

**Meeting of the Trust Board
Wednesday 5 December 2018**

Dear Members

There will be a public meeting of the Trust Board on Wednesday 5 December 2018 at 1:45pm in the Charles West Boardroom, Great Ormond Street, London, WC1N 3JH.

Company Secretary

Direct Line: 020 7813 8230

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AGENDA

	Agenda Item <u>STANDARD ITEMS</u>	Presented by	Attachment	Time
1.	Apologies for absence	Chairman	Verbal	1:45pm
Declarations of Interest All members are reminded that if they have any pecuniary interest, direct or indirect, in any contract, proposed or other matter which is the subject of consideration at this meeting, they must disclose that fact and not take part in the consideration or discussion of the contract, proposed contract or other matter, nor vote on any questions with respect to it.				
2.	Minutes of Meeting held on 27 September 2018	Chairman	G	1:50pm
3.	Matters Arising/ Action Checklist	Chairman	H	
4.	Chief Executive Update	Chief Executive	Verbal	1:55pm
GOVERNANCE				
5.	Board Assurance Committee reports <ul style="list-style-type: none"> • Quality and Safety Assurance Committee update – October 2018 meeting including QSAC Committee effectiveness review results • Audit Committee – October 2018 including Audit Committee effectiveness review results • Finance and Investment Committee Update – October and November 2018 	Chair of the Quality and Safety Assurance Committee Chair of the Audit Committee Chair of the Finance and Investment Committee	J K L	2:05pm
6.	Council of Governors' Update – September and November 2018	Chairman	M	2:20pm
7.	Revised Standing Financial Instructions and Scheme of Delegation	Chief Finance Officer	N	2:25pm
8.	Register of Seals	Company Secretary	O	2:35pm
<u>STRATEGY and RISK</u>				
9.	A 'deep dive' analysis of neuroscience: developing a strategy	Deputy CEO/ Sophie Varadkar, Chief of Service, Brain Directorate	P	2:40pm

10.	Patient Story - JH	Chief Nurse	Q	2:55pm
11.	GOSH Operational Plan 2019/20 – planning process and guidance update	Deputy CEO/ Chief Finance Officer	S	3:10pm
	<u>PERFORMANCE</u>			
12.	Integrated Quality Update Report – 31 October 2018	Medical Director/ Chief Nurse	T	3:20pm
	Infection Prevention and Control Report	Director of Infection, Prevention and Control	U	
13.	Learning from Deaths Mortality Review Group - Report of deaths in Q1 and Q2 2018/2019	Medical Director	V	3:30pm
14.	Integrated Performance Report - 31 October 2018	Deputy Chief Executive	W	3:40pm
	• Progress with Better Value Programme		X	
15.	Finance Update - 31 October 2018	Chief Finance Officer	Y	3:50pm
	<u>ASSURANCE</u>			
16.	Review of the Assurance and Escalation Framework	Company Secretary	Z	4:00pm
17.	CQC Inspection Action Plan	Medical Director	1	4:10pm
18.	Safe Nurse Staffing Report (September and October 2018)	Chief Nurse	2	4:20pm
	And			
	Annual Nursing Establishment Review		3	
19.	Report from the Guardian of Safe Working	Medical Director/ Guardian of Safe Working	4	4:30pm

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.)

Next meeting

The next Public Trust Board meeting will be held on Thursday 7 February 2019 in the Charles West Room, Great Ormond Street, London, WC1N 3JH.

**DRAFT Minutes of the meeting of Trust Board on
27th September 2018**

Present

Sir Michael Rake	Chairman
Dr Peter Steer	Chief Executive
Lady Amanda Ellingworth	Non-Executive Director
Mr Chris Kennedy	Non-Executive Director
Ms Kathryn Ludlow	Non-Executive Director
Mr Akhter Mateen	Non-Executive Director
Mr Matthew Shaw	Medical Director
Ms Alison Robertson	Chief Nurse
Ms Helen Jameson	Interim Chief Finance Officer
Ms Nicola Grinstead	Deputy Chief Executive

In attendance

Mr Matthew Tulley	Director of Development
Ms Cymbeline Moore	Director of Communications
Professor David Goldblatt	Director of Research and Innovation
Dr Anna Ferrant	Company Secretary
Ms Victoria Goddard	Trust Board Administrator (minutes)
Ms Herdip Sidhu-Bevan*	Deputy Chief Nurse for Patient Experience and Quality
Ms Emma James*	Patient Involvement and Experience Officer
Ms Sarah Ottoway*	Assistant Director of HR and OD

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

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

80	Apologies for absence
80.1	Apologies for absence were received from Mr James Hatchley, Non-Executive Director; Professor Rosalind Smyth, Non-Executive Director and Ms Alison Hall Interim Director of HR and OD.
81	Declarations of Interest
81.1	No declarations of interest were received.
82	Minutes of Meeting held on 25 July 2018
82.1	The minutes were approved by the Board.
83	Matters Arising/ Action Checklist
83.1	The actions taken since the last meeting were noted.
84	Chief Executive Update
84.1	Dr Peter Steer, Chief Executive gave an update on the following matters:

	<ul style="list-style-type: none"> • A power outage had occurred August 2018 which led to power loss in the Southwood Building and Nurses Home for 48 hours. A report on the incident had been drafted and the cause of the issue identified with remedial action taken. • A new prayer room was opened on 7th September which was a key part of family and staff experience at GOSH. • Discussion had taken place during the confidential Board meeting about developing a new grants approval process which would see a steering committee developed which would be chaired by a hospital Non-Executive Director.
85	Patient Story
85.1	The Board received a patient story via video from Tracy whose son Jason is twelve years old and was first referred to the Nephrology Team in February 2013.
85.2	<p>Tracy gave the following feedback:</p> <ul style="list-style-type: none"> • Nurses talk directly to Jason in a way that he can understand • There is access to play therapists and a youth club which is very helpful • Staff try to make reasonable adjustments to support families and this is vital • Food vouchers are very helpful however Tracy said that Jason did not enjoy the food at the hospital and it was expensive and inconvenient to buy food from outside GOSH to bring in • It is challenging as a one parent family to look after another child who is not in hospital. Tracy said that at a previous hospital where Jason had been an inpatient, Jason's sibling was able to stay and attend the hospital school despite not being a patient. • Tracy suggested that cooking facilities could be available for families with instructions on use of equipment provided in picture form for parents who are unable to read.
85.3	Ms Herdip Sidhu-Bevan, Deputy Chief Nurse for Patient Experience and Quality said that means-tested meal vouchers were provided to families to help with the additional costs of London living rather than to cover the full cost of all food. She said that the rules around family accommodation meant that if a patient was being treated in ICU, one parent was able to stay at the bedside and one in hospital accommodation. Mr Matthew Shaw, Medical Director said that the Trust had relationships with a local school and a sibling of a GOSH inpatient could be placed in this school.
85.4	Ms Alison Robertson, Chief Nurse said that there were a number of criteria around access to family accommodation which required review, however there was currently insufficient capacity to allow flexibility.
85.5	Action: Lady Amanda Ellingworth, Non-Executive Director highlighted the importance of receiving patient stories and suggested that these should also be received from staff about their experience of working at GOSH. It was agreed that this would be considered for future stories.

86	Board Assurance Committee reports
86.1	<u>Quality and Safety Assurance Committee update – July 2018 meeting</u>
86.2	Lady Amanda Ellingworth, Chair of the QSAC said that there had been a theme of cultural issues running through the QSAC papers. She said that an effectiveness review was taking place of the Committee which would determine the way in which information was received.
86.3	Mr Matthew Shaw, Medical Director gave an update on an issue that had been discussed at QSAC around consultant presence at ward rounds. He said that following receipt of a red complaint, a clinical audit had shown that there had been unacceptably low consultant presence at ward rounds in one area however it was likely that this also affected other areas in the Trust. It had been made clear to consultants that this was a professional responsibility and a re-audit would take place.
86.4	<u>Finance and Investment Committee Update – July 2018</u>
86.5	Mr Akhter Mateen, Member of the Finance and Investment Committee said that there had been an additional meeting on 21 st September which considered the commissioning contract for 2019/20. The Committee had asked that Chief Finance Officer to model the impact of the potential changes to the contract.
86.6	The Committee continued to undertake post-implementation reviews of development projects in order to learn lessons in advance of future large projects. A template for these reviews had been agreed.
86.7	A review had taken place of Barking, Havering and Redbridge University Hospitals NHS Trust which had been gone into financial special measures. The review sought to identify learning and be assured of the checks that were in place to ensure similar issues could not arise at GOSH.
86.8	Mr Mateen said that the committee had also reviewed progress with the Electronic Patient Record programme and would continue to do so.
87	Council of Governors' Update – July 2018
87.1	Dr Anna Ferrant, Company Secretary presented the update and said that a workshop would take place at the next Council of Governors meeting to review the implications of phasing elections and making changes to constituencies.
87.2	Non-Executive Directors agreed that it had been challenging to arrange meetings with Governor 'buddies' who had been assigned to them due to availability of both parties however it was agreed that work continue on this with the support of the Deputy Company Secretary.
88	Update on progress with implementation of digital research platform
88.1	Mr Matthew Shaw, Medical Director said that as part of the Research and Innovation Strategy, the Trust had procured a data store and digital research platform from Aridhia. The platform and other systems comprised the overall Digital Research Environment (DRE) to work alongside the new Electronic Patient Record (EPR) system providing a collaborative research environment for the

	management, visualisation and analysis of routinely collected de-identified clinical as well as other data.
88.2	Mr Shaw said that the platform had been live for early adopters since October 2017 and other projects continued to be added with a target of 50 projects by the end of December 2018.
88.3	Sir Michael Rake, Chairman said that the Non-Executive Directors had been on a walkround of the DRIVE centre prior to the Board meeting and had been impressed by the environment. The Board's invitation to the DRIVE launch on 10 th October was noted.
89	Update on restructure
89.1	Ms Nicola Grinstead, Deputy Chief Executive said that an evaluation of the clinical operations structure had been undertaken in April 2018 and responses were received from over 400 staff suggesting significant change. Following the development of a proposed structure a consultation was carried out in June 2018 with final structure confirmed in July 2018. Interviews were held for new roles throughout August and September and the new structure would become live on 1 st October.
89.2	The key aims of the change in structure was to be clear about points of accountability within a tripartite structure and to ensure there was appropriate visibility of all professional groups.
89.3	A successful two day team building event had taken place which had substantially accelerated preparedness for the structure becoming live. Ms Grinstead said that teams would be empowered to manage their own budgets with a target outturn and a skills based training programme had been developed.
89.4	Action: Lady Amanda Ellingworth, Non-Executive Director requested a flow chart of governance accountability and the way the operational structure fed into this.
89.5	The Board welcomed the work that had taken place to develop and implement the structure.
90	Safety and Reliability Improvement Programme
90.1	Mr Matthew Shaw, Medical Director said that the programme with Cognitive Institute had been launched in January 2018 and GOSH was the first UK partner in the Safety and Reliability Improvement Programme. The Executive Team had received training and the pilot phase would begin in November 2018 with safety champions being trained in January 2019. The Professional Accountability part of the programme would begin in June 2019. Mr Shaw said that the timeline was going to plan however some work was required in order to raise the programme's profile.
91	Quality Update Report – 31 August 2018
91.1	Mr Matthew Shaw, Medical Director said that the next QSAC meeting would receive an example of a revised format for the integrated quality report which would include an increased volume of data and metrics. Ms Nicola Grinstead, Deputy Chief Executive cautioned that there may be some delays with changes to

91.2	the data required as a result of members of the performance team making a substantial contribution to the EPR programme.
91.2	Mr Shaw said that there had been seven information governance serious incidents in 2018 in various areas. He said that guidance had been provided to staff however it was important to reflect on this theme of incidents.
91.3	Ms Alison Robertson, Chief Nurse said that PALS data had shown that it was vital to ensure the hospital's booking system was user friendly. She said that the Friends and Family Test had received a lower response rate than usual and a paper would be presented to the Operational Performance and Delivery Group to consider why the response rate had dropped. An electronic system for completing the FFT had now been introduced. Lady Amanda Ellingworth, Non-Executive Director suggested that volunteers could be used in PALS to support the process.
91.4	Ms Robertson said that under the new structure the divisional heads of nursing were also the heads of patient experience and work would take place to encourage divisions to look at PALS themes in their own areas which then be collated across the hospital to develop a Trust wide plan of emerging overall themes. Dr Peter Steer, Chief Executive added that the excellent quality of the work undertaken by the PALS team meant that clinical teams were becoming less skilled in resolving patient and family issues in their areas.
92	Integrated Performance Report (31 August 2018)
92.1	Ms Nicola Grinstead, Deputy Chief Executive said that GOSH continued to achieve against the 92% target for RTT incomplete pathways however Trusts were now being asked to overachieve against this target. Six patients had waited more than 52 weeks in the reporting period, one of whom was referred after 60 weeks and four were data challenges who waited longer than reported by the referring hospital.
92.2	There had been a number of breaches of diagnostic waits in August some of which were as a consequence of the power outage which caused scanners to be rebooted and led to substantial downtime.
92.3	Action: Sir Michael Rake, Chairman highlighted the high staff turnover rate in research and innovation. He asked for a steer on the causes of this in the context of a negative 68% vacancy rate. Mr Matthew Shaw, Medical Director said that, similarly to IPP staff, research nurses were a population who often moved around the Trust. He added that the team felt the turnover level had recently been improving. It was felt that the vacancy rate in that area was not correct and this would be reviewed for the next report.
93	Finance Update (31 August 2018)
93.1	Ms Helen Jameson, Chief Finance Officer said that the Trust was behind its control total by £0.3million at month 5 however it continued to forecast the over-delivery of the control total by £0.4million by year end primarily due to additional activity in the second half of the year. NHS income was below plan in month 5 due to the summer holiday however private patient income reported its highest ever total and there remained strong performance in CICU, respiratory and cardiac.
93.2	Mr Chris Kennedy, Non-Executive Director said a discussion had taken place at

	the Finance and Investment Committee which had emphasised the importance of meeting the control total.
94	Safe Nurse Staffing Report (July and August 2018)
94.1	Ms Alison Robertson, Chief Nurse confirmed that there had been no unsafe shifts in July and August 2018. She highlighted the slight increase in turnover and said that work was taking place to ascertain the cause.
94.2	GOSH was currently engaged with Capital Nurse around retaining nurses within London however the Trust had previously not taken the opportunity to become involved in the NHS Improvement programme on retention but would be doing so from the start of the next collaboration.
94.3	An internal transfer scheme was now open with the aim of supporting nurses who were considering leaving the Trust with the possibility of an offer to move work area. Ms Robertson noted the higher than average vacancy rate in IPP and confirmed that the workforce and recruitment teams were working closely with the directorate.
94.4	A key challenge in-month had been managing the impact of the reduction to the specialist bank rate. External colleagues at NHS Improvement, NHS England and the NMC had been briefed and additional detail would be provided to the next QSAC meeting.
94.5	Action: Dr Peter Steer, Chief Executive said that work was continuing to analyse care hours per patient day. He said that over 60% of GOSH patients outside ICU were nursed on a 1:1 or 1:2 basis which was substantially higher other organisations and led to GOSH's costs per patient being greater than other Trusts. Sir Michael Rake, Chairman requested that the top causes of GOSH costs per patient being greater than other organisations were presented at a future meeting.
94.6	Mr Chris Kennedy, Non-Executive Director asked for a steer on the retention statistics. Mr Robertson said that band 5 nurses were well retained however issues were with band 6 nurses. She said that Junior Sister role was being implemented in order to support a nurse's career pathway at GOSH.
95	Workforce Race and Equality Standard Report
95.1	Ms Sarah Ottoway, Assistant Director of HR and OD said that the Trust was required to publish data against the NHS Workforce Race Equality Standard (WRES) as part of the NHS standard contract and for the well led domain under CQC. There was also a requirement to develop and publish an action plan addressing any issues.
95.2	Just over one quarter of GOSH's workforce was from a BAME background which was similar to comparable Trusts but less than others nationally. A higher representation of staff continued to be at lower pay bands however there had been an increase compared to 2017 in the numbers of BAME staff in both clinical and non-clinical senior roles. Data showed that proportionally fewer BAME candidates were being appointed to roles than white applicants in common with other public sector organisation. Work was taking place around unconscious bias in recruitment and selection and PDR training.

95.3	Ms Ottoway highlighted that the Trust Board was not representative of the workforce population and said that it was important that executive search companies were asked to provide long list candidates who were representative of the staff population.
95.4	Sir Michael Rake said that alongside the work that was continuing on WRES it was vital to be clear about the Trust's commitment to the closure of the gender pay gap and the associated timeline. Ms Nicola Grinstead, Deputy Chief Executive said that HR had recommended that the Trust develop specific interest groups led by an Executive Director. Substantial feedback had been received that focus should be placed on the gender pay gap and other gender associated issues such as return to work from maternity leave.
95.5	Action: The Board welcomed the challenge around diversity of Board recruitment and it was agreed that unconscious bias training would be built into the Board development programme.
96	Revised Trust Board Terms of Reference 2018/19 – 2019/20
96.1	Dr Anna Ferrant, Company Secretary said that the Board Terms of Reference had been reviewed against guidance and taking into account inspections which had taken place at the Trust. She said the key areas which had been strengthened were around the wider health and social care economy, engaging with staff and governors, being open and transparent and raising concerns. The Board workplan would be reviewed following the effectiveness review of the QSAC.
96.2	The revised Terms of Reference were approved .
97	Any Other Business
97.1	Ms Nicola Grinstead, Deputy Chief Executive highlighted that the week beginning 1 st October 2018 was Open House Week and a Board Q&A would be taking place with the Chairman and Chief Executive and two members of the new Clinical Operations structure.

TRUST BOARD – PUBLIC ACTION CHECKLIST
December 2018

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
135.10	07/02/18	Mr David Lomas, Chair of the Finance and Investment Committee said that the meeting had considered the use of Patient Level Costing to allow patient level data to be cut in many ways giving an insight into the negative NHS contribution. The Committee had also reviewed the drivers of revenue in terms of activity volumes and tariff and it was agreed that both these topics would be discussed by the Board during 2018/19.	HJ	February 2019	Not yet due.
174.4	28/03/18	The Board discussed the hand hygiene audit results as part of the infection prevention and control report and it was agreed that discussion would take place outside the meeting to look at a different way of presenting the data.	John Hartley	December 2018	On agenda
54.8	25/07/18	Sir Michael Rake, Chairman welcomed the inclusive way in which the clinical operations restructure had been undertaken and requested an update on the outcome in one year. This would be built in to the Board calendar.	NG	February 2019 (updated Board workplan)	Noted for future Board workplan (for reporting to Board in February 2019)
57.13	25/07/18	It was agreed that summaries of individual complaints would be included in future complaints reports.	MS	November 2018	On agenda
85.5	27/09/18	Lady Amanda Ellingworth, Non-Executive Director highlighted the importance of receiving patient stories and suggested that these should also be received from staff about their experience of working at GOSH. It was agreed that this would be considered.	AF, AH	February 2019	Noted. To be acted on in 2019 and included as part of the Board workplan (for reporting to Board in February 2019)

Attachment H

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
89.4	27/09/18	Lady Amanda Ellingworth, Non-Executive Director requested a flow chart of governance accountability and the way the operational structure fed into this.	NG, AF	December 2018	On agenda under assurance and escalation framework
92.3	27/09/18	Sir Michael Rake, Chairman highlighted the high staff turnover rate in research and innovation. He asked for a steer on the causes of this in the context of a negative 68% vacancy rate. Mr Matthew Shaw, Medical Director said that, similarly to IPP staff, research nurses were a population who often moved around the Trust. He added that the team felt the turnover level had recently been improving. It was felt that the vacancy rate in that area was not correct and this would be reviewed for the next report.	NG	December 2018	On agenda
94.5	27/09/18	Sir Michael Rake, Chairman requested that the top causes of GOSH costs per patient being greater than other organisations were presented at a future meeting.	MS, HJ, NG?	February 2019	Not yet due
95.5	27/09/18	It was agreed that unconscious bias training would be built into the Board development programme.	AF, AH	On-going	Noted for inclusion in the Board development programme

**Summary of the meeting of the Quality and Safety Assurance Committee
held on 11th October 2018**

Matters arising

The Committee had requested an update on whether the reduction in scores in all areas of PLACE 2018 were statistically significant. It was noted that GOSH performed better than the national average in all areas except cleanliness and that the change in scores did not appear to be significant. A different methodology had been used in 2018 which was more complete than in previous years.

A charter had been introduced which included a set of expectations for teams which were not functioning well and meetings took place bi-monthly to hold teams to account. The Committee emphasised that it was vital that teams functioned well together in order to ensure there was good clinical governance in place. The Committee requested that this work took place in a timely fashion.

QSAC Effectiveness Review 2018

The results of the effectiveness survey showed that members and attendees felt that in general the committee was meeting its Terms of Reference however issues were raised about the way in which information was received as data rather than assurance reports and the way in which matters were escalated to the Committee. It was agreed that it was important to encourage and have time for free-flowing discussion on emerging issues. Discussion took place about the possibility of splitting out workforce and culture and addressing these issues in a NED led task and finish group.

Emerging clinical/quality issues

Deployment of the software required in order for GOSH and all other sites that irradiate blood to become compliant with specific safety procedures had been delayed. This was as a result of the software being the single available solution and the company was not able to meet demand. The Trust had written to the MHRA to explain the issue and had alternative arrangements in place which were accepted by the MHRA. There had been no incidents around the irradiation of blood.

Further to the recent update at Board, the national problem around disposing of clinical waste had exacerbated and some Trusts had had to take urgent response measures. GOSH had created additional space to store clinical waste bins and changed its licence for storing waste to allow storage of a different type of waste and for longer. Discussions were taking place about developing a pan-London response.

Overview of quality and safety flows in new clinical operational structure

Clear and published single points of accountability were in place for each area and heads of nursing had responsibility for patient experience and heads of service had responsibility for quality, safety and risk. Work was taking place to recut the data in Datix to match the new operational structure however this was a significant task.

