.5)	(0.7)	0.0	R
Total pay cost	48.5	4,979.7	58.4	46.7	4,765.9	58.7	1.8	213.8	2.1	(0.2)	G
Remove Maternity leave cost				(0.6)			0.6			0.6	G
Total excluding Maternity Costs	48.5	4,979.7	58.4	46.1	4,765.9	58.0	2.4	213.8	2.1	0.3	G

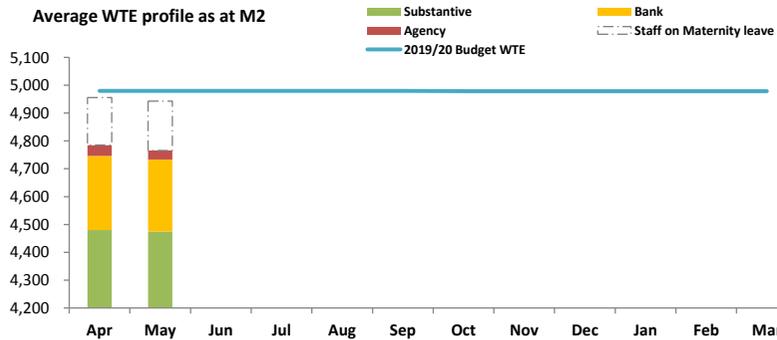
*Plan reserve includes WTEs relating to the better value programme



RAG Criteria:
Green
Favourable
Variance to plan
Amber Adverse
Variance to plan
(< 5%)
Red Adverse
Variance to plan
(> 5% or >
£0.5m)

Summary

- YTD pay spend is £46.7m which is £1.8m 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 (£2.1m).
- 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 176.7 average contractual WTE for staff on maternity leave which have cost £0.6m YTD. If this cost is excluded then the average cost per WTE is lower than plan by £0.4k per WTE.
- The reserve line contains the unidentified pay better value target and the plan for the apprenticeship levy which is offsetting part of 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.

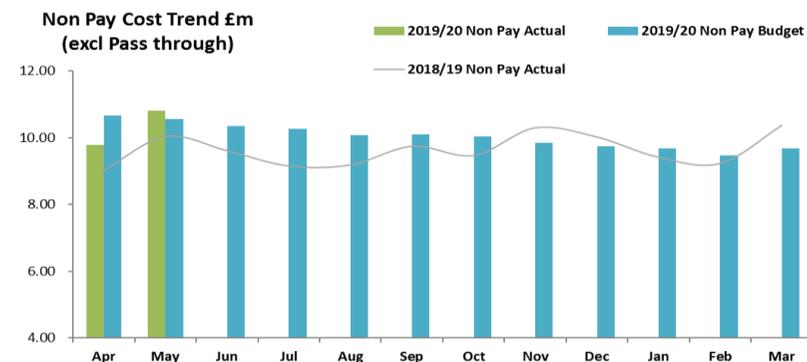


Non-Pay Summary for the 2 months ending 31 May 2019

Non-Pay Costs (excl Pass through) YTD				
	Budget (£m)	Actual (£m)	Variance	RAG YTD Actual variance
Drugs Costs	1.90	1.44	0.47	G
Blood Costs	0.34	0.33	0.01	G
Business Rates	0.70	0.70	0.00	G
Clinical Negligence	1.14	1.14	0.00	G
Supplies & Services - Clinical	7.56	6.75	0.81	G
Supplies & Services - General	0.87	0.76	0.12	G
Premises Costs	6.08	6.15	(0.07)	A
Other Non Pay	2.63	3.32	(0.68)	R
Total Non-Pay costs	21.22	20.57	0.65	G
Depreciation	3.78	3.78	0.00	G
PDC Dividend Payable	1.33	1.33	(0.00)	G
Total	26.33	25.68	0.64	G

Top 5 YTD Clinical* Non Pay overspends by Speciality (£m)				
	YTD 2019/20 Budget (£k)	YTD 2019/20 Actual (£k)	Variance (£k)	Trend
Haematology/Oncology	482	599	(117)	→
General Paediatrics	17	81	(64)	→
Medical Endocrinology	173	219	(46)	↑
Audiology	274	314	(40)	↑
Anaesthesia	5	25	(20)	→

Top 5 YTD Clinical* Non Pay underspends by Speciality (£m)				
	YTD 2019/20 Budget (£k)	YTD 2019/20 Actual (£k)	Variance (£k)	Trend
Theatre	1,402	1,181	222	↑
Clinical Immunology	344	203	141	↑
Cardiac Serv & H&L Central Bud	885	764	121	→
Nephrology	554	458	96	↑
Pharmacy	198	117	81	→



Summary

- YTD non-pay excluding pass through is favourable to plan (£0.6m). The key drivers behind this variance are the underspends on clinical supplies and drugs partially offset by the unidentified Better Value non-pay target.

Top 5 clinical over/under spends

The key areas with Non-pay overspends are:

- Haematology/Oncology** – Non Pay budget includes the Blood Cells and Cancer unidentified better value target which is the main driver for the overspend variance.
- General Paediatrics** - Majority of the overspend relates to chemical pathology recharges. A portion of this is following EPIC go-live and there is a review ongoing as to whether cost should relate to the admitting consultant specialities rather than General Paediatrics.
- Medical Endocrinology** - Mainly due to the overspend on chemical pathology for recharges following EPIC go-live.
- Audiology** – Overspend is on devices but in line with an over-performance on activity YTD.
- Anaesthesia** - Additional costs associated with Pathology use across the speciality linked to activity.

The key areas of Non-pay underspends are:

- 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
- Cardiac and H&L central Budget**- Driven by drugs expenditure estimates post EPIC implementation being below plan
- Nephrology** - Outpatient drugs underspent due to lower than expected activity post-EPIC
- Pharmacy** - Waste and expired stock were lower than expected. Drugs are continuing to be counted and updated to endure accurate values post EPIC Go live.

RAG Criteria:

- Green Favourable YTD Variance
- Amber Adverse YTD Variance (< 5%)
- Red Adverse YTD Variance (> 5% or > £0.5m)

*Clinical non-pay excludes passthrough

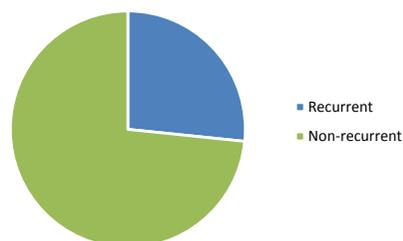
Better Value Summary						
DIRECTORATE	YTD performance £000's			Better Value Total £000's		
	YTD plan	YTD delivery	YTD variance	Better Value target	Unidentified target	Schemes identified
Blood Cells & Cancer	301	4	(297)	1,803	(1,778)	25
Body Bones & Mind	312	0	(312)	1,873	(1,873)	0
Brain	226	0	(226)	1,357	(1,315)	42
Clinical & Medical Operations	93	36	(57)	556	156	712
Corporate Affairs	21	1	(20)	127	28	155
Finance	48	50	2	289	152	441
Genetics Laboratory Hub	73	73	0	440	0	440
Heart & Lung	610	100	(510)	3,657	475	4,132
HR	48	29	(19)	290	8	298
ICT	112	0	(112)	671	(39)	632
IPP	157	0	(157)	944	0	944
Medical Director	29	0	(29)	173	(173)	0
Medicines Therapies & Tests	417	12	(405)	2,501	(2,308)	193
Nursing and Patient Experience	25	2	(23)	150	(116)	34
Operations & Images	376	8	(368)	2,257	(1,907)	350
Estates and Facilities	234	6	(228)	1,404	(697)	707
Built Environment	8	0	(8)	50	0	50
Sight & Sound	168	1	(167)	1,009	(859)	150
Central	75	75	1	447	0	447
Better Value phasing	(1,838)	0	1,838	0	0	0
Total	1,495	398	(1,097)	19,998	(10,246)	9,752
Vacancies		1,097	1,097	0	0	0
Total Better Value	1,495	1,495	(0)	19,998	(10,246)	9,752

Summary

- The Better Value program is only currently delivering £0.4m of the £1.5m YTD target at month 2. The rest of the delivery is being covered by Pay vacancies across the organisation.
- The Trust has identified better value savings (£9.8m) that have been removed from the Trust budgets. Additional saving plans have been worked up (£5.0m), these require additional work to remove from the Trust plans on a recurrent basis.
- Without the Trust vacancies supporting the Trust better value program the program would be £1.1m behind target. With the staffing posts in the Trusts plans these savings can only be recognised on a non recurrent basis which will add pressure onto the 2020/21 finances of the Trust.
- The Better Value program phasing can be seen in the graph below. This shows that the Better Value target increases significantly each quarter. It is therefore important that the savings across the organisation increase to cover the increased targets in later months.
- Savings across the Trust have been phased according to directorate plans and so a delivery central phasing adjustment has been made.

Recurrent / Non-recurrent	
	YTD 2019/20 Actual (£k)
Recurrent	398
Non-recurrent	1,097
Total Better Value	1,495

Recurrent / Non-recurrent split



Better Value Plan vs Actual (excl. non-recurrent)



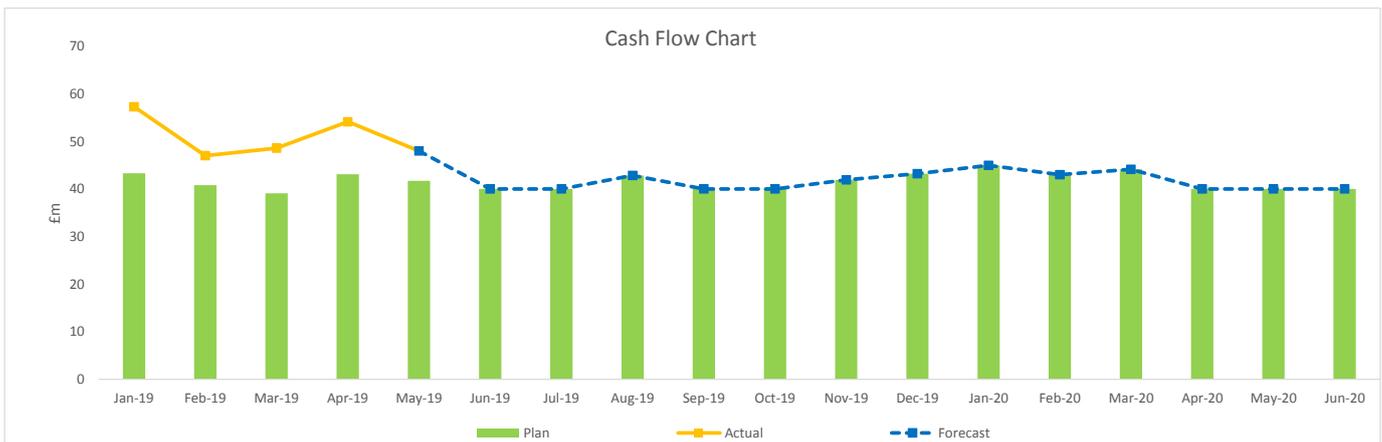
31 Mar 2019 Audited Accounts £m	Statement of Financial Position	Plan 31 May 2019 £m	YTD Actual 31 May 2019 £m	YTD Variance £m	Forecast Outturn 31 Mar 2020 £m	YTD Actual 30 Apr 2019 £m	In month Movement £m
499.04	Non-Current Assets	508.71	505.70	(3.01)	538.60	504.33	1.37
103.55	Current Assets (exc Cash)	87.87	100.92	13.05	88.79	99.79	1.13
48.61	Cash & Cash Equivalents	41.74	48.00	6.26	44.11	54.17	(6.17)
(74.89)	Current Liabilities	(62.46)	(79.47)	(17.01)	(66.27)	(82.24)	2.77
(5.01)	Non-Current Liabilities	(4.77)	(4.75)	0.02	(4.87)	(4.78)	0.03
571.30	Total Assets Employed	571.08	570.40	(0.68)	600.36	571.27	(0.87)

31 Mar 2019 Audited Accounts £m	Capital Expenditure	Plan 31 May 2019 £m	YTD Actual 31 May 2019 £m	YTD Variance £m	Forecast Outturn 31 Mar 2020 £m	RAG YTD variance
5.81	Redevelopment - Donated	3.99	3.44	0.55	35.25	A
9.06	Medical Equipment - Donated	3.49	1.00	2.49	9.30	R
9.78	ICT - Donated	2.05	2.05	0.00	2.17	G
24.65	Total Donated	9.53	6.49	3.04	46.72	A
6.99	Redevelopment & equipment - Trust Funded	1.44	0.95	0.49	8.90	A
1.61	Estates & Facilities - Trust Funded	0.74	0.20	0.54	3.06	R
4.73	ICT - Trust Funded	1.86	2.40	(0.54)	9.40	A
0.00	Contingency	0.55	0.00	0.55	0.47	R
13.33	Total Trust Funded	4.59	3.55	1.04	21.83	A
37.98	Total Expenditure	14.12	10.04	4.08	68.55	A

31-Mar-19	Working Capital	30-Apr-19	31-May-19	RAG	KPI
20.00	NHS Debtor Days (YTD)	12.0	12.0	G	< 30.0
253.00	IPP Debtor Days	243.0	233.0	R	< 120.0
36.70	IPP Overdue Debt (£m)	36.9	37.2	R	0.0
5.00	Inventory Days - Drugs	N/A	N/A		7.0
94.00	Inventory Days - Non Drugs	92.0	92.0	R	30.0
34.00	Creditor Days	30.0	32.0	A	< 30.0
43.6%	BPPC - NHS (YTD) (number)	43.3%	43.9%	R	> 90.0%
80.3%	BPPC - NHS (YTD) (£)	85.5%	83.8%	R	> 90.0%
85.5%	BPPC - Non-NHS (YTD) (number)	89.3%	86.4%	A	> 90.0%
91.1%	BPPC - Non-NHS (YTD) (£)	94.0%	90.7%	G	> 90.0%

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 behind plan by £4.1m at M2, due to slippage on Estates (£0.5m), Redevelopment (Children's Cancer Centre £1.4m) and Equipment purchases (£2.5m).
- Cash held by the Trust is higher than plan by £6.3m. This is largely due to higher than planned receipts from NHS England (£6.1m)
- Total Assets employed at M2 was £0.7m lower than plan as a result of the following:
 - Non current assets totalled £505.7m (£3.0m lower than plan)
 - Current assets excluding cash less Current liabilities totalled £21.4m (£3.9m lower than plan).
 - Cash held by the Trust totalled £48.0m (£6.3m higher than plan of which £6.1m was received from NHS England ahead of plan)
- Overdue IPP debt increased in month to £37.2m (£36.9m in M1) however there was a reduction in total IPP debt as a result of higher than expected receipts from Embassies in month.
- IPP debtor days decreased from 243 days to 233 days as a result of the overall decrease in IPP debt in month.
- The cumulative BPPC for NHS invoices (by value) decreased in month to 83.8% (85.5% in M1). This represented 43.9% of the number of invoices settled within 30 days (43.3% in M1)
- The cumulative BPPC for Non NHS invoices (by value) decreased in month to 90.7% (94.0% in M1). This represented 86.4% of the number of invoices settled within 30 days (89.3% in M1).
- Creditor days increased in month to 32 days as a result of the increase in unpaid invoices in month which are not yet due.
- Inventory days (drugs) cannot be calculated at month 2 because the value of Pharmacy inventory at 31 May 2019 is not available. Non-drug inventory days remained the same as M01 at 92 days.

Trust Board 18th July 2019	
Better Value Programme	Paper No: Attachment S
Submitted by: Richard Collins, Director of Transformation	
<p>Aims This paper describes progress towards signing off a Better Value programme for 2019/20 and actions being taken to address a remaining gap against the operating plan target.</p> <p>Summary position The scoping and delivery of a full £20m Better Value programme remains a significant challenge and risk for the organisation.</p> <p>Progress has been made to firm up plans reported to the last Board meeting and schemes worth just under £10m have now been signed off and adjusted out of the relevant budgets and cost centres. This figure will increase as further schemes currently on the pipeline are finalised, and the potential total value of the schemes that have been identified to-date remains at some £14m.</p> <p>This paper describes revised arrangements recently implemented and proposed actions to manage and develop the programme going forwards, forming a major component of the portfolio of programmes being managed within the newly-established transformation directorate.</p> <p>Recommendation The Board is asked to note the current position for the 2019/20 Better Value programme and consider this in the overall context of the decisions it will make on the annual operating plan.</p>	
<p>Contribution to the delivery of NHS / Trust strategies and plans The Better Value Programme is a significant contributor to the Trust's overall financial strategy and plans. Delivery of the Better Value target is important in the context of the Trust's overall control total and requirement to move towards delivering a robust ongoing financial surplus. For this reason, the actions described in this report are important and their successful delivery is being closely managed by the Programme Office and Executive team.</p>	
<p>Financial implications Included within the overall Trust position</p>	
<p>Legal issues None</p>	
<p>Who is responsible for implementing the proposals / project and anticipated timescales Director of Transformation & project/programme leads with support of Programme Office</p>	
<p>Who is accountable for the implementation of the proposal / project Director of Transformation</p>	

The Better Value programme 2019/20

Scheme identification

As identified in the programme status report attached to this paper, schemes valued at £9.8m have been signed off into budgets. In addition, schemes valued at a further £0.6m have been approved to go live and will be signed into budgets imminently. These schemes have been signed off through the Trust's Quality Impact Assessment process overseen by the Medical Director and Chief Nurse.

There is a further pipeline of schemes valued at £3.6m which is being firmed up for urgent incorporation into the programme. This figure of £3.6m can be delivered in-year, even though the schemes are still on the pipeline; for example, part of this figure relates to benefits from the new EPR system, and once the attribution of those benefits to individual budget lines is confirmed, the full sum will be counted within 2019/20.

In sum, the total current value of all schemes including the pipeline is £13.9m. The vast majority of these schemes are recurrent, although £0.7m is made from non-recurrent/one-off measures.

Year to-date delivery

Against a year to-date target of £1.5m by the end of month 2, the programme has delivered savings of £0.4m. The adverse variance in large part results from two factors:

- Failure to specify a programme to meet the £20m target in full; and
- Slippage against plans for a significant increase in IPP/PICU activity.

This adverse variance has been mitigated in full by underspends against pay budgets. Further detailed work is now being undertaken with individual directorate, finance and HR teams to understand the extent to which these savings can continue over the remainder of the year.

Actions and next steps to address the remaining gap

The engagement and encouragement of involvement from all staff will be key to the success of the programme going forwards, in parallel with robust programme management arrangements to ensure key milestones are met and arising issues/challenges identified and tackled rapidly.

Staff engagement began in May with two dedicated CEO extraordinary Big briefing meetings attended by several hundred staff. These are being followed by a targeted communication and engagement programme over the summer to raise and maintain awareness, gain support for upcoming projects and empower staff to develop their own local initiatives. A range of excellent ideas have been subsequently submitted by staff, many of which address key themes on environmental sustainability and waste reduction, which is being developed to form an additional cross-cutting theme within the programme. Other opportunities proposed by staff include the development of a GOSH wound care formulary, and review of the Trust's management of beds and mattresses; both of these schemes are being worked up for incorporation.

In addition as noted above, the Trust currently has a substantial underspend against its pay budgets, this mitigating the adverse variance against the Better Value target over the first two months of the year. Further work is being undertaken to confirm the extent to which

such underspends can continue over coming months without adverse impacts on quality and safety, or patient, family and staff experience.

Other initiatives to assist with the identification of further schemes to meet the target in full include piloting local improvement huddle boards to encourage rapid local idea generation and implementation, and ongoing work to identify further opportunities from the Model Hospital and other best practice guidance, combined with analysis of benchmarking information and of PLICS data.

As reported separately to this meeting, Better Value will now form part of the portfolio of programmes reporting to the new Director of Transformation, and will report to the newly-established CEO-chaired Transformation Portfolio Board.

Revised arrangements have also been put in place to manage and develop the programme going forwards, and to provide assurance on programme delivery. To that end:

- Better Value programme financial delivery will be routinely verified and reported by Finance;
- Fortnightly check in meetings have been established with each directorate, including PMO and finance business partners, chief of service, general manager and head of nursing and patient experience. These will cover both milestone and scheme delivery/assurance as well as future programme and ideas generation, including support required to bring these ideas to fruition;
- Directorate positions will be discussed and issues raised by exception to monthly directorate performance review meetings; and
- Assurance will be provided to the Transformation Portfolio Board and Trust Board/sub committees.

Recommendation

The Board is asked to note the current position for the 2019/20 Better Value programme and consider this in the overall context of the decisions it will make on the annual operating plan.

Overall programme status	Red/high risk	Status last month	Red/high risk
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Summary overview

Substantial work is still required to finalise plans for the full £20m contribution, with a remaining £6m gap against the £20m target. The programme therefore presents a significant risk to the Trust's underlying financial position. The majority of schemes identified are recurrent/ongoing in nature, although some £0.7m has been identified through non-recurrent/one-off measures.

The largest risk presented by the programme is that schemes have not yet been identified to meet the £20m target in full. If all identified schemes deliver in full, there remains a £6m gap against the £20m target. The PMO has applied risk adjustments to the programme such that low risk schemes are considered to have a 90% likelihood of full delivery, medium risk have a 75% likelihood, and high risk a 50% likelihood. This adjustment would add a further c£4m risk to year-end delivery, the largest components related to assumed growth in IPP/PICU activity, other additional non-contract activity, and some of the proposed shared service procurement schemes.

New frequent check in meetings have been established with directorates to help generate and develop further ideas, with an emphasis on engaging and encouraging involvement from all staff. That engagement began with two dedicated extraordinary big briefing sessions attended by several hundred staff and we are reviewing the many excellent ideas that our staff have subsequently submitted. There are some key themes on environmental sustainability and waste reduction which align with expectations of our patients and families. A targeted communication and engagement programme is planned to take place through the summer to raise awareness, gain support for upcoming projects and empower our staff to develop their own local initiatives.

Programmes off track

Complete sign off of PODs and QIAs	Significant progress has been made over the past month with additional PODs valued in excess of £6m signed off to go live
Flow/Length of Stay	New flow programme board first met June 2019. Weekly long stay patient meetings with chiefs of service began in May
Procurement	Some shared service schemes not yet signed off into budgets with concerns they may be over-optimistic. Overseen by procurement transformation board
Pharmacy	New schemes under development but attention has needed to focus on pharmacy-specific issues related to bedding in of the new EPR system
IPP/PICU	Early activity has been significantly below target and urgent progress to ramp up activity is now essential as this scheme is a major (£3.5m) contributor to the programme.

Programme dashboard

<p>Scheme sign off</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>Significant gaps remain within the programme both in terms of scoping and sign off. There is an overall gap against the £20m target of ££6m</p> </div>	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Area</th> <th style="text-align: right;">Out of budgets</th> <th style="text-align: right;">Signed off but not out of budgets</th> <th style="text-align: right;">Pipeline being finalised</th> <th style="text-align: right;">Total</th> </tr> </thead> <tbody> <tr> <td>Clinical directorates</td> <td style="text-align: right;">£5,357</td> <td style="text-align: right;">£579</td> <td style="text-align: right;">£736</td> <td style="text-align: right;">£6,672</td> </tr> <tr> <td>Corporate directorates</td> <td style="text-align: right;">£4,420</td> <td style="text-align: right;">£50</td> <td style="text-align: right;">£208</td> <td style="text-align: right;">£4,678</td> </tr> <tr> <td>Cross cutting schemes under development</td> <td style="text-align: center;">-</td> <td style="text-align: center;">-</td> <td style="text-align: right;">£2,641</td> <td style="text-align: right;">£2,641</td> </tr> <tr style="background-color: #0056b3; color: white;"> <td>Total</td> <td style="text-align: right;">£9,777</td> <td style="text-align: right;">£629</td> <td style="text-align: right;">£3,585</td> <td style="text-align: right;">£13,991</td> </tr> </tbody> </table>	Area	Out of budgets	Signed off but not out of budgets	Pipeline being finalised	Total	Clinical directorates	£5,357	£579	£736	£6,672	Corporate directorates	£4,420	£50	£208	£4,678	Cross cutting schemes under development	-	-	£2,641	£2,641	Total	£9,777	£629	£3,585	£13,991
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Clinical directorates	£5,357	£579	£736	£6,672																						
Corporate directorates	£4,420	£50	£208	£4,678																						
Cross cutting schemes under development	-	-	£2,641	£2,641																						
Total	£9,777	£629	£3,585	£13,991																						

Expenditure control

Programmes on long stay and vacancy review well established.



Flow constraint themes are being captured at long stay panel to identify priority opportunities to improve.

Pharmacy has needed to address EPR related issues although progress is also being made on two new schemes.

New work streams around accommodation, patient transport and annual/study leave are being scoped.

Area	RAG	Comment
Length of stay		Analysis to identify priority areas for pathway redesign under way both for long length of stay and for short stays
Pharmacy		EPR issues have required significant attention. Two new schemes being worked up – Parenteral Nutrition and use/holding of oxygen cylinders
Vacancy review		Vacancy control processes well established. Significant underspend on pay budgets over the year to date (not counted against Better Value).
Catering		Procurement Transformation Board has agreed a number of product switches. Further proposals under development
Staff Accom & Family Accom	-	<i>New programme recently proposed to be scoped and added</i>
Transport	-	<i>New programme recently proposed to be scoped and added</i>
Annual leave & Study leave	-	<i>New programme recently proposed to be scoped and added</i>

Commercial

Activity levels significantly below plan YTD



Commercial area	Target	Forecast Y/E	Comment
IPP/PICU	£3,500	TBC	Marketing update from IPP requested
ENT/N Park	£10	TBC	Paperwork subject to finalisation
Total	£3,510		

Other cross cutting

Programmes covering a broad spectrum have been proposed, many of which are progressing.



Over time, tackling areas such as rental accommodation and environment and sustainability may release significant financial efficiencies and lead in times mean the work must start now

Area	RAG	Comment
Flow		First of the new COO chaired Flow Programme Board meetings held in June. Other than length of stay (value £0.6m), flow does not have a separate target this year and is treated as an enabler for other schemes e.g. IPP/PICU
Environment & sustainability		Emerging ideas from the Centre for Sustainable Healthcare include improved theatre ventilation systems, green ward competition and green nephrology programme
eRostering		Majority of nursing staff plus ICT, HR and EPR on Allocate. AHPs and non-clinical staff will be added over June/July, with pharmacy and healthcare scientists to follow in October
Materials management		Rollout programme to core areas well under way. Will be in all wards by July and all theatres by November. Rollout to other areas eg OPD needs further discussion
Equipment replacement		New suggested programme, learning from Carter CIP opportunities report. Requires further scoping with procurement partners
Maintenance contracts		Procurement Transformation Board has established a task and finish group to progress work on maintenance contracts. Requires further scoping
Electronic HR solutions		New suggested programme, learning from Carter CIP opportunities report. Requires further scoping
Rental accommodation		Little/no scope for immediate contribution but planning needs to start now to consider upcoming potential opportunities

Risk summary

Risk ID	Risk description	Score pre mitigation	Score post mitigation	Comment
Programme level risks				
PMO01	There is a risk that staff may not always be fully signed-up to the need to deliver a full £20m programme, believing that things will still work out by the year-end - because they always have before	4Lx5I= 20	2Lx5I= 10	<ul style="list-style-type: none"> Dedicated extraordinary CEO Big Briefings held May 2019; Better Value regularly discussed at Senior Leadership Team; Dedicated meeting with Staff Partnership Forum May 2019.
PMO02	There is a risk of the programme containing unrealistic plans or missing other opportunities if it is too "top down", developed by management without significant engagement from front line	4Lx4I= 16	2Lx4I= 8	<ul style="list-style-type: none"> Reinstatement of business partnering by PMO following successful recruitment will enable it to support directorate teams to engage more staff in Better Value; New communications strategy being developed by PMO to include intranet, toolkits, more local/frontline staff engagement, events in the Lagoon, etc.
PMO03	There is a risk of failure to identify schemes to meet the target in full as well as risks of potential slippage against those schemes that have been identified	5Lx5I= 25	4Lx5I= 20	<ul style="list-style-type: none"> More emphasis being placed on working with ward sisters and service managers to develop new ideas with local staff; Arrangements being finalised to obtain views and input from YPF; Development of local improvement huddle boards to encourage rapid local idea generation and implementation; Continual work to identify further opportunities from Model Hospital and other best practice guidance, combined with analysis of benchmarking information and planned rollout of PLICS pilot; Revised frequent Programme Check In processes with all directorates; Detailed trackers developed for major and higher risk schemes, with updates reviewed at Programme Board; Revised in-year monitoring and performance management arrangements being developed by PMO and finance to ensure earlier identification, escalation and mitigation of emerging issues.
PMO05	There is a risk that schemes could have unintended consequences on patient service quality or safety.	4Lx2I= 8	2Lx2I= 4	<ul style="list-style-type: none"> Existing Quality Impact Assessment overseen by QIA Panel with assurance provided to QSEAC. Each scheme to be accompanied by agreed metrics for ongoing monitoring and rolling programme of deep dives.

Trust Board 18th July 2019	
Safe Nurse Staffing Report for April/May 2019	Paper No: Attachment U
Presented by: Alison Robertson, Chief Nurse.	
Aims / summary <p>This report provides the Board with an overview of the Nursing workforce during the month of April & May 2019 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>	
Action required from the meeting <p>To note the information in this report on safe staffing including:</p> <ol style="list-style-type: none"> 1. That the Trust operated within recommended parameters for staffing levels in both April and May. 2. The adoption of rostering metrics included in this report to ensure maximum benefit is derived from the implementation of HealthRoster & SafeCare. 3. The work to establish an accurate picture of Bank demand. 4. The ongoing work to address retention issues as part of the NHSI Retention Collaborative. 	
Contribution to the delivery of NHS Foundation Trust strategies and plans <p>Safe levels of nurse staffing are essential to the delivery of safe patient care and experience.</p>	
Financial implications <p>Already incorporated into 19/20 Directorate budgets.</p>	
Who needs to be told about any decision? <p>Directorate Management Teams Finance Department Workforce Intelligence</p>	
Who is responsible for implementing the proposals / project and anticipated timescales? <p>Chief Nurse; Assistant Chief Nurse, Director of Education and Heads of Nursing</p>	
Who is accountable for the implementation of the proposal / project? <p>Chief Nurse; Directorate Management Teams</p>	

1. Summary

This report on GOSH Safe Staffing contains information from the months of April & May 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.

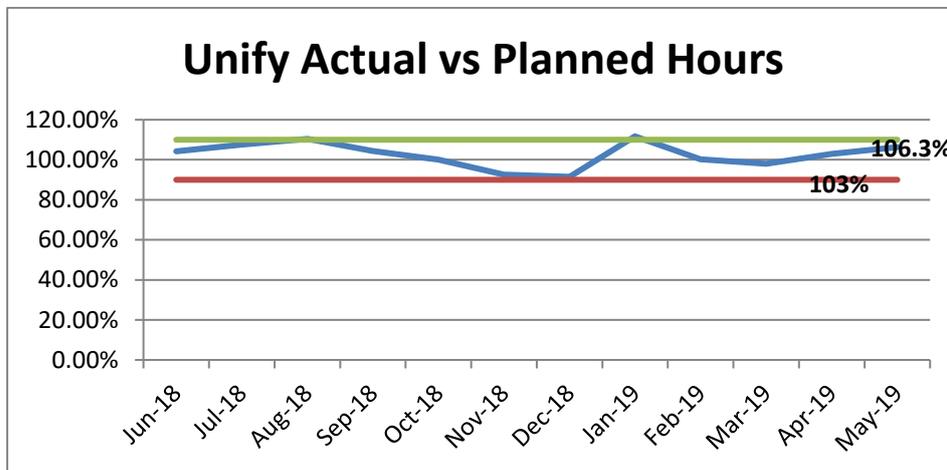
2. Safer Staffing.

2.1 Actual vs Planned

Actual vs Planned (AvP) Hours shows the percentage of Nursing & Healthcare Assistant (HCA) 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 April 2019 the overall fill rate of AvP was 103% which is within the recommended range and an improvement on the same month last year. In May the rate was 106.3%. HCA fill rates at night for May were lower at 77.5%, however Heads of Nursing have verified that despite these lower rates no shifts were unsafe, and local management of available staff resolved any staffing issues.

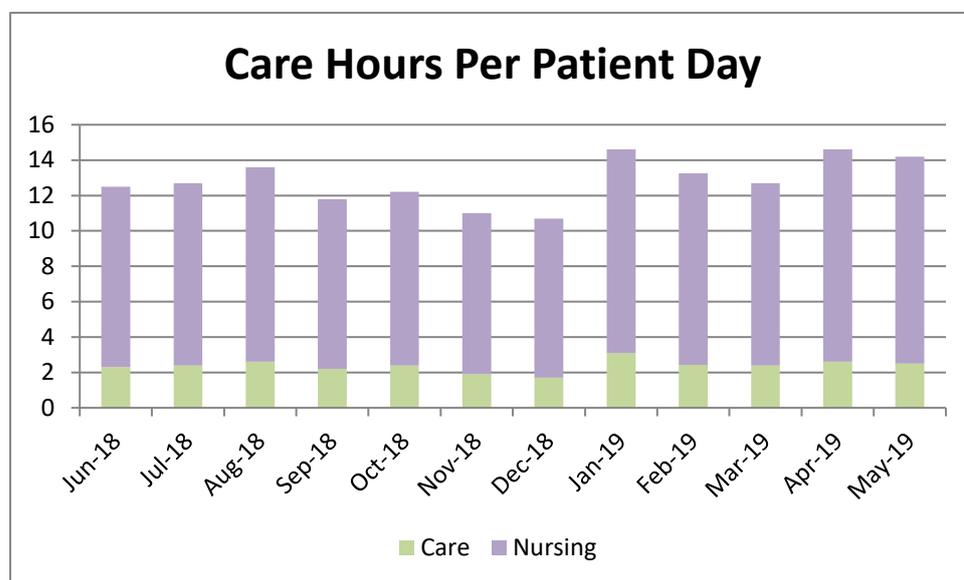
At a Directorate level, both Heart & Lung and International & Private Patients were outside of the recommended parameters in both months, exceeding the 110% upper range. These variances are being explored to ensure their reported plans reflect their current needs.



2.2 Care Hours Per Patient Day (CHPPD)

CHPPD is calculated by adding the hours of registered nurses and healthcare assistants 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 HCAs 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 April 2019 was 14.6 hours, made up of 12 registered nursing hours and 2.6 HCA hours. In May, the figure was slightly lower at 14.2 hours (11.7 RN and 2.5 HCA) however both months are much higher than the 2018/19 average of 12.6 total hours. It is important to note that in April & May, there was a planned reduction in patient activity during the EPIC launch, which will account for the higher than average CHPPD.



2.3 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 rostering team has been working with the EPIC team to develop a workflow between PANDA and EPIC reducing the need for double entries. The EPIC rollout had some impact on Safecare usage with input compliance falling from 88% in March to 36% in April. Remedial action and retraining of ward staff has improved compliance in May to 87%.

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. The SafeCare metric in the Rostering Scorecard will be included from June and will indicate staffing against acuity imbalances.