Integrated Quality Report

The Trust had a trend of decreasing mortality and arrests outside ICU as well as an increasing trend of recognising the deteriorating patient. A deep dive would be taking place into hospital acquired pressure ulcers and it was noted that the tissue viability team was comprised of 1.8WTE. The Committee requested assurance that, despite the time taken to complete an investigation, any immediate learning from Serious Incidents was embedded into practice immediately. It was confirmed that an Executive

review meeting took place to assess whether a serious incident should be declared and part of the remit of this meeting was to ascertain whether any immediate changes needed to be made.

Update on clinical outcomes development programme

Craniofacial and neurology dashboards had recently been developed and it was noted that GOSH published more clinical outcomes on its website than any other Trust. The Committee agreed that it was important that GOSH continued to benchmark internationally.

Update on issues arising from patient stories (including stories presented at Trust Board in July and September 2018)

The Committee welcomed the progress that had been made in responding to recommendations arising from patient stories.

Quarterly Safeguarding Report (July – September 2018)

There was substantial work to be done around adult safeguarding however a member of the safeguarding team was now the lead for adult safeguarding. Updates were being made to the Mental Capacity Act Policy which was key. There had been no cases of non-compliance in responding to safeguarding requests and the social work service would be recording their complete activity on the Epic system, however discussion was taking place with an external organisation who provided safeguarding services in oncology and had their own information system.

Internal Audit Report on Safeguarding

The review had provided a rating of significant assurance with minor improvement potential. Staff had been clear on their understanding of safeguarding referrals routes and had given excellent feedback about the support provided by the safeguarding team. The Committee congratulated the team.

Board Assurance Framework Update

Discussion took place around reducing the likelihood score of risk 4: recruitment retention however the committee expressed concern about this due to uncertainties around Brexit and the importance of continuing to focus on recruitment and retention. It was agreed that the score would not be reduced but that the remit of the risk would be widened to include the recruitment and retention of other staff such as junior doctors.

The Committee reviewed the following high level risks:

- Risk 6: The risk that the Trust is unable to sustainably provide and deliver specialist clinical services to the required level.

It was noted that the scope of this risk was very wide and discussion took place about the increase in medication errors. Work was taking place to ascertain whether this increase was in proportion to the Trust's overall increase in reporting.

- Risk 11: Quality and safety risks to implementation of EPR

Formal routes were in place to manage clinical safety and challenging areas had been shared with NHS Digital who had confirmed that they would provide additional advice over and above their usual review.

The Committee noted the risk management update.

Health and Safety Update

Fire safety training compliance had risen since the publication of the report and was now 90% and fire risk assessments continued. Only one RIDDOR had been declared so work could be taking place to raise the importance of declaring these occurrences. Discussion took place about the occupational health team which was very small and the resources available to undertake manual handling training, which was being provided externally. The Committee noted that following substantial work, sharps remained an issue and the committee requested that this was added to the health and safety action plan.

Compliance Update

A band 7 compliance manager would be in post by the end of the October and the committee expressed some concern that there had been a gap when the post had not been filled for some time.

Internal and external audit recommendations update

The Trust continued to maintain a low level of outstanding recommendations. Discussion took place about a recommendation related to the integrated quality report which was not fully aligned with the Single Oversight Framework (SOF). It was confirmed that the indicators which the SOF required to be reviewed were presented to the Board under different reports and the Committee emphasised the importance of highlighting the recommendations which were key and must be completed within the timeline.

Clinical Audit update (July – October 2018)

Discussion took place about the audit on unexplained fractures in IPP and it was confirmed that the correct safeguarding processes had been followed in all cases. The Committee highlighted the important work of the Clinical Audit Team and said it was vital that it was sufficiently resourced.

Update on quality and safety impact of Fit for the Future programme (linked to BAF risk 2: Productivity)

The increase in the number of Serious Incidents declared had been reviewed to ensure that it was not as a result of the Better Value programme and it was confirmed that this was not the case. The Committee undertook a deep dive into the flow project and congratulated the team on the substantial reduction in cancellations which had been achieved.

Workforce update

It was confirmed that the data would be provided to directorates to enable them to create their own action plans. It was confirmed that a number of forums had been developed and the BAME forum had run an excellent first meeting.

Whistle blowing update - Quality related whistle blowing cases

No new whistleblowing cases had been raised in the reporting period however the team continued to investigate and learn lessons.

Freedom to Speak Up cases

A new leaflet had been produced which would be available online and brought together all methods of raising concerns at GOSH. The service continued to receive bullying and harassment concerns as 50% of

their cases however issues reported under this heading were wide ranging. Issues raised had been around pressure on staff in the EPR team and staff dissatisfaction at the reduction in specialist nurse bank rates.

Freedom of Information Act Update

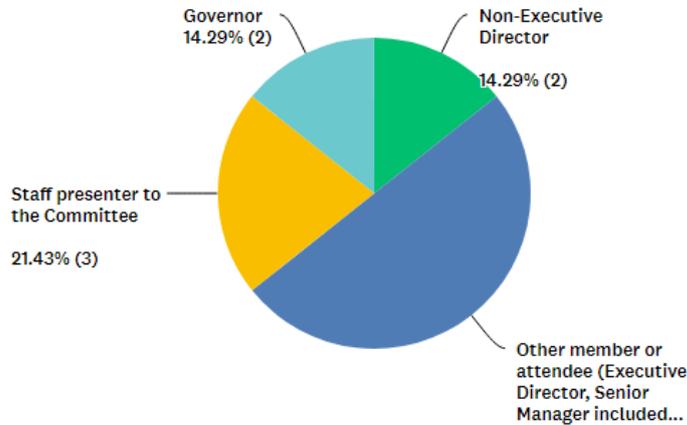
Posts in the team had now been filled and the team members were able to begin clearing the backlog of queries received. The ICO had written to the Trust about the time taken to respond to a requestor. GOSH had an open relationship with the ICO who had been satisfied with the response to the decision notice.

Any other business

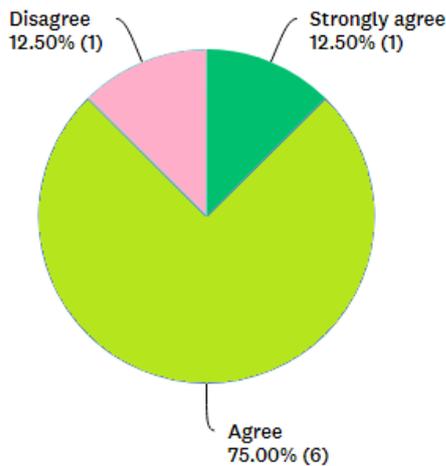
The Committee discussed whether there had been any patient safety implications as a result of the power outage in August 2018. It was noted that there had been some patient cancellations, all of whom had been rebooked and one patient was required to be woken up before surgery but after anaesthesia which had been the correct decision and one of which the family had been supportive of.

Appendix A

1. What is your role within the Quality and Safety Assurance Committee?



2. The Committee fulfils its role in obtaining assurance that the necessary structures and processes are in place to deliver safe, high quality, patient-centred care and an excellent patient experience at GOSH.

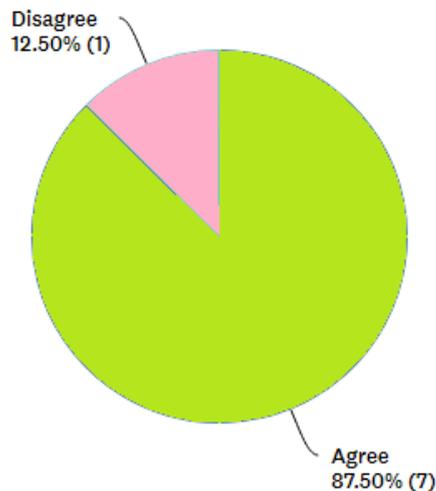


Comments

Potential to consider the need/appropriateness of continuing to promote the triangulation agenda (more independent direct corroboration of risks, trends and issues)?	It is of note that the CQC found an area "requires improvement" and something requiring an enforcement notice, both of which the committee was unaware of in advance. Should/could the committee have known about these gaps, and if so, what was missing in the committee's workplan? Did we know the weaknesses but they got lost in the large quantity of data (wood and trees?). The current work to prepare for future inspections was initiated by management. This is laudable but should the committee have also been more on the front foot looking for these overall systematic assurances?
I also think limitations e.g. finance or scope of work should also be considered.	More patient stories, linking the papers and its contents to the patients and their families.
I have only attended two meetings and there is now a	Whilst the committee received and requests a myriad of reports that are silo'd. I believe there is a need for more

new chair.	integrated reporting, looking across streams of data and information and identifying themes and providing assurance of mitigations to address these themes.
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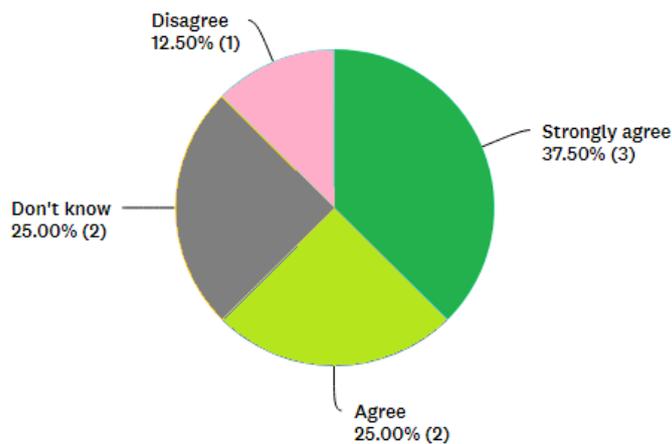
3. The Committee fulfils its role in seeking assurance on any quality, safety or patient experience matters or shortcomings arising from the Trust’s operational and quality and safety performance.



Comments

<p>How does the committee decide what is and is NOT reported to it? Is the committee clear on reporting triggers, should it not be a management judgement? Does the committee triangulate information to indicate possible areas of weakness to focus attention on? How does the committee identify where to focus the most attention? How does the committee assure its self that unwarranted variation is avoided? It would be useful for data to be presented 'per patient episode' rather than raw numbers as well as trends over a meaningful time period</p>	<p>Yes but at times we deviate from the aim we are trying to delivery on and the constraints that may not be in the control of the Trust should be acknowledged.</p>
<p>as above. From the latest agenda for the October meeting it would appear that there should be strong assurance mechanisms going forward</p>	<p>The workplan is wide. It relies on the execs identifying those issues and reporting. This does happen. Less data, more integrated information could help.</p>

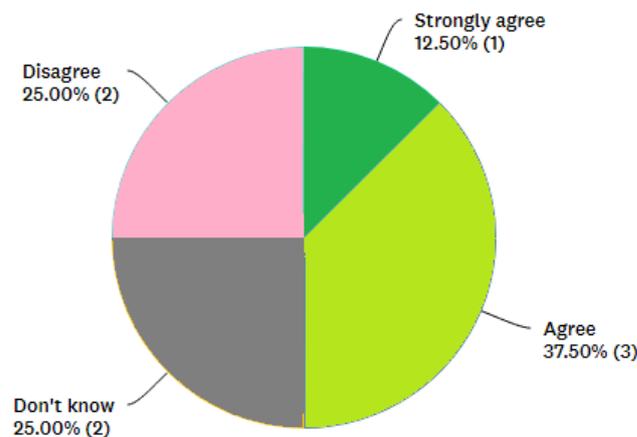
4. The split of responsibilities between the Quality Safety and Assurance Committee and the Audit Committee are clear.



Comments

<p>While I agree the definition of responsibilities are clear - there is sometimes overlap and slippage in "discipline" - to be fair there is also grey areas - appropriately dealt with in annual gathering</p>	<p>Sometimes, there is a not clear reason why an issue will go to Audit rather than QSAC; but the safety net is that it goes somewhere!</p>
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5. There is no unnecessary overlap of work conducted with other Committees or the Trust Board.

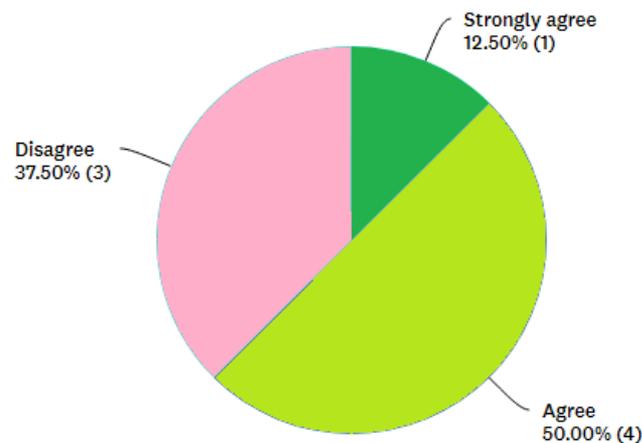


Comments

<p>I think it's reasonable that some issues are discussed at different meetings</p>	<p>There shouldn't be and at times it seems it is which means that we are deviating from the point of the committee.</p>
<p>CQC improvement plan work and the Quality Report etc. are reported to the board and QSAC. This is probably necessary but we should ensure such dual reporting is always the most efficient use of time in both places.</p>	

6. The Committee is supplied in a timely manner with information in a form and of a quality appropriate to enable it to discharge its duties. Please consider whether the information currently received is- in a format which draws the committee to the areas that most need its attention:- Sufficiently honest and not misleading- Sufficiently wide ranging- From a sufficiently wide range of

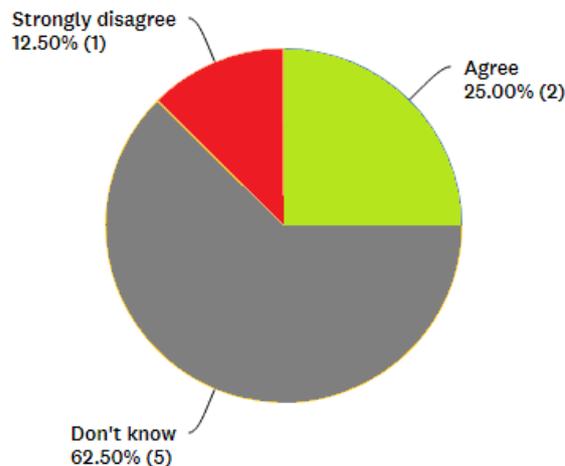
sources - Sufficient to enable the Committee to properly understand specific risks



Comments

<p>There is a huge amount of information reported. Is it reported in the most effective way, does it enable the committee to easily see the wood/trees? Is there too much detail? Should the committees that supply information to the committee only feed in quality and safety outliers with their remediation plans and date for completion etc.? Where appropriate it would be helpful for data to be presented 'per patient episode' "care day" etc. rather than as raw numbers and include trends over a meaningful time period. Graphics are also useful, supported by words. Focussing in on areas of weakness. Areas of strength are important too and should include consideration of how the good practice learning is being rolled out.</p>	
<p>It would be better to focus on less so that we have the time and detail around the topic/subject highlighted. Sometimes committees don't align so all the information may not be available to present such as quarterly data.</p>	<p>Could be tighter papers with purpose much clearer.</p>
<p>We need to consider whether all members of the TB are aware of the meaning of things like SPC charts and can interpret them appropriately.</p>	<p>I think there is work to be done to find the correct balance of assurance without too much detail</p>
<p>Need to make sure the committee has the latest view on trends and data coming from the hospital not just latest reported and audited facts</p>	

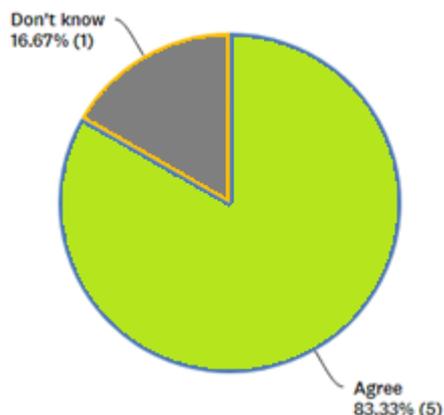
7. The Committee gains value and assurance from the work of the Risk Assurance and Compliance Group. Please consider whether the Committee might improve its effectiveness by receiving more focussed reports from the Risk Assurance and Compliance Group and/or directing tasks to be covered by that Group.



Comments

It doesn't seem to report in directly, which may be ok but...? Do we have the right reporting arrangements for groups and committees to feed to the committee in via management?	Don't attend RACG
RACG continues to improve in its work and contribution - still some way to go	The RACG hasn't met for a while so the QSAC can't be assured of the work done there.
The RACG has been under recent review. It's terms of reference have been updated and will now meet every 6 weeks. It reviews the BAF risks which are updated by risk owners between RACG meetings. Not sure the committee knows what it does though.	

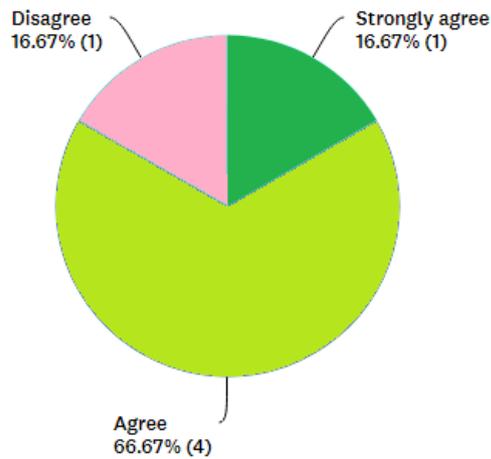
8. Time allocated to each agenda item by the agenda and the Chair is sufficient for discussion of the major risks facing the Trust and to achieve an effective dialogue.



Comments

It's always a challenge but taken together with the work of the other committees and the discussion at the board I think it is okay

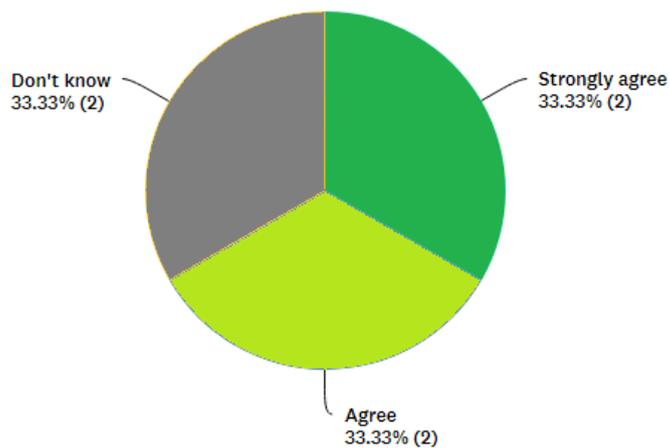
9. The breadth of quality and safety matters covered by the committee is appropriate.



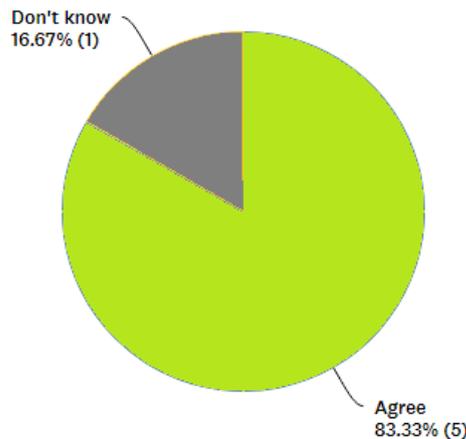
Comments

<p>But would be interesting to see some external benchmarking of the scope of other trusts QSACs - even if that means just speaking to a couple of other trusts and comparing agendas/the annual work plan especially from another highly rated trust</p>	<p>CQC gave us Requires Improvement so we were missing things we should have caught</p>
<p>Workforce matters need more integrated reporting and there is a need for a focus on culture at GOSH. Greater depth of review and assurance of the risks on the operational risk register is needed. Greater assurance around compliance against non CQC requirements.</p>	

10. Committee members are assured that they are informed of all significant clinical risks during the year and that these are reviewed during the course of a year.



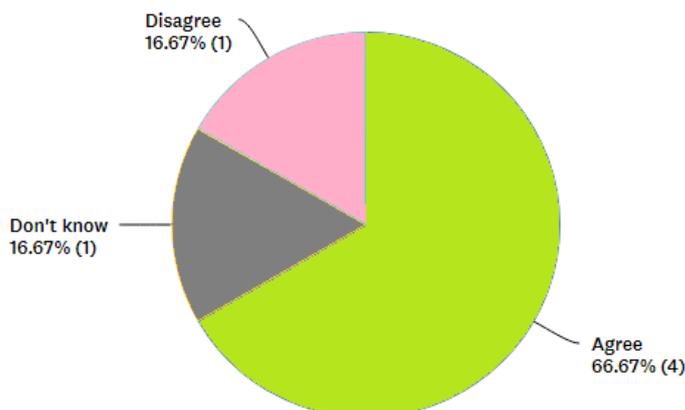
11. Authors of papers are clear about the role of the committee and this is demonstrated by the content of the papers presented.



Comments

it would be useful for data to be presented 'per patient episode' rather than raw numbers and as trends over a meaningful time period	there is room for improvement in this area
Some are, I think that we could do some more work to educate teams to understand the meaning of assurance as opposed to escalation or sharing information.	

12. The committee is assured by the management team that when an issue occurs which threatens the Trust's ability to deliver safe, high quality, patient-centred care and an excellent patient experience that this is managed and escalated appropriately and actions are taken and followed through.

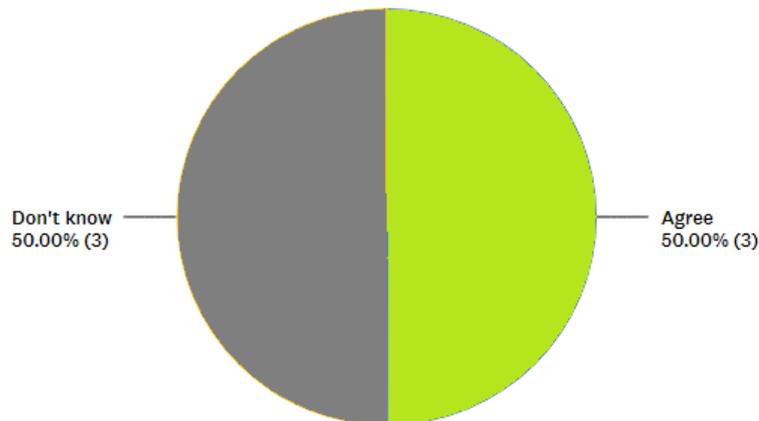


Comments

I am assured that this is the case but I would like to debate when items should be escalated to the NEDS/chair out of the meeting cycle timeline. This is always a difficult area given the volume of issues professionally managed by the executive team but it is probably worth debating	while improving there is still work to be done to consistently escalate some issues in a timely manner
I think more needs to be done to ensure timely action is taken. I can see several issues that have remained a concern over time	

13. The committee receives assurance that appropriate action is taken to identify implications for the delivery of safe, high quality, patient-centred care

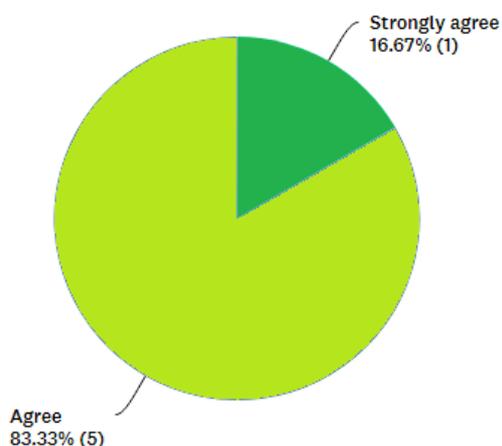
and excellent patient experience arising out of recommendations from external investigations of other organisations/ systems and processes.