3. Workforce Utilisation.

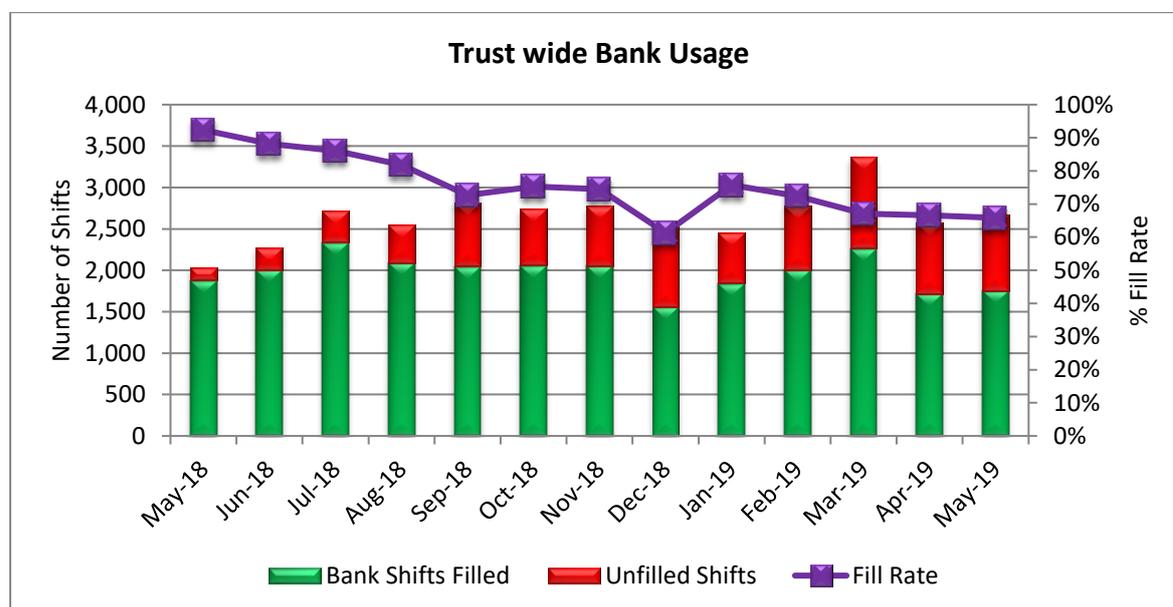
3.1 Rostering

Now all Nursing units are managing their staffing through HealthRoster, the Trust has relaunched its Rostering Scorecard which will report KPI's as previously reported in the last Board paper on a monthly basis at a ward level. Performance against these

measures will be used as the basis for identifying areas that require further support and training to realise the benefits of the new system. The information is measured against a 4 week roster period rather than a calendar month.

Metric	Target	April roster	May roster
Advance Publication of a roster.	42 days +	27	29
Time Balances.(Hours per WTE)	+/- 12 hrs	7.5	8.7
% Annual Leave Unavailability	15-20%	11.2%	12.2%
Demand vs Budget. (WTE)	0	116	171
Additional shifts created	0	991	892
% Staff working fair proportion of night and weekend duties	50%+	46%	43%
Safecare Acuity & Staffing Utilisation.	tbc	tbc	tbc

3.2 Temporary Staffing



Requested shifts during April (2,572 requests) and May (2,685 requests) continued to be higher than the long term average in April and May, although were lower than the March peak. The fill rate continued to be lower than the long term average at 67% and 66%. The ICUs in particular have seen a significant increase in requests over the last year (May-19: 754 /May-18: 478).

The increase in unfilled shifts and increase in requests is being explored to understand why there has been such a change over the last year. A new

Temporary Staffing working group has been established by HR with Nursing participation to look at reasons and make recommendations for improvement.

Agency nursing usage in the Trust remains well controlled. In May there were 14 RMN shifts supplied by Agency staff as specialist support skills were required, while there was a single Agency shift in April.

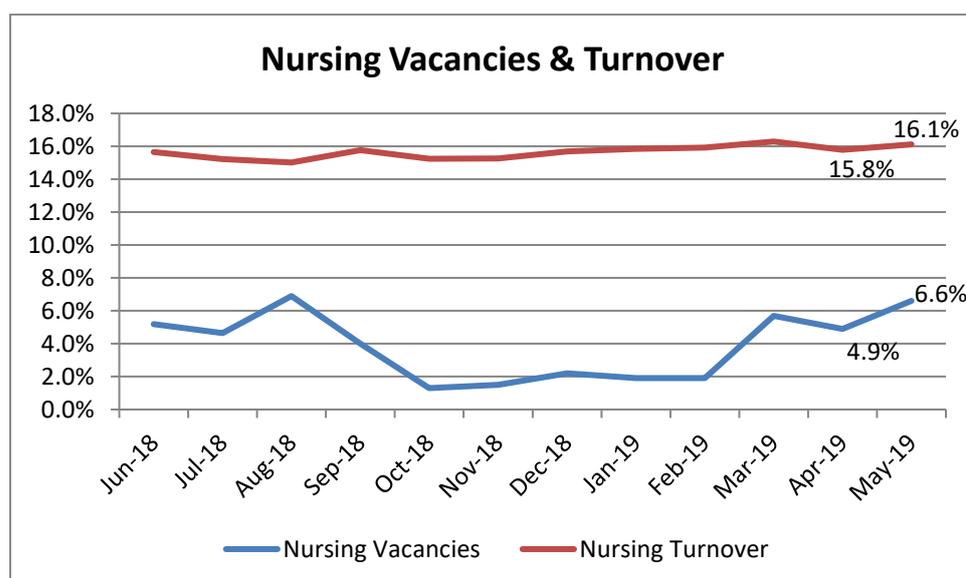
3.3 Vacancies & Recruitment

The Trust Nursing Vacancy rate for April was 4.9% (79.1 WTE) and had increased in May to 6.6% (108.1 WTE). This was in part due to increased turnover and in part slight increases to the 2019/20 finance budgets. Nursing vacancy rates remain highest in IPP (31 WTE 27.3% in May), Body, Bones & Mind (21.4 WTE, 8.5%), Operations & Images (17.9 WTE, 8.9%) and Heart & Lung which saw an increase between April and May of 2.5% (24.4 WTE, 4.6% in May) due to increased turnover.

Band 6 Vacancies remains above the Trust target and average at 71.9 (13%). 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 a business case to address areas of specific need and establish the cost effectiveness and efficacy of an international recruitment strategy.

Healthcare Assistants vacancies are for May are 8.5% (25.5 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.



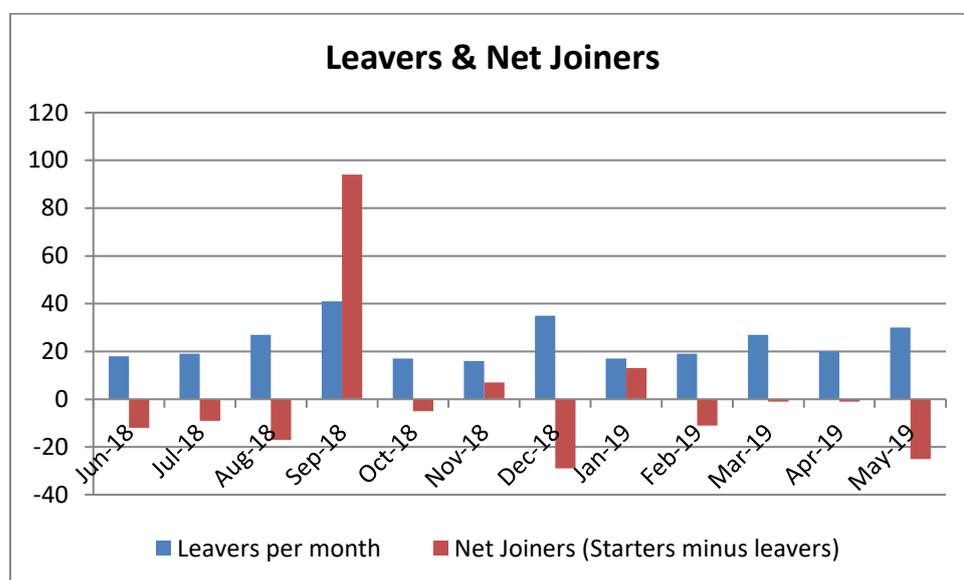
3.3 Retention

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 and workstreams supporting the 4 pillars have been established with nursing participation across all levels of the organisation.

The Trust has a 2019/20 (Q1) target of 13.75% Voluntary turnover, however the performance for April was 15.8%, which increased to 16.1% in May. Band 5 turnover remains significantly above the RN average at 23.4% in May. The Trust had 30 leavers in May (20 in April), and only 5 starters so had a net joiner rate of -25. Analysis of the net joiner data over the last 12 months indicates that only in 3 months of the year did the Trust have more joiners than leavers reflecting the major intake of Band 5 Nurses in the NQN recruitment drives.

Of the known reasons for leaving, relocation and promotion remain the most common given.



4. Patient Safety & Datix

As reported in the last board report (May 2019) the implementation of EPIC continued to have an effect on staffing as all nursing staff were required to undergo mandatory training prior to the launch.

Whilst planned activity levels were deliberately reduced in the weeks following 'Go Live', staffing levels remained either the same (or higher) in order to safely manage the transition.

There were two reported datix incidents in relation to nurse staffing in April, both were appropriately managed and escalated.

There were 9 reported incidents in May across 7 different clinical areas. Bumblebee and Hedgehog wards have temporarily merged due to recruitment issues for both doctors and nurses. It is evident in other datix that nursing staff were still managing the implementation of EPIC. All shifts were managed appropriately with remedial action being taken.

Appendix 1: April & May Workforce metrics by Directorate

Directorate	Actual vs Planned %	CHPPD (exc ICUs)	RN Vacancies (FTE)	RN Vacancies (%)	Voluntary Turnover %	Sickness %	Maternity %
Blood, Cells & Cancer	100.3%	14.3	9.5	4.1%	15.4%	2.8%	2.6%
Body, Bones & Mind	100.2%	13.7	16.8	6.6%	11.5%	2.6%	5.9%
Brain	91.1%	12.5	7.0	5.5%	16.9%	2.8%	5.3%
Heart & Lung	113.9%	14.8	11.3	2.1%	16.8%	3.5%	4.2%
International & PP	116.1%	12.4	28.3	24.9%	26.2%	4.3%	5.9%
Operations & Images	-	-	13.9	6.9%	10.0%	4.2%	2.0%
Sight & Sound	92.2%	8.8	6.6	11.7%	16.8%	3.1%	5.4%
Trust	103.0%	13.1	79.1	4.9%	15.8%	3.1%	4.1%

April Nursing Workforce Performance

Directorate	Actual vs Planned %	CHPPD (exc ICUs)	RN Vacancies (FTE)	RN Vacancies (%)	Voluntary Turnover %	Sickness %	Maternity %
Blood, Cells & Cancer	104.7%	15.3	11.9	5.1%	15.1%	2.9%	2.6%
Body, Bones & Mind	98.1%	12.7	21.4	8.5%	12.9%	2.6%	6.0%
Brain	98.0%	13.4	6.6	5.1%	15.4%	2.7%	5.3%
Heart & Lung	119.3%	15.3	24.4	4.6%	16.9%	3.5%	4.2%
International & PP	122.1%	13.9	31.1	27.3%	29.6%	4.4%	6.0%
Operations & Images	-	-	17.9	8.9%	11.0%	4.4%	2.8%
Sight & Sound	94.2%	12.2	6.7	11.9%	15.1%	3.3%	5.4%
Trust	103.0%	14.3	108.1	6.6%	16.1%	3.2%	4.4%

May Nursing Workforce Performance

Trust Board 18th July 2019	
<p>Learning from Deaths. Mortality Review Group - Report of deaths in Q4 2018/2019</p> <p>Submitted by: Dr Sanjiv Sharma, Interim Medical Director. Dr Isabeau Walker, Consultant Anaesthesia and co-chair of the MRG. Dr Finella Craig, Palliative Care Consultant & Co-Chair of MRG</p>	Paper No: Attachment W
<p>Aims / summary 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 an executive summary of a report that was reviewed at the July 2019 Patient Safety and Outcomes Committee. The report highlights two cases where there is learning that should be shared across the organisation. The Patient Safety and Outcomes Committee has agreed those learning points should be taken to Closing the Loop to identify appropriate mechanisms to share them across the organisation.</p>	
<p>Action required from the meeting The board is asked to note the content of the paper.</p>	
<p>Contribution to the delivery of NHS Foundation Trust strategies and plans 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? 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 Q4 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 Medical Director has convened a short life working party to implement the guidance with project management support provided by Emma Scott (Quality Improvement Manager). The target date for completion of the project is August 2019 when the project manager post ends. Funding has been identified for a Mortality Coordinator post and CDR Chair roles. The MRG reporting tool has been aligned with the new Child Death Review analysis form and a new mortality reporting form is being piloted at local M&M meetings. The Mortality Coordinator post (administrative, still to be appointed) will be critical for the smooth running of the process. The CDR Chairs are to be formally appointed (in progress).

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 January and 31st March 2019

Headlines

Twenty nine children died at GOSH between 1st January and 31st March 2019. 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 use of a bougie (a thin, flexible instrument used as a guide for a tracheal tube) may have contributed to pneumothorax, which may have been the precipitating factor in the child's cardiac arrest. The Trust wide learning is that the use of a bougie may cause pneumothorax in any patient and that bougies must be used with particular care in small infants.
- An infant with spinal muscular atrophy receiving treatment with a new drug as part of a clinical trial was admitted from clinic for respiratory support. The child's clinical condition improved so respiratory support was not commenced. The child was subsequently discharged back to a hospital nearer their home and had an abrupt deterioration there the following morning. It was felt by the neuromuscular and respiratory teams that had the non-invasive ventilation been instituted at GOSH this might have avoided the deterioration that subsequently occurred. Respiratory support in this setting is aimed as a

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

pre-emptive treatment to prevent deterioration. This case has prompted multidisciplinary discussions to ensure that a clear treatment pathway is established to support this new service, including specified HDU beds. The Trust wide learning is that patients who are discharged from ICU should ideally be monitored in a step-down unit before discharge, particularly if they have co-morbidities. The multidisciplinary team looking after the child should be involved in discharge planning.

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 January and 31st March 2019	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	3
Number of deaths of people with learning disabilities that have been reviewed	3
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 notifications requiring submission
May 2017 to 31st March 2019	9	7	Two are in the process of being submitted by the CNS for Learning Disabilities

Learning points for deaths occurring in Q4 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.

The Q3 Learning from Deaths Report highlighted that in some cases the Medical Certificate of Cause of Death (MCCD) is incorrect. The report recommended that the completion of the MCCD is considered as a potential Trust-wide quality improvement project in 2019. The cases reviewed in Q4 2018/19 continue show errors in completion of the MCCD. A process for supporting improvement has been discussed at the Closing the Loop group.

Year of pt death	% of MCCDs reviewed by MRG which were appropriate
2016	72%
2017	75%
2018	80%
2019	50%

Epic learning

Incorrect information in the electronic medical record will be carried forward through the record. It is important to edit information to make sure it is accurate.

Resuscitation decisions

The Trust has adopted the national ReSPECT process (Recommended Summary Plan for Emergency Care and Treatment) to facilitate communication between medical professionals in different settings and families as part of advanced care planning. This can be a difficult process for parents and they may change their minds, particularly about resuscitation decisions. It is important to consider arranging an MDT when resuscitation decisions are made/changed so that all teams are aware and messages are consistent and appropriate. Where a change is made, the resuscitation status should be updated in the appropriate tag on EPIC

Critically ill patients

Moving critically ill patients between different locations can be a challenge. Good communication, teamwork and use of safety checklists helps to reduce the risks.

Gastric aspiration on induction of anaesthesia can cause serious morbidity - appropriate precautions must be taken. This includes adherence to standard starvation guidelines and in the event of an emergency or delayed gastric emptying/bowel obstruction, use of modified rapid sequence induction and intubation.

It is important to access an interpreter at an early stage for all families where English is not their first language, particularly if their child becomes acutely unwell and there is potential for rapid deterioration. This will help parents to participate effectively in the child's care at a critical time.

It is essential to counsel parents effectively if ECMO is to be offered, particularly where this involves transfer from a local centre to GOSH. Decisions regarding the suitability of ECMO as a treatment option must involve the CICU team

Bougies and the risk of pneumothorax , particularly in small infants

In one case the use of a bougie may have contributed to pneumothorax, which may have been the precipitating factor in the child's cardiac arrest. The Trust wide learning is that the use of a bougie may cause pneumothorax in any patient and that bougies must be used with particular care in a small infant.

Establishing new care pathways

An infant with SMA type 1 receiving treatment with nusinersin as part of a clinical trial was admitted from clinic for respiratory support. The child's clinical condition improved so respiratory support was not commenced. The child was subsequently discharged back to a hospital in the north of England, nearer their home and had an abrupt deterioration there the following morning. It was felt by the GOSH neuromuscular and respiratory teams that had the non-invasive ventilation been instituted at GOSH this might have avoided the deterioration that subsequently occurred. Respiratory support in this setting is aimed as a pre-emptive treatment to prevent deterioration rather than a response to physiological deterioration and is unique to this group of neuromuscular patients. This case has prompted multidisciplinary discussions to ensure that a clear treatment pathway is established to support this new neuromuscular/ respiratory service, including specified commissioned HDU beds.

4th July 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 18th July 2019	
Guardian of Safe Working report Submitted by: Dr Renée McCulloch, Guardian of Safe Working	Paper No: Attachment X
Aims / summary This report is the first quarter report of 2019/20 to the Board regarding Junior Doctor working practice at GOSH. This report covers the period 1 st April to 30 th June 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	

Guardian of Safe Working First Quarter: 1st April – 30th June 2019

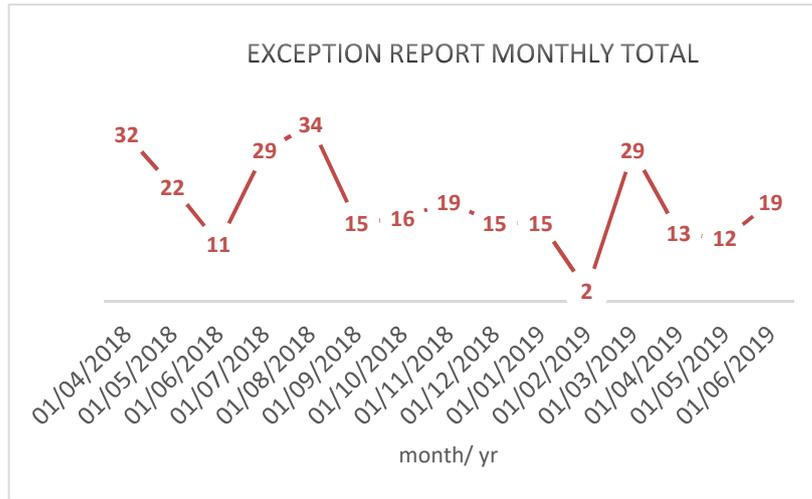
1. Purpose

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.

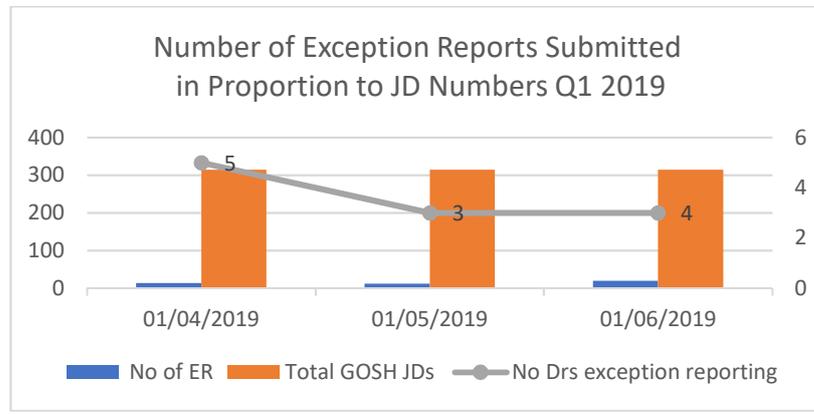
2. Background: See Appendix 1

3. High Level Data:

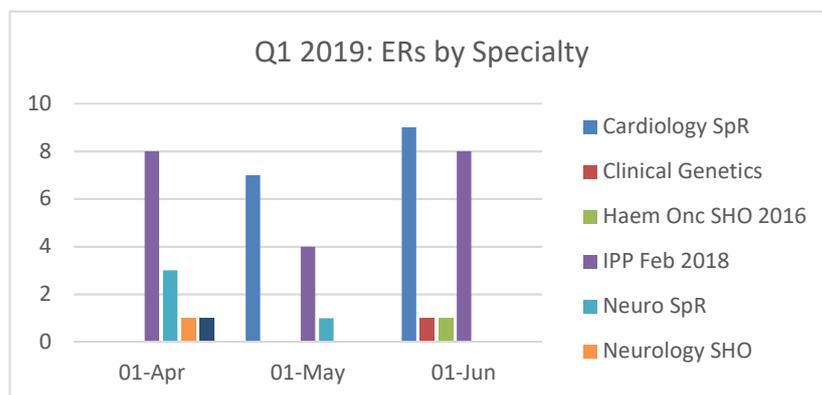
3.2. Number of exception reports (ER) at GOSH remain relatively low.



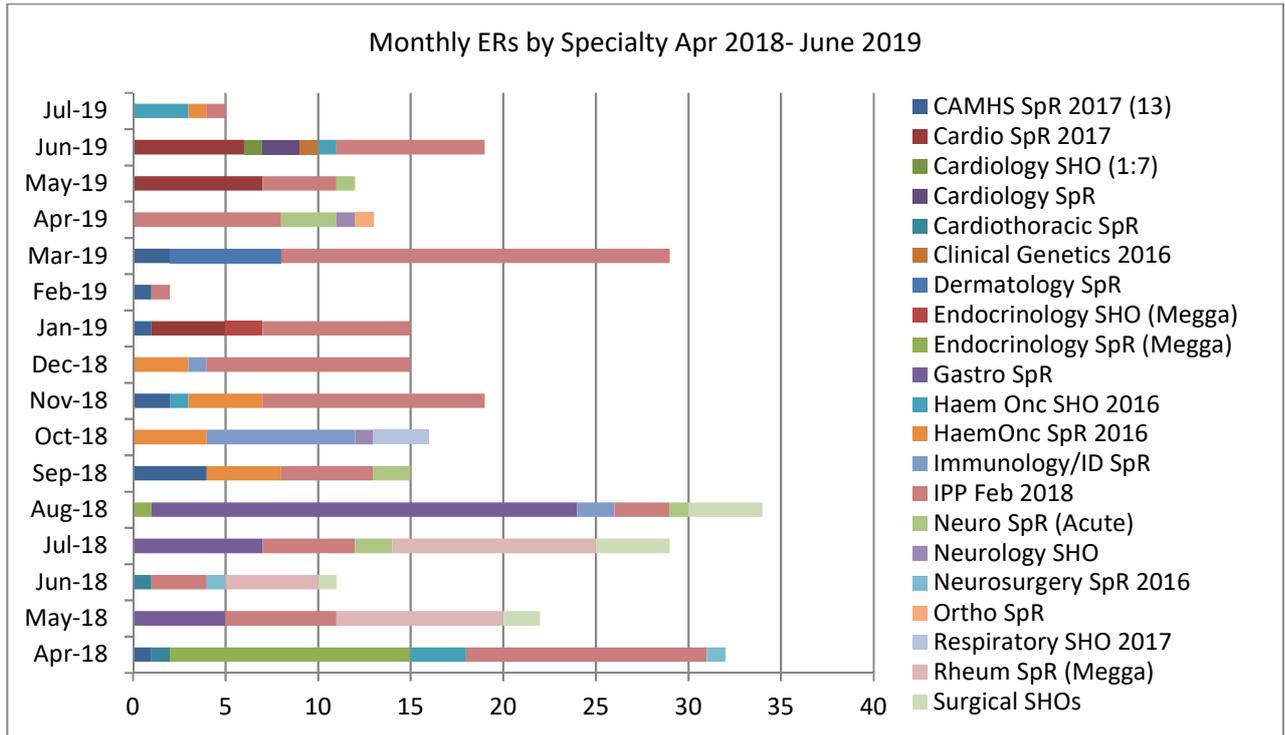
3.3. Numbers of doctors submitting reports as a proportion of total remains very low. All 44 ERs in this quarter are for extra hours worked.



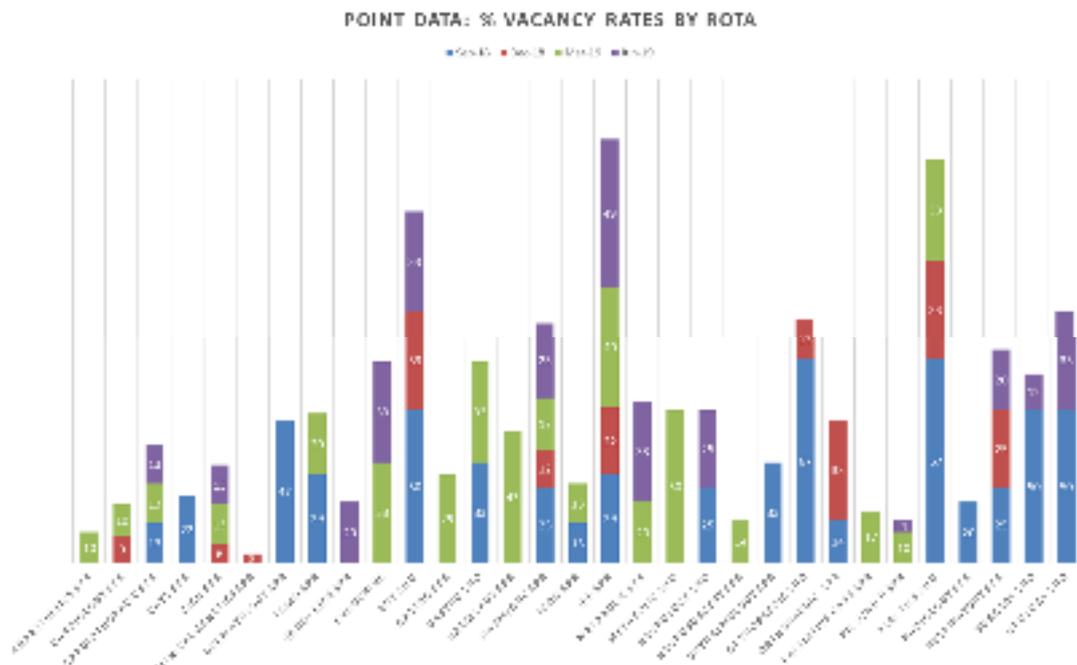
3.4. International private patients SpR and cardio SpR (specifically pulmonary hypertension) are the two specialties submitting the majority of ERs this quarter



3.5. Overall there are a diverse number of doctors from all specialties exception reporting



3.6. GOSH vacancy rates remain less than the national average however the impact of rota gaps on departments can be significant if the gaps are ongoing and involving both SHOs and SpRs in the same department. **Current overall vacancy rate is 7% with 20 FTE posts unfilled out of a total of 282 slots.**



4. Exception Reports

4.2. ER Narratives:

- 'workload not manageable – only Fellow ...colleague off on long term sick leave'
- 'overtime as no one to hand over to on time'
- 'too many sick patients on ...ward but inadequate numbers of doctors'
- 'huge workload, complicated patient to theatre'
- 'stayed late to complete admin tasks'

4.3. Exception Report Outcomes

Exception Report Outcomes April to June 2018 incl.					
Compensation with payment	TOIL	Work schedule review	Unresolved	Pending ES meeting	Level 1 review
39	1	2 (with GOSW)	1	3	-

Financial compensation has been paid to most doctors submitting an ERs. Time off in lieu is often unachievable particularly if a rota is short staffed. GoSW has supported two doctors and educational supervisors with work schedule reviews. Issues have been raised with Chiefs of Service.

5. Vacancy Spend – monthly with reference to rota

1st May 2019 to 31 May 2019			1st April 2019 to 30 April 2019			1st June 2019 to 30th June 2019		
Specialty	Number of Shifts	Cost	Specialty	Number of Shifts	Cost	Specialty	Number of Shifts	Cost
CATS	5	3,522.38	CATS	4	£2,322.22	CATS	3	£1,893.75
CICU	5	3,142.78	CICU	11	£6,969.00	CICU	10	£6,262.00
Haematology/Oncology	93	34,870.25	Haematology/Oncology	94	£39,148.44	Haematology/Oncology	81	£37,942.54
MEGGA	130	47,064.46	MEGGA	95	£39,050.55	MEGGA	118	£44,874.03
Neurology	29	9,462.59	Neurology	21	£8,823.51	Neurology	29	£11,869.30
Neurosurgery	6	1,887.66	NeuroResp Nights	5	£3,282.50	Neurosurgery	3	£1,969.50
NICU PICU ICON	10	6,235.91	NICU PICU ICON	5	£3,282.50	NICU PICU ICON	5	£2,446.74
Plastic Surgery	3	1,665.00	Plastic Surgery	4	£1,452.00	Plastic Surgery	79	£31,891.88
Respiratory Medicine	10	2,831.78	Respiratory Medicine	7	£2,222.01	Respiratory Medicine	5	£2,446.74
Surgery SHOs	44	16,311.87	Surgery SHOs	73	£24,798.38	Surgery SHOs	79	£31,891.88
Surgery SpRs	7	3,962.00	Surgery SpRs	1	£707.00			
Grand Total	342	130,956.68	Grand Total	320	£132,058.11	Grand Total	328	£139,149.74

6. Compliance with 2016 TCS

GOSH is compliant with the 2016 TCS with current ERs to date. No fines have been levied. 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.

7. JD 24/7 Task Finish Group

The Junior Doctors 24/7 'round-the-clock' (JD24/7) task and finish group was commissioned by Medical Director in response to issues raised through the Guardian of Safe Working. The group aims to devise and propose models and rota systems in GOSH with a focus on out of hours work.

7.2. Rota remodel

The JD24/7 group have developed, proposed and gained approval for a new rota to be implemented across eleven departments in September 2019. This work is a direct response to concerns relating to the MEGGA rota (excessive work out of hours with potential patient safety concerns due to overwhelming tasks) expressed by the junior doctors. This has been a significant piece of work that has involved reviewing existing workforce potential and collating new and existing evidence. Proposed new rotas are compliant, devised with junior doctors, provide minimal numbers of junior doctor cover stated by departments with time factored in for annual / study leave. These rotas offer better frequency on call than many other national rotas. JD24/7 is a collaborative piece of work with multiple departments and offers efficient use of workforce and potential cost savings pan Trust establishing equitable rotas and remuneration.

The summary report and recommendations will be shared with the Board.

8. Rest Facilities

The Trust has created temporary bed rest facilities on Penguin ward during site refurbishment. Costings and logistics to develop permanent rest facilities are required to meet requirements for out of hours working. The Junior Doctor Forum has been awarded £60,000 from the Department of Health to contribute towards improving out of hours rest facilities.

9. Summary

- ER numbers are generally low but despite this are used across the Trust and can be useful indicators of issues within departments that may require further attention and review
- The JD 24/7 task finish group have been actively working to identify issues relating to JD working. Remodelling of the MEGGA rota is being implemented in September 2019. A full report is being finalising.
- Costings and logistics to develop permanent rest facilities for junior doctors are required.
- 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.

Attachment X

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

Trust Board 18 July 2019	
Annual Infection Prevention and Control report	Paper No: Attachment Y
Submitted by: John Hartley, Director of Infection Prevention and Control	
Aims / summary To present to the Board the progress and issues in Infection Prevention and Control in 2018/19	
Action required from the meeting Feed back Approval for display on public web site	
Contribution to the delivery of NHS Foundation Trust strategies and plans Prevention and control of health care associated infections prevents harm and reduces cost.	
Financial implications Failure to prevent avoidable infection leads to harm and cost.	
Who needs to be told about any decision? Infection prevention and control is the responsibility of all staff	
Who is responsible for implementing the proposals / project and anticipated timescales? On-going programmes implemented by all Directorates and Corporate units, supported by IPC Team	
Who is accountable for the implementation of the proposal / project? Director of Infection Prevention and Control	

**GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST
INFECTION PREVENTION AND CONTROL ANNUAL REPORT**

April 18 - March 19 (Part A)

and

ACTION PLAN April 19 - March 2020

(Part B)

Compiled by: Dr John Hartley - Director of Infection Prevention and Control
Helen Dunn- Lead Nurse Infection Prevention Control
(Format - Modified from the template recommended in Health and Social Care Act 2008)

Summary	Page 2
Part A:	
Executive summary of full report for Activity in 2018/19	Page 3 - 6
Full report for Activity in 2018/19	Page 7 - 90
Part B	
Infection Prevention & Control (IPC) Team Annual work plan 2019/20	
New Projects	Page 92 – 95
Ongoing Projects	Page 96 - 98

**GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST
INFECTION PREVENTION AND CONTROL ANNUAL REPORT
April 18 - March 19**

Summary

There is a fully functioning Infection Prevention and Control programme established at GOSH, with involvement of all staff.

Many of the children are susceptible to infection because of their illness or the treatment and are often already infected or colonised. We strive to protect them from their own and each other's bugs – especially respiratory and enteric viruses and antibiotic resistant organisms. The latter is a major challenge as the worldwide threat from antibiotic resistance increases.

Key achievements this year include:

- The successful expansion of the antimicrobial stewardship team
- Development and roll out of the updated Trust wide infection control audit days with associated action plans
- No lapses of care around C.difficile
- Involvement and implementation of EPR system both trust wide and bespoke system for IPC
- Business case approval for MEDU & EDU
- Reduction in needle stick injuries by 1/3. May be due to the work around safer sharps roll.

Key Challenges and Risk include:

- Shortage of staff within estates and facilities which may lead to risks around the environment- primarily around compliance with water and ventilation.
- Cross transmission of resistant micro-organisms and enteric and respiratory viruses. Cleaning of the environment. is a recognised risk factor amongst these transmissions.
- Increase in gram negative resistance identified around single antimicrobial agents except amikacin.
- Compliance with MRSA and stool screening on admission.
- Compliance with the care bundles including central line.

We strive to keep the right balance.

J C Hartley DIPC

Part A Executive summary of full report

1 Introduction

Great Ormond Street Hospital for Children NHS Trust recognises the obligation placed upon it by the Health and Social Care Act Code of Practice of the prevention and control of infections and related guidance.

2) Description of infection control arrangements

Director of Infection Prevention and Control (DIPC) and ICD- Dr John Hartley

Executive lead for IPC - Chief Nurse, Alison Robertson

Lead Nurse for Infection Prevention and Control – 1 wte, Helen Dunn

Deputy Lead Nurse in IP&C 1 wte; IPC nurse 1 wte;

Clinical Scientist in IP&C 1wte (currently 0.4 in place as scientist on NIHR fellowship 0.6; returns to wte June 2019)

Other consultant microbiologists – 4 PAs (a fourth consultant microbiologist commenced Nov 18)

IPC Administrative support and Data Management – 0.6 wte

IPC Data analyst – 2 years fixed contract commenced Mar 2018

Infectious Diseases CNS leads on Tuberculosis related issues;

Antimicrobial stewardship: As part of job plan for infectious disease consultant (chair of AMS committee), Antimicrobial Policy Group Chair - consultant microbiologist 1 PA (as part of IPC activity), One wte pharmacist – started July 2018 (Previously one day a week antimicrobial pharmacist)

Sepsis Programme – now lead by ID Consultant 0.5 PA; supported by ID CNS

Development of IPC Team

- New antibiotic pharmacist started July 2018
- ID Consultants – new post with time allocated for stewardship, commencing June 2018
- New Microbiology Consultant with time for AMS started Nov 2018.
- IPC team member to work with Development and Property Service – plan was to include as part of phase 4 business case but not progressed.

Data analysis - Quality Improvement team

- Dashboard development and display.
- New data analyst to develop service and transition to new integrated system (RL Solutions & Epic)

2.3 Directorate Responsibility

Each Directorate had a local group to drive local planning and implementation of IPC actions. This has faltered following the clinical service restructure and is being reformed in 2019/20.

2.4 The Infection Prevention and Control Committee (IPCC) meets every month (except Aug & Dec). The committee reports to Patient Safety and Outcome Committee.

2.5 Reporting lines

The DIPC is accountable to the CEO and reports quarterly to the Board.

The DIPC and Lead nurse for IPC meet bi-weekly with Executive lead.

A report of all significant IPC issues is presented weekly to the Safety Team.

Significant IPC issues are entered on Datix, collated and passed through reporting line.

An annual plan is written and included in each annual report.

2.6 Antimicrobial stewardship and Sepsis

There is an expanded antimicrobial stewardship programme; Surviving Sepsis QI Programme ended, but programme continues as part of normal trust business.

2.8 IPC advice and On-call service.

Continuous advice service provided by IPC Team / Consultant Microbiologists (out of hours ID consultant contribution to IPC service was withdrawn)

3.3 Outbreak Reports, Serious incidents and investigations

Contemporaneous outbreak reports are written by the IPCT and fed back to clinicians and managers and disseminated through the IPC Committee. There were no IPC SI's in 2018/19. A performance review was required and completed for outsourced cleaning services; a performance review has been required and is ongoing for outsourced Decontamination services. A major outbreak group was commenced for a potential TB exposure.

4 Budget allocation to IP&C activities

4.1 Staff

IPC Team Staff budget sits within Department of Microbiology, Virology and IPC Directorates fund own audit and surveillance staff, including surgical site infection surveillance

4.2 Support

IT Support and hardware: is supplied within the departmental budget.

There is no separate IPC budget, but emergency outbreak funding is provided by the Trust.