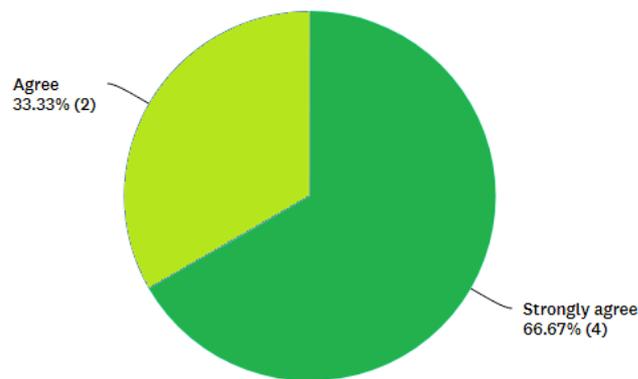
Comments

<p>We do get assurance and sight of all such investigations which have implications for the trust - given the volume of such it is unlikely to be practical to have a recommendation by recommendation type audit list. I think the question above might be too far reaching and maybe it should reference the ..major recommendations from external... ?</p>	<p>Do we systematically do this and what is the trigger or threshold for learning from others, and for reporting on it to the Committee?</p>
<p>I am not sure the QSAC receives action which has arisen from external investigations of other organisations.</p>	<p>could improve our discipline and timely response to these feedback elements</p>
<p>Have not really seen too much evidence of this so far</p>	<p>But needs a more deliberate report on this at every meeting stating what reviews have happened and what actions taken and then follow up. Where no reviews for the period it should state this at the meeting.</p>

14. The committee receives sufficient information about the quality focused internal audits conducted to provide assurance of the effectiveness of the clinical and quality controls in place to mitigate risk.



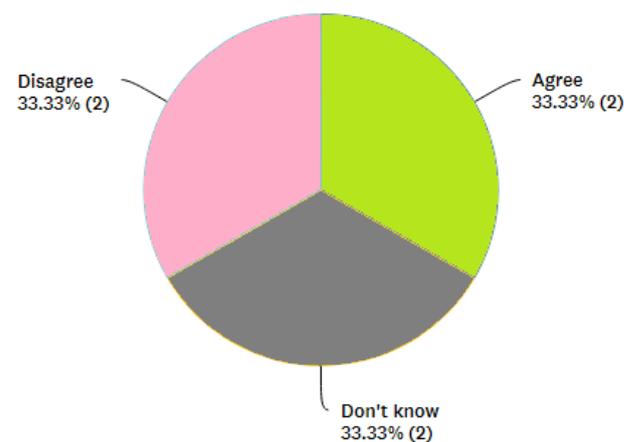
15. The committee receives sufficient information from the clinical audit team including progress with completion of the clinical audit annual plan.



Comments

The internal clinical audit function is excellent and we should ensure adequate resource is given to this function	always high quality work
we have an excellent but under resourced audit team	Need better triangulation of all audit findings with the BAF to show assurance and gaps.

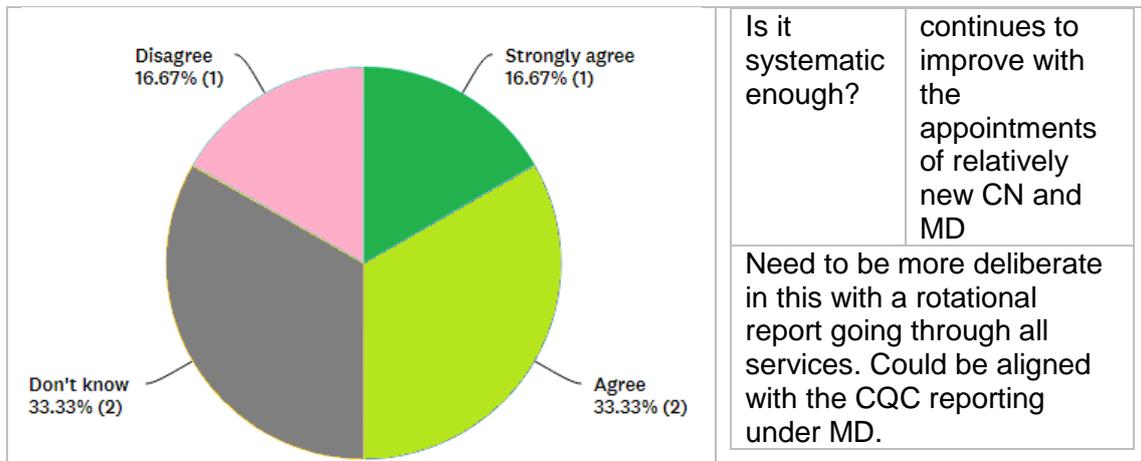
16. The committee receives sufficient information about and assurance of progress with quality improvement priorities set in the Quality Strategy and Quality Report.



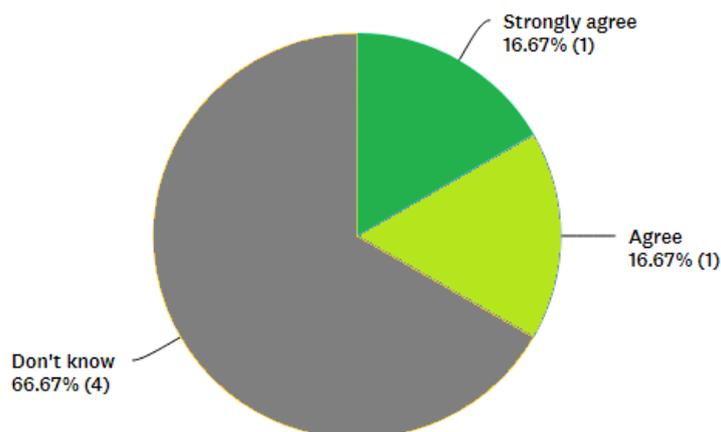
Comments

Is it reported in the most effective way?	I think we could celebrate the successes of the quality improvement programme more so that the QSAC members receive a more balanced view of the Trust.
more work to be done to develop the Trust quality Strategy	Good annual report but need assurance of progress during the year against the priorities.

17. The committee receives sufficient information about the effectiveness of governance systems and assurance of risks identified in management of clinical services.



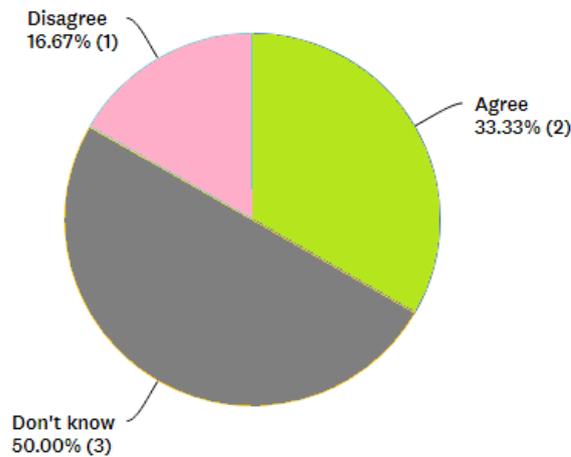
18. The committee receives sufficient information about the effectiveness of governance systems and assurance of risks identified in research and development.



Comments

We do see a lot of risks discussed related to funding, issues like consent and certain H&S issues but perhaps not enough focus on the other generic clinical/ethical risks in research?	not seen it better managed anywhere/ a real strength for the organisation
Don't recall any information on research in the two meetings I have attended and it is not a feature on the next agenda either	There is now an annual review of assurance of research governance. Maybe needs more.

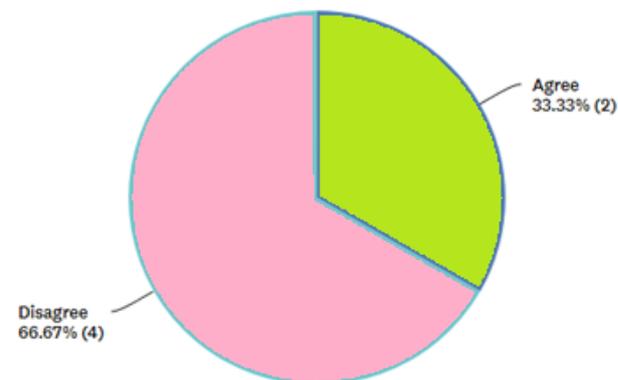
19. The committee receives sufficient information about the effectiveness of governance systems and assurance of risks identified in education and training.



Comments

We missed risks until they crystallised.	We see lots of numbers and performance measures on training but nothing on competency levels following training or the outcome of post training evaluations.
will continue to improve with recent appointments in leadership roles	As above - education matters tend to be presented to the education and workforce committee although risk around stat/man compliance have been flagged
None received at the committee.	

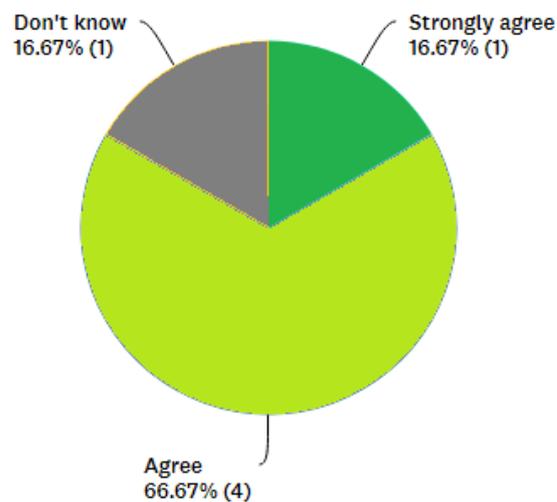
20. The committee receives sufficient information about the effectiveness of governance systems and assurance of risks identified in workforce



Comments

We missed risks until they crystallised.	I can't recall seeing a report detailing a thematic review of exit interviews, disciplinary outcomes, allegations made etc.
New report under development now.	lots of work to be done here - there is sufficient focus on nursing but limited in other areas

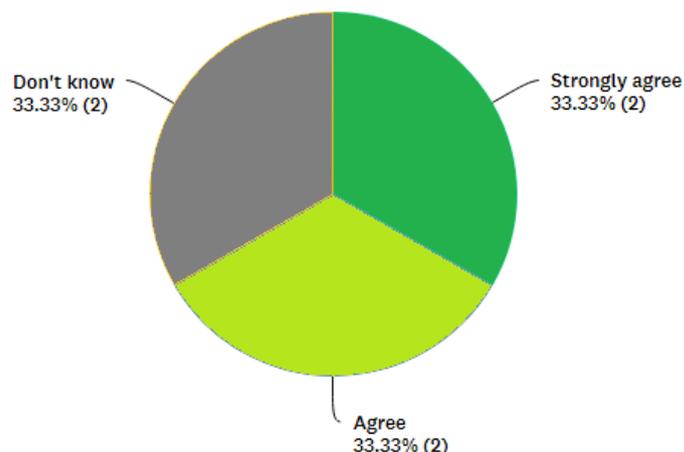
21. The committee receives sufficient information about the effectiveness of governance systems and assurance of risks identified in clinical outcomes.



Comments

Need to continue to develop and reconcile the public facing data and the information we rely on internally and check timeliness of such (this is WIP)	Is it systematic and wide enough to focus the committee on the right areas?
Although I do think that we could focus in on some areas to ensure consistency of collecting outcome measures.	Reporting just starting so early days.

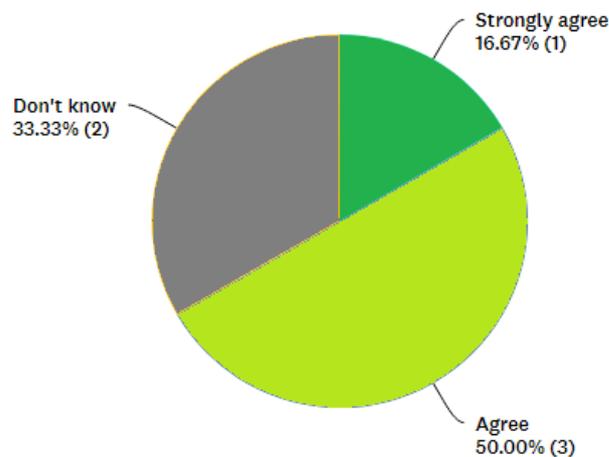
22. The Committee as a whole possess the necessary skills and experience required to deal with the terms of reference.



Comments

Would have liked to have left this blank until members fully confirmed. Current composition adequate but we remain one member short at the time of my writing. Need to confirm replacement of Professor Stephen Smith	Have we looked at that formally recently? Should we look at our membership against ToR. Should we recruit independent members to cover high scoring risk areas? Do our papers allow 'lay' non expert members to interrogate the right areas? is there always enough rigour amongst management and attendees in themselves challenging areas of weakness?
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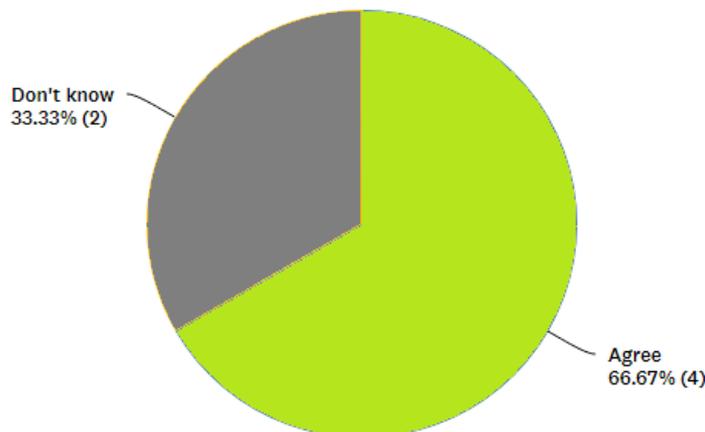
23. The Committee’s agendas and work programme prioritises the right issues to focus on within the remit of the terms of reference.



Comments

I would like the committee to re-look at our annual plan as an outcome of this review

24. The subcommittee structure reporting to the QSAC (Risk Assurance and Compliance Group (RACG), Patient Safety and Outcomes Committee (PSOC), Patient Family Experience and Engagement Committee (PFEEC) and Clinical Ethics Committee (CEC) is appropriate and effective.

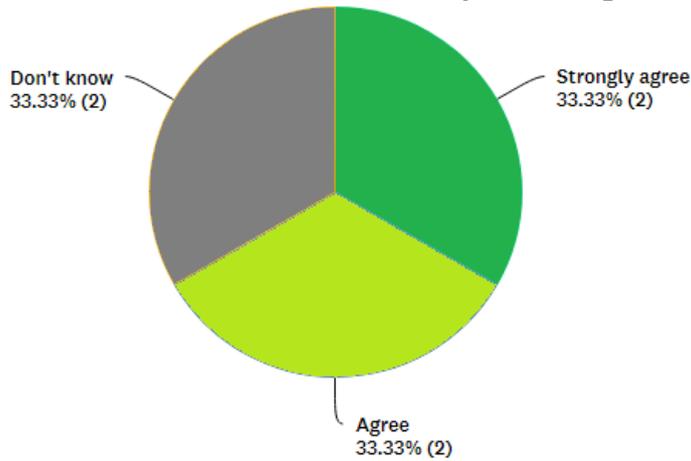


Comments

Though I haven't seen much visibility in terms of clinical ethics as I recall	I feel that PSOC, PFEEC and RACG report appropriately. I think the QSAC could have better oversight of the Clinical Ethics Committee.
Do these sub committees report in directly? Is there a template or agreed plan of what should come, when and how from these committees? Are they or should they filtered or aggregated by management first?	

25. Communications between the Committee and the Board are effective and enable Board members and others to:-Receive assurance from the Committee that the necessary structures and processes are in place to deliver safe, high quality, patient-centred care and an excellent patient experience Understand when issues have been escalated their attention -Receive

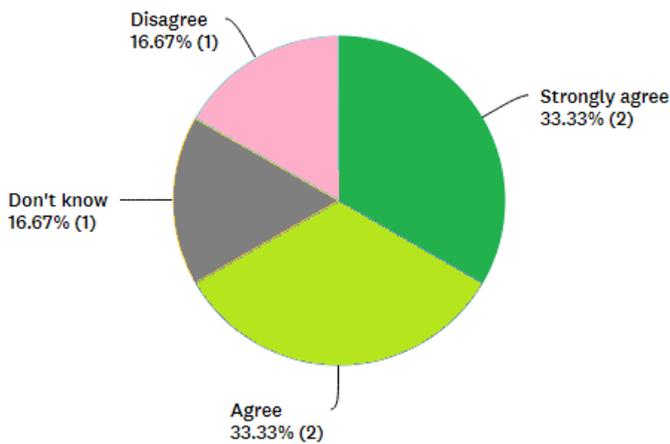
assurance that the Committee is performing its role effectively.



Comments

I do not sit on the Board

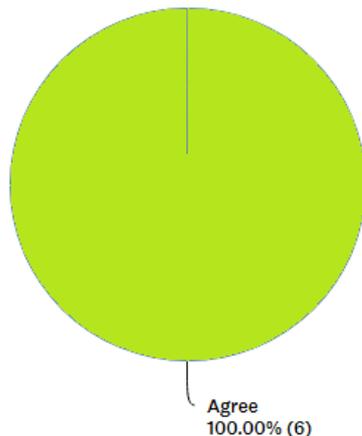
26. There is sufficient time allocated at the Board to consider the reports from the Quality and Safety Assurance Committee.



Comments

When taken together with the general discussion at the Board on matters of safety and quality of services	We should perhaps distinguish where we are reporting for information or where we want the board to be taking some action? We need to work hard to avoid gaps and duplication in what goes to the Board/QSAC
Believe there needs to be triangulation across board items and more assurance throughout from the QSAC rather than just a one of item on the agenda.	

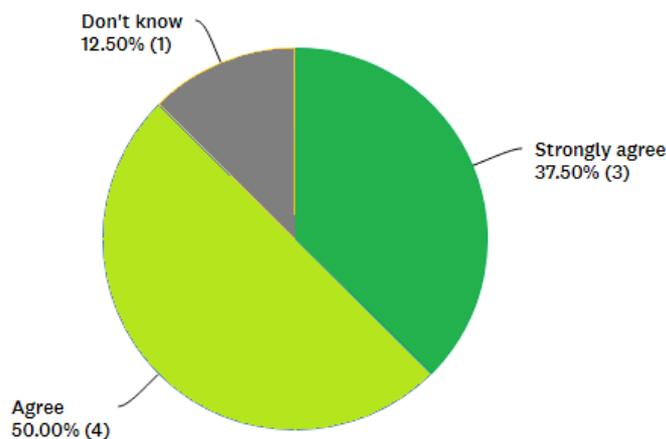
27. The attendees at the Committee provide sufficient and appropriate input to the respective agenda items.



Comments

I welcome the culture of bringing of all the bad news.	Executive ownership could be improved
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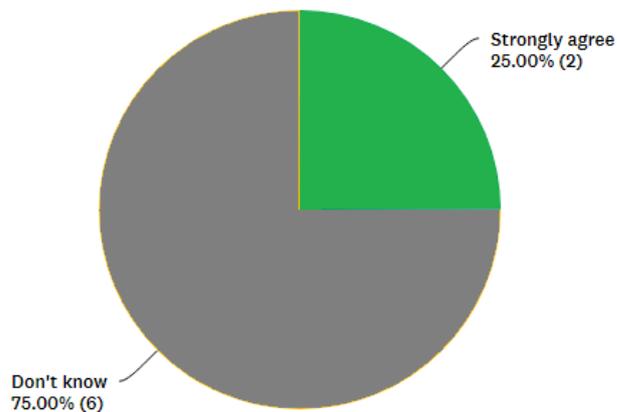
28. Governors who observe the committee are: welcomed and introduced.



Comments

We don't always have observers - we would like observers at every meeting and this point should be re-raised with the Lead Governor	I hope so - they are important part of the jigsaw. I would like to think how they can most effectively contribute where appropriate as well as observe.
I was not sure if I could contribute to discussion of items- there was one in particular that it may have been helpful for me to comment on as it is another committee that I am involved in. It will be very helpful to clarify when introduced if it is appropriate for staff governors to comment or if one is purely observing.	I felt welcome and included especially so on the second meeting I attended.

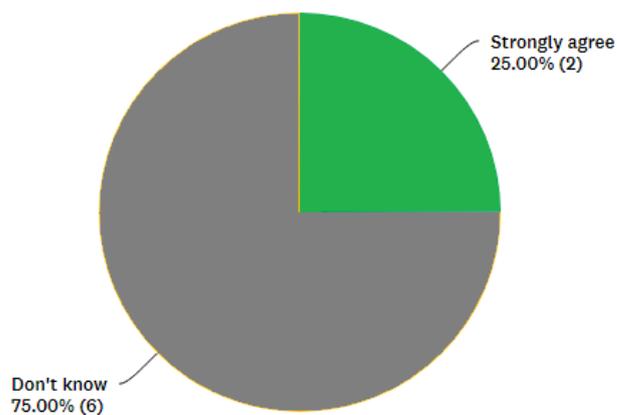
29. Governors who observe the committee understand the remit of the committee.



Comments

<p>Would depend on the Governor - whilst training should cover this there will inevitably be a range of experience and it may take a couple of meetings for observers to settle in, in terms of understanding of the agenda and the individual reports. This should be expected</p>	<p>Do we always have the same governors? Should we?</p>
<p>I had been provided with enough information to read regarding the remit of the committee and had chance to meet one of the committee members prior to the first meeting.</p>	

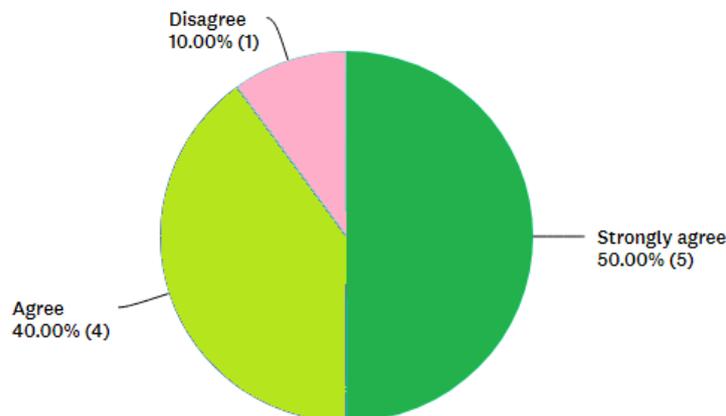
30. Governors who observe the committee understand the content of the information provided.



Comments

<p>All material was very understandable to a lay person</p>

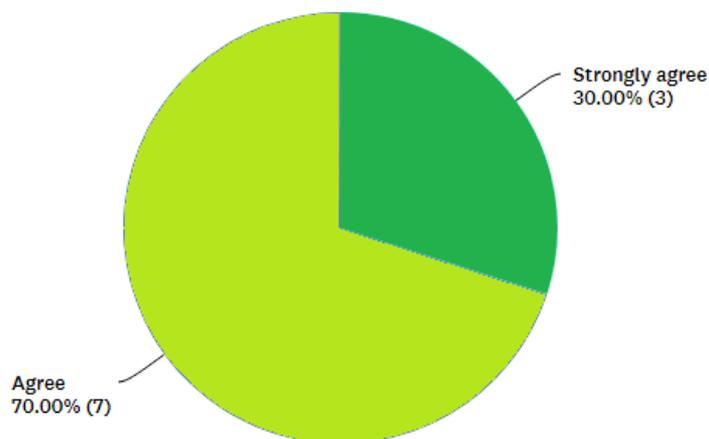
31. Authors of papers who are not members of the committee and attend a meeting are welcomed and invited to report on their item in a timely manner to avoid delays.



Comments

<p>I hope so!</p>	<p>It has varied enormously. There have been occasions when I have been advised of the time I will be presenting only on the day (after chasing) and then wait in the meeting for a significant time period beyond that because previous items are over-running. This can use up a lot of unnecessary time. However, the Committee has a new Chair so I am hopeful that this situation will sit firmly in the past.</p>
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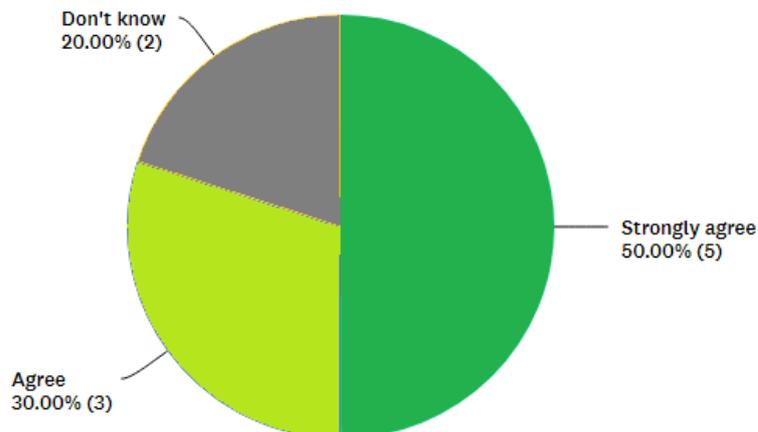
32. Committee members - through their questions - adequately challenge the management assessments of clinical and quality risk, risk mitigation and assurance.



Comments

<p>I thought that the discussion was rigorous and addressed the quality and safety thoroughly. It was very informative for me to join the committee and also reassuring to know the matters are addressed in this way.</p>	<p>I felt the questions were very robust and all issues were challenged in a positive understanding manner.</p>
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33. The Chair facilitates the effective contribution of all staff and non-executive directors and allows adequate time for discussion and decision-making on all agenda items.



Comments

The agendas are very packed - over packed??	Both the Chair's I observed managed this well.
Difficult to comment as I only attend for one item, and there is a new Chair	

34. Do you have any other comments which might increase the effectiveness of the Committee?

Does the CoSec office have the right role/time to co-ordinate and drive the committee's work? Plus It feels that the committee is already in a state of change through the changed membership of key personnel. Let's continue that journey and formalise it.	timings of the board and QSAC need to be scheduled to enable better reporting from the sub committee
I was impressed and reassured by the observing this committee, it illustrated that there is a body looking after the interests of the child but importantly also the welfare of the staff.	The Committee has an extremely busy agenda and has also been starting to consider areas such as culture. In trying to take on too large a volume it risks restricting the ability to give sufficient scrutiny to the individual items on the agenda so the committee may wish to consider whether it can effectively work with other committees to seek assurances in certain areas.
No - I am not close enough to the full committee agenda and discussions to be able to provide informed comment	

35. Are there areas or risks that you think the Committee should review and seek assurance of within its remit?

To be decided by the board	There are many day to day issues which arise which are dealt with by incident reports. Possibly inviting a representative from the Risk assessment Group for each directorate on a rotational basis to detail the main issues which arise may be helpful to have more of a picture of issues which do not reach the highest threshold but are nevertheless important.
I think the committee should pay close attention to the key pieces of work that	More consideration of patient experience, this is not lacking but could have more

Attachment J

<p>are required to ensure CQC compliance and better prepare for future inspections</p>	<p>importance in terms of quality especially in a specialist children hospital.</p>
<p>I think they cover the main areas. A question I would ask for Board committees in any organisation is the extent to which they may stray into "executive" and management territory, and the extent to which they remain at a strategic/assurance level making sure that they are confident that escalation processes and supporting information are adequate for their purposes - I am not close enough to the Committee to know where they are on this spectrum but perhaps a question worth posing?</p>	<p>Workforce risks</p>

**Summary of the meeting of the Audit Committee
held on 18th October 2018**

The Committee noted the minutes from the Trust Board Risk Management meeting which took place on 4th September 2018 and requested that any actions were incorporated into the Trust Board and Audit Committee action checklists.

Board Assurance Framework (BAF) Update

The Committee agreed to recommend to the Board an increase in the likelihood score for risk 11: EPR risk from 3 to 4 as a result of the complexity of patient data which was required to migrate across to the Epic System and the result of a refresh of the Long Term Financial Model (LTFM) which showed greater financial risk to the hospital overall.

The Committee undertook a deep dive into the following BAF risks:

- Risk 1: Financial Sustainability

The Committee agreed to recommend to the Board an increase in the likelihood score from 3 to 4 and an increase in the impact from a score of 4 to 5. This was as a result of risks around the Trust's income through tariffs, the potential impact of Brexit and risks around IPP performance and debtors. Mitigations against these areas were noted.

- Risk 2: Productivity and Efficiency

The Committee agreed that it was important to work towards a culture in which staff were engaged collectively in working towards the better value target and in working in the best interests of the Trust as a whole. Discussion took place around the action that would be taken in the event of a significantly larger efficiency target being assigned to the Trust in 2018/19 and it was agreed that some actions that had been taken at other Trusts could be initiated at GOSH but in some cases there was likely to be significant staff feedback.

- Risk 7: GOSH Strategic Position

GOSH continued to improve its engagement with external organisations such as STPs and through the Children's Alliance in order to advocate appropriately within the system.

Risks arising since last Audit Committee meeting: Power Outage

An update was provided on the root cause of the power outage which had taken place in August 2018 and it was agreed that the Board and Council of Governors would be briefed. It was emphasised that, other than the Southwood building for a period of approximately three hours, the GOSH site was covered by generator power. Eleven patients were affected by cancellations however it was confirmed that they had been rebooked and the hospital had been safe throughout this time. An action plan was in place and the committee asked for this to include the work that was being undertaken by the authorised engineer to review the way the system power system, which was currently overcomplicated, could be simplified.

Update on GDPR and data quality

Information sheets were being developed based on privacy notices to make them more user friendly and education sessions were taking place with staff around the use of email as some incidents involving email had taken place. Discussion took place around subject access requests (SARs) and the large scale of some of the requests received by the Trust.

The focus of the data quality work was now around what was required for the EPR programme. The Committee noted that following a review of the external auditor opinions given to the quality report, no Trusts reviewed had received an unqualified report. Discussion took place around the way in which GOSH could achieve this and the committee agreed that the Trust's first priority must be to ensure that patients were receiving treatment within an appropriate timeframe and that the Board was assured of this.

Serious Incidents and Claims

The Committee reviewed the number of open claims and the number of these which had an associated complaint or Serious Incident investigation. It was agreed that the committee would continue to review the cost of liabilities as although GOSH's liability was capped at its insurance premium it was contributing to an NHS system.

Losses and Ex-gratia Payments

The total write off in the period was noted and it was confirmed that the Trust continued to minimise losses. It was agreed that a trend would be included in future reports.

External Audit Planning Report

A draft plan had been submitted by Deloitte due to the external audit tender process currently underway. The scope of the work remained consistent with previous years. Discussion took place about the way in which the EPR system would be valued once it came into use as the judgements taken would be scrutinised by the auditors.

Internal Audit Progress Report and Technical Update October 2018

The internal audit on safeguarding was received which provided a rating of significant assurance with minor improvement potential. Discussion took place about the phasing of the audit calendar and the large number of reports which were received in the second half of the financial year. The committee requested a tracker from the auditors for each report to show the progress made.

Internal and external audit recommendations – update on progress– October 2018

Discussion took place about a recommendation related to the integrated quality report which was not fully aligned with the Single Oversight Framework (SOF). It was confirmed that the indicators which the SOF required to be reviewed were presented to the Board under different reports and the Committee emphasised the importance of highlighting the recommendations which were key and must be completed within the timeline.

Counter Fraud Update – October 2017

One on-going case continued to be investigated and it was noted that referrals in the NHS in general were reducing which was against the trend in the private sector.

Update on accounting standards – IFRS

- IFRS 15 – A risk had been identified around impact of the standard on research and innovation income and it had been agreed that GOSH would speak to the Department of Health. A review of approximately 200 contracts was required to ascertain whether variations were required.
- IFRS 16 – Although this standard was not adopted until 2019/20 a disclosure on the potential in the annual accounts was required in 2018/19.

Review of SFIs, Standing Orders and Scheme of Delegation

Documents had been updated to reflect changes such as the change in procurement provider and clinical operations structure. A two page guide was being produced for budget holders.

Whistle blowing Update – October 2018

One issue was ongoing and one case had recently concluded and learnings were being gathered. Work on whistleblowing was taking place with an HR consultant with experience of whistleblowing in other Trusts and they had confirmed they were not concerned about the number of cases received. It was highlighted that due to the implementation of Freedom to Speak Up, staff were becoming more aware of how to raise concerns and activity was increasing.

Updates from Board Assurance Committees

The Committee noted the minutes from the previous Finance and Investment Committee and Quality and Safety Assurance Committee.

Procurement Waivers – October 2018

The Committee requested a review of the approach to waivers was undertaken at a future meeting.

Role	The Terms of Reference specify the Role of the Committee as follows: The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and financial and non-financial internal controls that supports the achievement of the organisation's objectives
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App A: Audit Committee Effectiveness Survey Results		Strongly Agree%	Agree%	Don't know%	Disagree %	Strongly Disagree %	Comments to explain reasons for assessment
Role within the Trust's Governance Structure							
1	The Committee fulfils its role in reviewing and obtaining assurance on the Trust's risk management processes	37.5 ↑	50 ↓	12.5 ↑			<ul style="list-style-type: none"> • Good focus on the BAF and independent assessment of risks facing the Trust. Solid understanding • BAF and Strategic Risks are reviewed at each meeting • Agree - responsibly shared for some risks with the QSAC • Although it does feel like 30 - 40 minutes in each meeting are focused on the concepts or presentation of risks, it might be if these could be locked down more time could be devoted to the more complex task of risk management.
2	The Committee fulfils its role in monitoring the integrity of the financial statements and overseeing the work of the internal and external auditors	37.5 ↓	50 ↑	12.5 ↑			<ul style="list-style-type: none"> • Good liaison with internal and external auditors and in oversight of their work and areas of focus. • Good linkage (and overlap in attendees) with F&I on the financials
3	The split of responsibilities between the Audit Committee, the Clinical Governance Committee and the F&I Committee are clear	37.5 ↑	25 ↑	37.5 ↑			
4	There is no unnecessary overlap of work with other Committees or the Board. <i>If you disagree please detail areas of overlap</i>	12.5	50	37.5			<ul style="list-style-type: none"> • Key word is unnecessary. There is overlap but in these cases the overlap is of comfort. In some areas the more eyes looking the better • The Committee Chairs have worked to eliminate overlap any residual overlap may be unavoidable and therefore acceptable.

Attachment K

App A: Audit Committee Effectiveness Survey Results		Strongly Agree%	Agree%	Don't know%	Disagree %	Strongly Disagree %	Comments to explain reasons for assessment
		↓	↑	↑			
Skills of the Committee							
6	The Committee as a whole possess the necessary skills and experience required to deal with the terms of reference. <i>If you disagree please detail what skills you think are missing</i>	50 ↓	33 ↑	17 ↔			<ul style="list-style-type: none"> Strongly Agree, From the perspective of a presenter there is rigorous questioning I'm not clear that a skills assessment against the Committee ToR has been completed.
7	The Audit Committee receives sufficient information and assurance from other operational committees to provide assurance to the Trust Board on the quality of data produced by Trust systems.	25 ↑	12.5 ↓	50 ↑	12.5 ↑		<ul style="list-style-type: none"> I think data quality is robust and significant work has been completed in this area. Further work is on-going. I think there is work that is ongoing to move this agenda forward. The Trust is on a journey here. I believe however that assurance is adequate today given the known facts The Committee does not often reference receipt of information or assurance from other committees.
Communications							
8	Communications between the Committee and the Board are effective and enable the recipients to: <ul style="list-style-type: none"> Understand when issues have been escalated their attention Receive assurance that the Committee is performing its role effectively 	28.8 ↓	14.3 ↑	57.1 ↑			
9	There is sufficient time allocated at the Board to consider the reports from the Audit Committee		37.5 ↓	62.5 ↑			<ul style="list-style-type: none"> To the extent time is required to deal with issues that require debate I believe it is given.

Attachment K

App A: Audit Committee Effectiveness Survey Results		Strongly Agree%	Agree%	Don't know%	Disagree %	Strongly Disagree %	Comments to explain reasons for assessment
<p>QUESTIONS 8 to 14 primarily for ATTENDEES AT THE AUDIT COMMITTEE</p>							
<p>Meetings and processes</p>							
10	The Committee's agendas and work programme prioritises the right issues and allocates sufficient time for discussion of the major risks facing the Trust.	17 ↓	83 ↑				
11	Time allocated to each agenda item is sufficient to achieve an effective dialogue <u>in addition to</u> the time allocated to the presenter	17 ↓	83 ↑				<ul style="list-style-type: none"> • There is sometimes a lot of time taken up discussing how the BAF is formatted and designed as opposed to considering the robustness of the controls and assurances cited for the individual risks • Occasionally it is a challenge but generally time allocation seems appropriate
12	<p>All significant non-clinical risks are reviewed during the course of a year <i>Please suggest risks which might merit further coverage:</i> <u>EG OPERATIONAL</u> <i>business continuity; IT Security / Cyber Staff eg satisfaction, grievances, reasons for leaving, EL claims; Delivery of efficiencies and value for money; Effective Procurement</i> <u>EG STRATEGIC / OPPORTUNITY LOSS</u> eg <i>Preparedness for change; Technology changes</i> <i>Not optimising the potential for innovation</i></p>	<p>Note: This has no scoring per se and only offers free text.</p>					<ul style="list-style-type: none"> • None to add • I believe the annual meeting on risk coverage by internal audit covers this in part as does the way the chair sets the annual agenda. • Insufficient knowledge to comment • Workforce Risks including recruitment, succession, education and talent development. • Staff Optimising the potential for innovation • Digital. Impact of nano technology Succession planning Regulatory requirements changing Middle East healthcare market

Attachment K

App A: Audit Committee Effectiveness Survey Results		Strongly Agree%	Agree%	Don't know%	Disagree %	Strongly Disagree %	Comments to explain reasons for assessment
	<i>Brand / reputation risks; Threats to the business model</i>						
13	The attendees at the Committee provide sufficient and appropriate input to the respective agenda items	17 ↓	83 ↑				
14	Committee members - through their questions - adequately challenge the management assessments of risk, risk mitigation and assurance	50 ↑	50 ↓				
15	<p>The Committee is supplied in a timely manner with information in a form and of a quality appropriate to enable it to discharge its duties.</p> <p><i>Please consider whether the information currently received is:</i></p> <ul style="list-style-type: none"> - Sufficiently honest and not misleading - Sufficiently wide ranging - From a sufficiently wide range of sources - Sufficient to enable the Audit Committee to properly understand specific risks - Adequately covers external threats to the Trust's business 		67 ↑	33 ↑			<ul style="list-style-type: none"> • Papers are of variable quality. Some papers are too dense and shy away from helping the reader understand the main issues. We should continue to focus on this. • We need to further rationalise the pre-read material making the brief and focused. Also submissions on strategic risk deep dives need further improvement

Attachment K

App A: Audit Committee Effectiveness Survey Results		Strongly Agree%	Agree%	Don't know%	Disagree %	Strongly Disagree %	Comments to explain reasons for assessment
	<i>model</i>						
16	<p>The Audit Committee gains value and assurance from the work of the Risk Assurance and Compliance Group</p> <p><i>Please consider whether the Committee might improve its effectiveness by receiving more focussed reports from the Risk Assurance and Compliance Group and/or directing tasks to be covered by that Group</i></p>		<p>67</p> <p>↑</p>	<p>33</p> <p>↓</p>			
Leadership							
16	<p>The chairman facilitates the effective contribution of all staff and non-executive directors and allows adequate time for discussion and decision-making on all agenda items.</p>	<p>50</p> <p>↑</p>	<p>50</p> <p>↑</p>				<ul style="list-style-type: none"> Chairman allows sufficient time to discuss the agenda items and any decisions need to me made during the time slot.
17	<p>OTHER COMMENTS: Do you have any other comments which might increase the effectiveness of the Committee?</p>	<ul style="list-style-type: none"> None 					

Summary of the Finance and Investment Committee held on 14 November 2018

Summary of purpose and scope of report

This report summarises the Finance and Investment Committee's (FIC) work since its last written report to the Trust Board on 27 September 2018.

The FIC held a formal meeting on 14 November 2018 and met as an informal working group, to be updated on the development of the Long Term Financial Model (LTFM) on 1 November 2018.

Highlights from the 14 November meeting are covered below.

Trust 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.

Key issues for the Trust Board's attention

- The Trust ended Month 6 of the 2018/19 financial year £0.1m ahead of its control total.
- Modelled variables and assumptions for the Trust's Long Term Financial Management (LTFM) Plan.
- The plans for Phase 4 were examined and additional information was requested.
- Discussed the EPR programme noting that the project remained on track.

Performance and finance standing updates

Finance report 2018/19 Month 6 finance report

The Trust was ahead of its control total by £0.1m at Month six. This result was post the release of £1.1m of contingency. In terms of a more real time picture of the finances across the Trust, it was noted in the update from the CFO that there were a number of clinical areas which were experiencing underperformance in Month 6 and 7 which, if not addressed could impact on the ability of the Trust to meet its annual control total. Management informed the committee that they were very focused on necessary actions that ensured any such risks were minimised. Cash was higher than plan by £6.9m due to lower than planned expenditure on Trust funded capital projects.

International and Private Patient debt increased in Month to £27.4m.

It was agreed that the 'magic numbers report' would be revised to give the committee the same transparency on individual Directorates' performance as that received by management in their internal management meetings.

Integrated Performance Report

The Trust achieved referral to treatment (RTT) incomplete pathway national standard for the 8th consecutive Month. However, for September, five patients were reported waiting 52 weeks and over. All patients were treated in October 2018.

The Trust continued to report compliance against the five relevant national cancer indicators both in month for August and year to date.

The Committee requested that future reports provide:

- information by specialty, so service specific challenges could be identified,
- the revised levels of performance required to ensure the Trust can meet performance targets at year end.

Productivity and Efficiency (Better Value) update

All new Clinical Directorates had produced new ideas for localised productivity and efficiency schemes. There was a remaining challenge in implementing ideas that 'cross cut' the Clinical Directorates.

To deliver the 2018/19 target (currently forecast to be a £1.3m gap), it was essential that all current schemes were delivered and that a number of new schemes are identified.

Given the discussion on the financial report above the importance of better value initiatives were reinforced by the Committee.

Project updates / reviews

Long Term Financial Model (LTFM) review

On 1 November 2018, the Non-Executive Director members of FIC met to be updated on the development of the LTFM and the variables within the model. The model was revisited for the 14 November meeting. Committee discussion focused on the following areas:

- Demand and capacity forecasts and the degree to which such assumptions were owned by the individual directorates (assurance was received)
- The tariff discussions and environment and ways to model this going forward
- Appropriate occupancy benchmarks embedded in the LTFM
- Control totals and Better Value target assumptions to be used to set the base case
- The risks of unrealistic targets and the potential impact on quality and safety.
- The need to make all staff aware of the financial challenges ahead.

The Committee requested a further discussion on the model before the December Trust Board meeting

Phase 4

The Committee also focused on Phase 4. Following discussion, the Committee requested additional information before they would be able to give the Trust Board an informed opinion. They requested a report that considered, inter alia, the following points:

- Impact on the Trust's master plan, clinical capacity (bed numbers) and Long Term Financial Model.
- More detail on each of the Phase 4 options and implications for subsequent phases and consistency with the Trust's strategy
- Flexibility with regards to versatility and compromise on build quality.
- High level overview of an alternative to Phase 4.