5. HCAI Statistics Mandatory reporting for 2018/19

5.1 MRSA bacteraemia = 2 episodes attributed to trust (1 previous year)

5.2 MSSA bacteraemia = 28 episodes (20 previous year)

5.3 E. coli bacteraemias = 21 episodes * 6 from one child (18 previous year)

5.4 Klebsiella species = 19 episodes (18 previous year)

5.5 Pseudomonas aeruginosa = 17 (13 previous year)

5.6 Glycopeptide resistant enterococcal bacteraemia (GRE) = *7 in one child (6 previous year)

5.7 Clostridium difficile associated disease = 6 reported; 0 lapse in care.

Local surveillance

5.8 GOS acquired Central Venous Catheter related bacteraemia

1.7/1000 line days (82 episodes). *13 unavoidable episodes in one child 1.5 last year. Highest area NICU, Eagle and Squirrel Gastro.

5.10 Other bacteraemia episodes and antimicrobial resistance

Number of episodes - 432 clinical episodes. Similar to last year.

Rate of primary gram negative resistance – there has been an increase in resistance to single agents other than amikicin.

5:12 Surgical Site Infection Surveillance and Prevention

Continuous active SSI surveillance was undertaken across the organisation.

5.13 Surgical specialties

We remain an outlier for spinal surgery but have seen a decrease in the reported rate of infection; variation explained by the complex case mix. A specific programme to improve the surgical pathway has assisted with this decrease in rates.

5.12 Cardiothoracic specialities

The Cardiothoracic SSI group has met regularly throughout the year with good involvement from the MDT. Due to staffing issues surveillance was not completed every month. Organ space infection was rare.

5.13 Neurosurgery

Continuous surveillance is undertaken as part of weekly audit programme, with dash boards for permanent shunts.

It is difficult for the Divisions to maintain surveillance, especially due to staff turnover, and alternative structure may be needed in the long term, for which a proposal will be developed. Future services – work is underway to utilise EPIC /RL solutions to replace the current Trust S4 data base.

5:16 Viral infections detected while at hospital

There was an increase in admitted and potentially 'acquired in hospital' infection with outbreaks requiring ward restrictions (but no closures).

Failure to identify and isolate symptomatic children continues to be a problem but is improving with more patients being placed in isolation when symptoms develop.

Respiratory viral infections detected:			
	Total	Community onset	Hospital onset
Total in 2017/18	526	364	162
Total in 2018/19	751	500	251
Enteric viral infections detected			
Total in 2017/18	527	287	240
Total in 2018/19	624	317	307

5:18 MRSA Admission Screening and colonisation/carriage

We continue with a universal admission screening policy, with the change to EPR new systems to report ward compliance with screening are under development.

In 2017/18 there were 209 children with first detections, 9 acquired in the hospital. In 2018/19 there were 218 first detections with 22 acquired in hospital. Extensive investigation found no point source related to these acquisitions.

5:19 Multiple resistant 'gram negative' (MDRGN) organisms screening and rates

Universal admission faecal screening is advocated. MDR-GN carriage/colonisation – has increased, both on admission and acquired while in hospital. In 2018/19 219 children were detected, 56 acquired while in (compared to 58 in 2016). Highly resistant, carbapenemase producing organisms, reached 29 in 2018/19.

5.18 Vancomycin resistant enterococci

An increase in carriage has been detected. Hospital acquisition has continued at a lower rate this year. As with the increase in other acquisitions, cause will be multifactorial, including cleaning efficacy.

5.19 Serious Untoward incidents and complaints involving Infection, major outbreaks and threats

An SI was declared regarding the use of Vaporised Hydrogen Peroxide (HPV) terminal cleaning. One major outbreak was declared in relation to a staff member with TB, no hospital acquisition was detected.

6. Hand Hygiene and CVC on going care guidelines

Appropriate guidelines are in place and audited. Care bundle audits have been updated to reflect newly updated national guidance.

7. Facilities

Cleaning- No report received. Improvement plan completed and maintenance of cleaning standards achieved. SI regarding VHP occurred- action plan completed.

Decontamination- The trust appointed a lead in April 2018. There have been an number of issues identified with the current off-site provider and an action plan is underway. Business cases for Medical Equipment Decontamination Unit (MEDU) and Endoscopy Decontamination Unit (EDU) have been approved.

8. Estates- no report received.

Ventilation: The trust specialist ventilation programme continues but has fallen behind with the planned schedule. Commissioning of PICB ventilation was completed.

Water: The Water Safety Management Group continues to develop and manage risk associated with water. Risk from heater cooler units has been controlled.

Redevelopment / projects – IPC continue to work with redevelopment. The development of the IPC post within redevelopment has been reviewed but not currently achieved at this time.

9. Trust wide audit

A Trust annual IPC audit programme is followed with results available on the trust intranet and Nursing Care Quality Dashboards.

Trust IPC days have been in place since Oct 2018 with all links coming to audit days quarterly to complete hand hygiene and point prevalence audits as well as associated action plans.

'Bare-below-the-elbows' component of hand hygiene remains continues to be excellent with compliance over 90%, hand hygiene compliance has dropped following re-education of audit process and peer auditing being introduced but remains at around 70%.

Central venous line care bundle audit – sits at 64%, most issues are identified around the documentation of care. Work is underway with EPR to improve this.

9:5 Antimicrobial stewardship and Sepsis

Antimicrobial Stewardship – the 2017-2019 CQUINS and we are confident the full attainment of the CQUIN was met. The successful business case has increased AMS capacity with additional staffing and activity occurring in 18/19.

9.6 Sepsis report

Sepsis is led by an ID consultant. The programme is now part of normal business for the organisation. Work continues to embed sepsis following the EPR go-live.

10. Occupational Health

OH continues to provide 'new entrants' screening, "Exposure Prone Procedures" clearance, staff immunisation (including influenza, final uptake 61% (61% previous year) and blood borne virus exposure follow up (65 events, compared to 91 in previous year).

11 Targets and Outcomes

	Target	Outcome
MRSA bacteraemia –	0	1
<i>Clostridium difficile</i> infection (lapses in care)	<14	6 (0 lapse in care)
Rate of GOS acquired line infection /1000 days	< 1.3	1.7
Analysis for <i>S. aureus</i> bacteraemias	100%	100%
MRSA colonisation acquisition	0	22
Hand hygiene audits	95%	72%,
CVL care bundle audits	90%	64%
For substantive staff:		
IPC level 1 induction	95%	93%
IPC level 2 update	95%	86%

12. Training activities

Basic IPC training and update is provided for all staff through either e-learning, face to face teaching from the IPC team or both. Update is now only through e-learning, including assessment questions. Attendance is monitored.

New training modules:

The online level 2 update training package is due to be updated.

IPC training days: A popular training day programme continues.

Hand hygiene training for staff on wards is provided locally, and by the IPC team for staff without a ward. All episodes should be recorded by the training department.

IV and aseptic non-touch technique training an update is provided for nursing staff locally but currently there is no assurance that this is provided to all medical staff.

Training and competency assessment for intravascular catheter insertion is provided locally and all divisions should be working towards a standard policy. This is not yet completed. Vessel health programme will help this.

Trust Board 18th July 2019	
Responsible Officers Report	Paper No: Attachment Z
Submitted by: Dr Andrew Long, Deputy Medical Director and Responsible Officer	
Aims / summary This report is presented to the Board to provide assurance that the statutory functions of the Designated Body and Responsible Officer are being appropriately discharged; to report on performance in relation to those functions; to update the Board on progress since the 2018 annual report; to highlight current and future issues; to present action plans to mitigate potential risks.	
Action required from the meeting The Board is asked to note the contents of the update/complete the Statement of Compliance attached to the report at Annex A, Section 7	
Contribution to the delivery of NHS Foundation Trust strategies and plans Revalidation is an essential part of clinical governance.	
Financial implications	
Who needs to be told about any decision? Higher Level Responsible Officer	
Who is responsible for implementing the proposals / project and anticipated timescales?	
Who is accountable for the implementation of the proposal / project? Dr Andrew Long, Deputy Medical Director and Responsible Officer	

Annual Responsible Officers' Board Report

2019

1. Purpose of the Paper

The purpose of this paper is to inform Board members of Appraisal and Revalidation arrangements within GOSH, to provide assurance that the Responsible Officer and the Designated Body are discharging their statutory responsibility and to highlight current and future issues with action plans to mitigate potential risks.

The Board is also requested to sign the Statement of Compliance at Section 7 of the attached document.

2. Summary

The process of Appraisal and Revalidation for doctors within Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH) has become well established since its commencement in 2012.

This year the AOA return has been simplified, omitting most of the non-numerical questions. These have now been included in the Board Report template to support designated bodies in reviewing their progress over time. The new AOA now captures only the numerical data on appraisal rates, the new Board Report (attached at Appendix A) now helps designated bodies in their pursuit of quality improvement, provide necessary assurance to the Board and higher-level responsible officer and act as evidence for CQC inspections. The statement of compliance has also been combined with the Board Report.

The completed AOA for the Trust is attached at Annex B.

2.1 Medical Appraisal

The Annual Organisational Audit (AOA) End of year Questionnaire was returned to NHS England on 21st May 2019. This reported that 90.3% of non-training grade doctors that had a connection to GOSH had a Completed Appraisal or Approved Deferral (AOA Categories 1 and 2) a significant improvement to last year's figure of 82.6%. We have not yet received the comparator report for 2018/19 (this is expected in August), however using the report from 2017/18 which shows that nationally appraisal rates were at 91% and for London Trusts the average was 88%, our compliance is now above London average.

Category	2018/19 Appraisal Status	%
1	Completed Appraisal	71.8
2	Approved Incomplete or Missed Appraisal	18.5
3	Unapproved Incomplete or Missed Appraisal	9.7

There were 117 doctors (18.5%) classed as having an Approved Incomplete or Missed Appraisal (AOA Category 2) and the reasons are shown below:

- 73 joined the Trust from abroad and had been employed for less than 12 months on 31/03/19 and were therefore not yet due an appraisal;
- 3 had an agreed postponement due to long term sick leave;
- 11 had an agreed postponement due to maternity leave;
- 1 is relinquishing his licence to practice;

Attachment Z

- 14 had left the Trust during the appraisal year unfortunately they weren't removed from the DB list at the appropriate time;
- 1 came out of retirement very short term and was therefore not due an appraisal;
- 14 were new starters without sufficient time at the Trust to undertake an appraisal.

There were 61 doctors (9.7%) who were classed as having an Unapproved, Incomplete or Missed Appraisal (AOA Category 3) which is the significantly lower than last year.

The Trust has recently made it mandatory for all doctors (consultants, fellows and those with honorary contracts) to conduct their appraisal on the Premier IT Revalidation e-Portfolio (PReP) system, previously only consultants were required to use PReP. This has generated an amount of confusion and uncertainty in the cohort of doctors that are new to the system who have historically completed their appraisals in a paper format. Support has been put in place to assist them in preparation and understand what is required.

Directorate Breakdown of Appraisals due 1st April 2018 – 31st March 2019

	Blood, Cells & Cancer	Body, Bones & Mind	Brain	Heart & Lung	IPP	Medicine, Therapies & Tests	Ops & Images	Sight & Sound	Corp	Total
Cat 1	66	88	70	91	4	30	66	28	10	453
Cat 2	20	16	16	38	4	1	9	4	9	117
Cat 3	9	3	13	21	1	0	1	6	7	61
Total	95	107	99	150	9	31	76	38	26	631

2.2 Appraisers

The Trust had 134 trained appraisers at 31st March 2019. There are plans to increase the appraiser pool with 2 New Appraiser Training sessions scheduled for the year ahead held by MiAD.

Appraisers are further supported with the Appraiser User Group Forums, held 6 monthly, led by the RO. There are plans to invite the GMC Employment Liaison Advisor and PremierIT representatives to future forums. Additionally appraisers have been provided with documents describing the quality of Appraisal Output forms expected and how to navigate the PReP system as an appraiser. They have also been advised of the Trust intention to improve the quality of appraisal by the introduction of regular use of the Appraisal Summary and PDP Audit Tool (ASPAT) from NHS England.

2.3 Revalidation

Between 1st April 2018 and 31st March 2019 a total of 108 doctors for whom GOSH is the Designated Body have had Revalidation Recommendations made to the GMC. 80 have been revalidated and 28 were deferred, of whom 7 were recommended later in 2018/19, 21 were deferred to 2019/20.

Attachment Z

In March 2019 the Medical Appraisal and Revalidation Committee (MARC) commenced. MARC membership consists of the Medical Director, Responsible Officer, Medical Appraisal and Revalidation Manager, Associate Director for HR & OD, Expert Appraiser, SAS doctors representative, Junior Doctors representative, Chief of Service representative and LNC representative. The meeting is in two parts. The first part consisting of MD, RO, Revalidation Manager and Ass. Director HR to review those under GMC notice and their progress towards receiving a revalidation recommendation, reasons for any likely deferrals, issues (eg non-engagement) etc. The second part involves the whole membership, the purpose being to implement and update Medical Appraisal and Revalidation Policy and procedures and provide overall quality assurance of the appraisal and revalidation processes and outcomes.

2.4 Quality Assurance

Those due for revalidation have a complete review of all appraisal input forms, output forms and related supporting evidence. Both the RO and the Revalidation Manager provide constructive feedback to appraisees and appraisers where the requisite standard has not been reached even if this doesn't result in deferral.

Outside of the revalidation review, a random selection of appraisal output forms are reviewed as part of the ASPAT process (Appraisal Summary PDP Audit Tool). There is an expectation that the percentage reviewed will be increased during the next revalidation year.

Appraisers are scored by their appraisees, this is done anonymously at the end of their appraisal following acceptance of their Appraisal Output Form. To maintain anonymity a report will be produced for the appraiser once they have completed a minimum of 3 appraisals. The report is attached to their portfolio for reflection in their own appraisal. The report covers nine different aspects of appraisal and also includes areas for free typed comments.

2.5 Responding to Concerns and Remediation

In the past year there have been 2 completed Maintaining High Professional Standards (MHPS) investigation reports. Neither of these have resulted in any disciplinary hearings or sanctions. They have led to informal letters or conversations. At present there is 1 ongoing MHPS investigation. These cases have been discussed with the Practitioner Performance Advice Service (previously NCAS), part of NHS Resolution.

In terms of GMC cases, an average of 2-3 cases are active at any one time (approximately 0.25% of Trust doctors).

During the past year 1 doctor has had sanctions imposed by the GMC and these include warnings and undertakings. 2 cases have been closed with no further action.

Designated Body Annual Board Report 2019

The Board of Great Ormond Street Hospital for Children NHS Foundation Trust can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

Date of AOA submission: 21 May 2019, attached at Annex B

Action from last year: In the AOA for 2017/8 the designated body answered “no” to 3 questions – 1) Those with missed appraisals have an explanation recorded, 2) Appraisers are supported in their role to calibrate and quality assure their appraisal practice and 3) The designated body have sufficient trained case investigators and case managers.

Comments: Explanations for missed appraisals are now requested and recorded, and promotion of quality appraisals encouraged via appraiser forums; Quality assurance, 1-2-1 training and have been provided with a quality output guide. The Trust has now committed to training more case investigators and case managers through external providers (NHS Resolution)

Action for next year: Continuing support and guidance to be given to appraisers; GMC and PremierIT to attend appraiser forums; PReP to attend appraiser/appraisee “Drop In” session; GOSHWEB to be updated. ASPAT to be introduced more regularly.

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: None

Comments: The Responsible Officer, Andrew Long (Deputy Medical Director), completed RO training in November 2016 and was appointed as RO 1 January 2017.

Action for next year: To maintain expertise using RO Network meetings

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes

Action from last year: Review of admin support required to support RO in discharging duties.

Comments: Medical Appraisal and Revalidation Manager appointed December 2018.

Action for next year: None

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: No actions identified last year, however Board noted inconsistencies in requesting transfer of information from a doctors previous designated body and that improvements needed to be made.

Comments: The Responsible Officer and the Revalidation Manager both have access to GMC Connect to allow connection and disconnection of doctors where appropriate. An accurate list of prescribed connections is now

maintained by a threefold process: 1 - When a doctor connects to GOSH as their designated body an automatic email is sent to the revalidation inbox, the doctors details are checked on ESR/SRS to ensure that the connection is appropriate; 2 – Monthly starter and leaver lists are received from ESR which are checked against the list, and doctors are added or removed as appropriate; 3 – Should a doctor not add themselves to our designated body list on GMC Connect and are not yet listed on the month Medical Staffing list, they can be picked up at induction - a slide has been produced for inclusion in the induction presentation detailing next steps and contact details, additionally there is a revalidation presence at induction.

Once a doctor has connected to GOSH appropriately, details are requested from their previous Trust(s) via MPIT (Medical Practitioner Information Transfer) to confirm that no outstanding issues or concerns exist for the doctor, and that no additional or specialised support is required.

Action for next year: Maintain process for accurate prescribed connections and transfer of information.

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: No actions identified.

Comments: There are mechanisms through the Trusts governance procedures to actively monitor all policies and procedures to ensure that they are updated in a timely manner, or when there are changes to legislation.

Action for next year: To continue to update policies as appropriate

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year: No review undertaken in the last year

Comments: There was an external quality audit undertaken in January 2018. Actions following this have been completed

Action for next year: A review will be requested by the auditors

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: No actions from previous year

Comments: All doctors, irrespective of contract length or connection are offered 1-2-1 with the revalidation manager, to help them understand the requirements of revalidation and appraisal – this is particularly useful for doctors who have come from overseas. The revalidation manager provides a presence at their induction, and a contact details slide has been included in the induction presentation. Transfer of information is requested once they have connected to us, and this identifies whether an appraisal has previously been held. In most cases there is no appraisal history, contact is made with the doctor and a plan to bring them up to date with appraisal and plan towards revalidation implemented.

Action for next year: Improve the information on the GOSHWEB to assist short-term/locums etc and continue to provide support.

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year: Create systems to remind appraisees to complete appraisal

Comments: Reminder emails are now generated and sent to appraisees at 3 months, 2 months and 1 month prior to their appraisal due date reminding them of the need to complete prior to their due date and also reminding them of the process to request and approved deferral from the RO.

Information sheets have been sent to all appraisees describing the expectations for supporting evidence and reflection for their appraisal.

Action for next year: Investigate the possibility of centrally uploading SI/Complaint information on to the PReP system for use in appraisals; Include information regarding timing of appraisal meetings in the appraisal policy when reviewed in line with NHS England requirements.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: No actions identified

Comments: The Trust have developed a local process where doctors have failed to complete their appraisal and without reason. These doctors are discussed at the Medical Appraisal and Revalidation Committee, and recent GMC guidance advises that all those more than 3 months overdue are discussed with the ELA to decide next steps. Doctors are made aware of this before they reach this milestone.

Action for next year: Continue with the process and review its success, with the aim of reducing the number overdue.

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: No actions identified last year.

Comments: The appraisal policy was approved January 2017. It is due for review by December 2019 and will need a number of amendments. It will need to include recent GMC guidance regarding supporting evidence for appraisal and the shift towards qualitative rather than quantitative for this cycle of revalidation.

Action for next year: Review appraisal policy by December 2019 to incorporate new guidance.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Ensure appraisee/appraiser relationship is consistent.

Comments: The Trust had 134 appraisers at 31 March 2019, for 631 doctors (of course this number is fluid). Trust Policy states that the number of appraisals an appraiser should conduct per year is between 3-6. A number of appraisers do more than the required number to maintain expertise, while other appraisers aren't being used. The Trust has booked 2 New Appraiser Training sessions which should increase the pool by approx. 40 appraisers.

Action for next year: Consider appraiser allocation following a quality review of appraisers.

5. Medical appraisers participate in ongoing performance review and training/development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers¹ or equivalent).

Action from last year: None identified

Comments: Appraisal output forms are now quality assured using the ASPAT (Appraisal Summary PDP Audit Tool) on PReP, findings are fed back to the appraiser; additionally appraisers have now received supporting documentation on completion of appraisal outputs highlighting what is required to score well in ASPAT; ROAN Information Sheets are circulated; Appraiser Forums are run twice a year and future meetings will have GMC and PremierIT involvement; Appraisees are required to complete a Medical Appraisal Feedback questionnaire following their appraisal – the anonymised reports are included in an appraisers portfolio for their review and reflection during their own appraisal.

Action for next year: Develop appraiser refresher training in-house

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: None identified

Comments: Internal assurance is provided by the following sources:

- RO reports to Board, to which the Annual Organisational Audit (AOA) is appended;
- Information from NHS England on comparative Appraisal compliance rates;
- RO and Appraisers continue to update their skills in Revalidation and Appraisal matters.

Action for next year: None

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: None identified

Comments: A total of 108 doctors for whom GOSH is the Designated body were due for a recommendation regarding Revalidation between 1st April 2018 and 31st March 2019. 80 (74%) were recommended for Revalidation and

¹ <http://www.england.nhs.uk/revalidation/ro/app-syst/>

² Doctors with a prescribed connection to the designated body on the date of reporting.

28 were deferred by the RO (26%). 7 of these deferred doctors were Revalidated later in 2018/19 and 21 were deferred to 2019/20.

Action for next year: Review revalidation portfolio within 1 month of "Going Under Notice" to provide greater time to resolve any issues ahead of submission date.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: None identified

Comments: The doctor is contacted where the portfolio is lacking to allow time to resolve ahead of the submission date. At the point of the recommendation being made, the RO uses the PReP platform which allows for comment regarding the recommendation being made. There was an issue during 2018/9 where PReP was not connected to GMC Connect, therefore recommendations were not made on the system and therefore no feedback could be left on the doctors portfolio – this would be done via email. The problem was resolved, however the GMC then made changes in March 2019 to the way deferrals are made, and this again impacted on appraisal and revalidation systems as changes were required on these platforms.

Action for next year: Maintain process

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:

Comments: Over the last year, the Trust has sought to strengthen its approach to Medical Governance by creating a culture of collective governance and ensuring discussions and actions are appropriately documented.

Action for next year: The Trust's approach to Medical Governance is undergoing an evaluation, to determine effectiveness and efficacy, following which the Trust intends to put actions in place to further strengthen its approach to Medical Governance.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year:

Comments: All doctors where there are concerns around conduct and performance are regularly monitored, with regular support from senior management to address these concerns. Meetings are held weekly with the Medical Director and the Responsible Officer to review progress in relation to practitioners where there are concerns about their performance or conduct.

Action for next year: To develop the competency of senior management through a formalised training programme.

3. There is a process established for responding to concerns about any licensed medical practitioner's¹ fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:

Comments: Over the last year the Trust has sought to strengthen its process for responding to concerns, ensuring that there is a collective leadership approach to issues. Advice from NHS Resolution and the GMC are sought on both informal and formal cases.

Action for next year: To continue to work closely with NHS Resolution and the GMC; and to continue to develop the Trust's approach to collective leadership when responding to concerns.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors².

Action from last year:

Comments: The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board. Analysis includes numbers, type and outcome of concerns as well as aspects such as consideration of protected characteristics of the doctors.

Action for next year:

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation³.

Action from last year:

Comments: Through the weekly review meetings, actions are identified (eg the transfer of information/concerns to other relevant Responsible Officers) and monitored.

Action for next year: To continue to ensure that there is a robust process for the timely transfer of information.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year:

⁴This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

³ The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: <http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents>

Comments: The Trust's approach of taking a collective leadership to managing concerns, in addition to the weekly review meetings, ensures that all decisions are evaluated to ensure that they are free from bias and discrimination.

Action for next year: To continue to develop this approach, coupled with the implementation of a senior management programme to increase the levels of competency in managing doctors in difficulty.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: None identified

Comments: The Trust ensures that when doctors join the Trust (regardless of contract type) that they hold the appropriate professional registration with either the GMC or GDC. Part of the GMC/GDC vetting process is to ensure that, prior to the issuing of professional registration, a doctor holds the appropriate qualifications and post graduate experience to obtain registration.

The Trust also ensures that doctors go through a recruitment and selection process that involves shortlisting and interview stages. As such, during the shortlisting stage, shortlisters have the opportunity to review and subsequently select or reject candidates at this stage based upon information provided by candidates on their application/CV in respect to their qualifications, skills and abilities, knowledge and experience. Furthermore, those candidates shortlisted then go through an interview process where as part of this process there is the further opportunity for the interview panel to explore and assess the candidates skills and knowledge in respect of the role that they are in before being offered a role.

Action for next year: TRAC to be implemented, which will allow better visibility of pre-employment checks.

Section 6 – Summary of comments, and overall conclusion

The majority of the action plan from the 2018/9 is complete or ongoing:

- Inadequate administrative support – a Revalidation Manager has now been appointed;
- Ensure that appraisee/appraiser relationships are consistent – this is in progress, the Trust has arranged additional New Appraiser Training and following this will then review the allocation process;
- Ensure that high quality appraisal is taking place in a timely fashion to support revalidation – reminders are now being sent to appraisees at 3 months, 2 months and 1 month prior to their due date, process is being implemented for going overdue. Processes are also now in place to review the quality of inputs, outputs and evidence;
- Process to ensure information is available to be included in the appraisal portfolio – this has not yet been completed, however there are plans to review how information can be requested and centrally

uploaded to PReP where a doctor has been involved in complaints and SI's;

- Identifying movement of doctors in non-training grade posts – there is now a process in place for “Transfer of Information” when a doctor joins the Trust;
- Clarify responsibility for appraisal for doctors with honorary contracts – not complete. There has been a data cleanse of honorary contracts (across all grades) and responsibility largely lies with the Directorates supporting the honorary contract

Ensure that there is access to trained Case Investigators – The Trust has now committed to training more case investigators and case managers through external providers (NHS Resolution)

- **Actions for 2019/20** Appraiser Allocation – on completion of New Appraiser Training an allocation process needs to be investigated, with input from the directorates to ensure fairness;
- Investigate the possibility of central uploading of SI's and complaint information for doctors reflection in appraisal;
- Formalise the appointment of a Lead or Expert Appraiser;
- Review/rewrite Appraisal Policy to include new guidance from GMC, timeliness of appraisal information from NHS England, local process for overdue appraisals and quality;
- Increase ASPAT process for internal quality assurance

Overall conclusion:

2018/9 has seen improvements both in compliance and in processes. We aim to continue this trend during 2019/20 with an ambition to achieve 95% compliance for the next Annual Organisational Audit/Board Report. The challenge will always be those on short term contracts, however our actions for the year ahead include targeting such contract holders, which will assist the Trust in achieving an even higher compliance.

Section 7 – Statement of Compliance:

The Board of Great Ormond Street Hospital for Children NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: Great Ormond Street Hospital for Children NHS Foundation Trust

Name: Mr Matthew Shaw

Signed: _____

Role: Chief Executive

Date: _____



Annual Organisational Audit (AOA) End of year questionnaire 2018-19

NHS England INFORMATION READER BOX

Directorate

Medical	Commissioning Operations	Patients and Information
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

Publications Gateway Reference:

000182

Document Purpose	Resources
Document Name	Annual Organisational Audit Annex C (end of year questionnaire)
Author	Lynda Norton
Publication Date	24 March 2019
Target Audience	Medical Directors, NHS England Regional Directors, GPs
Additional Circulation List	
Description	The AOA (Annex C of the Framework for Quality Assurance) is a standardised template for all responsible officers to complete and return to their higher level responsible officer via the Revalidation Management System. AOAs from all designated bodies will be collated to provide an overarching status report of progress across England.
Cross Reference	A Framework for Quality Assurance for Responsible Officers & Revalidation April 2014 Gateway ref 01142
Superseded Docs (if applicable)	2017/18 AOA cleared with Publications Gateway Reference 07760
Action Required	
Timing / Deadlines (if applicable)	
Contact Details for further information	Lynda Norton Professional Standards Team Quarry House Leeds LS2 7UE 0113 825 1463

Document Status

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Annual Organisational Audit (AOA)

End of year questionnaire 2018-19

Version number: 1.0

First published: 4 April 2014

Updated: 24 March 2015, 18 March 2016, 24 March 2017, 23 March 2018,
January 2019

Prepared by: Lynda Norton Project Manager for Quality Assurance, NHS England

Classification: OFFICIAL

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

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1 Introduction

The Annual Organisational Audit (AOA) is an element of the Framework of Quality Assurance (FQA) and is a standardised template for all responsible officers to complete and return to their higher level responsible officer. AOAs from all designated bodies will be collated to provide an overarching status report of the responsible officer function across England. Where small designated bodies are concerned, or where types of organisation are small, these will be appropriately grouped to ensure that data is not identifiable to the level of the individual.

As the first cycle of medical revalidation is now complete, it is the right time to update the FQA and its underpinning annexes. The update started by reviewing the AOA and taking account of the feedback received at the beginning of this work, we have produced a slimmed down questionnaire for responsible officers to complete for the 2018/19 exercise.

In response to feedback from designated bodies, we have simplified the categories of appraisals in the 2018/19 AOA to:

- Category 1 - a single figure of completed medical appraisals
- Category 1a – fully compliant appraisal figure (optional)
- Category 2 – no change ('approved missed' e.g. maternity, sickness)
- Category 3 – no change ('unapproved missed')

This slimmed down AOA concentrates primarily on the quantitative measures of previous AOAs, the numbers of doctors with a prescribed connection and their appraisal rates. As the systems and processes that support medical revalidation are established, the emphasis has moved to reporting on how these should be developed year on year through the newly revised Board report instead. The Board report is also a component of the FQA. In time, we expect to introduce suitable quantitative measures about the remaining components of the responsible officer function, for example responding to concerns, monitoring of performance and identity checks.

The AOA 2018/19 questionnaire is divided into four sections:

Section 1: The designated body and the responsible officer

Section 2: Appraisal

Section 3: Annual Board report and Statement of Compliance

Section 4: Additional Comments

The questionnaire is to be completed by the responsible officer on behalf of the designated body for the year ending 31 March 2019. Inputting the information can be appropriately delegated. The completed questionnaire should be submitted before or by the deadline

The final date for submission will be detailed in an email containing the link to the electronic version of the form, which will be sent after 31 March 2019.

Whilst NHS England is a single designated body, for this audit, the national, regional and local offices of NHS England should answer as a 'designated body' in their own right..

Following completion of this AOA exercise, designated bodies should:

- Consider using the information gathered to produce a status report and to conduct a review of their organisations' appraisal developmental needs.
- Complete their Board report and submit it to NHS England by 27 September 2019. The Board report template has also been revised as described above and now includes the annual statement of compliance. The new version will enable designated bodies to review and develop their systems and processes. It will also enable them to provide assurance that they are supporting patient care by fulfilling their statutory obligations in respect of the responsible officer function.

For further information, references and resources can be found at page 16 www.england.nhs.uk/revalidation

2 Guidance for submission

Guidance for submission:

- A small number of questions require a 'Yes' or 'No' answer. To answer 'Yes', you must be able to answer 'Yes' to all the statements listed under 'to answer 'Yes''
- Please do not use this version of the questionnaire to submit your designated body's response.
- You will receive an email with an electronic link to a unique version of this form for your designated body.
- You should only use the link received from NHS England by email, as it is unique to your organisation.
- Once the link is opened, you will be presented with two buttons; one to download a blank copy of the AOA for reference, the second button will take you to the electronic form for submission.
- Submissions can only be received electronically via the link. Do not complete hardcopies or email copies of the document.
- The form must be completed in its entirety prior to submission; it cannot be part-completed and saved for later submission.
- Once the 'submit' button has been pressed, the information will be sent to a central database collated by NHS England.
- A copy of the completed submission will be automatically sent to the responsible officer.
- Please be advised that Questions 1.1-1.3 may have been automatically populated with information previously held on record by NHS England. The submitter is responsible for checking the information is correct and should update the information if and where required before submitting the form.

3 Section 1 – The Designated Body and the Responsible Officer

Section 1	The Designated Body and the Responsible Officer	
1.1	Name of designated body: Great Ormond Street Hospital for Children NHS Trust	
	Head Office or Registered Office Address if applicable line 1 Great Ormond Street	
	Address line 2	
	Address line 3	
	Address line 4	
	City London	
	County	Postcode WC1N 3JH
	Responsible officer: Title ***** GMC registered first name ***** GMC reference number ***** Email *****	GMC registered last name ***** Phone *****
	Medical Director: Title ***** GMC registered first name ***** GMC reference number ***** Email *****	GMC registered last name ***** Phone ***** No Medical Director <input type="checkbox"/>
	Clinical Appraisal Lead: Title GMC registered first name GMC reference number Email	GMC registered last name Phone No Clinical Appraisal Lead <input checked="" type="checkbox"/>
Chief executive (or equivalent): Title ***** First name ***** GMC reference number (if applicable) Email *****	Last name ***** Phone *****	

1.2	Type/sector of designated body: (tick one)	NHS	Acute hospital/secondary care foundation trust	<input checked="" type="checkbox"/>
			Acute hospital/secondary care non-foundation trust	<input type="checkbox"/>
			Mental health foundation trust	<input type="checkbox"/>
			Mental health non-foundation trust	<input type="checkbox"/>
			Other NHS foundation trust (care trust, ambulance trust, etc)	<input type="checkbox"/>
			Other NHS non-foundation trust (care trust, ambulance trust, etc)	<input type="checkbox"/>
			Special health authorities – NHS Litigation Authority, now NHS Resolution, NHS Improvement, NHS Blood and Transplant, etc)	<input type="checkbox"/>
		NHS England	NHS England (Local office)	<input type="checkbox"/>
			NHS England (regional office)	<input type="checkbox"/>
			NHS England (national office)	<input type="checkbox"/>
		Independent / non-NHS sector (tick one)	Independent healthcare provider	<input type="checkbox"/>
			Locum agency	<input type="checkbox"/>
			Faculty/professional body (FPH, FOM, FPM, IDF, etc)	<input type="checkbox"/>
			Academic or research organisation	<input type="checkbox"/>
			Government department, non-departmental public body or executive agency	<input type="checkbox"/>
			Armed Forces	<input type="checkbox"/>
			Hospice	<input type="checkbox"/>
Charity/voluntary sector organisation	<input type="checkbox"/>			
Other non-NHS (please enter type)	<input type="checkbox"/>			

1.3	The responsible officer's higher level responsible officer is based at: [tick one]	NHS England North	<input type="checkbox"/>
		NHS England Midlands and East	<input type="checkbox"/>
		NHS England London	<input checked="" type="checkbox"/>
		NHS England South East	<input type="checkbox"/>
		NHS England South West	<input type="checkbox"/>
		NHS England (National)	<input type="checkbox"/>
		Department of Health	<input type="checkbox"/>
		Faculty of Medical Leadership and Management - for NHS England (national office) only	<input type="checkbox"/>
		Other (Is a suitable person)	<input type="checkbox"/>
1.4	A responsible officer has been nominated/appointed in compliance with the regulations. To answer 'Yes': <ul style="list-style-type: none"> The responsible officer has been a medical practitioner fully registered under the Medical Act 1983 throughout the previous five years and continues to be fully registered whilst undertaking the role of responsible officer. The responsible officer has been formally nominated/appointed by the board or executive of the organisation. 	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	

4 Section 2 – Appraisal

Section 2		Appraisal					
2.1	IMPORTANT: Only doctors with whom the designated body has a prescribed connection at 31 March 2019 should be included. Where the answer is 'nil' please enter '0'.		1	1a	2	3	
	See guidance notes on pages 12-14 for assistance completing this table	Number of Prescribed Connections	Completed Appraisal (1)	(Optional) Completed Appraisal (1a)	Approved incomplete or missed appraisal (2)	Unapproved incomplete or missed appraisal (3)	Total
2.1.1	Consultants (permanent employed consultant medical staff including honorary contract holders, NHS, hospices, and government /other public body staff. Academics with honorary clinical contracts will usually have their responsible officer in the NHS trust where they perform their clinical work).	364	320	0	18	26	364
2.1.2	Staff grade, associate specialist, specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS, hospices, and government/other public body staff).	9	7	0	1	1	9
2.1.3	Doctors on Performers Lists (for NHS England and the Armed Forces only; doctors on a medical or ophthalmic performers list. This includes all general practitioners (GPs) including principals, salaried and locum GPs).	0	0	0	0	0	0
2.1.4	Doctors with practising privileges (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade).	0	0	0	0	0	0
2.1.5	Temporary or short-term contract holders (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc).	258	126	0	98	34	258
2.1.6	Other doctors with a prescribed connection to this designated body (depending on the type of designated body, this category may include responsible officers, locum doctors, and members of the faculties/professional bodies. It may also include some non-clinical management/leadership roles, research, civil service, doctors in wholly independent practice, other employed or contracted doctors not falling into the above categories, etc).	0	0	0	0	0	0
2.1.7	TOTAL (this cell will sum automatically 2.1.1 – 2.1.6).	631	453	0	117	61	631

2.1

Column - Number of Prescribed Connections:**Number of doctors with whom the designated body has a prescribed connection as at 31 March 2019**

The responsible officer should keep an accurate record of all doctors with whom the designated body has a prescribed connection and must be satisfied that the doctors have correctly identified their prescribed connection. Detailed advice on prescribed connections is contained in the responsible officer regulations and guidance and further advice can be obtained from the GMC and the higher level responsible officer. The categories of doctor relate to current roles and job titles rather than qualifications or previous roles. The number of individual doctors in each category should be entered in this column. Where a doctor has more than one role in the same designated body a decision should be made about which category they belong to, based on the amount of work they do in each role. Each doctor should be included in only one category. For a doctor who has recently completed training, if they have attained CCT, then they should be counted as a prescribed connection. If CCT has not yet been awarded, they should be counted as a prescribed connection within the LETB AOA return.