EPR Programme Update

The Committee was informed that the programme was on track. The Committee was assured that the Trust's clinical leadership had been sufficiently briefed and were well aware that the system change was imminent. The Committee was also assured that there were control measures in place to support staff during the implementation.

The Trust's legacy Wi-Fi systems would be replaced by 2019 with weak signal areas receiving a boost.

Other items

It was agreed up front in the meeting that selected non-urgent agenda items were deferred to the December meeting as the discussion on the LTFM and Phase 4 was considered the priority for the meeting.

End of report

Summary of the Council of Governors' meeting held on 7 November 2018

Chief Executive Report

The Trust work on Workforce Race and Equality Standard Report was acknowledged, in particular the start of GOSH's lesbian, gay, bisexual and transgender (LGBT) Group and Black, Asian and minority ethnic (BAME) Group, who had held initial meetings.

Phasing governor elections and constituency boundary changes – a discussion paper

At the July 2018 meeting, the Council agreed to consider the options around phasing elections. The Council met on 7 November 2018 and agreed to Option 3: *begin transition for Public and Patient/carer and staff classes in 2020*. As a consensus decision was reached, it was agreed that the Constitution working group would convene and develop implementation and communication plans. The plans would be presented to the February 2019 Council of Governors' meeting for approval.

Update on GOSH Strategy and its delivery

The Chief Executive provided an overview on the following:

- the Board's discussions into the GOSH strategy, specifically how it fits into the NHS landscape.
- Ongoing work on the GOSH workforce strategy.
- Plans for the Council of Governors to receive a report on the options for implementation of the future aspects of the redevelopment master plan.
- Feedback, learning and potential next steps arising from the high profile media case.
- The restructured Senior Management Team and Clinical Operational Teams.

Integrated Performance Report (September 2018)

The Council received an update on Trust performance for Month five which included:

- Our Inpatient Friends and Family Test remained above the national standard of 95%, with 98.07% reported in September.

Finance report (September 2018 - highlights)

The Council received an update on the financial position of the Trust for Month five.

NHS Improvement has released the potential national tariffs for NHS activity in 2019/20. These showed a potential significant reduction in income for the Trust for delivering the same work over the next year. The Council was advised that the Trust was working with partners across London and nationally to ensure any impact is minimised and appropriate.

Reports from Board Assurance Committees

Quality and Safety Assurance Committee (July and October 2018)

The Committee had discussed the ways in which Trust workforce culture could be reviewed in the future. One possible idea was for a NED led task and finish group for the discussion to take place.

Audit Committee (October 2018)

The Committee reviewed the Board Assurance Framework and requested focus on the finance risks due to the potential changes in tariffs which had the potential to significantly adversely impact the Trust's finances. The Trust was on track to deliver £15m worth of better value savings for the first time.

Update from the Young People's Forum (YPF)

Members of the YPF reviewed the membership requirements for the forum to ensure that it was able to provide the most relevant feedback to the hospital. Following consultation, the forum agreed to reduce the upper age limit from 25 years old to 21 years old and specified that members must be either: a current patient, or a sibling of a current patient. Membership of the YPF remains viable a single year after their last GOSH contact.

Appointment of the GOSH external auditor

The Council approved the appointment of Deloitte as GOSH's external auditor from 1st April 2019 to 31st March 2022, with an option to extend for a further 24 months in 12 month intervals.

Governance update

The Council were informed that the Trust Board terms of reference had been reviewed, updated and approved.

A draft Council of Governors' development plan for 2018/19 and 2019-2021 was presented. The plan covered the learning objectives linked to the Governors key duties. The development sessions would start on Wednesday 6th February 2019.

All Non-Executive Directors had met with their buddies, had meetings / telephone calls scheduled with their buddies or offered time slots that were not used. The programme would be evaluated for the July 2019 meeting.

Membership Engagement Recruitment and Representation Committee Update and AGM/ AMM Plan

The first draft of the Membership Engagement Strategy was reviewed. The final version will be presented to the February 2019 Council of Governors.

Content for the Governors' online library was suggested and would be taken forward by the Deputy Company Secretary.

Any other business

As a general observation, it was requested that the Trust should refer to both children and young People, rather than just children.

Peter Steer, Chief Executive was thanked for all his work at his last GOSH Council of Governors' meeting.

End of report

Trust Board 5 December 2018	
Revised SFIs and Scheme of Delegation Submitted by: Helen Jameson, Chief Finance Officer	Paper No: Attachment N Appendix 1: Updated Scheme of Delegation Appendix 2: Updated Standing Financial Instructions
Aims / summary In line with the Trust's governance arrangements, the Scheme of Delegation and Standing Financial Instructions have been updated. This paper presents the revised versions for approval. Updates have been made to the existing documents in respect of the following: <ul style="list-style-type: none"> • The Trust has moved procurement providers to GSTT from PPS and references have been changed accordingly. • Updates have been made to reflect the new Directorate structure • Pay budgets have been updated to reflect the new Vacancy Approval process. • Tendering rules have been changed to reflect the 'light touch regime' <p>Both the Scheme of Delegation and Standing Financial Instructions have also been reviewed to ensure that they are consistent with each other and minor changes have been made accordingly.</p> <p>It is proposed the Scheme of Delegation and Standing Financial Instructions are reviewed on an annual basis going forwards, in line with the update process for the Standing Orders and Constitution. Both the revised SFIs and the Scheme of Delegation were reviewed at the October meeting of the Audit Committee and it was agreed to recommend their adoption to the Trust Board.</p>	
Action required from the meeting The Trust Board is asked to approve the updated Scheme of Delegation and Standing Financial Instructions Following approval by the Trust Board, the follow actions will take place: <ul style="list-style-type: none"> • A copy of the revised Scheme of delegation will be circulated to all budget holders via email • A brief budget holder guide will be produced • The rules around Special Purpose Funds may require revision as a result of IFRS 15, if this is the case then an updated version will be brought to the January meeting of the Audit Committee • There may be changes as a result of the implementation of EPR – if this is the case then an updated version will be prepared for approval by the Trust Board 	
Contribution to the delivery of NHS Foundation Trust strategies and plans The Standing Financial Instructions and Scheme of Delegation form part of the Trust's	

governance arrangements.
Financial implications Both documents describe how finance processes and authorisations have been designed.
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.
Who is responsible for implementing the proposals / project and anticipated timescales? Neil Redfern, Financial Controller
Who is accountable for the implementation of the proposal / project? Helen Jameson, Chief Finance Officer

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.

Since the last version of the Scheme of Delegation was approved a number of things have happened. These include:

- The Trust has moved procurement providers to GSTT from PPS and references have been changed accordingly.
- A new Directorate structure was launched on 1 October 2018

Therefore, 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 in February 2018:

Section	Amendments
1. Introduction and Purpose	No changes
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 Note added to highlight that the definition of 'Significant transactions' is prescribed by NHS Improvement
5. Summary of Expenditure Approval Financial Delegations	Movements from reserves deleted – as this is covered by the virement process Note added to virements to reflect that the form must be signed by both the budget holder from whom the budget is transferring and the budget holder to whom the budget is transferring. NHS Litigation Authority update to NHS Resolution Invoice requests now include budget holder approval Pay budgets section updated to reflect the new Vacancy Approval Process Confirmation that ODPG is required to scrutinise and endorse all revenue business cases as part of the

Section	Amendments
	<p>business case approvals process, to enable virements of existing budgets as appropriate and within current resources;</p> <p>Confirmation ODPG has the authority to approve business cases requiring no additional funding with a maximum income generation requirement £500,000</p> <p>Section on losses of patient or staff property or cash added</p> <p>Note added to the section on capital business case approval highlighting the need for capital business cases with revenue consequences to be approved in line with revenue business case approval</p> <p>The distinction between capital and ICT business cases removed</p>
6. Summary of Procurement Delegations	<p>Updated to include OJEU 'Light Touch'</p> <p>Waivers in respect of contract above OJEU value to be authorised by the Chief Executive</p>
7. Summary of Contract Signing Delegations	<p>UCLPPS references updated to GSTT</p> <p>Works contracts lower than £2.5m to be signed by the Director of Development AND one of Chief Executive OR Deputy Chief Executive OR Chief Finance Officer</p>
8. Summary of non-Financial Delegations	<p>Head of Supply Chain amended to Head of Materials Management</p> <p>Diesel fuel, catering supplies and GOSH CC shop stock delegated</p> <p>responsibility changed from Deputy Director of Estates & Facilities to Director of Estates & Facilities</p>
Schedule 1 – Delegated Approval Limits	<p>Job titles amended to reflect the new structure</p> <p>The distinction between credit notes and credit notes where an invoice is being re-raised has been eliminated</p>

Standing Financial Instructions

The Standing Financial Instructions were last formally issued in October 2015, although informal reviews of them have taken place since this time. 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	Amendments
1. Audit Committee	No changes
2. Business Planning, Budgets, Budgetary Control and Monitoring	Inclusion of CIPs/ Better Value in preparation of budgets References to Monitor updated to NHSI
3. Annual Accounts and Reports	Reference to the Quality Report now included
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 or Service Agreements for the Provision of Services	No changes
7. Terms of Service and Payment of Directors and Employees	Deputy Chief Executive amended to Director of HR & OD as the person responsible for issuing guidance to staff
8. Non-Pay Expenditure	No changes
9. Fixed Asset Register and Security of Assets	No changes
10. Capital Investment, Private Financing and Leasing	No changes
11. Stock Control and	Heading amended from 'Stores and Receipt of Goods' to 'Stock Control and Receipt of Goods'

Section	Amendments
Receipt of Goods	Stock take frequency amended from annually to at least twice a year
12. Disposals and Condemnations, Losses and Special Payments	<p>To align to the Scheme of Delegation authorisation of losses and special payments has been amended from Audit Committee to Chief Finance Officer for values under £10,000 and the Chief Executive for values over £10,000 in line with the Scheme of Delegation.</p> <p>This information is still presented to the Audit Committee for information</p>
13. Computerised Systems	Additional paragraph inserted highlighting that the Chief Executive will ensure that there is a nominated director responsible for accuracy and security of each critical information system within the Trust
14. Risk Management and Insurance	No changes
15. Tendering and Contracting Procedure	<p>Updated to include reference to the Public Contracts Regulations 2015</p> <p>Examples of framework agreements have been updated</p> <p>Paragraph on e-tendering included</p>
16. Retention of Records	No changes
17. Research and Development	No changes
18. Acceptance of Gifts by staff and other standards of business conduct	No changes

Great Ormond Street Hospital for Children NHS Foundation Trust

Scheme of Delegation

Version 2.0 – For Trust Board approval

Date: 5th December 2018

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
2.0	To Be Endorsed by	Executive Management Team	10/10/2018
2.0	To Be Recommended for Approved by	Trust Audit Committee	18/10/2018
2.0	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 28.2*.

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	<p>Clause 4 Powers</p> <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	<p>Annex 9 - Clause 1.1</p> <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 2006 Act.*
- 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 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.)***
- 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 those powers which it has delegated to officers and other bodies.*

Clause 20 Delegation to officers

- 20.1 *Those 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.*

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.*
- 47.2 *The Trust may enter into a significant transaction only if more than half of the members of the Members' Council 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.*

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 <u>within</u> the Trust's annual Budget Plan excluding:</p> <ul style="list-style-type: none"> • Business rates and NHS Resolution (refer Delegation 1.2) • Factor 8 blood and high cost drugs (refer Delegation 1.3) • Development (refer Delegation 1.4) • Situations where a business case is required (refer Section 4) 	
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 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 <u>within</u> budget	

#	Delegated Responsibilities	Delegated Officer or Group
1.2.1	Less than £5,000,000	Chief Executive OR Deputy Chief 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 <u>within</u> budget	
1.3.1	Less than £10,000,000	Chief Executive OR Deputy Chief Executive OR Chief Finance Officer
1.3.2	Over £10,000,000	Trust Board
1.4	Authority to approve non-pay expenditure <u>within</u> 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 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 Executive OR Chief Finance Officer OR Director of Development & Property Services
1.5	Authority to approve non-pay expenditure <u>in excess</u> 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>) (note: this applies to business-as-usual overspends per Directorate per month)	
1.5.1	Less than £500,000	Chief Executive OR Deputy Chief Executive OR Chief Finance Officer OR Executive Director
1.5.2	Over £500,000 up to £5,000,000	Chief Executive OR Deputy Chief Executive OR Chief Finance Officer <i>Approval noted by:</i> Audit Committee
1.6	Authority to approve non-pay expenditure <u>in excess</u> of individual project budget (Development)	
1.6.1	Approval of any increase to the overall capital expenditure budget as against the approved annual capital programme (<i>refer Section 5</i>)	Finance & Investment Committee <i>Prior endorsement required by:</i> Capital Investment Group
1.7	Authority to approve non-pay expenditure relating to non-audit based professional services to be provided by the Trust's external auditor	
1.7.1	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

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, 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</u> budget AND within existing HR establishment (e.g. recruitment to vacancies within the establishment)	
5.1.1	Staff appointment – up to and including Band 6 and Junior Doctors	Specialty Lead, Service Manager or Matron Corporate Directorates (including Research and Innovation) require authorisation from Budget Holder Finance and HR to be notified
5.1.2	Staff appointment – Band 7 to 8b or new posts	Chief of Service, General Manager or Head of Nursing Corporate Directorates (including Research and Innovation) require authorisation from Director, Deputy Director or Assistant Director <i>Prior endorsement required by:</i> Finance and HR
5.1.3	Staff appointment – Band 8c and 8d	Director of Operations Corporate Directorates (including Research and Innovation) require

#	Delegated Responsibilities	Delegated Officer or Group
		authorisation from Director, Deputy Director or Assistant Director <i>Prior endorsement required by:</i> Finance and HR
5.1.4	Staff appointment – existing Medical Consultant Posts	Chief of Service <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
5.1.6	Staff appointment – Executive Directors and other Directors referenced on the Trust Board	Chief Executive <u>AND</u> Relevant Executive Director <u>AND</u> 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 <u>AND</u> Relevant Executive Director <u>AND</u> 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

¹ Note 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
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	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	
6.1.2	Up to £2,500,000	Executive Management Team <i>Prior endorsement required by:</i> Operational Delivery & Performance Group
6.1.3	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
6.1.4	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
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> Capital Investment Group AND Executive Management Team AND Finance & Investment Committee

#	Delegated Responsibilities	Delegated Officer or Group
	Full Business Case	<p>Trust Board</p> <p><i>Prior endorsement required by:</i> Capital Investment Group AND Executive Management Team AND Finance & Investment Committee</p>
7.3	Authority to approve business cases requesting capital expenditure (ICT)	
7.3.1	Less than £500,000	<p>Information Management & Technology Board</p> <p><i>Prior endorsement required by:</i> Operational Delivery & Performance Group</p> <p><i>Approval noted by:</i> Executive Management Team AND Capital Investment Group</p>
7.3.2	Over £500,000 up to £2,500,000	<p>Executive Management Team</p> <p><i>Prior endorsement required by:</i> Operational Delivery & Performance Group AND Information Management & Technology Board</p> <p><i>Approval noted by:</i> Capital Investment Group Finance & Investment Committee</p>
7.3.3	Over £2,500,000 up to £4,500,000	<p>Finance & Investment Committee</p> <p><i>Prior endorsement required by:</i> Operational Delivery & Performance Group AND Information Management & Technology Board AND Executive Management Team</p> <p><i>Approval noted by:</i> Capital Investment Group</p>
7.3.4	<p>Over £4,500,000</p> <p>Outline Business Case</p> <p>Full Business Case</p>	<p>Trust Board</p> <p><i>Prior endorsement required by:</i> Operational Delivery & Performance Group AND Information Management & Technology Board AND Executive Management Team AND Finance & Investment Committee</p> <p><i>Approval noted by:</i> Capital Investment Group</p> <p>Trust Board</p> <p><i>Prior endorsement required by:</i> Operational Delivery & Performance Group AND Information Management & Technology Board AND Executive Management Team AND Finance & Investment Committee</p> <p><i>Approval noted by:</i> Capital Investment Group</p>

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 Executive OR Chief Finance Officer
8.2	Authority to approve losses of equipment and property	
8.2.1	Less than £100,000	Deputy Chief 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 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: Audit Committee</i>

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 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 must be invited to bid and the value is within the framework limit OR conduct a full EU-compliant tender process for which advice must be sought from the Procurement team
<p>Notes:</p> <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 Mini-competitions undertaken from 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. Award of contracts should be based on lowest cost or quality/price evaluation. 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 	
The Public Procurement thresholds for the period January 2018 to December 2019 are as follows:-	

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"> 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 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 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 office 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 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 16 Tendering and Contracting Procedure**.

#	Delegated Responsibilities	Delegated Officer or Group
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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 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 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 Custody of Seal

The following extract from the Trust Constitution outlines the use of the Sealing of Documents.

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 finance, or an officer nominated by him or her and authorised and countersigned by the chief 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 Signing non-legally binding administrative arrangements

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 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	<p><i>Diesel fuel, catering supplies and GOSH CC shop stock</i></p> <p>(including approving stock portfolio, stock replenishment, ensuring stock is held in registered locations, conducting stock takes, and signing off stock takes and obsolete stock)</p>	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 ^	£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 ⁴ 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 Officer 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	

^ Subject to FIC approval over £2.5million

⁴ As at January 2018 the other Executive Directors include: Medical Director, Chief Nurse, and Director of Human Resources & Organisational Development.

⁵ As 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.

GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST (“the Trust”)

Standing Financial Instructions

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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 Members Council, 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 Members' Council. 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. A statement of the significant assumptions on which the plan is based; and
 - b. Details of major changes in workload, delivery of services or resources required to achieve the plan including finances and workforce
 - c. Details of CIP requirements and plans for delivery and in year monitoring
- 2.1.2 At the start of business planning process the Chief Operating Officer will, on behalf of the Chief Executive, prepare and submit a business plan for the approval of the Board. The Business plan
- a. A detailed description of the activity plans for the Trust services taking into consideration commissioner intentions and national guidance.
 - b. The impact of the Trusts business cases and site development
 - c. Expected changes to workforce and plans of meeting the Trusts requirements
 - d. Identify risks
 - e. 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:
- a. Be in accordance with the aims and objectives set out in the Trust's annual business plan;
 - b. Accord with workload and manpower plans
 - c. Be produced following discussion with appropriate budget holders;
 - d. Take account of any limits of expected income arising, or expected to arise, from contracts with funders;
 - e. Identify potential risks; and
 - f. 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 Chief Operating 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 Members' Council. 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 16](#)).

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 16 "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 16 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 Public Contracts Regulations 2015 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 DH);
- 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 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 £5,000 or other such amount approved within the financial limits;
- b. where the supply is proposed under special arrangements negotiated by the DH or another NHS/public body which includes Procure21+ 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 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, eg 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, 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 £5,000, 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. 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.

Trust Board 5th December 2018		
Register of Seals	Paper No: Attachment	
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 November 2017.		
Date	Description	Signed by
23/02/2018	Licence for alterations – 4 th floor, Russell Square House	PS
23/03/2018	Sub-consultation warrantee relating to the design and construction of the Phase 4 redevelopment programme comprising sit preparation, demolition of existing buildings, external works and external services at Great Ormond Street Hospital. BDP, JS&S, GOSH.	PS, HJ
23/03/2018	Sub-consultation warrantee relating to the design and construction of the Phase 4 redevelopment programme comprising sit preparation, demolition of existing buildings, external works and external services at Great Ormond Street Hospital. Turley Associates, JS&S, GOSH.	PS, HJ
23/03/2018	Sub-consultation warrantee relating to the design and construction of the Phase 4 redevelopment programme comprising sit preparation, demolition of existing buildings, external works and external services at Great Ormond Street Hospital. McBains, JS&S, GOSH.	PS, HJ
23/03/2018	Sub-consultation warrantee relating to the design and construction of the Phase 4 redevelopment programme comprising sit preparation, demolition of existing buildings, external works and external services at Great Ormond Street Hospital. Essentia, JS&S, GOSH.	PS, HJ
23/03/2018	Early design agreement for the design of the Phase 4 redevelopment programme comprising site preparation, demolition of existing buildings, external works and external services at Great Ormond Street	PS, HJ
23/03/2018	Cardiac Intensive Care Unit L4 PICB – Stage 4 Contract	PS, HJ
23/03/2018	Spec CT – Stage 3 contract	PS, HJ
23/03/2018	Provision of a Cost Consultancy Service for Great Ormond Street Hospital.	PS, HJ
23/03/2018	Italian Hospital Refurbishment – stage 3 contract	PS, HJ
02/05/2018	DRIVE contract – JCT without quantities. CAT B fit out works required to create a high quality office space.	HJ, NG

25/05/2018	Grant application 18NC10 for Yael Hacohen	HJ
18/06/2018	Italian Hospital Project – Stage 4 Contract	HJ (AF witness)
18/06/2018	Spec CT Project – Stage 4 Contract	HJ (AF witness)
20/06/2018	Deed of agreement for the Great Ormond Street Hospital Sight and Sound Centre	HJ
22/08/2018	Stage 4 Contract Documents iMRI unit (Southwood Courtyard Project)	PS, AF
04/10/2018	Certificate to mark the occasion of the signing of the MOU between King Faisal Specialist Hospital and Research Centre and GOSH	N/A
28/11/2018	Fit out works to level 2 at Barclay House	HJ, AF
28/11/2018	MR2 Upgrade and Internal Refurbishment	HJ, AF
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		

Trust Board 5 December 2018	
A 'deep dive' analysis of Neuroscience: From diagnostics to therapeutics Submitted by: Sophie Varadkar, Chief of Service Martin Tisdall: Deputy Chief of Service	Paper No: Attachment P
Aims / summary The slides summarise the ambitions, challenges, opportunities, and themes that have emerged from an analysis of Neuroscience services at GOSH. Neuroscience has been identified as a strategically important area, so this work is important because it will be used to describe and make decisions about the future direction of our services. A few important features of neuroscience are presented to help explain its complexity and breadth in addition to a high-level outline of some the stages that were taken to complete the analysis. We then present, by specialty, some of the ambitions, challenges, and opportunities that have been uncovered – some of these are unique to certain services and areas while others cut across every aspect of neuroscience – and set out the next steps.	
Action required from the meeting Board members to note the points presented on slide 7.	
Contribution to the delivery of NHS Foundation Trust strategies and plans Neuroscience is specialist and highly specialist. The emerging work is relevant to care, people, voice, technology, research, funding, information, and space and is therefore aligned to 'helping children with complex health needs fulfil their potential'.	
Financial implications None at this time.	
Who needs to be told about any decision? The Board and the services that have been involved in this work. As the work develops into a formal strategy external stakeholders (e.g. NHS England, NHS Improvement, Advocacy Groups) will need to be included and told about decisions.	
Who is responsible for implementing the proposals / project and anticipated timescales? Each of the services and areas involved in the development of this work.	
Who is accountable for the implementation of the proposal / project? The chiefs and heads of services with support from strategy and planning.	

A 'deep dive' analysis of Neuroscience: From diagnostics to therapeutics

Sophia Varadkar, Chief of Service

Martin Tisdall, Deputy Chief of Service

James Scott, Head of Strategy & Planning

5 December 2018

Ambitious, successful and highly experienced surgical, medical and academic colleagues treating rare and complex conditions, disorders, and diseases.



Neurosciences at GOSH is well established and ambitious. We

- Operate within a rapidly evolving field where novel diagnostics and therapeutics are already changing demands and patient expectations.
- Provide specialised and highly-specialised paediatric services with a national and international reputation for clinical care and research.
- Are pioneering and driving developments in clinical assessment, diagnostics, and treatments to understand diseases and conditions.
- Manage complex brain, spine, and nervous system conditions, as well as other disorders, diseases and mental health problems.
- Work collaboratively with children, young people and parents, GOSH UCL ICH, UCLH, King's Health Partners, Young Epilepsy, community services and hospitals.
- Undertake and lead on translational research across many different and important areas of paediatric care.

Neuroscience has been identified as a strategically important area. As part of the process to develop a formal strategy, we have conducted a 'deep dive'*.

- Presents a high-level summary of the direction of the neuroscience strategy currently being developed.
- Individual, one-hour meetings with: Neurosurgery, Epilepsy, Clinical Neurophysiology, Acute, general and specialist Neurology, Neuromuscular, Neurodisability, Neuropsychology, Neuropsychiatry, diagnostic and interventional Neuroradiology, Neuropathology, Senior nursing, Endocrine, Metabolic , Academic Neuroscience, Critical Care, Medical Education leads, and Heads of Therapies. Approximately 90+ colleagues.
- Wide-ranging approach needed because Neuroscience is a diverse and complex area, and because there is a strong ethos of Multidisciplinary Team Meeting and therefore our services are clinically, operationally and strategically linked.
- As part of the deep dive teams were asked to consider a SWOT analysis, with a focus on resources, competencies, experience, systems and process, and innovation. Our aim was to develop a single analysis and review to help establish and justify the future direction as well as individual and cross-cutting priorities.

*Well documented deep dive processes and techniques were followed to explore ideas, consider options, create teams, identify problems, etc.

Each Neuroscience area has identified strengths and weaknesses, opportunities and threats. Discussions have then considered how, for example, weaknesses can become strengths*.

 **NEUROSURGERY**

Focus on specialised services from 'safe and sustainable'. Highly specialised services. Bed capacity has become rate-limiting. Desire to develop academic roles/neuro-therapeutics. Workforce challenges at ward level and need for general paediatric input. Pioneering new techniques (LiTT; in utero surgery, iMRI)

 **EPILEPSY**

Strong experience clinically and through research. Close links nationally and internationally (e.g. European Reference Network). Lead NHSE Children's Epilepsy Surgery Service. Consider outreach model of care to act as 'gatekeeper'. Develop Centre for Rare Epilepsies. (neonatal, infantile, genetic, structural, metabolic)

 **NEUROPHYSIOLOGY**

Expertise, and strong reputation. New technologies and training have driven progress. Raises issues of sustainability and scalability and adoption in clinical service. Desire to strengthen academic links. Shortage of trained physiologists and consultants: AI and expansion for technology-driven techniques; role of scientists; and MEG clinical technology.

 **NEUROLOGY**

Deliver services that can't be delivered elsewhere: acute in-patient service, Vein of Galen, Headache. Support key Trust areas e.g. critical care units. Building on good network links. Enhanced roles (e.g. AHPs) and fellowships. Develop networks partnership models; rapidly changing treatments for stroke and neurovascular.

 **NEUROMUSCULAR**

Highly specialised services. International reputation. National leadership. – networks, standards of care. Successful academic, research, and translational clinical work. MDT focus. Identify need for behavioural and neurodevelopmental input : Neuromuscular Centre - investigative admission and diagnostic unit

 **NEURODISABILITY**

National and international reputation. MDT model with expert therapies. Desire to continue to move forward. Demand driven by neuroscience expansion, pressures on capacity. Focus on training . London living costs. Consider acquired brain injury and neuro rehabilitation as future development.

 **NEUROPATHOLOGY**

Specialist services. Pioneering techniques. Strong research and academic links. Aware of national move to centralise and reorganisation, with ability to influence. Capacity constraints – facilities, resources, recruitment. Advanced roles valuable. Expand and strengthen senior team; structured training; and digital technologies.

 **NEUROPSYCHOLOGY**

National and international reach. Close academic links and combined clinical-academic roles. Contribution to guidelines and standards; longitudinal reach. Concerned with education and training and career development. Develop specialist protocols; harnessing new technologies and apps.

 **NEUROPSYCHIATRY**

Pan-Trust service. National recognition of impact of mental health in rare and complex conditions. Strong liaison and diagnostic. Challenge to capacity from 'vertical' services. Neurology and psychiatry well embedded. Opportunity to offer mental health interventions at GOSH; acute reactive psychiatry service for GOSH

 **NEURORADIOLOGY**

Changes in senior team; opportunity to develop together. Build on current national and international collaboration. Strengthen link with ICH . National shortage of consultants. Developing new techniques, deep learning AI; support new vistas e.g. foetal imaging; PET scanning technologies; and medical physicists.

*As part of the deep dive we also met with metabolic, endocrine, senior nursing, and critical care. We will ensure their 'voice' is included in the future strategy.

Each neuroscience area has identified strengths and weaknesses, opportunities and threats. Discussions have then considered how, for example, weaknesses can become strengths*.



NEUROMETABOLIC

Strong clinical service and translational research. Novel therapies and translation to practice a challenge. Involved in NHS future service designs. Need cross strategies with gastroenterology and neurology. **Develop formal integrated neuro-metabolic service in-house ; be partner of choice for other tertiary centres.**



GOSH UCL ICH

Currently refreshing strategy. Closely allied aims on patient benefits and improving outcomes. **Opportunities for joint teaching programmes (e.g. iBSc, MSc, PhDs); data management; developing younger colleagues' clinical & academic careers; Neurotherapeutics and Academic Neurosurgery; and expanding research portfolio**



NEUROENDOCRINE

Provide services not elsewhere. Strong link and shared services for transition with UCLH. Strong outreach. Attrition of clinical academics and research in recent years. **Succession planning clinically, leadership and academic; lead direction of new NHSE national services; integrated clinical academic metabolic bone service**

EXAMPLE INSIGHT:

Several insights were gained during the work and these have informed the development of our priorities and cross-priorities. For example, Neuroscience is a truly multidisciplinary service that is best managed with a pathway approach rather than as individual units. An important observation has been that:

We provide paediatric services for complex patients. We describe these services as vertical (tests, advice, methods, etc. for specific group of patients) and horizontal (assessments, tests, advice, methods, etc. for a wide range of patients e.g. clinical psychology sees patients presenting to epilepsy, neuro disability, metabolic, etc.)



Demand and activity for all services grows for various reasons (e.g. greater awareness, partnership working, new technologies, better diagnostics). As a result, we take on more work and (typically) continue to focus on vertical service growth. **Issue 1: capacity in horizontal services lags behind vertical service capacity.**

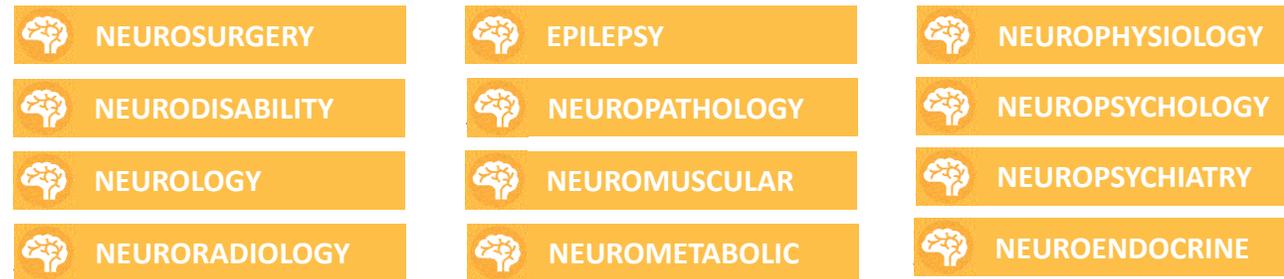


As demand and opportunities continue to grow, we strive for ever-improving quality, safety, efficiency, income, etc., but continue to focus on vertically-based trials, procedures, techniques, and assessments. This allows us to take on increasingly complex patients. **Issue 2: patients requiring horizontal services are also increasingly complex, presenting unique challenges, and often requiring more intensive (e.g. therapeutic) management. Given issue 1 this is difficult to accommodate.**



Capacity in horizontal services continues to fall behind horizontal services. **Issue 3: actions are taken to fix the demand-capacity imbalance (e.g. additional hours are worked and personal development is deprioritised) but some horizontal services struggle to provide true 'comprehensive, holistic, multi-professional co-ordinated care'.**

Our services have local plans and ambitions to continue to grow. Deep dive also identified multiple strategically-important themes that cut across all services.



MDT – multi-disciplinary, multi-professional, multi-centre collaborative models of working; assessments, tests, procedures, and techniques; diagnoses and treatments

Networks and partnerships – maintaining access to networks, partnerships, alliances to access skills, knowledge, and expertise, and help Children Fulfil their potential

Joint partnership working service models across networks - for the right patients at the right time. Critically helping to act as ‘gatekeeper’ to specialist services.

Enhanced roles – expanding training for career progression and morale, and building capacity by shifting and challenging conventional skills & boundaries.

Teaching, education, and training – respond to external changes (e.g. RCPC Shape of Training); develop post-CCT fellowship programmes; succession-planning

Capacity and efficiency – focusing on critical limitations (staff, technologies, physical space, training, beds) to deliver safe and quality patient care.

Academic, clinical and research – balancing academic and clinical work and building the capacity to apply research findings to enhance care.

EPR – ensuring all services are ready to work with EPR; collect more structured data; utilise patient portals

Workforce and recruitment – workforce planning to support historically low recruitment rates, shortage of doctors and consultants; sufficient staff for service new models

Translation of novel therapies and techniques – Interface with NICE, NHS commissioning and regulatory bodies, opportunities for early delivery in partnership with IPP

Next steps: from diagnostic to therapeutic to help children fulfil their potential

What we need to do next

This piece is one of three steps:

1. Write the formal strategy that also sets out the framework for neuroscience, setting out our direction of travel and justifying why it's correct and describing 'Why are we doing this?'
2. Link the strategy to the business planning process – 'What are we doing?'
3. Operationalise the strategy and plan (e.g. roles, processes, technologies) – How will we do things?

Where we need support from the Board in the context of new and emerging demands on the service

- Acknowledge the strategic points and support the vision and direction of travel
- Offer feedback and guidance on points that we might have missed
- Acknowledge the business case currently in development to improve capacity across neuroscience and address RTT challenges
- Support discussions with regulators and commissioning (e.g. NHSE, NHSI, DoH, advocacy groups)

Trust Board 5 December 2018	
Patient Story- JH	Paper No: Attachment Q
Submitted on behalf of Alison Robertson, Chief Nurse	
<p>Aims / summary</p> <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 which are selected to represent a range of experiences across a variety of wards and service areas spanning different directorates and ensuring that the experiences of families are captured.</p> <p>The story to be shared on 5 December 2018 will be in person. The patient (Josephine, now 20 years old) will share her experiences of being a patient at Great Ormond Street Hospital between 2011 and April 2018 when she was discharged.</p> <p>Josephine has been under the care of the Epilepsy department since 2011. Following treatment including a temporal lobe resection in 2017, Josephine has been seizure free and she describes how this has transformed her life. Josephine's story also highlights what was important to her during her care and admissions to GOSH. This includes that:</p> <ul style="list-style-type: none"> • Staff were sensitive to the fact that Josephine was older than most patients and they ensured that she was fully involved in her care and decisions relating to that. • She was able to continue her studies in Health and Social Care due to the Wii-fi (although the connection could be erratic) and the help of the staff. • The presence of the visitor at the entrance of the hospital is welcoming at time that can feel overwhelming and her visitors were able to find her without getting lost around the hospital. 	
Action required from the meeting Review and comment	
<p>Contribution to the delivery of NHS Foundation Trust strategies and plans</p> <ul style="list-style-type: none"> • The Health and Social Care Act 2010 • The NHS Constitution 2010 • The NHS Operating Framework 2012/13 • The NHS Outcomes Framework 2012/13 • Trust Values and Behaviours work • Trust PPIEC strategy • Quality Strategy 	
Financial implications None	
Who needs to be told about any decision? N/a	

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

Claire Williams, Interim Head of Patient Experience and Engagement

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

Claire Williams, Interim Head of Patient Experience and Engagement

Josephine's Story

This story explores Josephine's experiences at GOSH between 2011 and 2018.

Josephine has been under the care of the Epilepsy department since 2011.

Josephine describes how treatment including a temporal lobe resection has left her seizure free which means she is *'embracing life to the fullest'*.

Her story highlights what was important to her during her care and admissions to GOSH.

Josephine was discharged from GOSH in April 2018.

Any questions?

Trust Board 5th December 2018	
Operational plan 2019/20 – planning process and guidance update	Paper No: Attachment S
Submitted by: Peter Hyland, Director of Operational Performance and Information	
Aims / summary The aim of this paper is to update the Board on the planning process for 2019/20. The paper sets out the key actions and timetable that will be followed by the Trust in order to meet our internal requirements for development of a robust business plan, as well as the external requirements set by NHS Improvement. A letter received from NHS Improvement on planning for 2019/20 is included as an appendix.	
Action required from the meeting The Board is asked to note this update on the planning process for 2019/20	
Contribution to the delivery of NHS Foundation Trust strategies and plans This paper provides an update on the process for developing the business plan for 2019/20	
Financial implications The Trust is required to establish a robust financial and operating plan for 2019/20 that ensure it remains safe and sustainable whilst delivering its strategic objectives.	
Who needs to be told about any decision? Peter Hyland, Director of Operational Performance and Information Tom Burton, Deputy Chief Finance Officer	
Who is responsible for implementing the proposals / project and anticipated timescales? Peter Hyland, Director of Operational Performance and Information Tom Burton, Deputy Chief Finance Officer	
Who is accountable for the implementation of the proposal / project? Nicola Grinstead, Deputy Chief Executive Helen Jameson, Chief Finance Officer	

Operational plan 2019/20 – update on planning process and guidance

1. Introduction

The aim of this paper is to update the Board on the planning process for 2019/20.

The paper sets out the key actions and timetable that will be followed by the Trust in order to meet our internal requirements for development of a robust business plan, as well as the external requirements set by NHS Improvement.

2. National process

In June 2018, the Government announced a five-year revenue budget settlement for the NHS from 2019/20 to 2023/24 which represented an annual real-term growth rate over five years of 3.4%. In return for this commitment, the Government has asked the NHS to develop a Long Term Plan, which will cover the 10 year period to 2029. This is due to be published in late November or early December 2018.

NHS England and NHS Improvement have written to all providers to set out the approach that will be taken to operational and strategic planning to ensure organisations can make the necessary preparations for implementing the NHS Long Term Plan.

The full planning guidance has not yet been published and is due early December. The key elements of the planning approach highlighted by NHS England and NHS Improvement at this stage are:

- One year plans for 2019/20 for final submission in April 2019
- Five year system plans to be submitted in Summer 2019
- Continuing focus on alignment of commissioner and provider plans
- Significant changes to the current financial framework
 - Changes to national tariff (including to the market forces factor, price relativities, specialist top ups and national variations to tariff related to urgent and emergency care)
 - A move away from individual Trust control totals in the medium term, with 2019/20 as a transitional year where control totals will still be set
 - Phasing out of the Provider Sustainability Fund and transferring the funding into baseline resources – with the intention to begin this in 2019/20.
 - CQUIN to be significantly reduced in value and simplified

The letter is included in full as an appendix.

3. GOSH process

The following sets out the timetable for the planning process at GOSH, taking into account the external deadlines for submission to NHS England and NHS Improvement (in bold).

November 1st	Launch of planning process through Senior Leadership Team and operational team meetings
End of November	Initial activity projections for 2019/20 submitted for internal review
Early December	Initial budgets issued by Finance
Early December	Outline strategic business plans developed by corporate and clinical directorates
December 14th	Planning event – including presentation of outline plans, structured discussions to align plans between directorates and initial challenge sessions
December 21st	Outline budgets submitted as draft for internal review
Early January	Budget review and challenge meetings
January 14th	Initial plan submission to NHS Improvement (focused on activity and efficiency)
January 31st	Monthly directorate review – review of progress in development of plans and budgets
February 7th	Planning event – market place and challenge sessions
February 12th	Draft 2019/20 operating plan submission to NHS Improvement
February 15 th	Finalised activity plans, reflecting challenges raised
February 22 nd	Finalised budgets, reflecting challenges raised
March 5th	Contract / Plan alignment submission to NHS Improvement
March 21st	Deadline for 2019/20 NHS contract signature
March 22nd	Senior review and finalising of Trust wide plan
April 3 rd	Trust Board review and approval of Trust plan and budgets
April 4th	Final 2019/20 operating plan submitted to NHS Improvement

4. Actions required

The Trust Board is asked to **note** this update on the planning process for 2019/20



To:
CCG AO
Trust CE

CC:
NHS Improvement and England Regional Directors
NHS Improvement and England Regional Finance Directors

**NHS Improvement
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www.improvement.nhs.uk

Publications Gateway Reference 08559

16 October 2018

Approach to planning

The Government has announced a five-year revenue budget settlement for the NHS from 2019/20 to 2023/24 - an annual real-term growth rate over five years of 3.4% - and so we now have enough certainty to develop credible long term plans. In return for this commitment, the Government has asked the NHS to develop a Long Term Plan which will be published in late November or early December 2018.

To secure the best outcomes from this investment, we are overhauling the policy framework for the service. For example, we are conducting a clinically-led review of standards, developing a new financial architecture and a more effective approach to workforce and physical capacity planning. This will equip us to develop plans that also:

- improve productivity and efficiency;
- eliminate provider deficits;
- reduce unwarranted variation in quality of care;
- incentivise systems to work together to redesign patient care;
- improve how we manage demand effectively; and
- make better use of capital investment.

This letter outlines the approach we will take to operational and strategic planning to ensure organisations can make the necessary preparations for implementing the NHS Long Term Plan.

Collectively, we must also deliver safe, high quality care and sector wide financial balance this year. Pre-planning work for 2019/20 is vitally important, but cannot distract from operational and financial delivery in 2018/19.

Planning timetable

We have attached an outline timetable for operational and strategic planning; at a high-level. During the first half of 2019-20 we will expect all Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) to develop and agree their strategic plan for improving quality, achieving sustainable balance and delivering the Long Term Plan. This will give you and your teams sufficient time to consider the outputs of the NHS Long Term Plan in late autumn and the Spending Review 2019 capital settlement; and to engage with patients, the public and local stakeholders before finalising your strategic plans.

Nonetheless, it is a challenging task. We are asking you to tell us, within a set of parameters that we will outline with your help, how you will run your local NHS system using the resources available to you. It will be extremely important that you develop your plans with the proper engagement of all parts of your local systems and that they provide robust and credible solutions for the challenges you will face in caring for your local populations over the next five years. Individual organisations will submit one-year operational plans for 2019/20, which will also be aggregated by STPs and accompanied by a local system operational plan narrative. Organisations, and their boards / governing bodies, will need to ensure that plans are stretching but deliverable and will need to collaborate with local partners to develop well-thought-out risk mitigation strategies. These will also create the year 1 baseline for the system strategic plans, helping forge a strong link between strategic and operational planning. We will also be publishing 5-year commissioner allocations in December 2018, giving systems a high degree of financial certainty on which to plan.

We are currently developing the tools and materials that organisations will need to respond to this, and the timetable sets out when these will be available.

Payment reform

A revised financial framework for the NHS will be set out in the Long Term Plan, with detail in the planning guidance which we will publish in early December 2018. A number of principles underpinning the financial architecture have been agreed to date, and we wanted to take this opportunity to share these with you.

Last week we published a document on [‘NHS payment system reform proposals’](#) which sets out the options we are considering for the 2019/20 National Tariff.

In particular, we are seeking your engagement on proposals to move to a blended payment approach for urgent and emergency care from 2019/20. The revised approach will remove, on a cost neutral basis, two national variations to the tariff: the marginal rate for emergency tariff and the emergency readmissions rule, which will not form part of the new payment model. The document will also ask for your views on other areas, including price relativities, proposed changes to the Market Forces Factor and a proposed approach to resourcing of centralised procurement. As in

previous years, these proposals would change the natural 'default' payment models; local systems can of course continue to evolve their own payment systems faster, by local agreement.

We believe that individual control totals are no longer the best way to manage provider finances. Our medium-term aim is to return to a position where breaking even is the norm for all organisations. This will negate the need for individual control totals and, in turn, will allow us to phase out the provider and commissioner sustainability funds; instead, these funds will be rolled into baseline resources. We intend to begin this process in 2019/20.

However, we will not be able to move completely away from current mechanisms until we can be confident that local systems will deliver financial balance. Therefore, 2019/20 will form a transitional year, in which we will set one year, rebased, control totals. These will be communicated alongside the planning guidance and will take into account the impact of distributional effects from any policy changes agreed post engagement in areas such as price relativities, the Market Forces Factor and national variations to the tariff.

In addition to this, we will start the process of transferring significant resources from the provider sustainability fund into urgent and emergency care prices. The planning guidance will include further details on the provider and commissioner sustainability funds for 2019/20.