Column - Measure 1 Completed medical appraisal:

A completed annual medical appraisal is one where either:

- a) All of the following three standards are met:
 - i. the appraisal meeting has taken place in the three months preceding the agreed appraisal due date*,
 - ii. the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor within 28 days of the appraisal meeting,
 - iii. the entire process occurred between 1 April and 31 March.

Or

- b) the appraisal meeting took place in the appraisal year between 1 April and 31 March, and the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor, but one or more of the three standards in a) has been missed. However, the judgement of the responsible officer is that the appraisal has been satisfactorily completed to the standard required to support an effective revalidation recommendation.

For doctors who have recently completed training, it should be noted that their final ACRP equates to an appraisal in this context.

Column - Measure 1a (Optional) Completed medical appraisal:

For designated bodies who wish to and can report this figure, this is the number of completed medical appraisals that meet all **three** standards defined in Measure 1 a) above. This figure is not reported nationally and is intended to inform the internal quality processes of the designated body.

Column - Measure 2: Approved incomplete or missed appraisal:

An approved incomplete or missed annual medical appraisal is one where the appraisal has not been completed according to the parameters of a Category 1 completed annual medical appraisal, but the responsible officer has given approval to the postponement or cancellation of the appraisal. The designated body must be able to produce documentation in support of the decision to approve the postponement or cancellation of the appraisal for it to be counted as an Approved incomplete or missed annual medical appraisal.

Column - Measure 3: Unapproved incomplete or missed appraisal:

An Unapproved incomplete or missed annual medical appraisal is one where the appraisal has not been completed according to the parameters of a Category 1 completed annual medical appraisal, and the responsible officer has not given approval to the postponement or cancellation of the appraisal.

Where the organisational information systems of the designated body do not retain documentation in support of a decision to approve the postponement or cancellation of an appraisal, the appraisal should be counted as an Unapproved incomplete or missed annual medical appraisal.

Column Total:

Total of columns 1+2+3. The total should be equal to that in the first column (Number of Prescribed Connections), the number of doctors with a prescribed connection to the designated body at 31 March 2019.

*** Appraisal due date:**

A doctor should have a set date by which their appraisal should normally take place every year (the 'appraisal due date'). The appraisal due date should remain the same each year unless changed by agreement with the doctor's responsible officer. Where a doctor does not have a clearly established appraisal due date, the next appraisal should take place by the last day of the twelfth month after the preceding appraisal. This should then by default become their appraisal due date from that point on. For a designated body which uses an 'appraisal month' for appraisal scheduling, a doctor's appraisal due date is the last day of their appraisal month.

For more detail on setting a doctor's appraisal due date see the [Medical Appraisal Logistics Handbook: \(NHS England 2015\)](#).

2.2	<p>Every doctor with a prescribed connection to the designated body with a missed or incomplete medical appraisal has an explanation recorded</p> <p>If all appraisals are in Categories 1, please answer N/A.</p> <p>To answer Yes:</p> <ul style="list-style-type: none"> • The responsible officer ensures accurate records are kept of all relevant actions and decisions relating to the responsible officer role. • The designated body's annual report contains an audit of all missed or incomplete appraisals (approved and unapproved) for the appraisal year 2018/19 including the explanations and agreed postponements. • Recommendations and improvements from the audit are enacted. <p><u>Additional guidance:</u></p> <p>A missed or incomplete appraisal, whether approved or unapproved, is an important occurrence which could indicate a problem with the designated body's appraisal system or non-engagement with appraisal by an individual doctor which will need to be followed up.</p> <p><u>Measure 2: Approved incomplete or missed appraisal:</u></p> <p><i>An approved incomplete or missed annual medical appraisal is one where the appraisal has not been completed according to the parameters of a Category 1 completed annual medical appraisal, but the responsible officer has given approval to the postponement or cancellation of the appraisal. The designated body must be able to produce documentation in support of the decision to approve the postponement or cancellation of the appraisal for it to be counted as an Approved incomplete or missed annual medical appraisal.</i></p> <p><u>Measure 3: Unapproved incomplete or missed appraisal:</u></p> <p><i>An Unapproved incomplete or missed annual medical appraisal is one where the appraisal has not been completed according to the parameters of a Category 1 completed annual medical appraisal, and the responsible officer has not given approval to the postponement or cancellation of the appraisal. Where the organisational information systems of the designated body do not retain documentation in support of a decision to approve the postponement or cancellation of an appraisal, the appraisal should be counted as an Unapproved incomplete or missed annual medical appraisal.</i></p>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
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5 Section 3 – Annual Board Report and Statement of Compliance

Section 3		
3.	The last Annual Board Report was signed off on: 25/07/2018 The last Statement of Compliance was signed off on: 25/07/2018	

6 Section 4 – Comments

Section 4	Comments	
4	<p>Category 2 11 doctors on maternity leave during appraisal window, 3 on Personal Illness, 1 is relinquishing his licence to practice, 73 started from overseas and were therefore given 1 year before appraisal was due, 14 have left the trust during the appraisal year unfortunately they were not removed from the Designated Body at the appropriate time, 1 came out of retirement very short term and was therefore not due an appraisal and 14 were new starters without sufficient time at the Trust to undertake an appraisal.</p> <p>Category 3 We have 61 doctors that fall into this category, however the Trust has recently made it mandatory for our Fellows and Honorary contract holders to conduct their appraisals on the electronic system rather than the previous paper based appraisals. This has caused some confusion and uncertainty, but support is now in place to assist them. We have included slides within the Junior Doctors induction, revalidation and appraisal team presence at induction, 1-2-1 training on using the system, updating the intranet page so that information is available and useful. We are confident that this will reflect in next years AOA.</p>	

7 Reference

Sources used in preparing this document

1. The Medical Profession (Responsible Officers) Regulations 2010 (Her Majesty's Stationery Office, 2013)
2. The Medical Profession (Responsible Officers) (Amendment) Regulations 2013 (Her Majesty's Stationery Office, 2013)
3. The Medical Act 1983 (Her Majesty's Stationery Office, 1983)
4. The National Health Service (Performers Lists) (England) Regulations 2013
5. Revalidation: A Statement of Intent (GMC and others, 2010)
6. Guidance on Colleague and Patient Questionnaires (GMC, 2012)
7. Effective clinical governance for the medical profession: A handbook for organisations employing, contracting or overseeing the practice of doctors (GMC 2018)
8. The GMC protocol for making revalidation recommendations: Guidance for responsible officers and suitable persons (GMC, 2012, updated in 2014)
9. Providing a Professional Appraisal (NHS Revalidation Support Team, 2012)
10. Appraisal in the Independent Health Sector (British Medical Association and Independent Healthcare Advisory Services, 2012)
11. Joint University and NHS Appraisal Scheme for Clinical Academic Staff (Universities and Colleges Employers Association, 2002, updated in 2012)
12. Preparing for the Introduction of Medical Revalidation: a Guide for Independent Sector Leaders in England (GMC and Independent Healthcare Advisory Services, 2011, updated in 2012)
13. Medical Appraisal Logistics Handbook (NHS England, 2015)

**Trust Board
18 July 2019**

Safeguarding Annual Report 2018-19

Paper No: Attachment 1

Prepared by: The Named Professionals for Safeguarding (Alison Steele and Janice Baker)
Presented by: Alison Robertson, Chief Nurse.

Aims / summary

The aim of this report is to provide the board with a summary of the safeguarding activities in 2019/20.

Key achievements include:

- The social work and safeguarding teams are now co-located
- An integrated duty system has been established
- Regular formal meetings between safeguarding and social work leads have been introduced
- Greater integration with the CLIC Sargent social work team has begun
- The social work and safeguarding team now both document on the trust EPR system
- A 24/7 safeguarding rota supported by some of the General Paediatricians has been implemented
- Mental Capacity Act Policy has been approved and a special interest group established
- Internal Audit of safeguarding arrangements received 'significant assurance'.

Please note – slide 5 summarises the safeguarding and social work structure and slide 15 outlines our supervision activity (previous request for further clarification from Trust Board).

Action required from the meeting

The Trust Board is asked to note the priorities for the year ahead and continue to support the development of arrangements for safeguarding children, young people and adults.

In summary the priorities are:

- Further develop safeguarding risk register
- Evaluate the 24/7 safeguarding rota
- Review and refresh the trust's approach to delivering safeguarding training (including an expansion of the access/availability of level 3 specialist training)
- Undertake a review of the guidance and policy for managing allegations against persons in a position of trust.
- Continue to promote the safeguarding supervision agenda
- Prepare for the introduction of the Liberty Protection Safeguards
- Increase awareness of the requirements under the Mental Capacity Act.

Contribution to the delivery of NHS Foundation Trust strategies and plans

CQC Core Standard 2 Child Protection. Requirements also from NHSE/I (London), Camden Safeguarding Children Partnership (formerly Camden Safeguarding Children Board), Camden Clinical Commissioning Group and Camden Safeguarding Adults Partnership for Trusts to provide a Safeguarding Annual Report.

Financial implications

None.

Who needs to be told about any decision?

Alison Robertson – Executive Lead for Safeguarding, Chief Nurse.

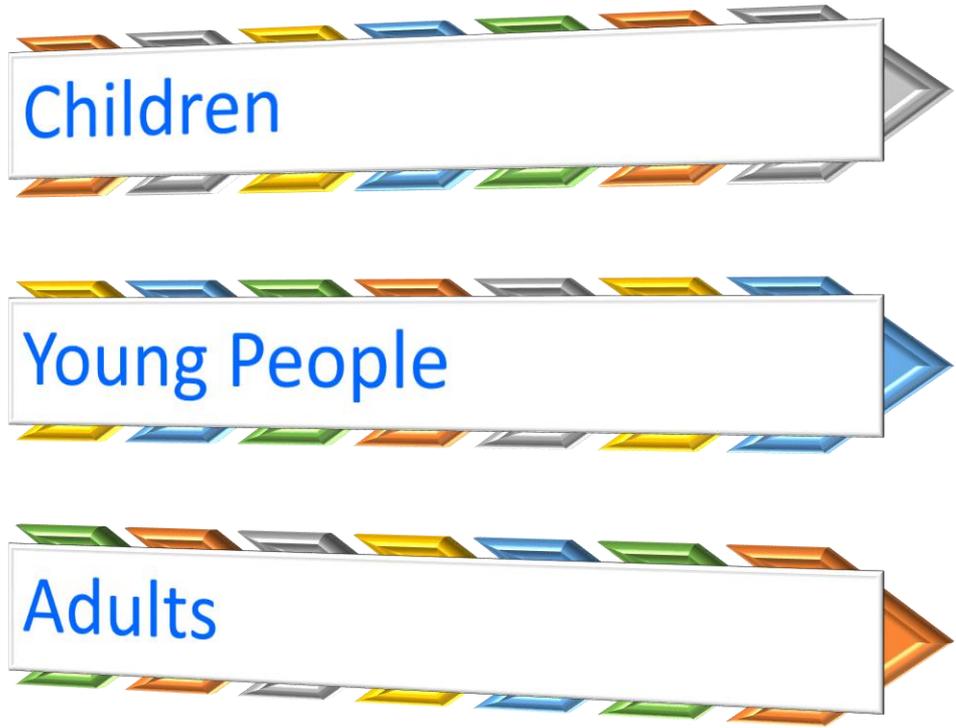
Who is responsible for implementing the proposals / project and anticipated timescales?

The Named Professionals for Safeguarding and the Head of the Social Work.

Who is accountable for the implementation of the proposal / project?

The Executive Lead for Safeguarding.

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Annual Report 2018 – 2019
Prepared by Named Safeguarding Professionals and Social Work Manager
Presented by Alison Robertson, Chief Nurse and Executive Lead for Safeguarding

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Introduction

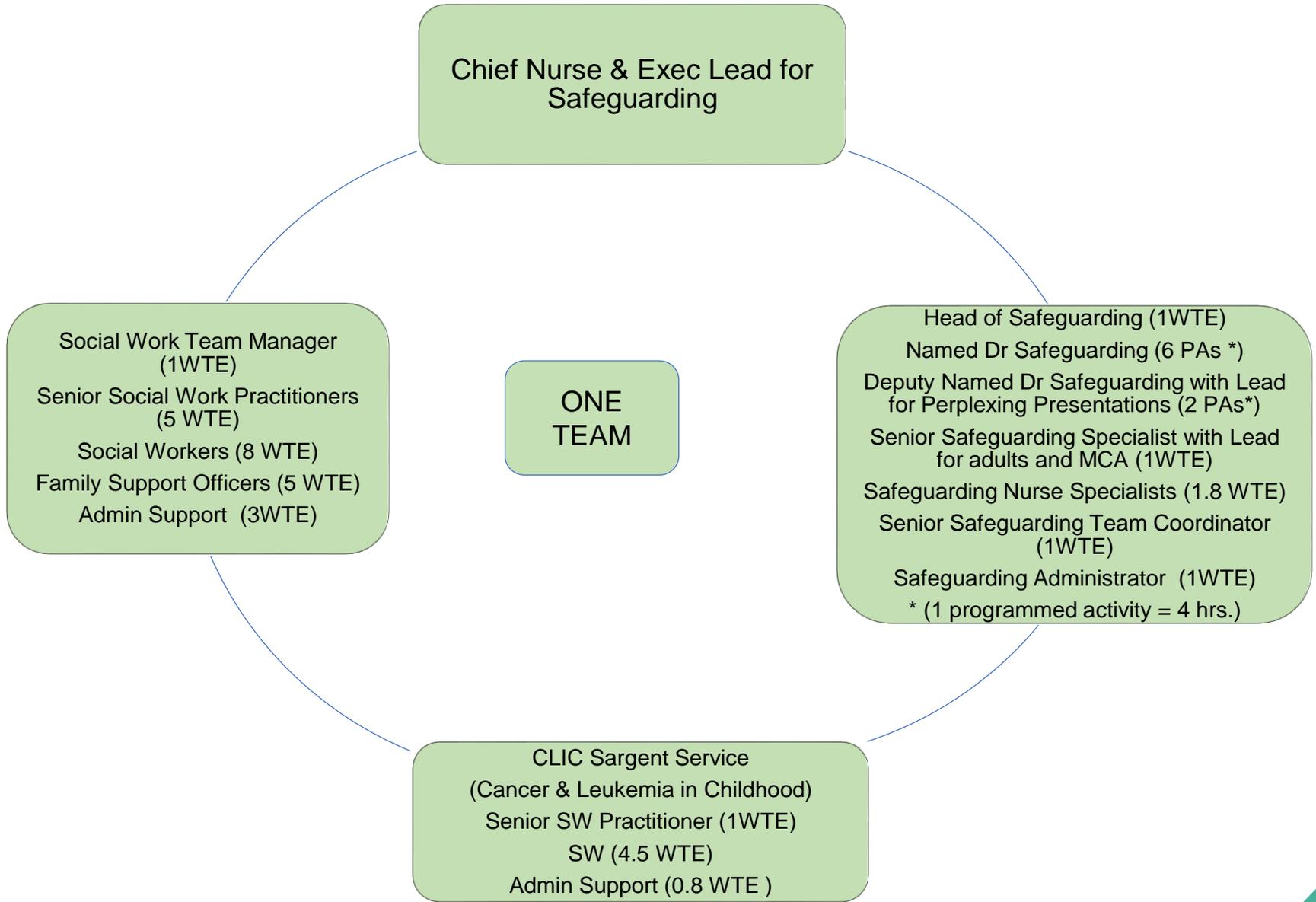
- Great Ormond Street Hospital (GOSH) is an international centre of excellence striving to provide the very best care for children with rare and complex conditions to enable them to achieve their full potential.
- We have 216,534 outpatient visits and 42,250 inpatients every year and a workforce of 4,787 employees. There are 60 different clinical specialities at GOSH; the UK's widest range of specialist health services for children on one site. More than half of our patients come from outside London being referred from other hospitals throughout the UK and overseas.
- The Children Act 2004 (Section 11) places a duty upon all NHS Provider Services to ensure their functions are discharged with regard to the need to safeguard and promote the welfare of children. The Trust is expected to ensure that its provider arrangements are robust and that safeguarding and promoting the welfare of children is integral to clinical governance and audit arrangements.
- The Care Act 2014 sets out the statutory principles which apply to all health and care settings to safeguard vulnerable people over the age of 18 years.
- The Safeguarding Children, Young People and Adults Annual Report relates to the period from 01/04/2018 – 31/03/2019, and seeks to provide high level assurance to the Trust Board of the responsibilities and value delivered by the Trust Safeguarding Team and Social Work Service.
- The report updates on progress on work streams agreed within the work plan for 2018/ 2019

One Team

- The safeguarding team is currently at full strength having replaced the 0.8 WTE post holder who left due to promotion.
- Following the departure of the Head of Social Work Service in May 2019, an interim Team Manager is fulfilling the managerial role within social work. A social worker has stepped up into the Interim Senior Practitioner role.
- Two longstanding CLIC Sargent social workers and the senior practitioner have retired and are presently being replaced by three new social workers all of whom have extensive hospital social work experience.
- This year has seen the Safeguarding and Social Work teams working with greater collaboration.
- The teams are now co located and have an integrated duty system in place Mon – Fri 9-5 to receive all referrals and provide advice and support for staff.
- Both teams meet for a 'Learning into Practice' event 3 times per annum, most recently with an external speaker, a barrister who advised on the requirements producing robust statements for court.
- The Named Professionals and Social Work Manager meet regularly and are working together to implement the wider recommendations of both safeguarding reviews.
- The CLIC Sargent Manager has been invited to join the Trust's Operational Safeguarding Group so that broader engagement is achieved.

Progress in 2018 – 2019

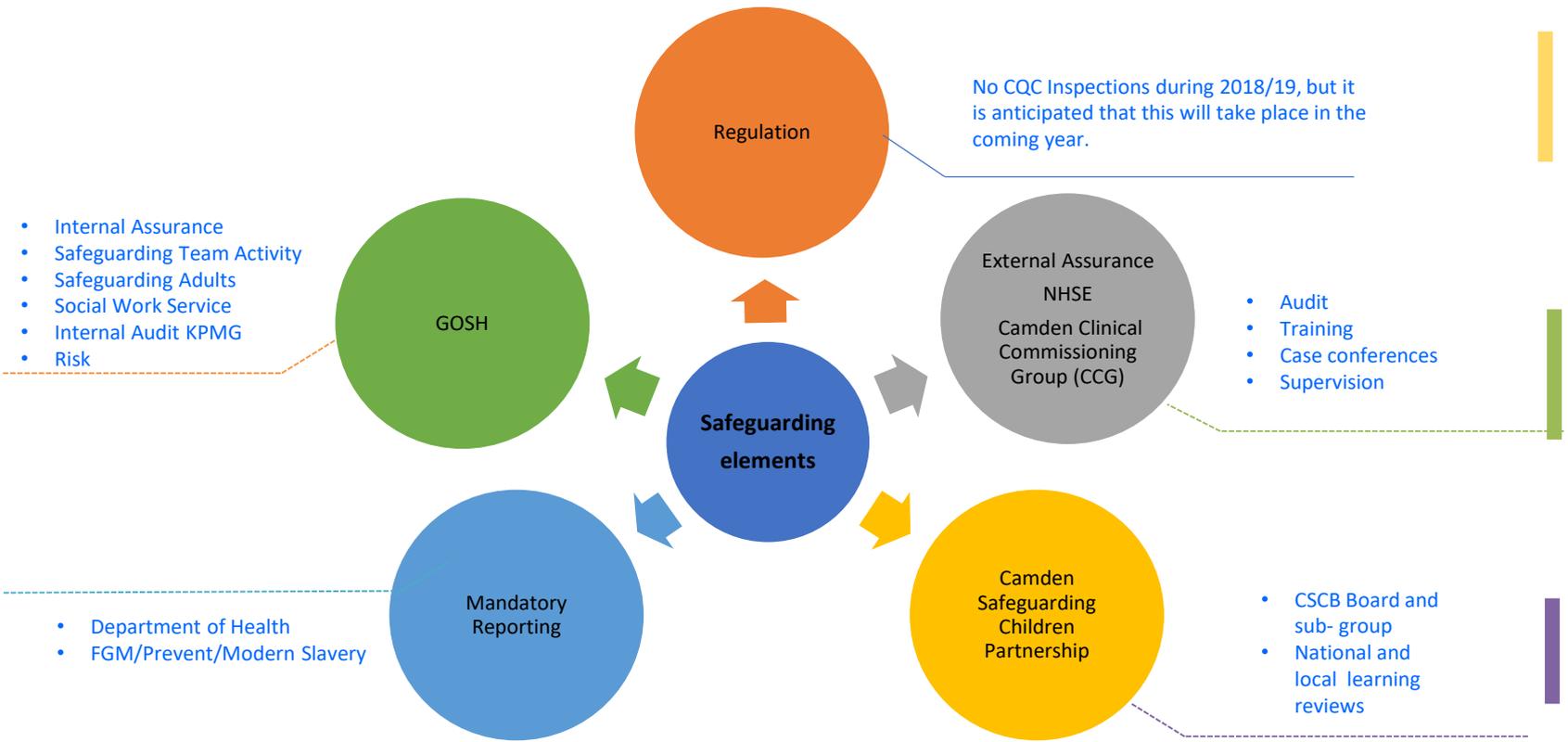
- The safeguarding and social work service are now co-located and have an integrated duty system in place to receive all referrals and provide advice and support for staff, a culture is embedding of one team.
- Establishment of a 24/7 safeguarding rota for general paediatricians from 1/04/2019.
- Bespoke training being implemented for consultant groups.
- Increased clinical medical support for complex cases.
- Proposal accepted for Perplexing Presentation Medical Lead (currently under discussion).
- The social work service has ceased recording on the Camden local authority data base and is now recording directly into the integrated patient record EPIC.
- GOSH facilitates regular meetings of tertiary centres to share best safeguarding practice and consider challenges.
- Implementation of the recommendations from the internal audit into safeguarding at GOSH.
- Mental Capacity Act Lead now incorporated into the Safeguarding Adult Lead role.
- A radical review of Safeguarding Training Strategy commenced.
- Expansion of membership of Safeguarding governance groups to broaden inclusion across the Trust.



Safeguarding Core Elements

The five core elements of safeguarding at GOSH aim to provide assurance on our safeguarding arrangements to our External Regulators, Commissioners, Trust Board and Quality, Safety, Experience and Assurance Committees.

We are continuing to build on our data collection bringing together the Safeguarding and Social Work Teams including the work of the CLIC Sargent Social Workers.



The Trust provides quarterly metrics to its commissioners from North West Central London reporting on four key areas

Involvement in Child Protection (CP)

Conferences

The Trust has received a total number of 171 invitations in 2018/19 for involvement in CP conferences. Throughout the year there has been a steady increase in the numbers of invitations received each quarter. In all 149 professionals contributed with either a report, linking in by teleconference or attending in person.

Where compliance has not been achieved this is mainly due to late or non receipt of invites.

Involvement in CP conferences are coordinated by the Safeguarding Administrative Team to ensure appropriate participation in the multi agency process.

Supervision

In 2018/19, the total number of individual staff that received planned and unplanned supervision was decreased by 22.7%. There have been a smaller number of individuals attending planned supervision sessions due to competing resource factors but overall more sessions (extra 59 in 2018/19) have been delivered.

There were 428 cases discussed (increase of 36% from the previous year) suggestive of key staff bringing more cases to each to supervision session.

More information on page 15

	Planned sessions	Planned Staff No.	Planned Case No.	Unplanned Sessions	Unplanned Staff No.	Unplanned Case No.
Q4	20	218	105	87	87	87
Q3	13	180	56	13	42	42
Q2	13	138	26	12	12	13
Q1	21	265	77	22	24	22

Audit

The Safeguarding and Social Work Teams have participated in the internal audit undertaken by KPMG.

The Trust has participated in 2 multi agency audits requested by Local Safeguarding Children Boards.

Camden Theme- Neglect

Hackney Theme - Children and Young People with mental health issues.

The trust internal safeguarding audit programme has been delayed by both reorganisation and the preparation for the implementation of the EPIC.

Audits in progress:

Learning from Serious Case Reviews (SCRs)

Was Not Brought

Supervision

External Assurance
NHSE
Camden Clinical
Commissioning
Group (CCG)

Training

Safeguarding Children	Staff compliant	%
Level 1	1493	91%
Level 2	499	91%
Level 3	2974	81%
Level 4	2	100%

The Trust has prioritised efforts across the organisation to improve the uptake of level 3 training particularly amongst holders of honorary contracts.

Further comments see page 14.



Camden Safeguarding Children Partnership

Partnership working

Following the publication of Working Together (2018) Camden Safeguarding Children Board became known as Camden Safeguarding Children Partnership from 1st June 2019 .

The Executive Lead and Named Professionals attend Camden Safeguarding Children's Board (CSCB) and its subgroups namely Quality Assurance and Health to ensure that the Trust is actively involved with local multi-agency developments and provision of assurance at all levels. During the past year there has been attendance by the member or their deputy at all meetings.

People in a position of trust

The Trust has a clear policy aligned with national and local guidance for dealing with allegations against people who work with children. Support is provided by the Local Authority Designated Officer (LADO). In the past year there have been 14 such allegations with one resulting in a criminal prosecution of a previous employee.

Local and national child safeguarding practice reviews

Following the publication of Working Together in July 2018 serious child safeguarding cases are now considered at either a national or local level.

In 2018/19 the Trust has been asked to contribute to 2 new SCRs involving 2 children. 4 cases remain active with independent overview reports in progress.

One Serious Case Review has been stepped down to a local review following Family Court proceedings.

- There have been requests for involvement to a further 3 local child safeguarding reviews.
- It is notable that for the first time this year the Trust has contributed to more cases where opioid dependency has occurred when the child's symptoms have been exaggerated or remain unexplained and is planning a learning event with subject matter experts.
- Learning is disseminated to staff through the Patient Safety Outcomes Committee, and from June 2019 the 'Closing the Loop' group. The learning is included in training and supervision.
- Serious cases of physical maltreatment, both external and internal are selected for discussion and learning at the Child Abuse Pathology Meeting.
- For the first time the majority of open SCRs with GOSH involvement have actual or suspected Fabricated or Induced Illness as their main factor, these require significant resources from the Safeguarding Team.

Mandatory Reporting

Female Genital Mutilation (FGM)

The Serious Crimes Act 2015 placed a mandatory duty on all regulated professionals to report FGM to the police on 101 if they have a direct disclosure from a child under the age of 18 that is a victim of FGM. Staff are required to report if they are the recipient of a direct disclosure. All staff are made aware of this duty within all levels of safeguarding training.

The Trust are required to report such cases to NHSE.

There has been 1 confirmed case of FGM which was reported to the Police.

Modern Slavery

The Government estimates that up to 13,000 people are in modern slavery in the UK today. Most people are trafficked into the UK from overseas, but there is also a significant number of British nationals in slavery.

Although health professionals are not required to mandatorily report to the National Referral Mechanism, they do have a responsibility to consider issues regarding modern slavery and their impact on those vulnerable groups many of whom come from backgrounds that deter them from seeking help from authorities.

There has been one case of modern slavery where concerns were raised but the subject declined any intervention or support.

Prevent

The Trust has remained responsive to the counter terrorism strategy and we recognise that all members of staff have a duty under the Counter Terrorism and Security Act (2015) to have due regard to the need to prevent people being drawn into terrorism and to act positively to report concerns.

There have been 2 concerns raised during the year, but none resulted in a referral to the local Prevent Channel Co-ordinator.

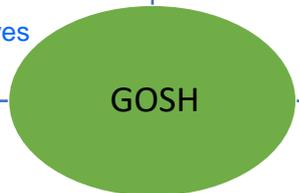
Internal assurance

- The Strategic Safeguarding Committee (SSC) meets quarterly and Camden’s designated safeguarding professionals are invited. The Operational Safeguarding Group (OSG) meets twice between each SSC. The aims of both groups are to provide assurance that the Trust promotes the safeguarding of children young people and vulnerable adults at all times.
- A quarterly report is compiled for the Quality Assurance, Experience and Safeguarding Committee (QSEAC), and an annual report for Trust Board.
- The Clinical Quality Review Group (CQRG) meets quarterly with commissioners from NHSE and receives safeguarding updates as required.

Requests for contributions to Local Authority Assessments

The safeguarding team have coordinated a total of 122 (50 assessments relating to child protection and 72 relating to child in need) requests for information from clinical professionals. The teams are supported by the safeguarding team to ensure comprehensive information is provided to the local authority.

The GOSH Social Workers contribute to those cases where they have had involvement.



Risks

The Disclosure and Barring Service

- The Trust undertakes checks at recruitment of all staff, which was 100% as of 31.03.2019. Existing staff have rechecks which are currently at 95%.

Persons Who Pose a Risk

- The Safeguarding Team works closely with the Risk, Social Work, Security and Directorate Nursing Teams to ensure a safeguarding perspective is included in the risk assessment where there are concerns about a person who may pose a risk.

Risk Register

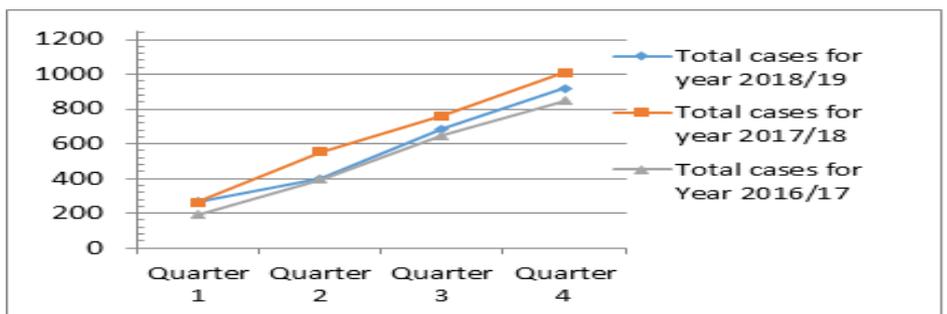
- A dedicated Safeguarding Risk Register is overseen by SSC.
- The register currently has risks in relation to migration of reporting systems and increasing compliance with MCA requirements.

National Independent Inquiry into Child Sexual Abuse

Set up due to serious concerns that some organisations had failed and were continuing to fail to protect children from sexual abuse.

- There have been no cases identified to the Trust from the Inquiry to date. The Trust is compliant with the Action Plan which is updated annually.

Safeguarding Team Activity



- Overall activity for this year has decreased from the previous year by 9%, but increased from 2016/17.
- The co-location of the safeguarding and social work teams has enhanced the single duty team approach. Cases are considered at social work and safeguarding daily hub meetings (SWASH) and allocated appropriately to a member of the duty team.
- This has led to a more effective use of resources within both teams and decreased the numbers of cases where work is duplicated.

GOSH Social Work Service

The Social Work service is funded from joint GOSH charity and NHS funding. In addition, there is a dedicated CLIC (Cancer and Leukaemia in Childhood) Sargent Service that works as part of the social work service. Of the total composition of the social work service 5.5 WTE posts are funded by CLIC Sargent and this includes a dedicated senior practitioner. There is a service level agreement which requires this service to be overseen by the GOSH Head of Social Work.

It has been agreed that future recruitment of social work posts (excluding CLIC Sargent) will be directly into the trust employment. It is hoped that this will further cement the integration of GOSH social work in to the multidisciplinary teams.

The delivery of the CLIC Sargent service is being changed in May/ June 2019 so that social workers will not be attached to specific areas, but will work across the three key areas of; Oncology, Haematology, and Neuro-Oncology. A duty system is to be established that will triage and allocate work, based on priority and safeguarding risk.

The CLIC duty service will work closely with the General Social Work duty service to ensure that all cases involving safeguarding are appropriately considered and notes recorded on GOSH's EPIC database.

Social workers are to be logged on patient records as being part of the care team and treatment team on the EPIC database.

The Social Work service at GOSH provides support to all wards and units within the hospital, operating a 9-5 duty service which ensures that there is always a social worker and a senior practitioner available. All qualified Social work staff within the service have updated their Camden Local Authority Child Protection(CP) training.

The Social Work and Safeguarding Teams have worked closely together to ensure that there is an integrated response to referrals identifying safeguarding/child protection concerns with information being shared routinely across both teams. New referrals are now received via EPIC, and sent to both teams who jointly review and plan next steps. A decision is then made as to who will take the lead in each case.

There is ongoing work to further develop best practice in social work around information sharing. Expert advice has been sought and guidance given to the social work team to guide improved practice in the context of recording on the hospital wide EPIC database versus previous practice of recording on a separate Mosaic database. Access to the Mosaic database for staff has been secured from Camden to ensure that social workers can draw upon our historic records whilst we transfer cases on to the new system.

2014/15	2015/16	2016/17	2017/18	2018/19
1183	945	1510	1392	1261

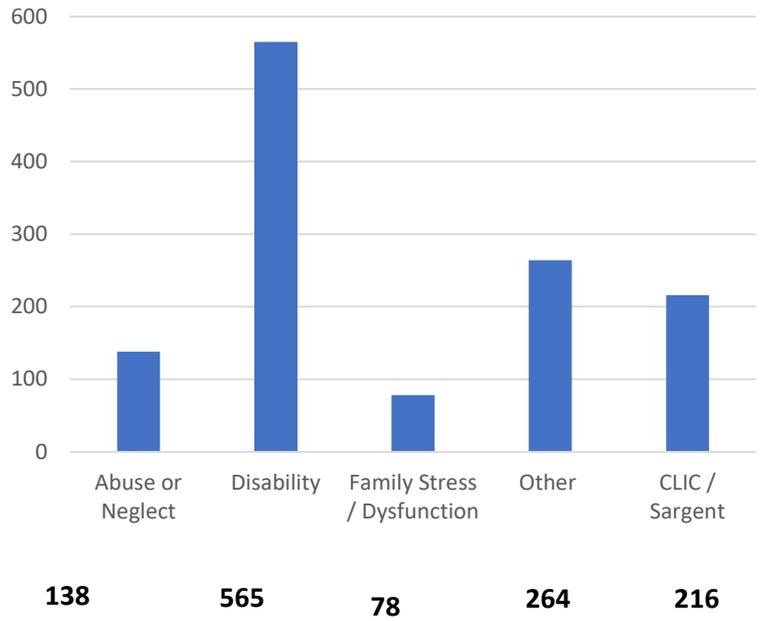
Total referrals for the year is 1,045. Whilst this represents a decline from the previous year (1392 referrals), CLIC Sargent received 216 referrals and these moved onto a different recording system. Including them gives an overall figure of 1,261 referrals.

Local Authority referrals

GOSH social workers have referred 122 patients to Local Authority social services depts. A great deal of early help support and preventative interventions are delivered by GOSH social workers and family support workers which mean that not all needs are referred externally. Many social workers continue to be part of the network around a child even after referral to a local authority.