Incentives and Sanctions

From 1 April 2019, the current CQUIN scheme will be significantly reduced in value with an offsetting increase in core prices. It will also be simplified, focussing on a small number of indicators aligned to key policy objectives drawn from the emerging Long Term Plan.

The approach to quality premium for 2019/20 is also under review to ensure that it aligns to our strategic priorities; further details will be available in the December 2018 planning guidance.

Alignment of commissioner and provider plans

You have made significant progress this year in improving alignment between commissioner and provider plans in terms of both finance and activity. This has reduced the level of misalignment risk across the NHS. We will need you to do even more in 2019/20 to ensure that plans and contracts within their local systems are both realistic and fully aligned between commissioner and provider; and our new combined regional teams will help you with this. We would urge you to begin thinking through how best to achieve this, particularly in the context of the proposed move to blended payment model for urgent and emergency care.

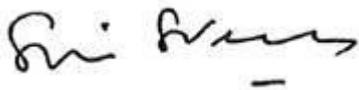
Good governance

We are asking all local systems and organisations to respond to the information set out in this letter with a shared, open-book approach to planning. We expect boards and governing bodies to oversee the development of financial and operational plans, against which they will hold themselves to account for delivery, and which will be a key element of NHS England's and NHS Improvement's performance oversight. Early engagement with board and governing bodies is critical, and we would ask you to ensure that board / governing body timetables allow adequate time for review and sign-off to meet the overall timetable.

The planning guidance, with confirmation of the detailed expectations, will follow in December 2018. In the meantime, commissioners and providers should work together during the autumn on aligned, profiled demand and capacity planning. Please focus, with your local partners, on making rapid progress on detailed, quality impact-assessed efficiency plans. These early actions are essential building blocks for robust planning, and to gauge progress we will be asking for an initial plan submission in mid-January that will be focussed on activity and efficiency (CIP / QIPP) planning with headlines collected for other areas.

Thank you in advance for your work on this.

Yours sincerely



Simon Stevens
Chief Executive
NHS England



Ian Dalton
Chief Executive
NHS Improvement

Annex

Outline timetable for planning	Date
NHS Long Term Plan published	Late November / early December 2018
Publication of 2019/20 operational planning guidance including the revised financial framework	Early December 2018
Operational planning	
Publication of <ul style="list-style-type: none"> • CCG allocations for 5 years • Near final 2019/20 prices • Technical guidance and templates • 2019/20 standard contract consultation and dispute resolution guidance • 2019/20 CQUIN guidance • Control totals for 2019/20 	Mid December 2018
2019/20 Initial plan submission – activity and efficiency focussed with headlines in other areas	14 January 2019
2019/20 National Tariff section 118 consultation starts	17 January 2019
Draft 2019/20 organisation operating plans	12 February 2019
Aggregate system 2019/20 operating plan submissions and system operational plan narrative	19 February 2019
2019/20 NHS standard contract published	22 February 2019
2019/20 contract / plan alignment submission	5 March 2019
2019/20 national tariff published	11 March 2019
Deadline for 2019/20 contract signature	21 March 2019
Organisation Board / Governing body approval of 2019/20 budgets	By 29 March
Final 2019/20 organisation operating plan submission	4 April 2019
Aggregated 2019/20 system operating plan submissions and system operational plan narrative	11 April 2019
Strategic planning	
Capital funding announcements	Spending Review 2019
Systems to submit 5-year plans signed off by all organisations	Summer 2019

Trust Board 5th December 2018	
Quality Update	Paper No: Attachment T
Submitted by: Salina Parkyn, Head of Quality and Safety Matthew Shaw, Medical Director Alison Robinson, Chief Nurse	
Aims / summary This is an update paper further to the Quarterly Integrated Quality Report updating the Board on: <ul style="list-style-type: none"> • Themes identified through FFT, Complaints, PALS and Incidents. • External Investigations • A selected Quality Improvement project This paper covers the reporting period of October 2018. The IQR report submitted to QSAC covering July-September 2018 has also been included for information.	
Action 57.13 (July 2018): It was agreed that summaries of individual complaints would be included in future complaints reports. Action Update: a summary of all complaints closed in October 2018 and the associated outcomes/learning has been included in the report for discussion; this can be viewed on pages 14-15 of the report.	
A meeting has been scheduled to discuss the IQR going forwards and to establish whether the reporting style, format and content are fit for purpose. The meeting will review similar reports from other Trusts to learn from reporting styles and to ensure that the report is useful to the Board. The report template will be amended in 2019 following these discussions.	
Action required from the meeting The board is asked to note the report.	
Contribution to the delivery of NHS Foundation Trust strategies and plans The work presented in this report contributes to the Trust's objectives.	
Financial implications None	
Who needs to be told about any decision? Head of Quality and Safety	
Who is responsible for implementing the proposals / project and anticipated timescales? Head of Quality and Safety	
Who is accountable for the implementation of the proposal / project? Medical Director and Chief Nurse	



Integrated Quality Report

Mr Matthew Shaw, Medical Director

Alison Robertson, Chief Nurse

October 2018

(covering July - September 2018)

Safety

Has patient care been safe in the past? Measures where we have no concerns	Page 3-9
Has patient care been safe in the past? Learning from closed serious incidents and never events	Page 10-17

Care/ Experience

Are we responding and improving? Patient and family feedback; open red complaints	Page 18
Are we responding and improving? Patient and family feedback; learning from closed red complaints	Page 19
Are we responding and improving? PALS data	Page 20-23
Are we responding and improving? Learning from friends and family test data- inpatient data	Page 24
Are we responding and improving? Learning from friends and family test data- outpatient data	Page 25
Are we responding and improving? Friends and family test updates/ benchmarking	Page 26
Are we responding and improving? Friends and family test positive feedback	Page 27
Are we responding and improving? Friends and family test- 'you said', we did	Page 28

Outcomes/ Effectiveness

Are we responding and improving? Featured project; Lab Samples Project	Page 29
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Improvement

Are we responding and improving? Quality improvement project updates (with Executive sponsorship)	Page 30-31
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Has patient care been safe in the past?

Measures – summary

This slide contains an overview of some of the key measures monitored within the Trust; these will be considered by exception. Where there are measures/trends of concern, a slide containing a deep dive of that information will be included in the report.

Measures for self reporting systems do not always have a direct correlation between the data and safety; e.g. an increase in reporting may not always be a result of an unsafe environment but instead as a result of a good reporting culture which in turn can improve safety via learning.

Please see appendix 1 for the methodology used for the measures below.

Measure	Comment
<p>Non-2222 patients transferred to ICU by CSPs**</p> <p>** patients should be transferred to ICU before they have an arrest where possible which would indicate the early identification of a deterioration prior to an arrest.</p>	<p>From September to April 2018 there was a statistically significant increase – a run of 8 consecutive months above the previous process mean. This increase did not sustain and the current mean is still 7.1 transfers per month. In July 2018 there were 6 unplanned ICU transfers, in August 2018 there were 16 (an outlier – being investigated by the resus team) and in September 2018 there were 8.</p>
<p>Cardiac arrests**</p>	<p>Overall, the data remains stable for this measure at 1.4 cardiac arrests per month; this has remained stable since 2015 with the exception of one outlier in January 2017. The Trust had zero cardiac arrests from March 18 to May 18, however there were 2 recorded in June (both in theatres). There were 2 cardiac arrests in July 2018 (one on Leopard, one on Chameleon), 2 in August 2018 (one on Chameleon and one on XMRI) and 0 in September 2018. Although the count of cardiac arrests remains stable, there has been a statistically significant reduction in the number of cardiac arrests outside ICU per 1000 bed days (see further slides for details).</p>
<p>Respiratory arrests**</p> <p>**The figures within the Integrated Quality Report includes arrests within all areas outside of ICUs (including day case Wards, day units, outpatient areas and non-clinical areas e.g. main reception) whilst the Safe Staffing Report arrest data only refers to arrests on in-patient Wards. The data will therefore differ between the two reports as the Integrated Quality Report includes additional areas.</p>	<p>The data remains stable for this measure at 2.67 respiratory arrests per month; this has remained stable since June 2015 (when there was a decrease) with the exception of an outlier in November 2015 and August 2017 (both high). The most recent 3 months indicate no change – there were 4 respiratory arrests outside ICU in July, 3 in August and 0 in September 2018.</p>

Has patient care been safe in the past?

Measures – summary

This slide contains an overview of some of the key measures monitored within the Trust; these will be considered by exception. Where there are measures/trends of concern, a slide containing a deep dive of that information will be included in the report.

Measures for self reporting systems do not always have a direct correlation between the data and safety; e.g. an increase in reporting may not always be a result of an unsafe environment but instead as a result of a good reporting culture which in turn can improve safety via learning.

Please see appendix 1 for the methodology used for the measures below.

Measure	Comment
Never Events	The last Never Event was on 23 rd March 2018, meaning there have been no never events in the previous two quarters. The mean time between never events is unchanged at 220 days, with the baseline for this data taken from 2010 until 2014. The Never Event declared in March 2018 was for retained foreign object while the previous never event in October 2017 was for wrong site surgery.
Serious Incidents** **by date of incident not declaration of SI	There has been a recently identified increase in the monthly number of serious incidents (Sis). From February 2018 to September 2018 the mean is 2.50 SIs per month, an increase on the previous monthly mean of 0.76 per month (based on a baseline between September 2016 and January 2018, which was a statistically significant reduction compared to the previous mean). There were 3 Sis reported in July, 3 in August and 2 in September 2018. The increase is yet to be sustained.
Mortality	<p>There has been a recently identified decrease (improvement) in the monthly inpatient mortality rate per 1000 discharges. The previous baseline mean of 6.3 inpatient deaths per 1000 discharges remained stable up to and including November 2017. However, from December 2017 there has been a run of points below the mean and therefore a statistically significant reduction – the current rate is 4.8 inpatient deaths per 1000 discharges. This improvement is yet to be sustained. The figures for July, August and September 2018 were 4.99, 5.07 and 4.92 inpatients deaths per 1000 discharges, respectively.</p> <p>Over 80% of GOSH inpatient deaths are on ICU, and ICU deaths must be risk adjusted to properly determine a trend. Raw survival/mortality rates do not take account of severity of illness and case mix so outcome data needs to be adjusted to take these factors into account. All ICU data is submitted, after risk adjustment, to the national Paediatric Intensive Care Audit Network (PICANET). This process will allow any trends or outlier performance to be determined. Internal monitoring of Variable Life Adjusted Plots (VLAD) from January – June 2017 showed an increase in the number of deaths on PICU compared to expected. A comprehensive internal review of cases did not suggest any obvious patterns or concerns about the quality of care in PICU/NICU, and no single cause that could explain the trend. GOSH has been informed by PICANET it will not be a statistical outlier for 2017 and the full PICANET data for the calendar year 2017 is due to be published on 31 March 2018. The most recent VLAD data suggests that the negative trend has not continued.</p>

Has patient care been safe in the past?

Measures – summary

This slide contains an overview of some of the key measures monitored within the Trust; these will be considered by exception. Where there are measures/trends of concern, a slide containing a deep dive of that information will be included in the report.

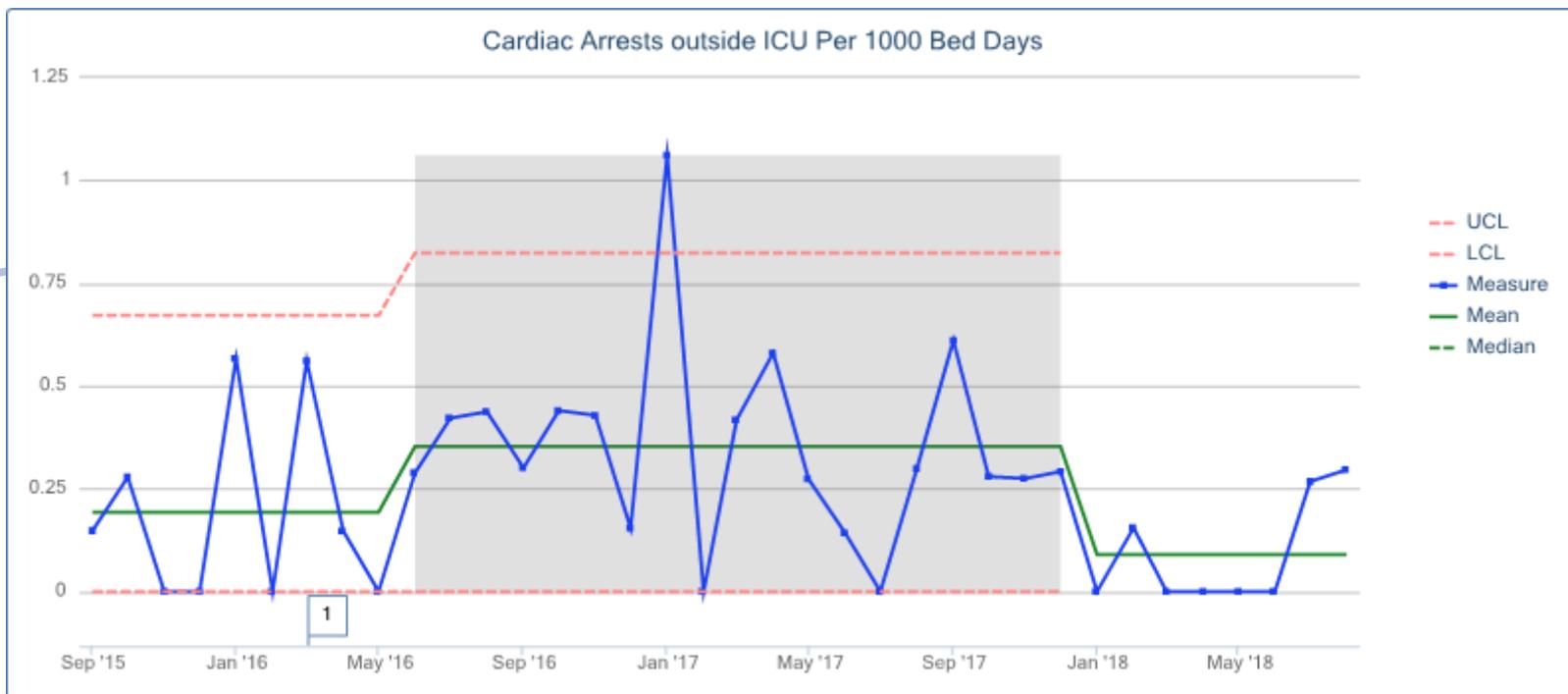
Measures for self reporting systems do not always have a direct correlation between the data and safety; e.g. an increase in reporting may not always be a result of an unsafe environment but instead as a result of a good reporting culture which in turn can improve safety via learning.

Please see appendix 1 for the methodology used for the measures below.

Measure	Comment		
Hospital acquired pressure ulcers reported (category 2+)	There has been a recently identified statistically significant reduction in the number of hospital acquired pressure ulcers reported. Starting in March 2017 (identified in August 2018 as 14 of 17 consecutive points were below the previous baseline mean), there was a reduction from 6.67 per month to 5.06 per month – this has been sustained. The figures for July, August and September 2018 are as below:		
	July 2018	August 2018	September 2018
Category 2 hospital acquired pressure ulcers	5	12	7
Category 3 hospital acquired pressure ulcers	1	0	0
Category 4 hospital acquired pressure ulcers	0	0	0
GOSH-acquired CVL infections	We have identified a reduction in the measure of CVL infections per 1000 line days. This reduction started in January 2017 and has been sustained – the current baseline mean from January 2017 to January 2018 shows a rate of 1.38 CVL infections per 1000 line days, compared to a previous mean of 1.78 CVL infections per 1000 line days. Since this reduction, the CVL infection rate per 1000 line days has remained stable and within normal variation, with 2.23, 0.81 and 1.27 CVL infections per 1000 line days recorded in June, July and August 2018 respectively.		
	September data not yet available – this data must be validated before publication as is the norm.		
The number of PALS cases	The number of PALS cases reported per month remains stable, with an average of 145. Since the outliers in summer 2017 (June and July), the process is currently in normal variation; there have been no runs, trends or recent outliers identified. There were 129 cases in July 2018, 136 cases in August and 100 cases in September 2018 – these are all within expected limits based on previous baseline data.		

Has patient care been safe in the past?

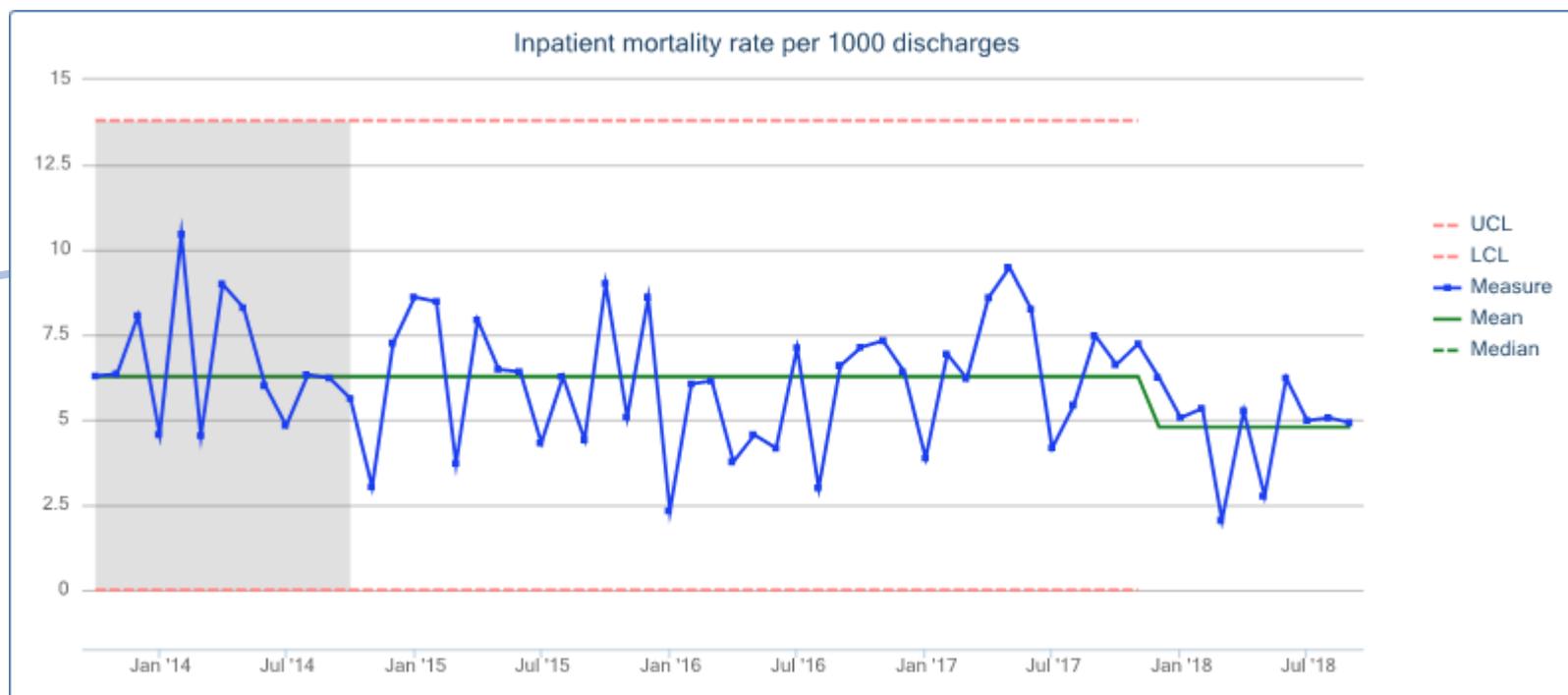
Measures – highlights/exception



Measure	Comments
Cardiac arrests outside ICU per 1000 bed days**	There has been a recently identified statistically significant reduction in the number of cardiac arrests outside ICU per 1000 bed days. The current mean is 0.09 cardiac arrests per 1000 bed days, a reduction on the previous mean of 0.35 per 1000 bed days, which was taken from a baseline period between June 2016 and December 2017. The current improvement is yet to be sustained but is a significant improvement.

Has patient care been safe in the past?

Measures – highlights/exception



Measure	Comments
Mortality	There has been a recently identified decrease (improvement) in the monthly inpatient mortality rate per 1000 discharges. The previous baseline mean of 6.3 inpatient deaths per 1000 discharges remained stable up to and including November 2017. However, from December 2017 there has been a run of points below the mean and therefore a statistically significant reduction – the current rate is 4.8 inpatient deaths per 1000 discharges. This improvement is yet to be sustained. The figures for July, August and September 2018 were 4.99, 5.07 and 4.92 inpatients deaths per 1000 discharges, respectively.

Has patient care been safe in the past?