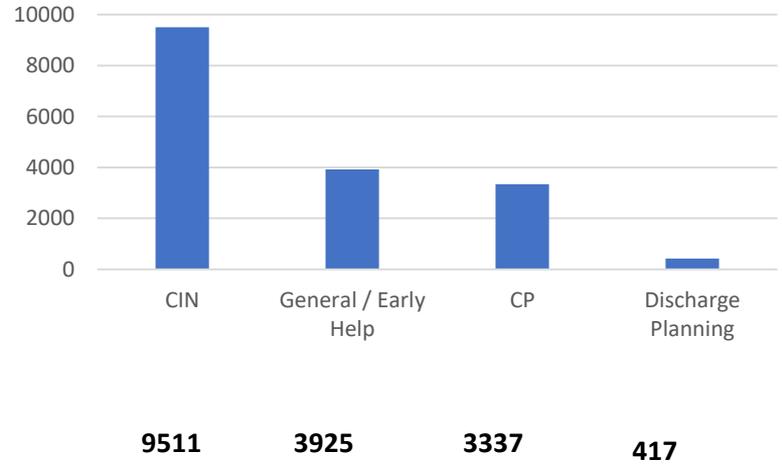
GOSH Social Work Service

Types of referrals 2018/19



Total referrals for the year is 1,045, CLIC Sargent received 216 referrals and these moved onto a different recording system. The combined total gives an overall figure of 1,261 referrals. Under the Mosaic system new referrals were categorised at the outset, and could not be changed so disability is logged as the default need when it is not clear from the initial information whether there are safeguarding issues in addition to needs resulting from having a sick child.

Social Work Activity by Intervention Type 2018 / 2019*



CIN refers to Children in Need level interventions on behalf of patients for whom there are safeguarding concerns or additional support needs to a degree greater than early help but beneath the Child Protection (CP) threshold.

Not all activities fit into these types. There were 19,499 case notes in 2018/19 on Mosaic, and the above accounts for 88%. The remaining 12% includes work primarily done in relation to Looked After Children recording on the database with respect to records of plans and decisions made, and supervision between social workers and managers.

Safeguarding Adults & Mental Capacity

Adult patients seen at GOSH in 2018/19:

Type of contact	Numbers	
	2018/2019	2017/2018
Admitted as an inpatient. (this includes cardiac MRI) *	671	601
Outpatients (2017/2018)	6392	6057
TOTAL	7063	6727
Top 5 admitting specialties:		
Cardiology	553	
Urology	32	549
Dental & Maxillary Facial	25	22
Neurology	9	15
Plastic Surgery	7	13
Spinal		10
Rheumatology	7	

❖ **Current data available does not distinguish between day cases and overnight inpatient stays.**

Training

Level 2 Safeguarding Adults training become mandatory for all qualified staff at GOSH from June 2018. This is currently a 30 minute assessed e-learning module.

Compliance with Safeguarding Adults Training:

Level 1 92% Level 2 88%

Additional Safeguarding Briefings have been delivered to the specialties with the most adult patients.

Supporting the local safeguarding system

GOSH attends the board of Camden Safeguarding Adults Partnership Board and the Quality and Performance Sub-group. Quarterly compliance reports are received by the North Central London Sustainability and Transformation Partnership, where NHS and local authorities work collaboratively to improve health and care.

The Senior Nurse Specialist for Safeguarding Adults and Children/MCA Lead represents GOSH at the London Safeguarding Adults Provider Forum and MCA/DoLS Network.

Safeguarding Adult Reviews (SARs)

Safeguarding Adult Boards (SABs) have a statutory duty to arrange a SAR when an adult in its area who has care and support needs dies as a result of abuse or neglect, and there is concern that agencies could have worked more effectively to protect the adult.

Islington SAB

An Individual Management Review has been completed for Islington SAB regarding an adult who had historic contact with GOSH. Although the case is not proceeding to a full SAR, a learning exercise will be undertaken.

Kingston SAB

A SAR is in progress in relation to the death of a young person who was known to the Trust for paediatric services which the organisation has contributed to.

Mental Capacity Act / Deprivation of Liberty Safeguards (DoLS)

The Senior Nurse Specialist has taken on the role of Trust MCA Lead.

An interdisciplinary MCA Group has been set up to develop policy/strategy; provide pragmatic advice to decision makers; and, provide co-supervision, support and agreement around capacity issues.

Training on MCA and DoLS is included in Level 2 Safeguarding Adults training and a training package has been developed to provide further training for key staff.

The MCA Lead sits on the task and finish group for the new Code of Practice for Liberty Protection Safeguards, which will inform our preparations for the impending change in legislation

Policy and procedures

The Safeguarding Adults Policy has been comprehensively reviewed to reflect current legislation and practice and was agreed in February 2019.

A new MCA Policy has also been developed and approved.

Supervision

- The importance of safeguarding supervision is a recurrent finding in the analysis of Serious Case Reviews.
- The Trust recognises that clinical supervision is essential to professional development and helps the supervisee develop confidence in decision making.
- The safeguarding supervision policy has been revised and provides the basis for evidencing that supervision is embedded within the Trust.
- Although the figures have varied from one quarter to another, overall there has been a 36% increase for the year in the numbers of cases brought to supervision.
- The number of stand alone supervision sessions has reduced as more supervision is incorporated into team training days as group sessions.
- Every member of staff can access safeguarding supervision on either an ad hoc or planned basis and individually or within a group setting.
- In a tertiary centre with over 4,500 staff delivery of supervision may be achieved in various formats from individual staff to groups, and can be achieved through case reflection and discussion in various settings.
- By developing a more flexible approach this has been reflected in increased numbers accessing supervision, leading to staff feeling empowered to assess safeguarding concerns and act in an appropriate and timely way.
- It is hoped that this will include the attendance at psycho social meetings in wards and departments to strengthen and standardise the model employed across the Trust. This will complement the presence of social work colleagues who currently provide a level of safeguarding oversight, and ensure that safeguarding concerns are identified and responded to in a timely and appropriate manner.
- The Named Doctor participates in regular supervision sessions with clinical professionals through regular multi disciplinary meetings and opportunities in education such as the monthly Child Abuse Pathology Meeting.
- Clinical supervisors must have an advanced level of knowledge and understanding of safeguarding children and adults including (but not limited to) identification of concerns, vulnerability factors, remedies, and statutory responsibilities.
- The safeguarding team are currently one supervisor less but it is hoped the new team member will receive specialised training within the near future. In addition safeguarding and social work teams co-facilitate sessions.
- To further expand supervision into the wider professional network, opportunities will be explored, to include increased numbers of medical staff and clinical nurse specialists through the introduction of peer and case reviews.

Audit

Internal:

Safeguarding Audit by KPMG:

The Safeguarding and Social Work Teams participated in the internal audit programme with an outcome of

Significant assurance with minor improvement opportunities

3 recommendations were made:

1. The SSC terms of reference have been updated and confirm committee is meeting its purpose. A dedicated safeguarding risk register is overseen by the SSC.
2. Reporting of CLIC Sargent activity
3. Closing out of safeguarding referrals

Think Family Audit

The collection of social information gathered is due to be re-audited following a period of embedding within the electronic patient record system (EPR).

Was Not Brought Audit

Guidance is being produced regarding children and young people not being brought to appointments. The introduction of EPR will improve awareness of failures to attend appointments

Current audits in progress:

Learning from Serious Case Reviews

Seeking assurance that professionals are embedding the learning into practice from recent SCRs that the Trust has contributed to.

Supervision Audit

To ascertain user experience across the Trust.

External:

Safeguarding Children Boards undertake a schedule of multi-agency audits as part of their statutory function under Section 14 Children Act 2004 to monitor the effectiveness of safeguarding practice.

The trust has participated in audits with :

Camden - thematic audit of neglect.

Several themes have been identified:

The links between which;

- child neglect and adult mental health problems and the need to measure the impact of such issues on the child
- neglect and poor school attendance
- the association between failed hospital appointments and other indicators of neglect
- the need for professionals to identify and interpret patterns of repeat referrals and to adopt a cumulative risk perspective
- challenges presented to professionals by non-compliance , hostility and disguised compliance on the part of parents and carers.

GOSH actions:

Each area is included in core safeguarding training and reinforced through supervision

Hackney – thematic audit of mental health.

Currently in progress. Awaiting outcomes from audit review.

Safeguarding across the Trust

Safeguarding Links

- The Safeguarding Links are health professionals across the Trust who provide an important and effective means of disseminating information and good practice across the organisation.
- They are expected to act as role models to front line practitioners and be champions of safeguarding within their local areas.
- The Senior Safeguarding Nurse Specialist co-ordinates quarterly meetings with the links, with support from the Safeguarding Nurse Specialists and Senior Practitioners from the Social Work team.
- We have instigated a system of 7 minute briefings on a range of safeguarding topics to help the links cascade information to update staff within their areas and to support staff in identifying concerns early and referring these appropriately.
- Topics covered in 2018/2019 include: Female Genital Mutilation, Sexual Abuse, Perplexing Presentations/Fabricated and Induced Illness and Looked After Children.

Directorates

- The Named Professionals and Head of Social Work engaged with the 2 directorates at their governance meetings prior to the re; structure.
- In October 2018 the organisational restructure created 8 directorates which necessitated a review of engagement from the Safeguarding Team to consider how best to deploy resources.
- The Named Professionals link with the Deputy Chiefs of Service to ensure that key safeguarding information is embedded into practice within each of the directorates, including any learning from Serious Case Reviews.
- The Named Nurse links with Matron and Ward Sister meetings and will engage with Heads of Nursing and Patient Experience.
- The Specialist Nurses attend Practice Educators meetings regularly.
- Safeguarding Newsletters are produced 6 monthly to provide an update to all staff.

Named Doctor Activity

- The Named Doctor for Safeguarding Children continues to work collaboratively with other members of the safeguarding and social work team, legal team, general paediatricians and others in ensuring the best safeguarding outcomes for our patients.
- Clinicians are supported with advice from the Named Doctor both formally and informally. A hands on approach is essential in building staff confidence in knowing that they can always rely on the support that they require in dealing with the most complex of issues.
- As well as supporting the early intervention and support agenda, child protection cases are not uncommon. These involve staff assessing and managing the most severe inflicted injuries in PICU, neglect of medical needs, perplexing presentations, fabricated and induced illness.
- We participate fully in multi-agency and court processes, including communicating vital information in a readily understandable form to non-health professionals at strategy meeting and child protection conferences.

Developments 2018/19

- 24/07 medical safeguarding rota was set up in March 2019, by the Named Doctor who is also part of the rota delivered by the general paediatric team, to ensure medical safeguarding support as required.
- Bespoke training continues to be offered to medical and nursing teams and this has been delivered this last year by the Named Doctor to neurology, PICU, geneticists, gastroenterology, nephrology, general paediatrics and social work.
- Discussion and advice regarding complex cases involving perplexing presentations are led by either the Named Doctor or Deputy Named Doctor who also liaise extensively with health teams outside the Trust.
- Updated chaperone policy and a new cannabinoid oil practice guidance has been developed in collaboration with colleagues.

The Named Doctor role is to be welcoming and helpful in order to ensure that we practice as experts in safeguarding and always work together as one team.

Practice Development

Policy development

- Safeguarding is a rapidly changing and growing area of work.
- The Trust Policies and procedures are required to be reviewed and updated in line with national and local policy.
- The Trust implemented the changes to the statutory document Working Together to Safeguard Children published July 2018.
- The Pan London Procedures are the overarching policy that supports local safeguarding policies to which Trust policy should be complementary.

Within the last year the following policies have been reviewed and approved.

- Safeguarding Children & Young People Policy
- Prevent
- Safeguarding Supervision
- Safeguarding Adults
- Mental Capacity and DoLS

The procedural appendices aligned to Safeguarding Children and Young People Policy are maintained within the safeguarding webpages to reflect changes to national and local practice policy and guidance to achieve real time updates.

Child Protection Information Sharing System (CP-IS).

The Trust has agreed with NHS Digital a deferred implementation date of April 2020 to more readily reflect our patient population.

The Safeguarding Nurses have developed and supported the Safeguarding Workflow Tool across the Trust to support clinical professionals.

Early recognition and management of Perplexing Presentations

- There has been increased awareness raising within the Trust of alerting signs for possible Fabricated and Induced Illness.
- The Deputy Named Doctor for Safeguarding and the Safeguarding Team are responding to increasing numbers of cases where clinicians identify the alerting signs, often at an earlier stage which can prevent the patient being exposed to unnecessary investigations and procedures. A business case is being developed to increase the resource required to meet this growing need.
- A pathway has been created for managing these situations when there is not an immediate serious risk to the child's physical health or life. These are termed Perplexing Presentations.
- Key aspects of management include the need for direct observation of the child and full and open communication between all professionals involved in the patient's care both within and external to GOSH, in order to ascertain the actual state of the health of the child.

European Children's Hospitals Organisation (ECHO)

- The Safeguarding Team with the support from the Clinical Outcomes Development Lead have devised an international research tool to be disseminated amongst the members of the ECHO in order to further understand the challenges encountered and benchmarking best practice in safeguarding.

Performance Priorities 2019/20

- Further develop the Safeguarding Risk Register to ensure all safeguarding risks are held in one area and are monitored by the Trust internal governance structure.
- Embed the 24/7 safeguarding rota for General Paediatricians.
- Build the business case for a Perplexing Presentation Support Service.
- Introduce a 'Top 3' list of hotspots to identify areas across the Trust requiring further input from Safeguarding and Social Work Teams.
- Review the guidance for managing allegations against Persons in a Position of Trust, in line with national and local procedures.
- Develop an Intentional Injury Protocol.
- Complete the training proposal to further expand the level 3 specialist training to more key specialist professionals.
- Continue to promote the safeguarding supervision agenda and explore further ways of increase access to more staff.
- Increase compliance across the Trust with The MCA and prepare for the introduction of Liberty Protection Safeguards.
- Continue to work with our partners in IT and NHS Digital and the EPR Team to ensure a robust system is in place to meet the agreed deadline of April 2020 for Child Protection Information Sharing system (CP-IS), which will also support an enhanced Looked After Children's Agenda.
- Support the Camden Children Safeguarding Partnership priorities:
 - Vulnerable adolescents
 - Youth safety
 - Prevention & recognition of child abuse
 - Neglect
 - Domestic Violence & Abuse

**Summary of the meeting of the Audit Committee
Held on 22nd May 2019**

Legal Claims Report

The number of claims received at GOSH was very low in comparison to other Trusts and the majority received had previously been investigated by the Trust as part of a complaint or serious incident investigation. When this had not happened, a retrospective investigation took place where necessary. Discussion took place on the impact of claims on staff members involved and it was emphasised that claims were brought against the Trust rather than individuals.

Cyber security update – breaches

Windows server patching had been paused for EPR roll out and would be up to date by 31st May 2019. All breach attempts in the month had been prevented at source and a paper was being presented to EMT to address replacement of outdated tools. Security updates for Windows 7 would continue to be provided until January 2020 and therefore the Trust must have upgraded to Windows 10 by then.

Minutes of subcommittees

The Committee noted the minutes of the March Finance and Investment Committee and a summary of the March QSEAC meeting.

Internal Audit Progress Report

A review of Fit and Proper Person Test (FPPT) processes had provided a rating of 'significant assurance with minor improvement potential'. An amber recommendation had been made around applying a similar FPPT process to Governors as was used for Directors.

Internal Audit Annual Report 2018/19 including Head of Internal Audit Opinion 2018/19

The Head of Internal Audit Opinion was significant assurance with minor improvement potential. The Internal Auditors confirmed that none of their clients had received significant assurance ratings and some had received partial assurance but this was not common.

Board Assurance Framework

The Risk Assurance and Compliance Group had reviewed patient safety data covering the period of the lead up to EPR go live and had found that no material trends or differences had been identified. Discussion took place around the phase that the EPR project was in in order to appropriately word the revised risk statement. The Committee agreed to increase the consequence score of the Better Value risk to 4.

Presentation of high level risks

- Risk 3: The risk that the organisation will not deliver IPP contribution targets

Discussion took place around the potential for GOSH to develop a clinical presence in the Middle East which would be primarily in order to secure and grow existing referral flows. The Committee highlighted the red rated performance of staff metrics in the division and emphasised the

Attachment 2

importance of improving these metrics in order to run an efficient service. The Committee discussed the work taking place to increase the work with more local private patients.

- Risk 2: The risk that the organisation will not deliver productivity and efficiency targets and that targets indirectly impact on patient care

Schemes totalling £14.4million had been identified for 2019/20 against a target of £20million. The majority of schemes were recurrent however there was a risk around the projects identified to close the gap which were likely to be non-recurrent. Discussion took place around staff engagement and it was noted that a successful extraordinary all-staff talk had taken place to discuss the Trust's Better Value obligations. Staff were becoming more engaged and the outturn for 2018/19 had been challenging which had been recognised by staff.

- Risk 10: The risk that the EPR programme will not be delivered on time or within budget
EPR had gone live as planned on 19th April 2019 and although a large number of issues had been experienced in the first two weeks these had not been as many or as severe as anticipated. A PhD study was being undertaken on the impact of an EPR on patients and families. The Committee requested that the QSEAC continued to review the medicines management risk was red rated and ensure that sufficient focus was placed on pharmacy.

EPR/DRE completion

The process for monitoring the degree of completion of the EPR and DRE assets to determine the amortisation start date had been revised following the discussion at a previous committee meeting. It was noted that the completion date was beyond 2019/20 as the Trust had gone live with the standard system which would require significant optimisation to deliver GOSH's requirements. The approach would be formally assessed by the external auditors' experts as this was an accounting judgement.

Chief Financial Officer's review of the Annual Financial Accounts 2018/19, including the Going Concern assessment

The Trust achieved a surplus in 2018/19 exceeding the control total by £116,000 and had therefore received £5.2million in PSF (Provider Sustainability Funding). Cash remained strong. Valuation of land and buildings had resulted in an impairment of approximately £4.5million.

Annual Financial Accounts 2018/19 and GOSH Draft Annual Report 2018/19

The Committee agreed to recommend the GOSH Annual Financial Accounts 2018/19 to the Board.

Final Report on the financial statement audit for the 12 month period ended 31 March 2019

Work was scheduled to be completed on 23rd May 2019 and subject to its completion no significant adjustments or disclosure deficiencies had been identified. The external auditor confirmed that he intended to offer an unmodified opinion and was not anticipating giving any further notes in any areas, subject to completion of the audit. Given the composition of the balance of NHS debtors the provisioning methodology was deemed to be reasonable and provisioning of IPP debt was within an acceptable range. No material misstatements or findings were made in respect of management override of controls.

GOSH Draft Annual Report 2018/19

The Committee requested that greater emphasis was placed on the importance of the GOSH Children's Charity in the Trust's ability to implement the EPR. The Committee agreed to recommend

Attachment 2

the GOSH Draft Annual Report 2018/19 including Annual Governance Statement and Annual Audit Committee Report to the Board for approval.

Quality Report 2018/19

It was agreed that the importance of the contribution of the GOSH Children's Charity would be further emphasised.

2018/19 Quality Assurance Review of the Quality Report

An unmodified opinion was provided for the 31 day cancer wait metric however a qualified opinion was provided for RTT incomplete 18 week pathways. Discussion took place around the substantial work that had taken place in this area and the likelihood that an unqualified opinion would be received following the introduction of Epic. It was agreed that the external auditor would meet with the performance team to review the errors which had been found and a report would be provided to the Audit Committee on those which could be improved over time through Epic.

Local Security Manager Work-plan 2019/20

The Committee noted the report.

Audit Committee Annual Effectiveness Survey Results

The continued to be comments around overlap between Committees which would be kept under review.

Revised Audit Committee Terms of Reference and Workplan

The Committee approved the revised Terms of Reference and noted that the workplan would be updated following the publication of the HFMA workplan for 2018.

Review of non-audit work conducted by the external auditors

The revised non-audit work policy was approved and one piece of non-audit work which had been undertaken in year was noted.

Making Tax Digital (MTD)

The Committee noted the update.

Assurance of compliance with the Bribery Act 2011

It was agreed that a date would be set for the Trust Board to receive counter fraud training.

Update on raising Concerns at GOSH (Whistleblowing)

One case which had been presented to the Trust Board remained open. A review was currently being undertaken by the RCPCH and no concerns had been highlighted from the initial phase.

Update on Freedom to Speak Up at GOSH

There had been a significant increase in the number of cases raised compared to the previous year due to increased awareness and senior staff being clear that it was important to raise concerns. The Committee welcomed the increase.

Q4 2018/19 Losses and Write Offs

An increase in write offs for quarter 4 was as a result of drugs associated with a single patient.

Trust Board Thursday 18 July 2019	
Board Assurance Committee reports: Finance and Investment Committee (June 2019) Report prepared by: Helen Jameson, Chief Finance Officer Paul Balson, Deputy Company Secretary Item presented by: James Hatchley, Chair of the Finance and Investment Committee	Paper No: Attachment 3
Aims / summary This report summarises the work of the Finance and Investment Committee's (FIC) since its last written report to the Trust Board on Wednesday 22 May 2019. The FIC held a formal meeting on 11 June 2019.	
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 results of the Committee's survey of effectiveness stated that the Committee was performing well and identified a few areas for further enhancement in 2019/20.
- The Trust ended Month one of the 2019/20 financial year £0.1m behind its control total.
- Cash was higher than plan by £11.1m.
- Performance in Month aligned to the expected reduction agreed as part of the implementation plan for EPIC's EPR. Activity will increase over the remainder of the year to deliver the plan.
- The Trust was developing recovery plans for the Diagnostic waiting times and RTT incomplete pathway performance measures.
- There remained a £5.8m gap between the identified Better Value schemes and the £20m target which remains a significant concern and area of focus for the committee
- The Committee initiated reviews of all directorates. It reviewed International and Private Patients in June.

Assessment of effectiveness

To inform its assessment of effectiveness, a survey was circulated to both Committee members and regular presenters. The results were discussed at the 11 June 2019 meeting.

In summary, members and presenters stated that the Committee was performing well against its terms of reference. In particular, the work undertaken to develop links with the GOSH Children's Charity was well received.

Key areas for consideration in 2019/20 included: how frequent certain reports are received, paper length and relevance to the Committee's terms of reference. The Committee would also be mindful of how consistently executives are challenged at the Committee.

Performance and finance standing updates

Finance report 2019/20 Month one finance report

At Month 1 the Trust was behind with its control total by £0.1m and behind its income target by £1.5m (excluding pass through).

Trust income had been reviewed in light of implementation of the new EPR system.

Pay was underspent by £0.5m in Month one.

Cash was higher than plan by £11.1m in Month one.

Activity monitoring April 2019/20

As part of the implementation plan for EPIC's EPR an agreement was made for a reduction in activity across inpatient and outpatient activity in April 2019. Performance in Month was as expected and the impact was expected to continue to have an effect into early May.

The Trust plans to make up the performance throughout the remainder of the financial year.

There were issues with coding of activity since implementation of EPIC which has led to an adverse impact on the depth of coding and income per spell. The total impact of the changes would be assessed.

Integrated Performance Report: April 2019 (Month 1)

The Trust was developing recovery plans for the Diagnostic waiting times and RTT incomplete pathway performance measures caused largely as a consequence of EPR delivery. Focus was placed on Cardiac MRI delays and continued underperformance in terms of theatre flow.

Staff appraisal rates remained challenging; however, improvement was seen in the rate of consultant appraisal and there are action plans for all other directorates.

The number of discharge summaries sent within 24 hours was below the national standard – again, part of this was due to EPR transition. The Trust has initiated a full data investigation into this metric.

Better Value Programme update

The Committee received a new-look Better Value Programme update report. The key item was that there remained a £5.8m gap between the worked up schemes and the £20m target. Whilst there is a palpable focus on organisational culture change and EPIC benefit realisation that would potentially increase the likelihood of the Trust being able to deliver the £20m target, the committee remains concerned about, and focused on the size of the gap. There was discussion and focus on step change initiatives. It was noted however, that there are a reduced number of other levers that could help the Trust deliver its control total given the block nature of the majority of revenue in 2019/20.

This is a major focus for 2019/20 and the agreed better value targets are extremely challenging.

NHS Contracts update

For 2019/20, the Trust agreed to a block contract with NHSE and with a number of CCGs. This was predominantly to safeguard the Trust against activity risk arising from EPIC implementation.

It was reported that the risks to income arising from coding difficulties and data capture post EPIC Go-Live were mainly mitigated by the block contract that is in place. However there could be an adverse impact on future contracts if not rectified quickly.

Project updates / reviews

GOSH Learning Academy

The Committee recommended some minor amendments to the Draft GOSH Learning Academy business case ahead of submission to the GOSHCC Grants Committee in June 2019. The GOSH Learning Academy would deliver the Trust's strategic priorities relating to education and training over the next five years.

Month 1 2019/20 Procurement Report

The Committee received an update on the Guys & St. Thomas Hospital Trust led "SmartTogether" shared procurement service activity. Key points reported included:

- Good feedback had been received from operational teams within the Trust, in particular there had been improvements in invoicing processing.

Attachment 3

- To date, delivery against the Better Value programme had not been in line with expectations. Measures have been taken to address this further.
- A procurement Transformation Board has been established to oversee the contract and savings programme.

Directorate reviews

In March 2019 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 a follow-up from the Body, Bones and Mind Directorate on performance against its objectives and requested that future Directorate reviews include reporting on their objectives and associated KPIs. A template for the Directorate reviews had been created.

In June 2019 the committee conducted a review of the International and Private patients and discussed:

- The staffing differences between the IPP Directorate and the NHS Directorates.
- Effectiveness of debt retrieval.
- Strategies for retaining existing markets and the scope for attracting new markets.

The proposed review of the Brain Directorate was deferred due to unavoidable staff absence and will be covered in the next committee meeting.

EPIC update

The Committee was informed that the EPR Programme achieved the go-live criteria (agreed by Trust Board) and the Epic system was taken into full live use at approximately 3pm on Friday 19th April (as per plan).

DRIVE update

The Committee received an overview of DRIVE as an enabler and discussed several options for commercialisation, including the recruitment of information technology commercialisation expertise.

Major projects update

The Committee received a summary of progress made on several major development projects:

- Zayed Centre for Research into Rare Disease in Children
- Children's Cancer Centre
- Sight and Sound Centre
- IMRI
- A post implementation review of the Chillers upgrade was also presented and discussed and lessons learnt noted.

Sustainability key performance indicators (KPIs)

The Committee reviewed the key performance indicators that would be used to measure performance. These included: clean air hospital framework, green champions network expansion, recycling target, combined heat and power (CHP) engines, Co2 emissions from energy and the overall Trust carbon footprint. It was agreed that the Finance and Investment Committee would receive a quarterly sustainability report to monitor performance.

Evaluation of papers

At the end of each meeting throughout 2018/19, the Committee reviewed the quality of the papers it received. It was agreed that this would continue throughout 2019/20.

End of report

Trust Board 18 July 2019	
Revised Standing Financial Instructions and Scheme of Delegation Submitted by: Helen Jameson, Chief Finance Officer	Paper No: Attachment 4 Appendix 1: Updated Scheme of Delegation (SD) Appendix 2: Updated Standing Financial Instructions (SFIs)
Aims / summary <p>The SFIs and Scheme of Delegation (SD) were both updated and approved by EMT, the Audit Committee and the Trust Board in October 2018. At the end of that process it was agreed that both documents would be reviewed on an annual basis in line with the update process for the Trust's Standing Orders and Constitution.</p> <p>A review of the documentation has been conducted with EMT oversight. The updated documents have been shared with the Audit Committee members and in discussion with the Audit Committee Chair it has been agreed that the documentation should be submitted to the Trust Board for approval rather than wait until the next Audit Committee in late Autumn.</p> <p>Both documents have been updated to reflect changes in job titles and changes in the structure of sub-committees of the Board.</p> <p>The SFIs have been updated in respect of the new Declarations of Interests and Gifts and Hospitality Policy</p> <p>Changes to the SD have been made to reflect:</p> <ul style="list-style-type: none"> • The amended vacancy approval process • Align to the updated Trust Constitution • The matrix of delegated expenditure approval limits has been updated given the financial constraints that the Trust is facing and in order to simplify the approval hierarchy. A comparison is shown in Schedule One below. • Approval levels for invoice requests remain in place (detailed in the SD) but have been removed from the table to simplify for the user. • Additional approvals for capital overspends (that remain within the Trust Board approved annual plan) have been included in line with business case sign off limits – where as previously only spend in excess of the total annual plan (rather than at project level) was required to be approved by the Finance and Investment Committee 	
Action required from the meeting <p>The Trust Board is asked to approve the updated Scheme of Delegation and Standing Financial Instructions.</p> <p>Following approval by the Trust Board, a copy of the revised Scheme of delegation will be circulated to all budget holders via email.</p>	
Contribution to the delivery of NHS Foundation Trust strategies and plans <p>The Standing Financial Instructions and Scheme of Delegation form part of the Trust's governance arrangements.</p>	

<p>Financial implications Both documents describe how finance processes and authorisations have been designed.</p>
<p>Who needs to be told about any decision? The Standing Financial Instructions apply to all directors, officers, employees and third parties contracted to the Trust. The Scheme of Delegation applies to all budget holders.</p>
<p>Who is responsible for implementing the proposals / project and anticipated timescales? Neil Redfern, Financial Controller</p>
<p>Who is accountable for the implementation of the proposal / project? Helen Jameson, Chief Finance Officer</p>

Scheme of Delegation

The Scheme of Delegation sets out the approval limits within the Trust in line with the requirements of the Standing Financial Instructions. These should be reviewed and updated on an annual basis to make sure they align to the latest guidance and procurement regulations, as well as the Trust's governance structure.

The Scheme of Delegation was most recently updated and approved in October 2018. Since then no significant changes have been made, but references to posts and sub-committees of the board which no longer exist have been amended. In addition, the SD has been updated to reflect the further controls agreed by EMT for approving vacancies, which require all requests to be reviewed either by the Clinical Directorate weekly panel (for posts in clinical directorates) or Deputy Panel (for all Corporate and Research and Innovation posts). The update also reflects the fact that all Consultant and Agenda for Change Band 8c and above roles will be reviewed by EMT vacancy panel before final sign off.

Each chapter of the Scheme of Delegation has been reviewed on a detailed basis to ensure that it remains fit for purpose and strengthens the Trust's governance processes. The following changes are proposed to the Scheme of Delegation, since its last version:

Section	Amendments
1. Introduction and Purpose	Updates to referencing in the Trust Constitution
2. Hierarchy of Delegation and Sub-Delegation	No changes
3. Principles	No changes
4. Relevant Legislation – GOSH Constitution	Updates to referencing in the Trust Constitution
5. Summary of Expenditure Approval Financial Delegations	<p>Pay budgets section updated to reflect the new Vacancy Approval Process (as described above)</p> <p>Amendment to capital expenditure authorisations. Individual capital schemes may be increased by up to £100,000 by CIG; any higher than that requires authorisation by either EMT, FIC or Trust Board as appropriate.</p> <p>Any increases to the total capital budget must be approved by FIC.</p>
6. Summary of Procurement Delegations	<p>A note has been included to explain that On award of contract, the service specification should not be significantly different from that assessed as part of the tender process otherwise this will render the process invalid.</p> <p>Other changes in wording to provide greater clarity</p>

7. Summary of Contract Signing Delegations	No changes
8. Summary of non-Financial Delegations	No changes
Schedule 1 – Delegated Approval Limits	This section has been updated

Standing Financial Instructions

The Standing Financial Instructions were last formally issued in October 2018. To ensure they are up to date and remain aligned to the Scheme of Delegation each chapter has been reviewed and updated accordingly. The following changes are proposed to the Standing Financial Instructions since their last approval:

Section	
1. Audit Committee	No changes
2. Business Planning, Budgets, Budgetary Control and Monitoring	Job title updates
3. Annual Accounts and Reports	No changes
4. Bank Accounts, External Borrowing and Investment of Cash	No changes
5. Income, Fees and Charges and Security of Cash, Cheques and Other Negotiable Instruments	No changes
6. NHS Contracts and Service Agreements for the Provision of Services	No changes
7. Terms of Service and Payment of Directors and Employees	No changes
8. Non-Pay	Correction of references to SFI 15
9. Fixed Asset Register and Security of Assets	No changes
10. Capital Investment, Private Financing and Leasing	No changes
11. Stock Control and Receipt of Goods	No changes
12. Disposals and Condemnations, Losses and Special Payments	No changes
13. Computerised Systems	No changes
14. Risk Management and Insurance	No changes
15. Tendering and Contracting Procedure	Changes in wording to improve clarity
16. Retention of Records	No changes
17. Research and Development	No changes

18. Acceptance of Gifts by Staff and Other Standards of Business Conduct	Updated to reflect the new Declarations of Interests and Gifts and Hospitality Policy
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Schedule 1 – Delegated Expenditure Approval and Invoice Request Limits

The following levels are created for the purposes of linking a position level to a level of authorisation in the electronic financial system for the Trust.

Where a significant contract is approved by the Trust Board, the Chief Finance Officer will have the delegation to raise any purchase orders required related to the approved contract. Evidence of Board approval must be provided with the requisition.

e-Delegation Level	Position	Purchase Order and Invoice Approval (excluding Development and Business Cases)	Credit Note Approval
Level 1	Trust Board	>£4,500,000	
Level 2	Chief Executive	£4,500,000	
Level 3	Chief Operating Officer	£2,500,000	
Level 4	Chief Finance Officer	£2,500,000	No limit
Level 5	Other Executive management Team members	£500,000	
Level 6	Deputy Chief Finance Officer	£100,000	£100,000
Level 7	Direct reports to the Executive Management Team	£100,000	
Level 8	Direct reports of level 7 including Chiefs of Service, Head of Nursing & Patient Experience and General Managers	£50,000	
Level 9	Financial Controller	£50,000	£25,000
Level 10	Budget Holders	£25,000	
Level 11	Budget Administrators	£2,000	

For information, the previously agreed matrix was as follows:

e-Delegation Level	Position	Expenditure Approval (excluding Development and Business Cases)	Invoice Requests	Raise Credit Notes
Level 1	Trust Board	>£4,500,000	n/a	n/a
Level 2	Chief Executive	£4,500,000	n/a	n/a
Level 3	Deputy Chief Executive	£2,500,000	n/a	n/a

Attachment 4

Level 4	Chief Finance Officer	£2,500,000	n/a	No limit
Level 5	Other Executive Directors Other Directors referenced on the Trust Board	£500,000	n/a	n/a
Level 6	Deputy Chief Finance Officer	£200,000	n/a	£100,000
Level 7	Directors of Operations Chief Information Officers Other Directors not referenced on the Trust Board	£200,000	n/a	n/a
Level 8	Deputy Chief Nurse Chiefs of Service Heads of Nursing and Patient Experience General Managers Deputy Directors	£100,000	n/a	n/a
Level 9	Deputy Chiefs of Service	£75,000	n/a	
Level 10	Specialty Leads Service Managers Matrons	£50,000	n/a	n/a
Level 11	Financial Controller	£25,000	n/a	£25,000
Level 12	Head of Contracts, Costing & Income Head of Financial Management	£25,000	>£1,000,000	n/a
Level 13	Finance Business Partners (and Budget Holder)	n/a	£1,000,000	n/a
Level 14	Finance Managers (and Budget Holder)	n/a	£500,000	n/a
Level 15	Senior Management Accountants Management Accountants (and Budget Holder)	n/a	£100,000	n/a
Level 16	Heads of Corporate Departments	£25,000	n/a	n/a
Level 18	Assistant Service Managers	£5,000	n/a	n/a
Level 19	Ward Sisters	£2,000	n/a	n/a
Level 20	Ward Administrators	£500	n/a	n/a

Great Ormond Street Hospital for Children NHS Foundation Trust

Scheme of Delegation

Version 32.0 – For Approved by the Trust Board by the Trust Board

Date: ~~5th December 2018~~ 8th July 2019

Document Control Page

This Scheme of Financial Delegations Manual has been created as a subset of the Standing Financial Instructions of Great Ormond Street Hospital NHS Foundation Trust.

Sign-Offs

Version	Role	Position	Date
23.0	To Be Endorsed by	Executive Management Team	10/10/2018
23.0	To Be Recommended for Approved by	Trust Audit Committee	18/10/2018
23.0	To Be Approved by	Trust Board	December 2018

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Section 1 Introduction and Purpose

Introduction

This document constitutes the Scheme of Delegation as required to be prepared in accordance with the *Great Ormond Street Hospital for Children NHS Foundation Trust Constitution (Constitution), Annex 9, Clause 280.2*.

[The Chief Executive shall prepare a scheme of delegation identifying his or her proposals, which shall be considered and approved by the Trust Board, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendments to the scheme of delegation that shall also be considered and approved by the Trust Board, as it see fit.](#)~~*The Chief Executive shall prepare the Scheme of Delegation for consideration and approval by the Board.*~~

The Constitution also outlines the definition of a significant transaction and the process for approval of any transaction that falls into this category. This should be read in addition to this *Scheme of Delegation* document. Refer to the extracts from the relevant extracts from the Constitution in Section below.

Purpose

The purpose of this Manual is to document and consolidate the guiding principles, functions, level and restrictions or conditions of delegated authority for executives and staff within the Trust.

Section 2 Hierarchy of Delegation and Sub-Delegation

Application of Delegation

Level 1 Board	Clause 4 Powers <p>4.1 <i>The powers of the Trust are set out in the 2006 Act.</i></p> <p>4.2 <i>All the powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.</i></p> <p>4.3 <i>Any of these powers may be delegated to a committee of directors or to an executive director.</i></p>
Level 2 Chief Executive	Annex 9 - Clause 1.1 <p><i>Save as otherwise permitted by law, at any meeting the Chairman of the Trust shall be the final authority on the interpretation of standing orders, the schedule of reservation and delegation of powers and/or the standing financial instructions (on which he or she should be advised by the Chief Executive.)</i></p>
Level 3-19	<p>Refer to Schedule 1 for Sub-Delegations to Positions in the organisation approved by the Chief Executive and Chairman.</p>

Levels of Sub-Delegation

The Delegation financial limits are also linked to the position/role of the staff member, if not specifically mentioned in Section 1. If these limits apply refer to Schedule 1 to determine the level of financial delegations that applies.

The Levels outlined in Schedule 1 will be those set on the financial system.

Types of Delegation Authority

The types of financial delegation outlined in this document include:

- Expenditure approval delegations
- Invoices and credit note requests
- Business case approval delegations
- Procurement delegations
- Contracts signing delegations
- Other non-financial delegations.

Section 3 Principles

General Delegation Principles

Delegates Must:

- 1) Act within your authority by ensuring you hold the relevant delegation
- 1) Understand your authority by referring to relevant guidance, limitations and directions
- 2) Act with the Trust's values in mind
- 3) Avoid conflicts of interest
- 4) Consider the Trust's business needs
- 5) Seek expert advice when making a decision
- 6) Make decisions objectively, reasonably and fairly.

Delegates Must Not:

- 1) Exercise delegations in respect of someone outside of your immediate line of control
- 2) Exercise powers in respect of a position higher than your own
- 3) Exercise a delegation in respect of yourself (i.e. confer a personal benefit)
- 4) Exercise a delegation on behalf of an absent employee unless it is within the scope of your delegated authority or you are officially acting in the position.

Compliance

- i. All delegates are required to comply with manuals and directives issued by the Trust, including their own unit's manuals and directives.
- ii. Delegated authority is subject to internal controls and to any overriding National laws, e.g. purchase or dispensing of dangerous drugs.

Responsibility

- i. Delegations are made to positions, not to persons, and are specific to the position's work unit and/or role. Ultimate responsibility for performance of the functions or exercise of the authority or power rests with the authority holder.
- ii. Where an authority holder delegates an authority to an individual position, the person occupying that position becomes personally accountable for the delivery of that authority.
- iii. The delegation to a position is unique and is not transferable by the delegate.
- iv. Delegations extend to the officer substantively appointed to that position and any person acting in that position for a specified period unless otherwise excluded in the terms of the temporary appointment. Delegations do not extend to volunteers or councillors.
- v. Where the Scheme of Delegation specifies a delegate, the position to which the delegate reports is also deemed to have the delegated authority except where otherwise determined by legislation, policy or a Chief Executive instruction.
- vi. Where the permanent officer takes leave, it is their responsibility to instruct the relieving officer of the level of delegation that is attached to the position and the responsibilities associated with the delegation.

Application

- i. Delegates are expected to exercise their powers, authorities, duties or functions delegated to them in a responsible, efficient, consistent and cost effective manner.

- ii. Discretion is to be utilised by the delegate in determining whether to exercise a delegation or refer the matter to a higher authority.
- iii. When an officer is exercising their financial delegation, they are required to clearly provide their name, position and date when signing.

Financial Delegation Principles

Delegates Must:

- 1) Only approve expenditure in cost centres under the delegate's authority
- 2) Only approve expenditure where there is sufficient budget to cover the cost
- 3) Only approve expenditure on goods and services related to official work and business use
- 4) Only approve expenditure where all relevant Trust's procedures and policies have been followed
- 5) Only approve expenditure to the financial limit of the delegation
- 6) Only approve expenditure where evidence exists that goods have been received and/or services have been performed in accordance with and at the rate/s of an agreed contract or arrangement
- 7) Employees are to note that an expenditure approval is to be given prior to any commitment being made, contract signed or purchase order raised.

Delegates Must Not:

- 1) approve a gift or settlement of any legal claim unless specifically delegated this authority
- 2) transfer the financial delegation granted by the Trust Chief Executive to another employee
- 3) break one purchase down into several smaller items to avoid breaching the financial limit of the delegation
- 4) approve expenditure on capital works, contracts or special payments unless specifically delegated this authority
- 5) exceed their delegation limits even if automated systems permit this to occur
- 6) Approve any expenditure incurred by the delegate on travel, meals, conferences and other similar expenditure
- 7) Assume the financial delegation of an absent delegate if you are not authorised to do so.

Suspension, Revocations and Reductions in Financial Delegations

- The terms of any financial delegation cannot be exceeded under any circumstances.
- Financial delegations cannot be sub-delegated once granted by the Trust Chief Executive.
- Improper performance of responsibilities may result in disciplinary action being taken against the employee concerned.
- The power to revoke, suspend or reduce financial delegations granted to positions within the Trust rests with the Chief Executive in respect of delegations made.
- If circumstances arise which warrant the suspension, revocation or reduction of a financial delegation, full details must be forwarded to the Trust's Chief Finance Officer. The Trust's Chief Finance Officer will submit an appropriate recommendation to the Chief Executive for consideration.
- If the recommendation is approved, the delegation will be amended to reflect that reduction, suspension or revocation.

- The amended Expenditure Approval Financial Delegation Register or Procurement Delegation Register or Contracts Signing Delegation Register will be published on the intranet.

Reviewing and Maintaining the Scheme of Delegations

This Scheme of Delegations Manual may be amended from time to time to reflect changes in legislation, Trust policy or operational requirements.

The Trust will coordinate annual reviews of financial, procurement and contracts signing financial delegations for positions and limits. A revised version is submitted to Trust Chief Finance Officer for endorsement before submitting it to Chief Executive and Board for approval.

Requests for changes outside the annual reviews can occur on the basis of urgency should there be a change in organisational structure or new position titles created. The requests should first be approved by the relevant Trust Executive and forwarded to the Chief Finance Officer for processing and coordination of approval by the Chief Executive.

Section 4 Relevant Legislation – GOSH Constitution

The following paragraphs from the GOSH Constitution outlines the powers of delegation and the requirement for standing orders for the Trust.

Powers of Delegation

Clause 4 Powers

- 4.1 *The powers of the Trust are set out in the [National Health Service 2006 Act 2006, as amended by the Health and Social Care Act 2012](#).*
- 4.2 *All the powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.*
- 4.3 *Any of these powers may be delegated to a committee of directors or to an executive director.*

Standing Orders Practice and Procedure

ANNEX 9 Standing Orders for the Practice and Procedure of the Trust Board of Directors

Clause 1 Interpretation and definitions

- 1.1 ~~*Save as otherwise permitted by law, at any meeting the Chairman of the Trust shall be the final authority on the interpretation of standing orders, the schedule of reservation and delegation of powers and/or the standing financial instructions (on which he or she should be advised by the Chief Executive.)*~~
- 1.1 *Save as otherwise permitted by law, the Chair of the Trust shall be the final authority on the interpretation of these paragraphs and the Standing Orders (on which they should be advised by the Chief Executive or Company Secretary).*

Clause 20 Delegation to Officers

- 20.1 *Those functions of the Trust which have not been retained as reserved by the Trust Board or delegated to a committee or sub-committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions they will perform personally and shall nominate officers to undertake the remaining functions for which they will still retain accountability to the Trust Board.*
- 20.2 *The Chief Executive shall prepare a scheme of delegation identifying his or her proposals, which shall be considered and approved by the Trust Board, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendments to the scheme of delegation that shall also be considered and approved by the Trust Board, as it see fit.*
- 20.3 *Nothing in the scheme of delegation shall impair the discharge of the direct accountability to the Trust Board of the director responsible for finance to provide information and advise the Trust Board in accordance with statutory or regulatory requirements. Outside these statutory or regulatory requirements, the role of the director responsible for finance shall be accountable to the Chief Executive for operational matters.*

Clause 26. Standards of Business Conduct

26.1 Directors of the Trust shall comply with standing financial instructions prepared by the director of finance and approved by the Trust Board for the guidance of all staff employed by the Trust.

~~2.4 The regulatory framework requires the Trust to adopt SOs for the regulation of its proceedings and business. **The Trust must also adopt SFIs as an integral part of the SOs setting out the responsibilities of individuals, additional responsibilities and additional detailed provisions.**~~

Clause 3 Reservation of powers

~~3.1 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in a separate document entitled the "Schedule of Reservation and Delegation of Powers" and shall have effect as if incorporated into these standing orders. This document also details these powers which it has delegated to officers and other bodies.~~

Clause 20 Delegation to officers

~~20.1 These functions of the Trust which have not been retained as reserved by the Board or delegated to a committee or sub-committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions he or she will perform personally and shall nominate officers to undertake the remaining functions for which he or she will still retain accountability to the Board.~~

~~20.2 The Chief Executive shall prepare a scheme of delegation identifying his or her proposals, which shall be considered and approved by the Board, subject to any amendment agreed during the discussion. **The Chief Executive may periodically propose amendments to the scheme of delegation that shall also be considered and approved by the Board, as it see fit.**~~

~~20.3 Nothing in the scheme of delegation shall impair the discharge of the direct accountability to the Board of the director responsible for finance to provide information and advise the Board in accordance with statutory or regulatory requirements. Outside these statutory or regulatory requirements, the role of the director responsible for finance shall be accountable to the Chief Executive for operational matters.~~

Clause 32. Schedule of Matters Reserved to the Trust and Scheme of Delegation of powers

32.1 The arrangements made by the Board as set out in the "Schedule of Matters Reserved to the Board" and "Scheme of Delegation" of powers shall have effect (as adopted from time to time) as if incorporated in these Standing Orders.

Significant Transaction Definition

Clause 47 - Mergers etc. and significant transactions

47.1 The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the ~~Members' Council~~ Council of Governors.

47.2 The Trust may enter into a significant transaction only if more than half of the members of the ~~Members'~~ Council of Governors of the Trust voting approve entering into the transaction.

~~47.3 In paragraph 47.2, the following words have the following meanings:~~

~~"Significant transaction" means a transaction which meets any one of the tests below:~~

~~47.3.1 the total asset test; or~~

~~47.3.2 the total income test; or~~

~~47.3.3 the capital test (relating to acquisitions or divestments).~~

~~The total asset test:~~

~~is met if the assets which are the subject of the transaction exceed 25% of the total assets of the Trust;~~

~~The total income test:~~

~~47.3.4 is met if, following the completion of the relevant transaction, the total income of the Trust will increase or decrease by more than 25%;~~

~~The capital test:~~

~~47.3.5 is met if the gross capital of the company or business being acquired or divested represents more than 25% of the capital of the trust following completion (where "gross capital" is the market value of the relevant company or business's shares and debt securities, plus the excess of current liabilities over current assets, and the Trust's total taxpayers' equity);~~

~~47.3.6 for the purposes of calculating the tests in this paragraph 49.3 figures used for the Trust assets, total income and taxpayers' equity must be the figures shown in the latest published audited consolidated accounts.~~

~~A transaction:~~

~~47.3.7 excludes a transaction in the ordinary course of business (including the renewal, extension or entering into an agreement in respect of healthcare services carried out by the Trust;~~

~~47.3.8 excludes any agreement or changes to healthcare services carried out by the Trust following a reconfiguration of services led by the commissioners of such services;~~

~~47.3.9 excludes any grant of public dividend capital or the entering into of a working capital facility or other loan, which does not involve the acquisition or disposal of any fixed asset of the Trust.~~

~~47.3 In paragraph 47.2, the following words have the following meanings:~~

~~47.3.1 "Significant transaction" means a transaction which meets any one of the tests below:~~

~~47.3.1.1 the total asset test; or~~

~~47.3.1.2 the total income test; or~~

~~47.3.1.3 the capital test (relating to acquisitions or divestments).~~

~~47.3.2 The total asset test is met if the assets which are the subject of the transaction exceed 25% of the total assets of the Trust;~~

~~47.3.3 The total income test is met if, following the completion of the relevant transaction, the total income of the Trust will increase or decrease by more than 25%;~~

~~47.3.4 The capital test is met if the gross capital of the company or business being acquired or divested represents more than 25% of the capital of the trust following completion (where~~

“gross capital” is the market value of the relevant company or business’s shares and debt securities, plus the excess of current liabilities over current assets, and the Trust’s total taxpayers’ equity).

47.3.5 For the purposes of calculating the tests in this paragraph 47.3 figures used for the Trust assets, total income and taxpayers’ equity must be the figures shown in the latest published audited consolidated accounts.

47.4 A transaction:

47.4.1 excludes a transaction in the ordinary course of business (including the renewal, extension or entering into an agreement in respect of healthcare services carried out by the Trust;

47.4.2 excludes any agreement or changes to healthcare services carried out by the Trust following a reconfiguration of services led by the commissioners of such services;

47.4.3 excludes any grant of public dividend capital or the entering into of a working capital facility or other loan, which does not involve the acquisition or disposal of any fixed asset of the Trust

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NB The definitions of significant transactions as described above have been prescribed by NHS Improvement.

Section 5 Summary of Expenditure Approval Financial Delegations

This section will summarise the delegated responsibilities and the associated delegated officer, linked to the Standing Financial Instructions.

This table also refers Schedule 1 where applicable.

5.1 Management of budgets and approval to spend revenue funds (non-pay)

The Trust’s annual Budget Plan is approved by the Trust Board at the commencement of the financial year following a review by the Finance & Investment Committee.

This delegation has application in respect of the management and approval to spend revenue funds for non-pay expenditure included within the annual approved Trust budget plan (for example, approval of purchase orders and sign-off of invoices).

Note – delegations relating to the approval of a business case, procurement or the signing of a contract are outlined separately (refer *Delegations 6.1, 7.2 and 7.3, and Sections 6 and 7*).

The detailed instructions are outlined in **SFI 2 Business Planning, Budgets, Budgetary Control and Monitoring**.

#	Delegated Responsibilities	Delegated Officer or Group
1.1	<p>Authority to approve non-pay expenditure within individual budgets if included within the Trust’s annual Budget Plan excluding:</p> <ul style="list-style-type: none"> • Business rates and NHS Resolution (refer <i>Delegation 1.2</i>) • Factor 8 blood and high cost drugs (refer <i>Delegation 1.3</i>) • Development (refer <i>Delegation 1.4</i>) • Situations where a business case is required (refer <i>Section 4</i>) 	

#	Delegated Responsibilities	Delegated Officer or Group
1.1.1	Management of individual budgets if included within the Trust's annual Budget Plan	Refer Schedule 1
1.1.3	<p>Virements:</p> <p>Less than £100,000 (this relates only to expenditure virements which do not cross directorates)</p> <p>Above £100,000</p>	<p>General Manager OR Chief of Service (or delegations as agreed with the Chief Finance Officer)</p> <p>Chief Finance Officer OR Deputy Chief Operating Officer Executive OR relevant Executive Director (or delegations as agreed with the Chief Executive)</p> <p>The virement must be signed by both the budget holder <i>from</i> whom the budget is transferring and the budget holder <i>to</i> whom the budget is transferring</p>
1.2	Authority to approve business rates and NHS Resolution non-pay expenditure within budget	
1.2.1	Less than £5,000,000	Chief Executive OR Deputy Chief Operating Officer Executive OR Chief Finance Officer
1.2.2	Over £5,000,000	Trust Board
1.3	Authority to approve home delivery of Factor 8 or high cost drugs non-pay expenditure within budget	
1.3.1	Less than £10,000,000	Chief Executive OR Deputy Chief Operating Officer Executive OR Chief Finance Officer
1.3.2	Over £10,000,000	Trust Board
1.4	Authority to approve non-pay expenditure within individual project budget (Development)	
1.4.1	Less than £1,000,000	Deputy Director of Development
1.4.2	Over £1,000,000 up to £5,000,000	Chief Executive OR Deputy Chief Operating Officer Executive OR Chief Finance Officer OR Director of Development & Property Services
1.4.3	Over £5,000,000	Two of Chief Executive OR Deputy Chief Operating Officer Executive OR Chief Finance Officer OR Director of Development & Property Services
1.5	Authority to approve non-pay expenditure in excess of budget excluding:	
	<ul style="list-style-type: none"> • Development (<i>refer Delegation 1.6</i>) • Situations where a business case is required (<i>refer Section 4</i>) <p>(note: this applies to business-as-usual overspends per Directorate per month)</p>	
1.5.1	Less than £500,000	Chief Executive OR Deputy Chief Operating Officer Executive OR Chief Finance Officer OR Executive Director

#	Delegated Responsibilities	Delegated Officer or Group
1.5.2	Over £500,000 up to £5,450 0,000	Chief Executive OR Deputy Chief Operating OfficerExecutive OR Chief Finance Officer <i>Approval noted by:</i> Audit Committee
1.6	Authority to approve non-paycapital expenditure <u>in excess</u> of individual project budget (Development)	
1.6.1	Approval of any increase to the individual overall capital expenditure budgets as against the approved annual capital programme <u>to a maximum of £100,000</u> (refer Section 5)	Finance & Investment Committee <i>Prior endorsement required by:</i> Capital Investment Group
1.6.2	Approval of any increase to the individual capital expenditure budgets as against the approved annual capital programme over <u>£100,000, where the revised budget is below £2,500,000</u> (refer Section 5)	Executive Management Team <i>Prior endorsement required by:</i> Capital Investment Group
1.6.3	Approval of any increase to the individual capital expenditure budgets as against the approved annual capital programme over <u>£100,000 where the revised budget is between £2,500,000 and £4,500,000</u> (refer Section 5)	Finance & Investment Committee <i>Prior endorsement required by:</i> <u>Finance & Investment Committee AND</u> Capital Investment Group
1.6.4	Approval of any increase to the individual capital expenditure budgets as against the approved annual capital programme over <u>£100,000 where the revised budget is in excess of £4,500,000</u> (refer Section 5)	Trust Board <i>Prior endorsement required by:</i> <u>Finance & Investment Committee AND</u> <u>Executive Management Team AND</u> Capital Investment Group
1.7	Authority to approve capital expenditure in excess of the total capital budget	
1.7.1	Approval of any increase in the total capital budget above the value signed off by Trust Board	Finance & Investment Committee <i>Prior endorsement required by:</i> Capital Investment Group
1.8.7	Authority to approve non-pay expenditure relating to non-audit based professional services to be provided by the Trust's external auditor	
1.7.8.1	Approval of any proposed non-audit based professional services to be delivered by the Trust's external auditor	Audit Committee <i>Prior endorsement required by:</i> Executive Management Team

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5.2 Special Purpose Funds

This delegation has application when Special Purpose Funds ("SPF") are donated to the Trust by the GOSH Children's Charity ("GOSHCC"). SPFs arise when funds are donated for a specific usage within the GOSHCC's objects, with the restriction being placed upon use by the donor. This may be for use by a specific department/ward or for a particular type of research.

Day-to-day administration of an SPF is delegated to relevant, senior Trust employees or individuals with joint contracts of employment with the Trust and ICH (known as "Fundholders"). Fundholders are named individuals rather than linked to position levels.

The detailed instructions are outlined in the **GOSHCC SPF Induction Pack**.

#	Delegated Responsibilities	Delegated Officer or Group
2.1	Authority to approve expenditure relating to an SPF	
2.1.1	Approval of expenditure relating to an SPF where the expenditure is in accordance with the charitable objectives of the GOSHCC and the restricted purpose of the SPF	SPF Fundholder AND co-signed by General Manager / Operational Lead

5.3 Invoice requests

This delegation has application in respect of the raising of an invoice requesting payment from an external organisation.

All invoices for NHS commissioning services must go via the Commissioning Contracts team within the Finance Directorate.

All invoices for International Private Patients must be approved via the IPP Accounts Receivable team and raised in accordance with the approved IPP tariff rates.

#	Delegated Responsibilities	Delegated Officer or Group
3.1	Authority to approve the raising of an invoice request to an external organisation	
3.1.1	Less than £100,000	Budget holder AND Management Accountant OR Senior Management Accountant
3.1.2	Over £100,000 up to £500,000	Budget holder AND Finance Manager
3.1.3	Over £500,000 up to £1,000,000	Budget Holder AND Finance Business Partner
3.1.4	Over £1,000,000	Budget Holder AND Head of Contracts, Costing & Income OR Head of Financial Management
3.2	Authority to approve a credit note relating to reimbursement of income previously invoiced	
3.2.1	Less than £25,000	Financial Controller OR Deputy Financial Controller
3.2.2	Over £25,000 up to £100,000	Deputy Chief Finance Officer
3.2.3	Over £100,000	Chief Finance Officer
NB For all invoice requests other than Clinical Income from NHS England and NHS Improvement, the budget holder remains the responsible person for confirming the validity of the charge to be raised to the external body.		

5.4 Expense claims

This delegation has application in situations where an employee is claiming reimbursement for an expense they have incurred personally. The Trust's detailed policy covering expense claims is outlined in the **Staff Expenses Policy**.

#	Delegated Responsibilities	Delegated Officer or Group
4.1	Authority to approve expense claims	
4.1.1	Approval of expense claim within assigned delegation limit (<i>refer Schedule 1</i>) and claim is allowable per the Staff Expenses Policy	Employee's line manager
4.1.2	Approval of expense claim above assigned delegation limit (<i>refer Schedule 1</i>) and claim is allowable per the Staff Expenses Policy	General Manager / Chief of Service / Deputy Director OR Executive Director

5.5 Management of budgets and approval to spend revenue funds (pay)

This delegation has application in respect of the management and approval to spend revenue funds for pay expenditure included within the annual approved Trust budget plan – in other words, this delegation applies to recruitment to fully funded staff posts that are included within the existing HR establishment. Note, any proposed increases to the HR establishment or new posts will require a business case to be approved (*refer Delegation 6.1*).

The detailed process to be followed when seeking to appoint temporary or permanent staff is outlined in the **Vacancy Approval Process**, including the role and membership of the Vacancy Review Panel, and the requirement for the relevant Recruitment Form to be signed off and approved.

#	Delegated Responsibilities	Delegated Officer or Group
5.1	Authority to approve staff appointments if <u>within budget AND within existing HR establishment (e.g. recruitment to vacancies within the establishment)</u>	
5.1.1	<u>Staff appointment – up to and including Band 6 – and Junior Doctors</u>	<u>Specialty Lead, Service Manager or Matron</u> <u>Corporate Directorates (including Research and Innovation) require authorisation from Budget Holder</u> <u>Finance and HR to be notified</u>
5.1.12	<u>Staff appointment – Band 7 up to and including 8b posts and Junior Doctors or new posts</u>	<u>Approval from appropriate Trust vacancy panel in line with the Vacancy Approval Process</u> <u>Pre-approval by Chief of Service, General Manager or Head of Nursing</u> <u>Corporate Directorates (including Research and Innovation) require authorisation from Director, Deputy Director or Assistant Director</u> <i>Prior endorsement required by:</i>

#	Delegated Responsibilities	Delegated Officer or Group
		Finance and HR
5.1.23	Staff appointment – Band 8c, and 8d, 9 and Very Senior Manager	<u>Executive Management Team</u> <u>Prior approval will be given at the appropriate Trust vacancy panel as per the Vacancy Approval Process</u> Director of Operations Corporate Directorates (including Research and Innovation) require authorisation from Director, Deputy Director or Assistant Director <i>Prior endorsement required by:</i> Finance and HR
5.1.34	Staff appointment – existing Medical Consultant Posts	<u>Executive Management Team</u> <u>Prior approval will be given at the appropriate Trust vacancy panel and the Chief of Service meeting as per the Vacancy Approval Process</u> <i>Prior endorsement required by:</i> Finance and HR
5.1.5	Staff appointment – Band 9 and Very Senior Manager (VSM), including Senior Medical Staff ¹	Relevant Executive Director <i>Prior endorsement required by:</i> Finance and HR
5.1.56	Staff appointment – Executive Directors and other Directors referenced on the Trust Board	Chief Executive AND Relevant Executive Director AND Director Human Resources & Organisational Development (for the purpose of confirming appropriate level of appointment / remuneration)
5.2	Authority to approve remuneration arrangements for staff	
5.2.1	Approval of remunerations arrangements (including additional allowances above basic salary) – all staff levels excluding Executive Directors and Directors referenced on the Trust Board	Director Human Resources & Organisational Development AND Relevant Executive Director AND Chief Executive Officer
5.2.2	Approval of remuneration arrangements – Executive Directors and other Directors referenced on the Trust Board	Remuneration Committee
5.3	Authority to approve pay expenditure relating to staff timesheets (including overtime)	
5.3.1	Approval of staff time sheets for both substantive and temporary staff	Relevant Executive Director OR Director OR General Manager OR Chief of Service OR Deputy Director OR Service Manager OR equivalent

¹Note is this relates to a Senior Medical or Nursing Position appropriate engagement with the Medical Director of Chief Nurse would be required.

5.6 Approval of business cases requesting revenue funding

A business case (also known as an investment proposal) is a document that provides the rationale for why the Trust should agree to fund a particular project.

This delegation has application when a business case requesting revenue funding (i.e. excluding capital) is required to be prepared and approved. Note, delegations relating to procurement or the signing of a contract are outlined separately (*refer Sections 6 and 7*).

A business case is required in the following situations:

- When revenue funding is requested in excess of allocated budget OR
- A change to the model of service delivery or model of care is proposed OR
- A change to the HR establishment is proposed OR
- An existing contracted service is required to be re-tendered.

Operational Delivery and Planning Group is required to scrutinise and endorse all revenue business cases requesting new budget from the contingency prior to the case going to EMT, FIC or Trust Board (dependent on the financial value) for final approval.

The detailed instructions are outlined in ***SFI 2 Business Planning, Budgets, Budgetary Control and Monitoring***.

Determining the appropriate approval process

The appropriate approval process for a business case is determined by the value of the business case. The following principles should be applied to calculate the value of the business case:

- For non-pay expenditure business cases, the value of the business case should be calculated on the basis of the total cost over 5 years
- For pay expenditure business cases, the value of the business case should be calculated based on the yearly cost, and
- For business cases combining non-pay and pay expenditure, the value of the business case should be calculated on the basis of the total cost over 5 years.
- New budgets can only be funded from the Chief Executive's contingency.

Escalating the business case approval process

There will be situations where a business case is relatively low value but of strategic importance to the Trust. Accordingly, any Executive Director has the right to override these delegations to escalate approval up the approval process. Example situations include:

- Politically or commercially sensitive, novel or contentious
- Outsourcing of a service with implications on staffing
- Deemed of strategic importance and intrinsically linked to the Trust's strategic direction and priorities, or
- Where the Directorate is not meeting its budget control total.

An Executive Director cannot override these delegations to de-escalate approval down the approval process.

#	Delegated Responsibilities	Delegated Officer or Group
Authority to approve business cases requiring no additional funding with a maximum income generation requirement £500,000		
6.1.1	Up to £500,000	Operational Delivery and Planning Group
Authority to approve business cases requesting revenue funding		
6.1.12	Up to £2,500,000	Executive Management Team <i>Prior endorsement required by:</i> Operational Delivery & Performance Group
6.1.23	Over £2,500,000 up to £4,500,000	Finance & Investment Committee <i>Prior endorsement required by:</i> Operational Delivery & Performance Group AND Executive Management Team
6.1.43	Over £4,500,000 Outline Business Case Full Business Case	Trust Board <i>Prior endorsement required by:</i> Operational Delivery & Performance Group AND Executive Management Team AND Finance & Investment Committee Trust Board <i>Prior endorsement required by:</i> Operational Delivery & Performance Group AND Executive Management Team AND Finance & Investment Committee

5.7 Approval of business cases requesting capital funding

The annual Capital Programme is approved by the Trust Board annually following a review by the Finance & Investment Committee. All capital schemes should form part of this outline programme, but approval of the programme does not constitute approval for expenditure for an individual capital scheme within the programme. A business case is required to be prepared and approved for these individual capital schemes.

A business case (also known as an investment proposal) is a document that provides the rationale for why the Trust should agree to fund a particular project. It must also include the revenue consequences.

This delegation has application when a business case requesting capital funding is required to be prepared and approved. Note, delegations relating to procurement or the signing of a contract are outlined separately (refer Sections 6 and 7). The detailed instructions are outlined in **SFI 9 Capital Investment, Private Financing and Leasing**.

#	Delegated Responsibilities	Delegated Officer or Group
7.1	Authority to approve the annual Capital Programme	
7.1.1	Approval of the annual Capital Programme and the overall capital expenditure budget	Trust Board <i>Prior endorsement required by:</i> Finance & Investment Committee
7.1.2	Approval of any increase to the overall capital expenditure budget as against the approved annual capital programme	Finance & Investment Committee <i>Prior endorsement required by:</i> Capital Investment Group
7.2	Authority to approve business cases requesting capital expenditure (excluding ICT)	
7.2.1	Less than £500,000 (if there are revenue consequences EMT, Finance and Investment Committee or Trust Board must approve as appropriate)	Capital Investment Group <i>Approval noted by:</i> Executive Management Team NB the Procurement of Equipment Group manage the prioritisation of spend on medical equipment+ but the responsibility for authorising expenditure remains with CIG
7.2.2	Over £500,000 up to £2,500,000	Executive Management Team <i>Prior endorsement required by:</i> Capital Investment Group <i>Approval noted by:</i> Finance & Investment Committee
7.2.3	Over £2,500,000 up to £4,500,000	Finance & Investment Committee <i>Prior endorsement required by:</i> Capital Investment Group AND Executive Management Team
7.2.4	Over £4,500,000 OR major redevelopment works Outline Business Case	Trust Board <i>Prior endorsement required by:</i>

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#	Delegated Responsibilities	Delegated Officer or Group
	Full Business Case	Capital Investment Group AND Executive Management Team AND Finance & Investment Committee Trust Board <i>Prior endorsement required by:</i> Capital Investment Group AND Executive Management Team AND Finance & Investment Committee
7.3	Authority to approve business cases requesting capital expenditure (ICT)	
7.3.1	Less than £500,000	Information Management & Technology Board <i>Prior endorsement required by:</i> Operational Delivery & Performance Group <i>Approval noted by:</i> Executive Management Team AND Capital Investment Group
7.3.2	Over £500,000 up to £2,500,000	Executive Management Team <i>Prior endorsement required by:</i> Operational Delivery & Performance Group AND Information Management & Technology Board <i>Approval noted by:</i> Capital Investment Group Finance & Investment Committee
7.3.3	Over £2,500,000 up to £4,500,000	Finance & Investment Committee <i>Prior endorsement required by:</i> Operational Delivery & Performance Group AND Information Management & Technology Board AND Executive Management Team <i>Approval noted by:</i> Capital Investment Group
7.3.4	Over £4,500,000 Outline Business Case Full Business Case	Trust Board <i>Prior endorsement required by:</i> Operational Delivery & Performance Group AND Information Management & Technology Board AND Executive Management Team AND Finance & Investment Committee <i>Approval noted by:</i> Capital Investment Group Trust Board <i>Prior endorsement required by:</i> Operational Delivery & Performance Group AND Information Management & Technology Board AND Executive Management Team AND Finance & Investment Committee <i>Approval noted by:</i> Capital Investment Group

#	Delegated Responsibilities	Delegated Officer or Group

Recording, monitoring and approval of payments under the losses and special payments regulations

This delegation has application in respect of the recording, monitoring and approval of payments under the losses and special payments regulations. The detailed instructions are outlined in **SFI12 Disposals and Condemnations**. The Chief Finance Officer is responsible for ensuring Losses and Special Payment Register is maintained.

#	Delegated Responsibilities	Delegated Officer or Group
8.1	Cash losses and bad debts	
	<i>Note: these write-offs, once agreed, will impact on individual budgets – there is no central provision. A bad debt write-off for these purposes is the writing off of any income due to the Trust, whether or not invoiced – it does not include adjustments relating to invoices raised in error.</i>	
8.1.1	Less than £10,000	Chief Finance Officer
8.1.2	Over £10,000	Chief Executive OR Deputy Chief Operating Officer-Executive OR Chief Finance Officer
8.2	Authority to approve losses of equipment and property	
8.2.1	Less than £100,000	Deputy Chief Operating Officer Executive OR Chief Finance Officer
8.2.2	Over £100,000 up to £500,000	Chief Executive <i>Approval noted by: Audit Committee</i>
8.2.3	Over £500,000	Audit Committee OR Trust Board
8.3	Authority to approve claims net of recovery from NHS Resolution	
8.3.1	Up to £100,000	Two of Chief Executive OR Deputy Chief Operating Officer-Executive OR Chief Finance Officer OR Executive Director
8.3.2	£100,000 to £500,000	Executive Management Team
8.3.3	Over £500,000	Audit Committee OR Trust Board
8.4	Authority to approve losses of stock	
8.4.1	All losses of stock	Chief Finance Officer <i>Approval noted by: Audit Committee</i>
8.5	Authority to approve settlements relating to staff grievance and patient complaints	
8.5.1	Staff grievance settlements other than in response to a formal process	Chief Executive AND Director of Human Resources & Organisation Development
8.5.2	Complaints	Chief Nurse AND Chief Finance Officer
8.6	Losses of patient or staff property or cash	
8.6.1	All losses of patient or staff property or cash	Chief Finance Officer <i>Approval noted by:</i>

#	Delegated Responsibilities	Delegated Officer or Group
		Audit Committee

5.8 Management of patients' property

The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

This delegation has application with respect to the management of patients' property, including the disposal of deceased patients' property. The detailed instructions are outlined in **SFI 14 Patients' Property**.

#	Delegated Responsibilities	Delegated Officer or Group
9.1	Authority to approve the release of property belonging to a deceased patient	
9.1.1	Property valued up to £5,000	Deputy Chief Finance Officer <i>Indemnity form must be signed prior to release</i>
9.1.2	Property valued over £5,000	Chief Finance Officer <i>Probate or Letters of Administration must be provided prior to release</i>

Section 6 Summary of Procurement Delegations

All UK Public Sector organisations are subject to *Public Procurement Regulations 2015* which stipulate how goods and services should be purchased fairly and transparently with evidence of good value for money.

The detailed instructions for tendering and contracting by or on behalf of the Trust are outlined in **SFI 16 Tendering and Contracting Procedure**. SFI 16 states the requirement for formal competitive tendering and the limits for quotations and tenders (summarised in the table below). It also states the exceptions and instances where formal competitive tendering is not required.

Total Contract Value ²	Procedure
Less than £20,000	Obtain alternate process/quotes where practicable
£20,000 to £50,000	Seek a minimum of three (3) written quotes (see below for instances where three written quotes cannot be obtained)
Goods and Services between £50,000 and £181,302 Light Touch Regime services (see below) £50,000 to £615,278 Works Contracts £50,000 to £4,551,413	Advertise through the Trust e-Tendering Portal AND Either undertake mini-competition through an approved multi-supplier framework agreement where all approved suppliers capable of providing the relevant requirements must be invited to bid OR undertake a tender exercise where a minimum of five (5) should be invited to bid for the contract
Good, supplies and services above £181,302 Light Touch Regime services (see below) above £615,278 Works Contracts above £4,551,413	Advertise through the Trust e-Tendering Portal AND Either undertake mini-competition through an approved multi-supplier framework agreement where all approved suppliers capable of providing the relevant requirements must be invited to bid and the value is within the framework limit OR conduct a full EU-compliant tender process compliant with the Public Contracts Regulations 2015 for which advice must be sought from the Procurement team
Notes:	
<ul style="list-style-type: none"> Works are defined as 'Activities constituting works' as per Schedule 2 of the Public Sector Procurement Regulations 2015 and fall under Common Procurement Vocabulary code 450000. If not specified under this schedule the threshold for goods and services apply. A single supplier (direct call off) from an approved multi-supplier framework is only permitted under the framework rules i.e. the supplier selected must be the top ranked as per the process set out in the framework who are capable of providing the relevant requirements Mini-competitions undertaken form multi-supplier frameworks MUST invite all suppliers under the relevant lot and only the suppliers listed on the framework All suppliers invited to bid for Trust contracts must have been verified that they have the technical capability to supply the goods, services or works required. On award of contract, the service specification should not be significantly different from that assessed as part of the tender process otherwise this will render the process invalid. 	

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² 'Total Contract Value' is exclusive of VAT and relates to the whole of life cost of the contract.

Total Contract Value ²	Procedure
	<ul style="list-style-type: none"> Award of contracts should be based on the lowest cost or quality/price evaluation most economically advantageous offer. Where quality/price evaluation is planned, the criteria must be pre-determined and set out in the Request for Quotation or tender to ensure fair competition
<p>The Public Procurement thresholds for the period January 2018 to December 2019 are as follows:-</p> <ul style="list-style-type: none"> Supply and Service Contracts - £181,302 Social and other specific services covered by the 'Light Touch Regime' as set out in Schedule 3 of the Public Contracts Regulation 2015 - £615,278 Works contracts - £4,551,413 	

6.1 Waiving of formal competitive tendering

This delegation has application when:

- The total contract value is over £20,000 and up to £50,000, and a minimum of three (3) quotations have not been received, OR
- The total contract value is over £50,000 and up to the OJEU limit, and a minimum of three (3) formal competitive tenders have not been received, OR
- The total contract value is either over the OJEU limit, an OJEU tender process has not been conducted OR a minimum of three (3) formal competitive tenders have not been received.

Formal competitive tendering can be waived only in limited circumstances, and these are outlined in SFI 16. In instances where formal competitive tendering is to be waived, an 'SFI Waiver Form' must be completed and approved by those with delegated authority.

#	Delegated Responsibilities	Delegated Officer or Group
10.1	Authority to approve waiving of formal competitive tendering	
10.1.1	Supply of goods, services and design contracts up to OJEU limit	Chief Finance Officer AND one other Executive Director
10.1.2	Works contracts up to OJEU limit	Chief Finance Officer AND Chief Executive Officer <i>Approval noted by:</i> Executive Management Team AND Trust Board
10.1.3	Contracts above the OJEU limit (in the case of sole suppliers)	Chief Executive Officer <i>Approval noted by:</i> Executive Management Team AND Trust Board

6.2 Selection of preferred tenderer(s) for contract award

This delegation has application when a formal competitive tender process is conducted.

At the conclusion of the tender evaluation stage, the evaluation team will make a decision on the award of contracts and will prepare a recommendation report that recommends the preferred tenderer(s). The report will detail the factors (including price, quality, and timing) that define the tender that provides the best overall value for money, and provide a comparison with the details of the nearest competing bids, where appropriate, with reasons for their rejection.

The Delegated Officers have authority to approve the recommendation report. Following approval award, post-tender negotiations can be initiated with the successful tenderer to improve the successful offer, where appropriate, and the formal contract should be prepared.

#	Delegated Responsibilities	Delegated Officer or Group
11.1	Authority to approve selection of preferred tenderer(s) for contract award	
11.1.1	Capital	Chief Finance Officer
11.1.2	Non-capital Less than £50,000 Over £50,000	Executive Director OR Chief of Service OR General Manager Chief Executive OR Deputy-Chief Operating Officer-Executive OR Chief Finance Officer

6.3 Acceptance of late tenders

This delegation has application when a formal competitive tender process is conducted.

The Invitation to Tender documentation will specify the date and time by which tenderers must submit a tender response. Late tenders should not be accepted unless in exceptional and genuine circumstances – including, issues outside of the tenderer’s control such as ICT difficulties uploading to the tendering portal, or where acceptance of the tender would ensure adequate competition.

#	Delegated Responsibilities	Delegated Officer or Group
12.1	Authority to approve acceptance of late tenders	
12.1.1	Tender received within two (2) hours after the specified tender closing time	Executive Director OR Chief of Service OR General Manager
12.1.2	Tender received more than two (2) hours after the specified tender closing time	Chief Finance Officer

Section 7 Summary of Contracts Signing Delegations

A contract is an agreement between two or more parties under which each party assumes an obligation (for example, to provide a service) which they intend will be legally binding (that is, it can be enforced by a court). A contract can be reflected in a formal document or can be formed by an exchange of correspondence or even verbal communication.

GOSH is a body corporate established under the *Health Services Act 2006* according to the laws of [the United Kingdom-England and Wales](#) on 1 March 2012, and may sue and be sued in its corporate name. The legal entity by which GOSH contracts with external organisations is the “Great Ormond Street Hospital for Children NHS Foundation Trust”, with [registered offices principal place of business](#) at Great Ormond Street, London WC1N 3JH.

There are **no values or limits** assigned to the Contracts Signing Delegations.

7.1 Signing healthcare funding contracts and service agreements

This delegation has application when the Trust is entering into a legally binding contractual agreement with a third party organisation for the provision of NHS healthcare services. The detailed instructions are outlined in **SFI 6 Funding Contracts**.

#	Delegated Responsibilities	Delegated Officer or Group
13.1	Authority to sign funding contracts and service agreements	
13.1.1	All contracts and service agreements with a third party organisation for the provision of NHS healthcare services	Chief Finance Officer OR Deputy Chief Operating Officer-Executive OR Chief Executive

7.2 Signing commercial contracts

This delegation has application when the Trust is entering into a legally binding contractual agreement with one or more other parties under which each party assumes an obligation. A commercial contract could relate to one of the following:

- the supply of goods (including equipment, consumables and consignment stock), services, maintenance or design services
- provision of “works” (as defined in the *Public Contracts Regulations 2015*)³
- research
- commercial intellectual property.

A commercial contract could take the form of a deed, contract, agreement, release, discharge, indemnity, guarantee, consent, instrument, and any other documents which binds the Trust legally to another party by imposing an obligation on each party.

The detailed instructions for tendering and contracting by or on behalf of the Trust are outlined in **SFI 165 Tendering and Contracting Procedure**.

³ Activities constituting “works” are defined in Schedule 2 of the *Public Contracts Regulations 2015* to include: construction of new buildings and works, restoring and common repairs; site preparation; building of complete constructions or parts thereof; building installation; building completion; renting of construction or demolition equipment.

#	Delegated Responsibilities	Delegated Officer or Group
14.1	Authority to sign commercial contracts	
14.1.1	Less than £2,500,000	Chief Executive OR Deputy Chief Operating Officer Executive OR Chief Finance Officer
14.1.2	Less than £2,500,000 (Works)	Director of Development & Property Services AND Chief Executive OR Deputy Chief Operating Officer Executive OR Chief Finance Officer
14.1.3	Over £2,500,000 up to £4,500,000	Chief Executive <i>Prior approval required by:</i> Finance & Investment Committee
14.1.4	Over £4,500,000	Trust Board Chair OR Chief Executive <i>Prior approval required by:</i> Finance & Investment Committee AND Trust Board (Delegation to the Chief Executive can occur following approval by the Trust Board; delegation to be evidenced in the minutes)

Before exercising this delegation, the Delegated Officer must ensure that the essential prerequisites have been completed – these include:

- **General Manager** OR **Head of Department** OR **Service Manager** has reviewed the contract specification to confirm it contains the correct scope, reflects any subsequent agreements or negotiations with the supplier, and that specific input has been obtained throughout the drafting process from relevant areas within the Trust (e.g. ICT, information governance and security, clinical service delivery, facilities, data protection including application of the *EU General Data Protection Regulation*)
- **Senior Finance Manager** OR **Deputy Chief Finance Officer** has reviewed the commercial and pricing schedule to confirm the pricing and budgetary aspects are appropriate.
- Where the contract relates to specific goods and/or services obtained through a tender process conducted by the Trust's external procurement partner (Guy's and St Thomas's (GSTT)), the **GSTT Business Partner** has reviewed the contract to confirm it complies with all applicable procurement rules and that the terms and conditions are appropriate.
- **GOSH Procurement & Commercial Contracts team** has reviewed the terms and conditions to confirm that they are appropriate and seek further input from specific areas in the Trust and / or legal review from external legal providers, where appropriate.

This contract review and approval process is outlined in the **Contract Approval Form**, which must be completed prior to contract signature and execution.

8 7.3 Custody of Seal

The following extract from the Trust Constitution outlines the use of the Sealing of Documents.

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37 Custody of Seal

37.1 The common seal of the Trust shall be the responsibility of the Trust Secretary and kept in a secure place.

38 Sealing of Documents

38.1 Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of two executive directors duly authorised by the Chief Executive, and shall be attested by them.

38.2 Before any building, engineering, property or capital document is sealed it must be approved and signed by the ~~director of~~Chief Finance Officer, or an officer nominated by him or her and authorised and countersigned by the ~~C~~Chief ~~e~~Executive, or an officer nominated by him or her who shall not be within the originating directorate.

38.3 All deeds entered into by the Trust and all documents conveying an interest in land must be executed by the application of the Trust's seal.

39 Register of Sealing

39.1 An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorized the document and those who attested the seal. A report of all sealing shall be made to the Board at least quarterly. The report shall contain details of the seal number, the description of the document and the date of sealing.

7.3 7.4 Signing non-legally binding administrative arrangements

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This delegation has application when the Trust is entering into non-legally binding administrative arrangement with one or more other parties. The non-legally binding administrative arrangements could relate to one of the following:

- Memoranda of Understanding (either intra-Trust, with other NHS organisations, or with a commercial third party)
- Service level agreements (intra-Trust)
- Operating level agreements (intra-Trust).

#	Delegated Responsibilities	Delegated Officer or Group
16.1	Authority to sign non-legally binding administrative arrangements	
16.1.1	All non-legally binding administrative arrangements	Chief Executive OR Deputy Chief Operating Officer Executive OR Chief Finance Officer

Section 8 Summary of Non-financial Delegations

8.1 Risk management and insurance

This delegation has application in respect of the management of risk across the Trust. The detailed instructions for risk management and insurance are outlined in **SFI 15 Risk Management and Insurance**.

#	Delegated Responsibilities	Delegated Officer or Group
17.1	Management of risk and insurance	
17.1.1	Ensuring the Trust has a risk management strategy in place and a programme of risk management	Chief Executive
17.1.2	Ensuring the Trust has arrangements in place for the provision of adequate insurance cover for the Trust that are not indemnified through the NHS Resolution	Chief Executive AND Chief Finance Officer
17.1.3	Approval of an agent to act on behalf of the Trust for providing the above cover via third party organisation	Chief Finance Officer

8.2 Management and control of stock

This delegation has application in respect of all stock held by the Trust, including medical and surgical consumables, pharmaceuticals, diesel fuel, catering supplies, and GOSH CC shop stock items. The detailed instructions for the management and control of stock are outlined in **SFI 11 Stock Control and Receipt of Goods**.

#	Delegated Responsibilities	Delegated Officer or Group
18.1	Management and control of stock	
18.1.1	<p><i>Medical and surgical consumables stock</i></p> <ul style="list-style-type: none"> Approving stock portfolio (including re-order levels and frequency) Replenishing stock to approved maximum levels Ensuring stock is held in registered stock locations Conducting stock takes Signing off stock takes and obsolete stock 	<p>Designated Area Manager (e.g. Ward Sister, Matron, Lead Nurse, Lab Manager)</p> <p>Head of Materials Management</p> <p>Head of Materials Management</p> <p>Head of Materials Management</p> <p>Head of Materials Management AND Designated Area Manager (e.g. Ward Sister, Matron, Lead Nurse, Lab Manager)</p>
18.1.2	<p><i>Pharmaceutical stock</i></p> <p>(including approving stock portfolio, stock replenishment, ensuring stock is held in</p>	Chief Pharmacist

#	Delegated Responsibilities	Delegated Officer or Group
	registered locations, conducting stock takes, and signing off stock takes and obsolete stock)	
18.1.3	<i>Diesel fuel, catering supplies and GOSH CC shop stock</i> (including approving stock portfolio, stock replenishment, ensuring stock is held in registered locations, conducting stock takes, and signing off stock takes and obsolete stock)	Director of Estates & Facilities

Schedule 1 – Delegated Expenditure Approval and Invoice Request Limits

The following levels are created for the purposes of linking a position level to a level of authorisation in the electronic financial system for the Trust.

Where a significant contract is approved by the Trust Board, the Chief Finance Officer will have the delegation to raise any purchase orders required related to the approved contract. Evidence of Board approval must be provided with the requisition.

e-Delegation Level	Position	Expenditure Approval (excluding Development and Business Cases)	Invoice Requests	Raise Credit Notes
Level 1	Trust Board	>£4,500,000	n/a	n/a
Level 2	Chief Executive ^Δ	£4,500,000	n/a	n/a
Level 3	Deputy Chief Executive	£2,500,000	n/a	n/a
Level 4	Chief Finance Officer	£2,500,000	n/a	No limit
Level 5	Other Executive Directors ⁺ Other Directors referenced on the Trust Board ⁵	£500,000	n/a	n/a
Level 6	Deputy Chief Finance Officer	£200,000	n/a	£100,000
Level 7	Directors of Operations Chief Information Officers Other Directors not referenced on the Trust Board	£200,000	n/a	n/a
Level 8	Deputy Chief Nurse Chiefs of Service Heads of Nursing and Patient Experience General Managers Deputy Directors	£100,000	n/a	n/a
Level 9	Deputy Chiefs of Service	£75,000	n/a	n/a
Level 10	Specialty Leads Service Managers Matrons	£50,000	n/a	n/a
Level 11	Financial Controller	£25,000	n/a	£25,000
Level 12	Head of Contracts, Costing & Income Head of Financial Management	£25,000	>£1,000,000	n/a
Level 13	Finance Business Partners (and Budget Holder)	n/a	£1,000,000	n/a
Level 14	Finance Managers (and Budget Holder)	n/a	£500,000	n/a
Level 15	Senior Management Accountants Management Accountants (and Budget Holder)	n/a	£100,000	n/a
Level 16	Heads of Corporate Departments	£25,000	n/a	n/a
Level 18	Assistant Service Managers	£5,000	n/a	n/a
Level 19	Ward Sisters	£2,000	n/a	n/a
Level 20	Ward Administrators	£500	n/a	n/a

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⁴As at January 2018 the other Executive Directors include: Medical Director, Chief Nurse, and Director of Human Resources & Organisational Development.

⁵As at January 2018 the other Directors referenced on the Trust Board include: Director of Development & Property Services, Director of Research & Development, Director of Communications, and Director of International & Private Patients.

△ Subject to FIC approval over £2.5million

e-Delegation Level	Position	Purchase Order and Invoice Approval (excluding Development and Business Cases)	Credit Note Approval
Level 1	Trust Board	>£4,500,000	
Level 2	Chief Executive	£4,500,000	
Level 3	Chief Operating Officer	£2,500,000	
Level 4	Chief Finance Officer	£2,500,000	No limit
Level 5	Other Executive management Team members	£500,000	
Level 6	Deputy Chief Finance Officer	£100,000	£100,000
Level 7	Direct reports to the Executive Management Team	£100,000	
Level 8	Direct reports of level 7 including Chiefs of Service, Head of Nursing & Patient Experience and General Managers	£50,000	
Level 9	Financial Controller	£50,000	£25,000
Level 10	Budget Holders	£25,000	
Level 11	Budget Administrators	£2,000	

GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST (“the Trust”)

Standing Financial Instructions

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These Standing Financial Instructions were approved by the Trust Board on 5 December 2018

1 Audit and Counter Fraud

1.1 Audit Committee

1.1.1 In accordance with Standing Orders the Board shall establish an Audit Committee, with clearly defined terms of reference and membership consistent with relevant guidance issued by Regulators or the Department of Health. The role of the Audit Committee is to provide assurance to the Board by obtaining an independent and objective view of the Trust's financial systems, financial information, and compliance with relevant laws and guidance.

1.1.2 The Committee will:

- a. Ensure that the reporting systems for Audit shall be consistent with any guidance on reporting issued by, or endorsed by, the Regulator (e.g. the NHS Audit Committee Handbook) and approved by the Audit Committee.
- b. Ensure there is an effective audit function and oversee Internal and External Audit services. The Audit Committee shall be involved in the selection process when there is a proposal to review the provision of internal and external audit services.
- c. Review the adequacy and effectiveness of:
 - i. the system of integrated governance, risk management and internal control, across the whole of the Trust's activities, (but excluding clinical governance and clinical risk management systems whilst there exists a separate committee of the board with equivalent responsibilities for clinical governance), that supports the achievement of the organisation's objectives;
 - ii. financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgements;
 - iii. the information prepared to support the assurance framework prepared on behalf of the Board and advise the Board accordingly; and
 - iv. policies and procedures for all work related to fraud and corruption and security management and as required by NHS Protect.
- d. Ensure compliance with:
 - i. relevant codes of governance issued by Regulators and the Department of Health; and
 - ii. the Trust's Standing Orders and Standing Financial Instructions.
- e. Review schedules of:
 - i. losses and compensations and make recommendations to the Board; and
 - ii. debtors/creditors balances over 6 months old and £50,000 and explanations/action plans.
- f. Review the Annual Report and Accounts and all risk and control related disclosure documents (in particular the Annual Governance Statement) together with any appropriate independent assurances prior to endorsement by the Board.

1.1.3 Where the Audit Committee feel there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the committee wish to raise, the chair of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to Regulators.

1.1.4 The terms of reference of the Audit Committee, including its role and the authority delegated to it by the Board and by the Council of Governors, should be made publically available.

1.2 Role of Internal Audit

1.2.1 Internal audit will review, appraise and report upon:

- a. The extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;
- b. The adequacy and application of financial and other related management controls;
- c. The suitability and quality of financial and other related management data;
- d. The extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:
 - I. Fraud and other offences,
 - II. Waste, extravagance, inefficient administration,
 - III. Poor value for money or other causes.

1.2.2 The Head of Internal Audit shall be accountable to the Chief Finance Officer. Where, in exceptional circumstances, the use of normal reporting channels could be seen as a possible limitation of the objectivity of the audit, the Head of Internal Audit shall seek advice from the Trust Board Chairman or Chairman of the Audit Committee. This reporting system shall be reviewed at least every three years.

1.2.3 The Chief Finance Officer will refer audit reports to the appropriate officers designated by the Chief Executive. The Head of Internal Audit will agree timescales for implementing audit recommendations with designated officers. Failure to adhere to these timescales shall be reported to the Audit Committee who shall take necessary action to ensure compliance with such recommendations.

1.2.4 The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee Members, the Chairman and Chief Executive of the Trust. The Head of Internal Audit will issue an annual opinion to the Audit Committee and the Board in accordance with the requirements of Regulators and the Department of Health.

1.2.5 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Chief Finance Officer must be notified immediately.

1.2.6 The Chief Finance Officer is responsible for:

- a. Ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control which include the establishment of an internal audit function;
- b. Ensuring that the internal audit is adequate and meets, as a minimum, the NHS mandatory audit standards and is in compliance with Regulator's Audit Codes; and

- c. Ensuring that the Audit Committee receive an annual report from the Internal Auditors and an assessment of their effectiveness.

1.2.7 The Chief Finance Officer and designated internal auditors are entitled without necessarily giving prior notice to require and receive:

- a. Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
- b. Access at all reasonable times to any land, premises or members of the Board and Executive Team or employee of the Trust;
- c. The production of any Trust cash, stores or other property of the Trust under a member of the Board and an employee's control; and
- d. Explanations concerning any matter under investigation.

1.3 External Audit

1.3.1 The external auditor is appointed by the Council of Governors. The Audit Committee must ensure a cost-efficient service.

1.3.2 The Auditor shall be required by the Trust to comply with the Audit Code for NHS Foundation Trusts.

1.3.3 In the event of the auditor issuing a public interest report the Trust shall forward a report to the regulator within 30 days (or shorter period if specified by the Regulator). The report shall include details of the Trust's responses to the issues raised within the public interest report.

1.4 Security Management

1.4.1 In line with their responsibilities, the Trust Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management and will nominate a Director, the Security Management Director (SMD) to be responsible to the Board for NHS Security Management.

1.4.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the NHS Protect Standard Contract and Standards for Providers.

1.4.3 The SMD will ensure the appointment of a LSMS who will provide a written report, at least annually, to the Audit Committee.

1.5 Fraud and Corruption

1.5.1 In line with their responsibilities, the Chief Executive and Chief Finance Officer shall monitor and ensure compliance with relevant directions and guidance on countering fraud and corruption within the NHS including the *Bribery Act 2010*.

1.5.2 The *Bribery Act 2010* replaces the "*Prevention of Corruption Acts 1889 - 1916*" with new corporate and individual offences as defined within these Standing Financial Instructions. All staff and contractors should be made aware of the Act to ensure compliance. Any breach of the Act may result in criminal proceedings being commenced.

- 1.5.3 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist (LCFS) as specified by the NHS Counter Fraud and Corruption Manual and relevant directions and guidance.
- 1.5.4 The Chief Finance Officer should also prepare a “Counter Fraud Policy and Response Plan” that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it.
- 1.5.5 The LCFS shall report to the Chief Finance Officer and shall work with staff in NHS Protect and the Area Anti-Fraud Specialist (AAFS) in accordance with the NHS Counter Fraud and Corruption Manual.
- 1.5.6 The LCFS will provide a written report, at least annually, to the Audit Committee.
- 1.5.7 It is the responsibility of the Chief Finance Officer to decide at what stage to involve the police in cases of misappropriation, and other irregularities other than fraud and corruption after taking advice from the LCFS and/or LSMS.

2 Business Planning, Budgets, Budgetary Control and Monitoring

2.1 Preparation and Approval of Annual Plans and Budgets

- 2.1.1 The Chief Executive will compile and submit to the Board an annual business plan, which takes into account financial targets and forecast limits of available resources. The annual plan will comply with the Regulator's requirements, set at authorisation and annually, and contain:
- A statement of the significant assumptions on which the plan is based; and
 - Details of major changes in workload, delivery of services or resources required to achieve the plan including finances and workforce
 - Details of CIP requirements and plans for delivery and in year monitoring
- 2.1.2 At the start of business planning process the [Deputy Chief Operating Executive](#) Officer will, on behalf of the Chief Executive, prepare and submit a business plan for the approval of the Board. The Business plan
- A detailed description of the activity plans for the Trust services taking into consideration commissioner intentions and national guidance.
 - The impact of the Trusts business cases and site development
 - Expected changes to workforce and plans of meeting the Trusts requirements
 - Identify risks
 - Demonstrate compliance with any regulatory requirements.
- 2.1.3 At the start of the financial year the Chief Finance Officer will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will:
- Be in accordance with the aims and objectives set out in the Trust's annual business plan;
 - Accord with workload and manpower plans
 - Be produced following discussion with appropriate budget holders;
 - Take account of any limits of expected income arising, or expected to arise, from contracts with funders;
 - Identify potential risks; and
 - Demonstrate compliance, if practicable, with the minimum requirements of the Regulator.
- 2.1.4 The Chief Finance Officer shall compile the Budgets in line with the Business Plan produced by the [Deputy Chief Operating Executive](#) Officer and the Workforce plans produced by the Director of HR and OD.
- 2.1.5 All budget holders must provide information as required by the Chief Finance Officer to enable budgets to be set and monitored, as a consequence the Chief Finance Officer will have right of access to all budget holders on budgetary matters.
- 2.1.6 All budgets holders will sign up to their allocated budgets at the commencement of each financial year. Any non-compliance will be escalated to the relevant Director who will take responsibility or detail non-compliance to the Chief Executive.
- 2.1.7 The Chief Finance Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to facilitate successful budget management.

2.2 Budgetary Delegation

- 2.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. Delegation must be to specific post holders and in writing. The notice of delegation will include:
- a. The budget holder;
 - b. The amount of the budget;
 - c. The purpose(s) of each budget heading;
 - d. Individual and group responsibilities;
 - e. Authority to exercise virement (transfer of funds between budgets);
 - f. Achievement of planned levels of service; and
 - g. The provision of regular reports.
- 2.2.2 This Chief Executive may also delegate elements of budgets that cross the organisation which can include:
- a. Trust CIP responsibility
 - b. Cross Cutting business cases or individual schemes.
- 2.2.3 The Chief Executive and delegated budget holders must not exceed the budgetary total or budget transfer (virement) limits set by the Board, except as specified below:
- a. The Chief Executive is permitted to authorise expenditure over the budget up to an amount specified in the financial limits.
 - b. A budget may be varied on the basis of a business case for revenue or capital investment provided it has been approved by the EMT or Trust Board (as determined by the financial limits) and does not result in a material adverse change to the financial position reflected in the current year's budget or medium term financial plan.
 - c. Where total expenditure is forecast to exceed the Trust's expenditure budget but this excess is substantially offset by additional unbudgeted income and as a result it is reasonable to believe, based on forecast information reported to the Trust Board, that there is no material adverse change to the financial position of the Trust reflected in the current year's budget or medium term financial plan. This needs to take into account a review and risk assessment to the payment of the additional unbudgeted Income.
- 2.2.4 Any budgeted funds not required for their designated purpose revert to the immediate control of the Chief Executive, subject to any authorised use of virement.
- 2.2.5 Non-recurring budgets must not be used to finance recurring expenditure without the written authority of the Chief Executive.
- 2.2.6 Commitment to overspend against the budget to year end or to raise expenditure against unfunded initiatives arising in year will need written authorization from the Chief Executive.

2.3 Budgetary Control and Reporting

- 2.3.1 The Chief Finance Officer will devise and maintain systems of budgetary control. These will include:
- a. Monthly financial reports to the Board in a form approved by the Board containing:
 - i. Income and expenditure to date showing trends and forecast year-end position;
 - ii. Movements in working capital;
 - iii. Other Statement of Financial Position changes where these are material;

- iv. Explanations of any material variances from plan;
 - v. Details of any corrective action, proposed or taken, where necessary along with the Chief Executive's and/or the Chief Finance Officer's view of whether such actions are sufficient to correct the situation; and
 - vi. Monthly reports on capital project spend and projected outturn against plan.
- b. The issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;
 - c. Investigation and reporting of variances from financial, workload and manpower budgets;
 - d. Systems to ensure adequate pre-authorisation of all pay and non-pay expenditure, including authorised signatory arrangements.
 - e. Monitoring of management action to correct variances; and
 - f. Arrangements for the authorisation of budget transfers.

2.3.2 Each budget holder is responsible for ensuring that:

- a. Any likely overspending or shortfall in income which cannot be addressed by virement is not incurred without the prior consent of the Chief Executive;
- b. The amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;
- c. No permanent employees are appointed without the approval of the Chief Executive other than those provided for in the budgeted establishment as approved by the Board;
- d. Identifying and implementing cost improvements, cost savings and income generation initiatives to achieve a balanced budget; and
- e. Effective systems exist within the directorate to ensure that all expenditure is authorised in advance of commitment (e.g. operation of authorised signatory systems) and that the individuals incurring expenditure fully understand their budgetary control responsibilities.

2.3.3 The Chief Executive is responsible for authorising the implementation of cost improvements, cost savings and income generation initiatives in accordance with the requirements of the Annual Business Plan.

2.3.4 The Chief Finance Officer shall monitor financial performance against budget and annual plan, periodically review them, and report to the Board.

2.4 Capital Expenditure

2.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in SFI - 9).

2.5 NHSI Returns

2.5.1 The Chief Executive is responsible for ensuring that any required NHSI returns are submitted to the appropriate regulatory organisations.

3 Annual Accounts and Reports

3.1 Annual Accounts and Reports

3.1.1 The Chief Finance Officer, on behalf of the Trust will:

- a. Prepare and submit financial returns in accordance with the Trust's accounting policies, guidance applicable to NHS and public bodies and relevant financial reporting standards; and
- b. Prepare annual accounts in such form as the Regulator may with the approval of Treasury direct.

3.1.2 The Trust's annual accounts must be audited by an independent external auditor appointed by the Council of Governors. The Trust's audited Annual Accounts must be presented to the Board for approval and received by the Councillors at a public meeting and made available to the public.

3.1.3 The Trust will publish an Annual Report, including a Quality Report, in accordance with guidelines from the Regulator and in compliance with any other relevant guidance for NHS Foundation Trusts and shall also take account of good practice from the public and private sector.

3.1.4 The report will give:

- a. Information on any steps taken by the Trust to secure that the actual membership of its public constituency and the patients' constituency is representative of those eligible for membership and any information the regulator requires; and
- b. Any other information the regulator requires.

4 Bank Accounts, External Borrowing and Investment of cash

4.1 General

- 4.1.1 The Board, through the Finance and Investment Committee, shall approve the treasury and cash management strategy and all banking arrangements.
- 4.1.2 The Chief Finance Officer is responsible for managing the Trust's banking arrangements, ensuring compliance with relevant regulatory guidance, directions and legislation and for advising the Board on the provision of banking services and operation of accounts, borrowing and investment requirements. The Chief Finance Officer shall seek the approval of the Board prior to engagement of any bank or financial institution.

4.2 Bank Accounts

- 4.2.1 The Chief Finance Officer is responsible for:
 - a. Authorising the opening or closing of bank accounts and Government Banking Service (GBS) accounts in the name of the Trust;
 - b. Operating all bank accounts and GBS accounts;
 - c. Reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn and ensuring payments made from the bank account and GBS account do not exceed the amount credited to the account except where arrangements have been made; and
 - d. Monitoring compliance with relevant guidance from the Regulator or the Department of Health on the level of cleared funds and amounts overdrawn.

4.3 Banking and Investment Procedures

- 4.3.1 The Chief Finance Officer will prepare detailed instructions on the operation of bank accounts and GBS accounts, which must include:
 - a. The conditions under which each account is to be operated;
 - b. The limit to be applied to any overdraft; and
 - c. Those authorised to sign cheques or other orders drawn on the Trust's accounts.
- 4.3.2 A Treasury Management Policy that sets out arrangements for investment of surplus funds and associated risk management. This policy will be approved by the Finance and Investment Committee.
- 4.3.3 The Chief Finance Officer must advise the Trust's bankers in writing of the conditions under which each account will be operated.

4.4 Tendering and Review

- 4.4.1 The Chief Finance Officer should monitor performance of banking services providers to ensure that the levels of service are in accordance with the agreed contract, reflect best practice and represent best value for money.
- 4.4.2 Competitive tenders should be sought at least every 5 years. The results of the tendering exercise should be reported to the Board. This review is not necessary for accounts held through the GBS.

4.5 Signatories

- 4.5.1 The Chief Finance Officer will advise the bankers in writing of the officers authorised to release money from or draw cheques on each bank account and GBS account of the Trust. Cancellation of authorisation will be notified promptly to the bankers.

4.6 Charitable Donations/ Special Trustees

- 4.6.1 Charitable funds associated with the Trust are administered by the Great Ormond Street Hospital Children's' Charity. Any charitable donations received by the Trust should be paid over to the Charity for administration.

4.7 External Borrowing

- 4.7.1 The Trust must ensure compliance with any relevant guidance issued by the Regulator before undertaking any borrowing arrangement.
- a. The Trust may borrow money from any commercial source for the purposes of or in connection with its operations.
 - b. Any application for a loan or overdraft must be approved by the Chief Finance Officer or by an employee so delegated by him/her.
 - c. All short term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position. Any short term borrowing requirement in excess of one month must be authorised by the Chief Finance Officer.
 - d. The Chief Finance Officer must establish a monitoring system to ensure that any covenants within credit agreements are adhered to.
- 4.7.2 The Chief Finance Officer must prepare detailed procedural instructions concerning applications for loans and overdrafts.
- 4.7.3 All long term borrowing must be consistent with the plans outlined in the current annual business plan.
- 4.7.4 The Chief Finance Officer will include key information relating to the Statement of Financial Position in each monitoring report prepared for the Trust Board. This will include changes to long term debt, Public Dividend Capital and other borrowings. Taken together with the revenue account report it will show the planned and projected position on interest and capital.

4.8 Investments

- 4.8.1 Temporary cash surpluses must be held only in such public or private sector investments as approved through the Treasury Management Policy and should be consistent with relevant guidance from the Regulator.
- 4.8.2 The Chief Finance Officer is responsible for reporting periodically to the Finance and Investment Committee concerning the performance of investments held.
- 4.8.3 The Chief Finance Officer will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

4.9 Public Dividend Capital

- 4.9.1 On authorisation as a foundation trust the Public Dividend Capital (PDC) held immediately prior to authorisation must continue to be held on the same conditions as applied prior to authorisation.

- 4.9.2 Draw down of PDC, if made available by the Secretary of State, will be authorised in accordance with the mandate determined with the Department of Health.
- 4.9.3 The Trust shall pay a dividend on its PDC calculated according to the method determined from time to time by the Department of Health or the Regulator.

5 Income, Fees and Charges and Security of Cash Cheques and Other Negotiable Instruments

5.1 Income Systems

- 5.1.1 The Chief Finance Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due, including NHS, commercial and Research and Development (R&D) income.
- 5.1.2 The Chief Finance Officer is also responsible for the prompt banking of all monies received. All cash must be banked directly with the Cashiers Department by the payer unless specific authority from the Chief Finance Officer has been received and suitable procedures are in place to ensure the security of funds.

5.2 Fees and Charges (other than in relation to provision of NHS services for patient care – refer to [SFI 6](#))

- 5.2.1 The Chief Finance Officer is responsible for regularly reviewing and approving the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered relevant guidance on ethical standards in the NHS shall be followed.
- 5.2.2 It is the responsibility of all employees to inform the Chief Finance Officer promptly of money due arising from transactions which they initiate/deal with, including all NHS Contracts and Service Agreements, commercial agreements and contracts (including Research and Development), leases, tenancy agreements, private patient undertakings and other transactions.
- 5.2.3 The Trust must comply with the rules around non-NHS income as required under NHSI's Risk Assessment Framework and any Department of Health guidance.

5.3 Debt Recovery

- 5.3.1 The Chief Finance Officer is responsible for ensuring that:
 - a. Appropriate recovery action is taken on all outstanding debts;
 - b. Income not received and deemed irrecoverable is dealt with in accordance with losses procedures, and reported to the Trust's Audit Committee;
 - c. No officer, without prior express authority from the Chief Finance Officer is allowed to agree with any third party, to the cancellation or reduction of a legitimate debt owed to the Trust; and
 - d. Overpayments should be detected (or preferably prevented) and recovery initiated.

5.4 Security of Cash, Cheques and Other Negotiable Instruments

- 5.4.1 The Chief Finance Officer is responsible for:
 - a. Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;
 - b. Ordering and securely controlling any such stationery (or approving delegated arrangements where this is considered appropriate);

- c. The provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and
 - d. Prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.
 - e. Reporting, recording and safekeeping of cash, cheques and negotiable instruments.
- 5.4.2 Official money shall not under any circumstances be used for the encashment of personal cheques or IOUs.
- 5.4.3 All cheques, postal orders and cash, shall be banked intact on a timely basis. Disbursements shall not be made from cash received, except under arrangements approved by the Chief Finance Officer.
- 5.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

6 NHS Contracts or Service Agreements for the Provision of Services

6.1 Contracts for NHS Services

- 6.1.1 The Board shall maintain the capacity and capability of the Trust to provide commissioner requested services and shall regularly review compliance.
- 6.1.2 The Chief Executive, as the Accounting Officer, is responsible for ensuring the Trust enters into suitable contracts with service commissioners for the provision of NHS services.
- 6.1.3 All contracts shall be legally binding and should include terms and conditions consistent with good commercial practice within the NHS and should have effective risk management clauses in so far as is reasonably achievable.
- 6.1.4 The Chief Executive, as the Accounting Officer, will ensure that regular reports are provided to the Audit Committee, the Finance and Investment Committee and the Trust Board detailing amounts contracted for, actual and forecast income from contracts.
- 6.1.5 In respect of contracts for the provision of NHS patient services no officer, except within the boundaries of any delegated authority, is allowed to confirm or agree with a third party the reduction or waiver to the Trust's normal charges, without the prior express authority of the Chief Finance Officer.
- 6.1.6 Where the Trust enters into a relationship with another organisation for the supply or purchase of any other services, clinical or non-clinical, the responsible officer should ensure that an appropriate contract is concluded and authorised by both parties.

6.2 Non-NHS Income

- 6.2.1 Any planned increase of five per cent or more of the proportion of total income from non-NHS sources must be supported by a majority of councillors in a vote.

7 Terms of Service and Payment of Directors and Employees

7.1 Remuneration and Terms of Service

- 7.1.1 The Councillors are responsible for setting the remuneration of non-executive directors including the Chair of the Board. The Councillors should seek advice from external professional advisers to market test remuneration levels as appropriate but not less frequently than every five years or if they intend to make a material change to remuneration of any non-executive director.
- 7.1.2 The Board should establish and determine the terms of reference of a Remuneration Committee, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.
- 7.1.3 The Remuneration Committee will:
- a. In respect of the Chief Executive, Executive Directors, notify the Board about appropriate remuneration and terms of service, including:
 - i. all aspects of salary (including any performance-related elements/bonuses);
 - ii. provisions for other benefits, including pensions and cars; and
 - iii. arrangements for termination of employment and other contractual terms.
 - b. report decisions to the Board on the remuneration and terms of service to ensure they are fairly rewarded for their individual contribution to the Trust, having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff as appropriate;
 - c. monitor and evaluate the performance of individual executive directors; and
 - d. advise on and oversee appropriate contractual arrangements including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.
- 7.1.4 The Committee shall report in writing to the Board the bases for its decisions. The Board remains accountable for taking decisions on the remuneration and terms of service of executive directors. Minutes of the Board's meetings should record such decisions.
- 7.1.5 In respect of lay members and employees other than Executive Directors, the Remuneration Committee will receive and consider proposals for setting remuneration and conditions of service, and make recommendations to the Board.
- 7.1.6 The Remuneration Committee will receive reports detailing all Trust employees who have been made redundant or taken early retirement. These reports will include the cost to the Trust of the redundancy or early retirement.

7.2 Consultant Discretionary Points

- 7.2.1 Annually the Medical Director will make recommendations to the Trust Board regarding the award and funding (having taken advice from the Chief Finance Officer) of Consultant Discretionary Points.

7.3 Funded Establishment

- 7.3.1 The manpower plans incorporated within the annual budget will form the funded establishment (see also SFI 2). The funded establishment of any department may not

be varied without the approval of the Chief Executive (or as delegated under the Scheme of Delegation).

7.4 Staff Appointments and Redundancies

7.4.1 No director or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary basis, or hire agency staff, or agree to changes in any aspect of remuneration:

- a. Unless it is within the approved budget and funded establishment and the Director or employee has appropriate delegated responsibility; and
- b. The proposal conforms to any establishment control procedure that may be in place at the time.

7.4.2 No director or employee may commit the Trust to any redundancy, early retirement or negotiated employment termination settlement without the approval in advance of the Chief Finance Officer and the Director of Human Resources and Organisational Development.

7.5 Processing of Payroll

7.5.1 The Chief Finance Officer is responsible for:

- a. specifying timetables for submission of properly authorised time records and other notifications;
- b. ensuring that the final determination of pay and allowances have been calculated in accordance with national agreements where relevant or otherwise Trust-determined agreements;
- c. making payment on agreed dates; and
- d. agreeing method of payment.

7.5.2 The Chief Finance Officer will issue and maintain procedures regarding:

- a. Verification and documentation of data;
- b. The timetable for receipt and preparation of payroll data and the payment of employees;
- c. Maintenance of subsidiary records for superannuation, income tax, national insurance contributions and other authorised deductions from pay;
- d. Security and confidentiality of payroll information;
- e. Checks to be applied to completed payroll before and after payment;
- f. Authority to release payroll data under the provisions of the Data Protection Act;
- g. Methods of payment available to various categories of employee;
- h. Procedures for payment by cheque or bank credit, to employees and officers;
- i. Procedures for the recall of cheques and bank credits;
- j. Pay advances and recovery thereof;
- k. Maintenance of regular and independent reconciliation of pay control accounts;
- l. Ensuring the principle of separation of duties is applied in the preparation of records;
- m. A system to ensure the recovery, from persons leaving the employment of the Trust, of sums of money and property owed by them to the Trust;
- n. That payroll records are retained in accordance with statutory and other requirements; and

- o. Systems exist to detect and recover overpayments.

7.5.3 The Director of HR& OD will issue guidance and procedures to managers who have delegated responsibility for:

- a. Submitting termination forms, time records, and other notifications in accordance with agreed timetables and procedures;
- b. Completing time records and other notifications in accordance with instructions and in the form prescribed;
- c. Submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination, or retirement.

7.5.4 Regardless of the arrangements for providing the payroll service, the Chief Finance Officer shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures, and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

7.6 Contract of Employment

7.6.1 The Board shall delegate responsibility to the Director of Human Resources and Organisational Development:

- a. Ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and
- b. Dealing with variations to, or termination of, contracts of employment.

7.7 Managers' Responsibility

7.7.1 Managers are responsible for:

- a. Following the procedures and guidance relating to the completion and submission of payroll documentation. It is particularly important that termination forms are submitted promptly upon becoming aware of an employee's resignation, termination or retirement. Where an employee fails to report for duty in circumstances that suggest they have left without notice, Human Resources department must be notified immediately.
- b. Ensuring there are appropriate systems of internal check and control in place within their directorate or department to ensure that time records and expense claims are capable of meaningful certification.

8 Non-Pay Expenditure

8.1 Delegation of Authority

8.1.1 The Board will approve the level of non-pay expenditure within the budget on an annual basis and the Chief Executive will determine the level of delegation to budget managers, in line with NHS best practice and following guidance from boards and committees as appropriate. The Trust's **Scheme of Delegation** (attached at Appendix A) sets this out and delegated limits can be varied in-year only with the approval of the Chief Executive.

8.1.2 The Chief Finance Officer will set out:

- a) A list of requisitioners authorised to requisition goods and services
- b) The maximum level of each requisition and the system for authorisation above that level.

8.1.3 The Chief Finance Officer will establish and maintain procedures on the seeking of professional advice regarding the supply of goods and services and will ensure that all requisitioners authorised to place requisitions are aware of the procedures. This will include maintaining guidance on ***Tendering Procedures for Goods and Services*** (see also [SFI 165](#)).

8.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

8.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust and ensure that he/she has no conflict of interest or contravene the requirements of *The Bribery Act 2010*. In so doing, the advice of the Trust's procurement department shall be sought.

8.2.2 The Chief Finance Officer will:

- a. advise the Board regarding the setting of thresholds above which quotations, competitive or otherwise, or formal tenders must be obtained (having regard to legislation and directives regarding public sector procurement); and, ensure the thresholds are reflected in the Scheme of Delegation and financial limits referenced to these SFIs and regularly reviewed;
- b. issue and maintain procedural instructions on obtaining goods, works and services. (Refer to [SFI 165 "Tendering for Goods and Services Procedures"](#));
- c. Design and maintain systems to ensure that there are controls over the commitment of funds; and
- d. Design and maintain systems for the verification and certification of the receipt of goods and services to ensure that only valid invoices are paid and minimise the opportunity for overpayment. The system shall provide for:
 - i. A list of directors/employees (including specimens of their signatures) authorised to approve invoices;
 - ii. Certification that:
- e. Goods have been duly received, examined and are in accordance with specification and the prices are correct
- f. Work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;

- g. In the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the appropriate rates, the materials have been checked as regards quantity, quality and price and the charges for the use of vehicles, plant and machinery have been examined;
- h. Where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- i. The account is arithmetically correct; and
- j. The account is in order for payment.
- k. be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms unless there is a valid dispute, or otherwise, in accordance with the NHS Better Payment Practice Code. Provision shall be made so that advantage can be taken of accounts subject to cash discounts.—
~~stress 'attempt'~~
- l. design and maintain systems for:
 - a. ensuring that payment for goods and services is only made once the goods and services are received (except as for 8.2.4 below)
 - b. the use and control of purchasing cards.

8.2.3 Prepayments are only permitted where exceptional circumstances apply. In such instances:

- a. Prepayments are only permitted where the financial advantages outweigh the disadvantages;
- b. The appropriate director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments;
- c. The Chief Finance Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the Public Contracts Regulations 2015 where the contract is above a stipulated financial threshold); and
- d. The budget holder is responsible for ensuring that all items due under a prepayment contract are received and he/she must immediately inform the appropriate Director or Chief Executive if problems are encountered.

8.2.4 The Chief Executive and the Chief Finance Officer shall ensure that the arrangements for financial control and the financial audit of building and engineering contracts and property transactions comply with all applicable guidance. The technical audit of these contracts shall be the responsibility of the relevant Director.

8.3 Responsibilities of All Employees

8.3.1 All employees must follow the Trust's procedures when obtaining goods, works and services (also refer to [SFI 165 Tendering for Goods and Services Procedure](#)) and obtain best value for money.

- a. Ensuring that all contracts (other than for purchases permitted within the scheme of delegation), leases tenancy agreements and other commitments which may result in a liability must be approved by the Chief Finance Officer in advance of any commitment being made (refer to SFI 9.2);
- b. Ensuring that the Public Contracts Regulations 2015 for advertising and awarding contracts are followed;
- c. Ensuring that adequate budgetary provision exists against the budget code they are using, or they have made appropriate arrangements for virement or reporting the expected over commitment;

- d. Ensuring that all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract, purchases from petty cash or with approved purchasing cards;
- e. Follow the Trust's procedures on certifying receipt of goods, works and services to enable invoices to be paid (relevant management procedures); and in particular note and comply with the following points:
 - i. All non-stock orders must be placed via requisitions on the Trust's purchasing system (except where the employee has been issued specifically with a Trust-authorized purchasing card);
 - ii. Ensure that stock items are used wherever possible;
 - iii. Take goods on trial or loan where this commits the Trust to a future purchase;
 - iv. Split requisitions to avoid financial thresholds;
 - v. Enter contracts, including rental and leasing agreements, that are for items of a capital nature without the express approval of the Chief Executive and Chief Finance Officer (see [SFI 9](#)); - add more detail to SFI9 re leasing policies
 - vi. restrict purchases from petty cash or through the employee expense reimbursement system to items of very low value unless exceptionally authorised.

8.3.2 Employees should also be aware of the restrictions in relation to accepting gifts, inducements or other personal advantage which could be considered to be bribes under *The Bribery Act 2010*.

- a. This includes ensuring that no order shall be issued to an organisation which has made an offer of gifts, reward or benefit to directors or employees other than:
 - i. Isolated gifts of a trivial character or value; or
 - ii. Conventional hospitality, such as lunches in the course of working visits.
- b. No visits, at supplier's expense should be made without the prior written approval of a director.

8.4 Procurement

8.4.1 The procurement function will:

- a. Only process fully authorised requisitions and ensure that competition is (or has been) appropriately taken in accordance with the Trust's Tendering for Goods and Services Procedure;
- b. Liaise with the Chief Finance Officer on issues regarding the systems for ordering, receipt and payment;
- c. Place sequentially numbered Purchase Orders incorporating the Trust's terms and conditions of trade.

8.5 Petty Cash

8.5.1 Purchases that will be reimbursed from petty cash are restricted in type and value and must be supported by receipt(s) and certified by an authorised signatory

8.5.2 The Chief Finance Officer will determine record-keeping and other instructions relating to petty cash.

9 Fixed Asset Register and Security of Assets

9.1 Asset Registers

- 9.1.1 The Chief Finance Officer is responsible for the maintenance of registers of assets, and arranging for a periodic physical check of assets against the asset register.
- 9.1.2 The Trust shall maintain a computerised asset register recording fixed assets which should include the minimum data specified by the Regulator.
- 9.1.3 Additions to the fixed asset register must be clearly identified to an appropriate manager and be validated by reference to:
- a. Properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchase from third parties;
 - b. Stores, requisitions and wage records for own materials and labour including appropriate overheads; and
 - c. Lease agreements in respect of assets held under a finance lease and capitalised.
- 9.1.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate). The Trust may not dispose of any protected property without the approval of the regulator. This includes the disposal of a part of such property or the granting of an interest in or over it.
- 9.1.5 The Chief Finance Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
- 9.1.6 The value of each asset shall be revalued at current values in accordance with appropriate methods for NHS Foundation Trusts.
- 9.1.7 The value of each asset shall be depreciated using methods and rates in accordance with guidance issued by the Regulator.

9.2 Security of Assets

- 9.2.1 The overall control of fixed assets is the responsibility of the Chief Executive.
- 9.2.2 Asset control procedures for fixed assets, including donated assets, must be approved by the Chief Finance Officer. This procedure shall make provision for:
- a. Recording managerial responsibility for each asset;
 - b. Identification of additions and disposals;
 - c. Identification of all repairs and maintenance expenses;
 - d. Physical security of assets
 - e. Periodic verification of the existence of, condition of, and title to, assets recorded;
 - f. Identification and reporting of all costs associated with the retention of an asset.
- 9.2.3 Any discrepancies revealed by verification of physical assets to the fixed asset register shall be notified to the Chief Finance Officer.

- 9.2.4 Whilst each employee has responsibility for the security of property and assets of the Trust, it is the responsibility of directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with Trust Guidance
- 9.2.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported initially to the Director responsible for Estates and the Chief Finance Officer by directors and employees in accordance with the procedure for reporting losses.
- 9.2.6 In line with Trust guidance, managers should ensure that where practical, assets should be marked as Trust property.
- 9.2.7 Equipment and other assets may be loaned to the Trust. Employees and managers must ensure that the Trust management procedure is followed; in particular that conditions attaching to the loan are documented and the asset identified. Loaned assets must not be entered in the Trust's asset register.

10 Capital Investment, Private Financing and Leasing

10.1 Capital Investment

10.1.1 The Board shall approve financial limits for the Trust's annual programme of capital investment as part of the budget process. The approval of a capital programme shall not constitute approval for expenditure on any scheme within the programme.

10.1.2 The Chief Executive shall ensure that:

- a. there is an adequate appraisal and approval process (including proposed changes to projects after their initial approval) in place for determining capital expenditure priorities and the effect of each proposal upon annual plans;
- b. there are processes in place for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;
- c. capital investment in new facilities or major redevelopments is not undertaken without confirmation of commissioner's(s) support and the availability of resources to finance all revenue consequences, including capital charges; and
- d. all processes and procedures are consistent with relevant guidance and regulatory requirements.

10.1.3 The Trust's scheme of delegation will include limits for capital investment management which must be reviewed and approved on a regular basis.

10.1.4 For every significant capital expenditure proposal the Chief Executive shall ensure that:

- a. a business case (in line with Department of Health or the Regulator's guidance) is produced and approved prior to the commitment of expenditure setting out:
 - i. An option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to cost
 - ii. Appropriate project management and control arrangements
 - iii. The involvement of appropriate Trust personnel and external agencies
- b. the Chief Finance Officer has validated the costs and revenue consequences detailed in the business case.

10.1.5 For capital schemes where the contracts stipulate stage payments, the responsible Director, as relevant, will issue procedures for their management, incorporating any relevant external regulations or guidance

10.1.6 The Chief Finance Officer shall assess on annual regular basis the requirement for the operation of the construction industry tax deduction scheme in accordance with HM Revenue and Customs guidance.

10.1.7 The Chief Finance Officer shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

10.1.8 The Chief Executive shall ensure that there are procedures in place to identify managers' responsible for each scheme and specify:

- a. levels of authority to commit expenditure;
- b. authority to proceed to tender;
- c. approval to accept a successful tender.

10.1.9 The Chief Finance Officer shall issue procedures governing the financial management, (including variations to contract), of capital investment projects and valuation for accounting purposes.

10.2 Leasing

10.2.1 Any finance or operating leases must be agreed and signed by the Chief Finance Officer.

11 Stock Control and Receipt of Goods

11.1 General position

- 11.1.1 Stock should be:
- a. Kept to optimum levels;
 - b. Subjected to at least two stock takes per year;
 - c. At the lower of cost and net realisable value

11.2 Control of Stock, Stocktaking, condemnations and disposal

- 11.2.1 Subject to the responsibility of the Chief Finance Officer for the systems of control, overall responsibility for the control of stock locations shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him/her to departmental employees and / or the Supply Chain employees, subject to such delegation being entered in a record available to the Chief Finance Officer. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel oil and coal of a designated Estates Manager.
- 11.2.2 The responsibility for security arrangements and the custody of keys for any stock locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer.
- 11.2.3 The Chief Finance Officer shall set out procedures and systems to regulate the stock locations including records for receipt of goods, issues, returns to suppliers, and losses.
- 11.2.4 Stocktaking arrangements shall be agreed with the Chief Finance Officer and there shall be a physical check covering all items in stock at least twice a year.
- 11.2.5 Where a complete system of stock control is not justified, alternative arrangements shall require the approval of the Chief Finance Officer.
- 11.2.6 The designated Manager/Head of Pharmacy shall be responsible for a system approved by the Chief Finance Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Chief Finance Officer any evidence of significant overstocking and of any negligence or malpractice (see also [SFI 12 Disposals and Condemnations, Losses and Special Payments](#)). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

12 Disposals and Condemnations, Losses and Special Payments

12.1 Disposals and Condemnations

12.1.1 The Chief Finance Officer must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers. The Trust may not dispose of any protected property without the Regulator's consent.

12.1.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the Chief Finance Officer of the estimated market value of the item, taking account of professional advice where appropriate and ensuring the disposal process is structured so as to achieve best value for the asset.

12.1.3 Unserviceable articles:

- a. can only be condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Finance Officer;
- b. disposals must be recorded by the Condemning Officer in a form approved by the Chief Finance Officer which will indicate whether the articles are to be converted, destroyed or otherwise disposed of, and all entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Chief Finance Officer; and
- c. the Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Finance Officer who will take the appropriate action.

12.2 Losses and Special Payments

12.2.1 The Chief Finance Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses and special payments.

12.2.2 Any employee discovering or suspecting a loss of any kind must immediately inform the Chief Finance Officer or inform an officer charged with responsibility for responding to concerns involving loss or fraud confidentially. This officer will then appropriately inform the Chief Finance Officer and/or Chief Executive. Where a criminal offence is suspected, the Chief Finance Officer must immediately inform the police, following advice from the LSMS, if theft or arson is involved.

12.2.3 In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Chief Finance Officer must inform the LCFS and any other relevant organisations in accordance with DH guidance or direction.

12.2.4 The Chief Finance Officer must notify NHS Protect and the External Auditor of all frauds and consider whether any other organisations should also be so notified.

12.2.5 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Chief Finance Officer must immediately notify:

- a. the Board;
- b. the LSMS;
- c. the Audit Committee; and
- d. the External Auditor.

12.3 Authorisation and Reporting of Losses and Special Payments

- 12.3.1 The writing off of losses shall be approved by the Chief Finance Officer where the loss is under £10,000 and approved by the Chief Executive where the loss is over £10,000. All losses written off shall be reported to the Audit Committee in line with guidance within the HM Treasury manual, Managing Public Money.
- 12.3.2 For any loss, the Chief Finance Officer should consider whether any claim can be made against insurers.
- 12.3.3 The Chief Finance Officer shall maintain a Losses and Special Payments Register in which write-off action is recorded.
- 12.3.4 The Trust Board shall approve a scheme of delegation for the approval and authorisation of losses and special payments within the limits of delegation granted to the Trust by the Regulator. Authorising officers must undertake fuller reviews of systems to reduce the risk of similar losses occurring in the future and seek advice where they believe a particular case raises issues of principle.
- 12.3.5 Payments in excess of delegated limits must be referred for approval by the Regulator; payments cannot be made without prior approval.
- 12.3.6 The Chief Finance Officer will compile a quarterly schedule of all losses and special payments. These will be reviewed and reported to the Trust's Audit Committee.

12.4 Bankruptcies, Liquidations and Receiverships

- 12.4.1 The Chief Finance Officer shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

13 Computerised Systems

13.1 Responsibilities

13.1.1 The Chief Finance Officer, with the Chief Information Officer, is responsible for the accuracy and security of the computerised financial data of the Trust. In consultation with other officers as appropriate, he/she shall ensure the adequacy of:

- a. procedures to protect the Trust's data, programmes and computer hardware from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for Data Protection legislation and information governance requirements.
- b. controls over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy completeness and timeliness of the data, as well as the efficient and effective operation of the system.
- c. controls which ensure that the computer operation is separated from development, maintenance and amendment.
- d. the audit trail through the computerised systems and that such computer audit reviews as he/she may consider necessary are being carried out.

13.2 Responsibilities and duties of other Directors and Officers in relation to computer systems of a general application

13.2.1 In the case of other computer systems which are generally used with the Trust, the Chief Executive will ensure that there is a nominated director responsible for the accuracy and security of each critical information system in the Trust. The responsibilities of each director will be equivalent to those set out in 13.1.1 above for financial systems.

13.2.2 In addition the Senior Information Risk Owner (SIRO) will ensure that there is a nominated Information Risk owner at a senior level and the responsible directors /employees will send to the SIRO:

- a. Details of all information flows into and out of the system;
- b. Details of the access controls and procedures used to protect confidential information;
- c. Risk registers detailing any significant information risks as defined within the Trust's information governance policies;
- d. Processes put in place to ensure best practice standards in maintaining data quality; and
- e. Controls over usage of the internet.

13.3 Contracts for Computer Services with other health bodies or outside agencies

13.3.1 The Chief Information Officer shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

13.3.2 Where another health organisation or any other agency provides a computer service for financial applications, the Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.

13.4 Risk Assessment

- 13.4.1 The Chief Information Officer shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.
- 13.4.2 Privacy Impact assessments should also be undertaken on all relevant systems and updated in the event of major changes to systems.

13.5 Requirements for Computer Systems which have an impact on corporate financial systems

- 13.5.1 Where computer systems have an impact on corporate financial systems the Chief Finance Officer shall need to be satisfied that:
- a. Systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;
 - b. Data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;
 - c. Chief Finance Officer staff have access to such data; and
 - d. Such computer audit reviews as are considered necessary are being carried out.

13.6 Requirements for Computer Systems which have an impact on processes involved in patient care

- 13.6.1 The Chief Executive will ensure that a lead clinician at Board Level is appointed as the Clinical Safety Lead - Clinical Systems to be responsible for ensuring clinical risk arising from the use of IT systems / health software and implementation of changes in such systems or new systems is managed effectively.

14 Risk Management and Insurance

14.1 Risk

14.1.1 The Chief Executive shall ensure that the Trust has a risk management strategy and a programme of risk management, equivalent to the Department of Health assurance framework requirements, which must be approved and monitored by the Board.

14.1.2 The programme of risk management shall include:

- a. A process for identifying and quantifying risks and potential liabilities;
- b. Engendering among all levels of staff a positive attitude towards the control of risk;
- c. Management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;
- d. Contingency plans to offset the impact of adverse events;
- e. Audit arrangements including; internal audit, clinical audit, health and safety review;
- f. A clear indication of which risks shall be insured; and
- g. Arrangements to review the risk management programme.

14.1.3 The existence, integration and evaluation of the above elements will assist in providing a basis to make a statement on Internal Control within the Annual Report and Accounts.

14.2 Insurance

14.2.1 The Chief Executive in consultation with the Chief Finance Officer will be responsible for ensuring adequate insurance cover is effected in line with the risk management policy approved by the Board. This will include insuring through the risk pooling schemes administered by NHS Resolution, self-insuring for some or all of the risks covered by the risk pooling schemes and purchasing insurance from an external company. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

14.2.2 Where the Board decides to use the risk pooling schemes administered by NHS Resolution or external insurance the designated officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The designated officer shall ensure that documented procedures cover these arrangements.

14.2.3 Where the Board decides not to use the risk pooling schemes administered by NHS Resolution for one or other of the risks covered by the schemes, the designated officer shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision.

14.2.4 The Chief Finance Officer should ensure documented procedures also cover the management of claims.

14.2.5 The value of all assets insured shall be reviewed annually by the designated officer.

14.2.6 The Director of Estates shall ensure that all engineering plant under the Trust's control is inspected by the relevant insurance companies within the periods prescribed by legislation.

- 14.2.7 Each officer of the Trust shall promptly notify the designated officer of all new risks or property which may require to be insured and alterations affecting existing risks or insurances.
- 14.2.8 The Trust may purchase and maintain insurance for risks involving liability by the Trust for the Trust's benefit, and for the benefit of members of the Council, the Board and the Secretary.

15 Tendering and Contracting Procedure

15.1 Duty to comply with Standing Orders and Standing Financial Instructions

15.1.1 The procedures for making all contracts by or on behalf of the Trust shall comply with these Standing Orders and Standing Financial Instructions (except where Standing Order No. 42 Suspension of Standing Orders is applied).

15.1.2 The *Bribery Act 2010* replaces the fragmented and complex offences at common law and in the *Prevention of Corruption Acts 1889 -1916*. This broadly defines the two sections below:

- Two general offences of bribery – 1) Offering or giving a bribe to induce someone to behave, or to reward someone for behaving, improperly and 2) requesting or accepting a bribe either in exchange for acting improperly, or where the request or acceptance is itself improper;
- The corporate offence of negligently failing by a company or limited liability partnership to prevent bribery being given or offered by an employee or agent on behalf of that organisation.

15.1.3 All personnel involved in tendering and contracting activities must be aware of the *Bribery Act 2010* and must ensure that all dealings with other organisations and their staff do not bring them in breach of the Act that could leave them open to criminal proceedings being commenced.

15.2 EU Directives Governing Public Procurement

15.2.1 ~~EU procurement directives and~~The Public Contracts Regulations 2015 ~~and such EU procurement directives as have effect in English law,~~ which prescribe procedures for awarding all forms of contracts by a public sector body shall have effect as if incorporated in these Standing Orders and Standing Financial Instructions.

15.3 Regulator Guidance for capital investments

15.3.1 The Trust shall comply with the requirements of the Regulator's Annual Reporting Manual and any other guidance in respect of the procurement of capital investment, estate and property transactions. In addition the Trust shall comply with the guidance issued in respect of *The Bribery Act 2010*.

15.4 Reverse eAuctions

15.4.1 The Trust should have policies and procedures in place for the control of all tendering activity carried out through Reverse eAuctions.

15.5 Formal Competitive Tendering

15.5.1 General Applicability

Subject to clause 16.5.3, The Trust shall ensure that competitive tenders are invited for:

- a. the supply of goods, materials and manufactured articles;
- b. the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DHSC);
- c. the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); for disposals.

15.5.2 Health Care Services

Where the Trust wishes to procure the supply of Social and Other Specific Services as detailed in Schedule 3 of the Public Contracts Regulations 2015 (whether by sub contract or otherwise), the Trust must consider its duties [under the EU Treaty in law](#) and whether such services requirements must be advertised. Where the circumstances require it to advertise these Standing Orders and Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure and need to be read in conjunction with Standing Financial Instruction No. 8 and 9.

15.5.3 Exceptions and instances where formal tendering need not be applied

Formal tendering procedures need not be applied where:

- a. the estimated expenditure or income does not, or is not reasonably expected to, exceed **£50,000 excluding VAT or other such amount approved within the financial limits**, although it is still required to seek a minimum of three quotations, where practicable, where the estimated expenditure is above **£520,000** or other such amount approved within the financial limits;
- b. where the supply is proposed under special arrangements negotiated by the [DHSC](#) or another NHS/public body which includes [Procure24+](#) and framework agreements in which event the said special arrangements must be complied with;
- c. regarding disposals as set out in Standing Financial Instructions [SFI 12](#);
- d. where the requirement is covered by an existing contract;
- e. where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members which includes the Trust.

Formal tendering procedures may be waived by the Chief Finance Officer together with one other executive director (that is, Single Tender Action or “**Use of the negotiated procedure without prior publication of a contract notice**”, [in respect of procurements which would otherwise be subject to advertisement under the Public Contracts Regulations 2015, in the circumstances set out in Regulation 32 and in respect of all other procurements](#) in the following circumstances:

- a. when, for reasons of extreme urgency brought about by events unforeseen by the Trust, the goods or services could not be obtained in time under competitive tendering, e.g. where remedial works are required following a disaster, but failure to plan the work properly would not be regarded as a justification for a single tender;
- b. when the goods or services can be supplied only by one source and there is no reasonable alternative or substitute;
- c. when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;
- d. there is a clear benefit to be gained from maintaining continuity with an earlier project, however in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;
- e. where the requirement is for the provision of legal advice and services providing that any legal firm or partnership commissioned by the Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel’s opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned. The Chief Finance Officer will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work; or
- f. where there is an exceptional clinical emergency.

The waiving of competitive tendering procedures should not be used to avoid competition or the lack of planning or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Audit Committee at each meeting.

15.5.4 Fair, transparent and Adequate Competition

Where the ~~exceptions set out in SFI Nos. 15.5.3 apply~~ [requirement to carry out a competitive tender does apply](#), the Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than two firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

The only exception to this rule would be in the case that Competitive dialogue tendering procedures are to be used. In this case, the minimum number of economic operators invited to dialogue shall be no less than three, in the case that the total value of the contract is above the OJEU limit. However, at the post dialogue phase this can be reduced to a minimum of two tenders, unless exceptional circumstances exist where this isn't possible, and with the approval of the Project Team on behalf of the Chief Finance Officer. If the Trust considers it appropriate to continue with less than three bidders, it must ensure there is transparent competition and all evidence is documented. Public sector procurement guidelines must be followed in all instances.

Where a purchase exceeds the OJEU limit, but only a single provider is identified having advertised our requirements, approval must be sought from the Chief Finance Officer together with one other executive prior to award of the contract.

15.5.5 Building and Engineering Construction Works

Competitive Tendering cannot be waived for building and engineering construction works and maintenance without Regulator approval.

15.5.6 Items which subsequently breach thresholds after original approval

Items estimated to be below the limits set in this Standing Financial Instruction for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive, and be recorded in an appropriate Trust record.

15.6 Instances where formal competitive tendering or competitive quotation is not required

15.6.1 Where competitive tendering or a competitive quotation is not required the Trust should adopt one of the following alternatives:

- a. Where tenders or quotations are not required, because expenditure is below [£520,000](#), the Trust shall procure goods and services in accordance with procurement procedures approved by the Chief Finance Officer.
- b. where the supply is proposed under special arrangements negotiated by the DH or a framework agreement (for example, Crown Commercial Service, NHS London Procurement Partnership, PPC, NHS Supply Chain) in which event the said special arrangements must be complied with.

15.7 Private Finance for capital procurement (overlap with [SFI No. 9](#))

15.7.1 The Trust should normally market-test for PFI (Private Finance Initiative funding) when considering a capital procurement. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

- a. The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.
- b. Where the sum exceeds delegated limits, a business case must be referred to the appropriate Department of Health for approval or treated as per current guidelines.
- c. The proposal must be specifically agreed by the Board of the Trust.
- d. The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

15.8 Compliance requirements for all contracts

15.8.1 The Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

- a. The Trust's Standing Orders and Standing Financial Instructions;
- b. [Relevant](#) EU Directives, Public Contracts Regulations 2015 and other statutory provisions;
- c. Any relevant directions including the Capital Investment Manual, Estate code and guidance on the Procurement and Management of Consultants;
- d. Such of the NHS Standard Contract Terms and Conditions as are applicable;
- e. Contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance;
- f. Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited;
- g. In all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust. All contracts shall be recorded in the Trust's system for contract management.

15.9 Personnel and Agency or Temporary Staff Contracts

15.9.1 The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

15.10 Healthcare Contracts and Services Agreements (see overlap with [SFI No. 6](#))

15.10.1 Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with the relevant NHS service provision contract and administered by the Trust. A contract with a Foundation Trust, being a Public Benefit Corporation (PBC), is a legal document and is enforceable in law.

15.10.2 The Chief Executive shall nominate officers to commission service agreements with providers of healthcare in line with a commissioning plan approved by the Board.

15.11 Disposals (See overlap with [SFI No. 12](#))

15.11.1 Competitive Tendering or Quotation procedures shall not apply to the disposal of:

- a. any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his nominated officer;
- b. obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;
- c. items to be disposed of with an estimated sale value of less than £50,000, this figure to be reviewed on a periodic basis;
- d. items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;
- e. land or buildings concerning which DH guidance has been issued but subject to compliance with such guidance.

15.12 In-House Services

15.12.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

15.12.2 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

- a. Specification group, comprising the Chief Executive or nominated officer/s and specialist.
- b. In-house tender group, comprising a nominee of the Chief Executive and technical support.
- c. Evaluation team, comprising normally a specialist officer, a supplies officer and a Chief Finance Officer representative.
- d. For services having a likely annual expenditure exceeding £500,000, a non-officer member should be a member of the evaluation team.

15.12.3 All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

15.12.4 The evaluation team shall make recommendations to the Board.

15.12.5 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

15.13 Applicability of SFIs on Tendering and Contracting to assets purchased from grants or donations

15.13.1 These Instructions shall not only apply to expenditure from Exchequer funds.

15.13.2 They also apply to the procurement of works, services and goods purchased from funds donated by a charity, a grant giver or any other organisation which provides funds to the Trust to enable it to purchase a specified item.

15.14 Use of e Procurement and eTendering

15.14.1 The Chief Finance Officer will approve use of electronic systems for procurement.

15.14.2 Electronic Tendering - All invitations to tender using the Trust's or its agent's E-Tendering Portal will be on a formal competitive basis. Issue of all tender documentation will be undertaken through a secure website with controlled access. All tenders will be received into a secure electronic vault so that they cannot be accessed until an agreed opening time. The details of persons opening the documents will be recorded in the audit trail together with the time and date of opening.

16 Retention of Records

- 16.1.1 The Chief Executive shall be responsible for maintaining archives for all records, including electronic records, required to be retained in accordance with Department of Health guidelines.
- 16.1.2 All records held in archives shall be capable of retrieval by authorised persons.
- 16.1.3 Records held in accordance with latest Department of Health guidance shall only be destroyed at the express instigation of the Chief Executive. Detail shall be maintained of records so destroyed.

17 Research and Development

- 17.1.1 All research and development activities within the Trust shall be notified to the Director of Research and Innovation through the Research and Innovation Office.
- 17.1.2 The Director of Research and Innovation shall ensure that there are appropriate governance procedures in place to ensure any research is conducted in accordance with relevant regulations and that there are processes in place to assess and approve contractual commitments relating to the execution of research.
- 17.1.3 The Chief Finance Officer shall ensure that procedures are implemented and monitored which ensure that all such activities are properly accounted for and that all funding is used as directed by the grantor / funder.

18 Acceptance of Gifts by staff and other standards of business conduct

~~18.1.1 The Chief Executive shall ensure that all staff are aware of Trust policies in respect of conflicts of interest and acceptance of gifts or other benefits in kind conferring an advantage to the member of staff. Policies should be consistent with the Standards of Business Conduct for NHS staff.~~

~~18.1.2 Employees should also be aware of the restrictions in relation to accepting gifts, inducements, benefits in kind or other personal advantage which could be considered to be bribes under *The Bribery Act 2010*. This includes ensuring that no order shall be issued to an organisation which has made an offer of gifts, reward or benefit to directors or employees other than:~~

- ~~• Isolated gifts of a trivial character or value;~~
- ~~• Conventional hospitality, such as lunches in the course of working visits.~~

~~This includes travel, at supplier's expense, unless the prior written approval of a director has been obtained. The Chief Executive will ensure that all staff are aware of the Declarations of Interests and Gifts and Hospitality policy. The policy requires that all staff members and board members with private or personal interests which might affect their role within the Trust, declare these interests on joining the organisation, on a regular basis and whenever the potential for conflict arises. It covers financial interests, non-financial professional interests, non-financial personal interests and indirect interests.~~

~~The policy also provides guidance to staff and board members on the procedure to be followed in the event of any gift, hospitality or sponsorship being offered. It outlines restrictions in relation to accepting gifts, inducements, benefits in kind or other personal advantage which could be considered to be bribes under *The Bribery Act 2010*.~~

Trust Board 18th July 2019		
Register of Seals		Paper No: Attachment 5
Submitted by: Anna Ferrant, Company Secretary		
Aims / summary Under paragraph 39 of the NHS Foundation Trust Standing Orders, the Trust is required to keep a register of the sealing of documents. The attached table details the seal affixed and authorised since end of April 2019.		
Date	Description	Signed by
25/04/2019	CBL Lift Project – stage 4 contract	HJ, AF
25/04/2019	Cath Lab and MRI 4 Project – stage 4 contract	HJ, AF
10/06/2019	Trade Mark Licence	HJ
Action required from the meeting To endorse the application of the common seal and executive signatures.		
Contribution to the delivery of NHS / Trust strategies and plans Compliance with Standing Orders and the Constitution		
Financial implications N/A		
Legal issues Compliance with Standing Orders and the Constitution		
Who is responsible for implementing the proposals / project and anticipated timescales N/A		
Who is accountable for the implementation of the proposal / project Anna Ferrant, Company Secretary oversees the register of seals		