Measures – highlights/exception

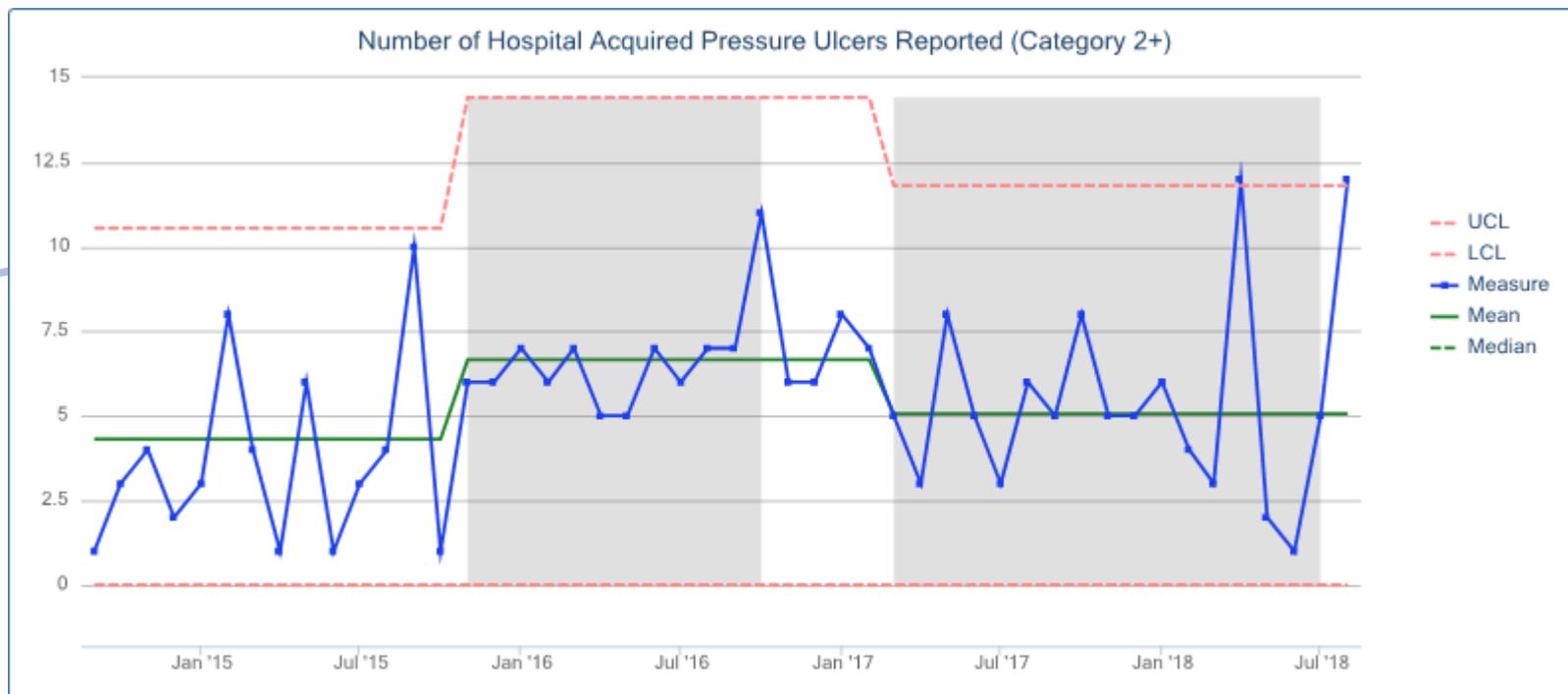
NHS Foundation Trust



Measure	Comments
<p>Serious Incidents**</p> <p>**by date of incident not declaration of SI</p>	<p>There has been a recently identified increase in the monthly number of serious incidents (Sis). From February 2018 to September 2018 the mean is 2.50 SIs per month, an increase on the previous monthly mean of 0.76 per month (based on a baseline between September 2016 and January 2018, which was a statistically significant reduction compared to the previous mean). There were 3 SIs reported in July, 3 in August and 2 in September 2018. The increase is yet to be sustained.</p>

Has patient care been safe in the past?

Measures – highlights/exception



Measure	Comments
Hospital acquired pressure ulcers reported (category 2+)	There has been a recently identified statistically significant reduction in the number of hospital acquired pressure ulcers reported. Starting in March 2017 (identified in August 2018 as 14 of 17 consecutive points were below the previous baseline mean), there was a reduction from 6.67 per month to 5.06 per month – this has been sustained. There were 5 category 2+ pressure ulcers in July, 12 in August (which is now an outlier based on the recently improved process mean and control limits) and 7 in September 2018.

Has patient care been safe in the past?

Learning from closed Serious Incidents and Never Events

Serious Incidents and Never Events July - September 2018

No of new SIs declared in July - September 2018:	10	No of new Never Events declared in July - September 2018:	0
No of closed SIs/ Never Events in July - September 2018:	7	No of de-escalated SIs/Never Events in July - September 2018:	0

SIs/Never Events declared in July – September 2018 (10)

STEIS Ref	Incident Date	Date Report Due	Description of Incident	Divisions Involved	Senior Responsible Officer (SRO)	Patient Safety Manager	Executive Sign Off	Divisional Contact
2018/16218	22/04/18	25/09/18	Grade 3 pressure ulcer (left nostril) on PICU	JM Barrie	AMD	Lead Patient Safety Manager	Chief Nurse	Matron
2018/17361	01/07/18	05/10/18	Medication error contributing to patient deterioration	Barrie	AMD	Patient Safety Manager	Medical Director	Divisional Co-chair
2018/17361	01/07/18	09/10/18	Patient on Berlin Heart. Anticoagulation plan being followed but INR high (Risk of bleeding). Patient suffered a cerebral bleed.	Charles West	AMD	Lead Patient Safety Manager	Medical Director	Divisional Co-chair
2018/17571	03/07/18	11/10/18	Missing CDs	Charles West	AMD	Patient Safety Manager	Medical Director	Divisional Co-chair
2018/17965	20/06/18	16/10/18	National New born Screening incident. Delay in potential diagnosis of cystic fibrosis	Charles West	AMD	Patient Safety Manager	Medical Director	Divisional Co-chair
2018/21643	16/08/18	28/11/18	Power Outage	Trust Wide	Director of Finance	Fire, Health and Safety Advisor	Medical Director	Director of Estates and Facilities
2018/21816	17/08/18	30/11/18	Overdose of GTN administered to a patient	Charles West	AMD	Patient Safety Manager	Medical Director	Medical Director
2018/22439	16/08/18	12/12/18	Significant delay in providing treatment to patients due to delay in releasing clinical assessment findings and treatment advice to local clinical team.	JM Barrie	AMD	Patient Safety Manager	Medical Director	Divisional chair
2018/22597	13/09/18	11/12/18	Information Governance Breach - SAR Request sent which included names and clinical information regarding other patients	Charles West	AMD	Patient Safety Manager	Medical Director	Service Manager for Medical Records
2018/23119	21/09/18	18/12/18	HR-disclosure Information Governance Breach	HR	AMD	Patient Safety Manager	Medical Director	Employee Relations and Deputy Director of HR

Has patient care been safe in the past?

Learning from closed Serious Incidents and Never Events

Learning from closed/de-escalated SIs/Never Events in July – September 2018 (7):

Ref:	Summary:	Root Cause:	Action to Remedy Root Cause:	Trust Wide Learning:
2017/20094	<p>The patient (who had scoliosis) attended for a day case MRI scan under anaesthetic as part of pre-operative spinal investigations. The following day his mother noticed that his lower limb function had changed- he had had a weakness prior to the scan (which was one of the reasons the MRI scan was ordered) but was now unable to move his legs at all. When assessed clinically it was suspected the patient had suffered a spinal cord injury.</p> <p>The Trust carried out an initial internal review and recommended that an external independent review of the patient's care was sought in order to help identify all appropriate causation and learning. The teams at GOSH have considerable experience in managing children with scoliosis but they have not known such a devastating cord injury to have occurred in this way previously.</p>	<p>The external reviewer concluded that it is possible to say definitively how the acute deterioration occurred, but has suggested several possible factors that may have contributed to the injury / hypotheses as to how the injury occurred:</p> <p>a) Blood supply to the cord may have affected from the previous surgery or the patient's pre-existing abnormal vasculature with regard to the coarctation of the aorta.</p> <p>b) Pressure over the apex of the kyphus or the positioning in the scan may have contributed to the problem of cord dysfunction. The patient is noted to have thin soft tissue coverage over the area. The reviewer has stated that he is not aware of such an injury having occurred in this way before but has had patients with thin coverage over the cord who have experienced neurological symptoms with light pressure on the skin</p> <p>c) The relative hypotension during anaesthesia may have also contributed to an acute vascular event in an already compromised cord</p> <p>d) The cord was already starting to fail and the acute change may have happened at some point even without the MRI scan (although the reviewer suspects it did have some influence in the acute presentation).</p> <p>The reviewer has concluded that there was no standard care in the patient's management but has identified several learning points for the Trust to consider</p>	<p>A review should be carried out of the admission process for spinal patients being admitted for day case MRI scans under anaesthetic. This should include the need for a detailed physical assessment and history taking at the clerking stage.</p> <p>A process will be developed by which the spinal surgery team assess and identify patients who may have an 'at risk' spinal cord.</p> <p>Any patients who are identified as having an 'at risk' cord should have regular neurological function assessments using the ASIA score (a tool developed by the American Spinal Injury Association for the essential minimal elements of neurological assessment)</p> <p>A process will be developed by which for patients deemed to be at risk, there is communication regarding this risk by the referring surgeon to the radiology and anaesthetic teams where a patient is booked in for an MRI scan (or where referred for another investigation/procedure, the relevant team is notified). This will facilitate appropriate planning of the investigation/ procedure to ensure that the risk to the patient's vulnerable cord is best managed. As recommended by NHS England this will include consideration of relative hypotension as a potential contributory factor</p> <p>Action: Head of Clinical Service for Spinal Surgery will write and implement a protocol that will cover all recommendations .</p>	<p>Both the Trust review and external review have concluded that this was an extremely rare outcome, and with the evidence available at the time, could not have been predicted by the team caring for this patient. The event has led the Trust to consider whether this type of injury could be avoided in the future for other patients with a clearer process of identifying and managing patients who might be deemed to have a vulnerable cord.</p>

Has patient care been safe in the past?

Learning from closed Serious Incidents and Never Events

Learning from closed/de-escalated SIs/Never Events in July – September 2018 (7):

Ref:	Summary:	Root Cause:	Action to Remedy Root Cause:	Trust Wide Learning:
2018/7762	<p>A swab was retained in the patient's abdomen during surgery to repair a bowel perforation.</p> <p>The patient required another operation under general anaesthetic to remove the swab when it was identified 3 days later but recovered well from a surgical perspective.</p> <p>The investigation has not been able to identify with certainty why the surgical count process did not highlight that a swab had not been returned to the scrub team. There were no concerns at the time of surgery and the counts were thought to be correct; the staff present cannot recall any significant or untoward events or factors that may have contributed to this error.</p>	<p>The final count, and possibly the first closure count, completed by two experienced scrub nurses did not identify that there was a missing swab and it was retained in the patient's abdomen.</p>	<p>Introduce consolidation count for all invasive procedures .</p> <ul style="list-style-type: none"> a) Teaching to be arranged for all theatre staff. b) Surgical Count Policy to be amended. <p>Ensure that all theatre staff carry out their counts in the same way and that care plans are completed appropriately to reflect the counts that have been performed.</p> <ul style="list-style-type: none"> a) Teaching to be arranged for all theatre staff. b) Surgical Count Policy to be amended. <p>Ensure that the 'count' is a protected part of the procedure in the same that for example the 'time out' part of the WHO checklist is. All staff present in theatre should be aware that the count is being carried out and there should be no unnecessary talking, interruptions etc (unless needed for patient care)</p> <ul style="list-style-type: none"> a) Amend the Surgical Count policy to reflect this. b) Teaching to be arranged for all theatre staff. c) Medical Director to send communication to all Surgical Consultants asking for this learning to be cascaded to their teams All theatre staff to complete NatSSIPs eLearning. <p>Reinforce behaviours in the operating theatres that minimise potential for distraction to all members of staff- for example if a member of staff needs to enter the theatre during a case to speak to one of the operating team, they must be able to ascertain that they will not be interrupting a surgeon during a critical point in the surgery, or the scrub staff during their count. ('do and don't/ theatre 'etiquette' list)</p> <ul style="list-style-type: none"> a) Refresher sessions on theatre etiquette. <p>Audit to be completed to ensure there is review of whether behaviours in the operating theatre minimise potential for distraction for all members of staff, and whether the count is protected.</p> <ul style="list-style-type: none"> a) Matron for Theatres to identify lead to work with Clinical Audit Manager to carry out this audit. 	None identified.

Has patient care been safe in the past?

Learning from closed Serious Incidents and Never Events

Learning from closed/de-escalated SIs/Never Events in July – September 2018 (7):

Ref:	Summary:	Root Cause:	Action to Remedy Root Cause:	Trust Wide Learning:
2018/10352	<p>The patient was admitted for elective craniofacial surgery which involved taking a rib cartilage graft and post operatively developed a haemothorax (a collection of blood in the pleural space). This was not identified prior to discharge and the patient presented to his local GP with increasing dyspnoea, fevers and night sweats on 10th April. He was transferred to his local hospital where the haemothorax was diagnosed.</p> <p>The investigating team did not find that there is evidence that the patient had signs of a significant haemothorax on discharge or that the teams should have taken any additional actions. From the history provided it appears that the patient became increasingly unwell following discharge. However the investigation identified several learning points around communication .</p>	<p>The patient developed a haemothorax following elective surgery which involved the known complication of a pleural breach. It is not possible to say with certainty at which point the bleeding started.</p>	<p>Operation notes should only be written by a member of the surgical team who has been present for the whole procedure, and should be checked by the Lead Surgeon when written by another member of the team.</p> <p>a) Medical Director to remind all Consultant surgeons of this and ask that they disseminate to their teams</p> <p>Documentation of medical reviews must reflect the full assessment and physical assessment that has been carried out.</p> <p>a) Structured ward round and documentation of this will be included in the Trust's roll out of electronic records (EPIC)</p> <p>All clinical staff should be reminded of the importance of handing over information regarding events that may have happened out of hours to the home team/ reviewing previous medical entries and observations.</p> <p>a) Item regarding this to be added to the Patient Safety Outcomes Committee. b) Divisional management staff will be asked to communicate this to their teams following discussion at PSOC.</p>	<p>Any significant events related to patient care that occur 'out of hours' should be handed over to the home team as soon as possible in working hours</p>

Has patient care been safe in the past?

Learning from closed Serious Incidents and Never Events

Learning from closed/de-escalated SIs/Never Events in July – September 2018 (7):

Ref:	Summary:	Root Cause:	Action to Remedy Root Cause:	Trust Wide Learning:
2018/10554	<p>The patient had an unwitnessed fall from his bed after which he was assessed as clinically stable. It was assessed however that it would be safest to nurse the patient on the floor, but his parents were not in agreement with this. The patient sustained a second fall 3 days later after which he had a brief period of unconsciousness. A CT scan was performed which was normal. It was requested again that the patient was nursed on the floor. Later that day the patient clinically deteriorated and experienced a prolonged seizure. He was transferred to the PICU.</p>	<p>The current documentation to undertake moving and handling risk assessment (combined mandatory risk assessment) is not fit for purpose and does not support adequate risk assessment to establish a patient's risk of falls and requires experts to assist in the decision making. Neither is there a suitable training programme to develop the expertise and confidence to assess and manage patients at risk of falls or higher moving and handling risk. It remains unclear whether the fall triggered the deterioration and the cause of the seizure. The patient had not had any recent seizures so it was unlikely that the fall was due to underlying disease as surgery had been successful and hemiparesis was improving. It was considered whether there was a new infection brewing as the patient had a raised white cell count so antibiotics were started but there was no other evidence to suggest this. Also concussion post fall or a new intracranial bleed following the fall is a possibility but the head scans showed no acute changes. One final explanation is hyponatraemia as the patient was prone to plasma sodium abnormalities.</p>	<p>All Combined Mandatory Risk Assessments must be completed on admission and updated as per the Moving and Handling Policy and the Falls Policy.</p> <p>a) Review and update combined mandatory risk assessment in line with NHSE changes and update any associated policies. Submit updated risk assessment to nursing board and associated policies to Policy Approval Group. Review and update teaching package. Discuss at sisters/charge nurse forum Launch and audit.</p> <p>Following a fall where a head injury has occurred or cannot be excluded, observations and neurological observation must be undertaken as per the Falls Policy and recorded on nervecentre.</p> <p>a) Online PEWS Training, Online Nervecentre Training, PEWS included in Trust Inductions, Neurological observation training, access to nervecentre is not granted until training is complete.</p> <p>Ensure that all patients are nursed on appropriate bed.</p> <p>a) Meeting to be convened to review current bed provision – availability, and develop a system that allocates specialist equipment including box beds based on patient needs as opposed to the current first come first served basis.</p> <p>Manual Handling should provide patient review and plan of care for individual patients at risk of falls</p> <p>a) Ensure Manual Handling training posts x 2 are recruited to. Monitor manual handling training compliance for all staff.</p> <p>Parental refusal of alternative bed options</p> <p>a) Admission talk, Arrange simulation training, ward teaching and bitesize teaching sessions.</p> <p>Flag any patients of concern including 'watchers'</p> <p>a) Patients with watcher status should be flagged at handover or the safety huddle and the PSAG board and nervecentre must be updated .</p>	<p>Ensure risk assessment is used effectively and acted upon for patients at risk of falls.</p>

Has patient care been safe in the past?

Learning from closed Serious Incidents and Never Events

Learning from closed/de-escalated SIs/Never Events in July – September 2018 (7):

Ref:	Summary:	Root Cause:	Action to Remedy Root Cause:	Trust Wide Learning:
2018/11435	<p>A patient attended GOSH in October 2016 for emergency urological surgery, reduction of a prolapsed bladder and soft tissue reconstruction of the pelvis. Immediately prior to surgery an x-ray of the patient's pelvis was undertaken. The purpose of this x-ray was to clarify the defect in the patient's pelvic bones and the x-ray was reviewed by the urology consultant. The x-ray also showed an incidental finding of a dislocated hip on the patient's left side which was not noticed by the urology consultant. The pelvic x-ray was formally reported by the radiology team the following day. The formal written report issued by the reporting radiologist confirmed the presence of symphysis diastasis (which the urology consultant had been looking for and noted) but also the presence of a dislocated hip, an unexpected finding. The findings on this x-ray were not telephoned through to the urology consultant. An automated email containing these results was sent to her in November 2016. The results in the email were not noticed by the urology consultant and, after an inpatient stay, the patient was discharged. The patient continued to recover at home and started to walk. In March 2018 the patient attended the urology consultant's outpatient clinic for a follow up appointment. The urology consultant then observed the patient's unusual gait and saw that she appeared to have a dislocated left hip. The urology consultant re-reviewed the patient's previous images and realised that this had been diagnosed in October 2016.</p>	<p>The process for communication of an unexpected finding to the clinical team failed in this incident. Whilst the images were sent to the consultant who reviewed them and the radiology report confirming the hip dislocation was also emailed to her this failure still occurred. This was due to a failure to red flag an unexpected radiological finding and confirm that this had been received by the consultant leading on the patient's care.</p>	<p>Unexpected findings on x-ray images for all modalities need to be communicated to the clinical team in a way that ensures that they are received, enabling them to be acted upon by the clinical team.</p> <ol style="list-style-type: none"> A 'red flag' system for unexpected clinical findings to be implemented using the PACS system. This will mean that a radiology report identified as a 'priority report' will be sent to a consultant in a separate, standalone email with a subject header highlighting that this report contains an unexpected finding. Audit to be undertaken with the trust clinical audit team to monitor the frequency of emails and follow-up they receive.. The 'Requesting and reporting of radiology investigations and procedures' SOP to be updated to include a more prescriptive criteria of when an unexpected or emergency finding should be phoned through to the clinical team. In the long term, the implementation of clinical system, EPIC will enable to trust to 'red light' imaging results as well as monitor whether a scan result has been opened by the clinical team. Epic will also enable imaging results to be sent to several members of a clinical team and not only one clinician. <p>Consultant clinicians must be provided with an appropriate allocation of administrative time in conjunction with the time they are working clinically.</p> <ol style="list-style-type: none"> Review of consultant job planning to be undertaken by the executive team at GOSH. <p>Telephone messages left by a patient or their family must be responded to by an appropriate member of either the clinical or management team.</p> <ol style="list-style-type: none"> Process for responding to patient telephone calls to be implemented amongst the administrative teams <p>This event was not reported as an incident by staff via the online incident reporting system, Datix. Review of education and training for incident reporting should be undertaken.</p> <ol style="list-style-type: none"> All staff are provided with education at trust induction. 'How to report an incident' training to be implemented and training to be led by the Patient Safety Team 	<p>The communication of examinations and diagnostic test results must be communicated to the clinical team effectively. Unexpected findings require an additional flag to clinical teams.</p>

Has patient care been safe in the past?

Learning from closed Serious Incidents and Never Events

Learning from closed/de-escalated SIs/Never Events in July – September 2018 (7):

Ref:	Summary:	Root Cause:	Action to Remedy Root Cause:	Trust Wide Learning:
2018/11637	In May 2018 an immunology research fellow was preparing for a meeting with the GOSH immunology consultant. The research fellow was aware the consultant had limited access to her GOSH email whilst at her office in ICH, so to ensure a spreadsheet would be received, the research fellow copied the email to what they thought was the immunology consultant's gmail account. The consultant was able to access her GOSH email via remote access on an iPad, and then realised the gmail address in the CC list was incorrect.	Whilst the root cause of this incident can be identified as human error, where a member of staff entered an email address incorrectly resulting in sending patient identifiable information to an unknown recipient, the processes surrounding this occurrence are more complex. The immunology research fellow had been working in an environment where they had been copied in to a lengthy email trail using unsecure email addresses, including the GOSH immunology consultants gmail address. The data had also been sent through to her unsecurely from the SCETIDE registry. The immunology research fellow had also been so concerned regarding submission to the registry that she had wanted to ensure the GOSH immunology consultant received the spreadsheet so she was able to review which data was missing. Given the barriers for ICH staff accessing GOSH emails, she copied the email to the GOSH immunology consultant's personal gmail address. She had also communicated with the GOSH immunology consultant's gmail account previously and felt that this was acceptable.	<p>Submission of any research data to a registry should be undertaken according to the information sharing agreements and secure portals where possible. All information should be anonymised according to these agreements but, in the case of long term outcome measures it must be possible to link back to a patient where necessary.</p> <p>a) Continue to submit data to the SCETIDE and EBMT secure portals as introduced by those registries. Surgical Count Policy to be amended.</p> <p>There is a need for a secure and robust system of communication between medical, clinical and academic staff nationally and internationally.</p> <p>a) GOSH to offer and supply encrypted devices which allows clinicians to access their GOSH emails remotely, even when working at ICH.</p> <p>b) Incident to be reported to ICH and discussion to be held with their ICT and information governance team with regards to future ICT arrangements.</p> <p>c) GOSH ICT to investigate the implementation of a more secure email system to enable staff from different organisations to communicate via email securely.</p> <p>An organisational review of email communication by clinical staff undertaking research is necessary to understand the extent of the challenges faced by research clinicians trust wide.</p> <p>a) Trust clinical research leads will coordinate a project to determine: 1. How many researchers have multiple email addresses for work; 2. What steps they have taken for data confidentiality. This information will be reported back to the Electronic Patient Records, IT and Information Governance teams and will inform their strategic plans on staff email communication. The scoping project will be introduced with an email to relevant clinicians reiterating the appropriate use of the multiple email accounts staff use, At the end of the project the staff will be send a summary of the results, with guidance on safe, effective email communication.</p> <p>Staff must be made aware of how to send data in a secure form by email including how to encrypt or password protect attachments if necessary.</p> <p>a) Guidance regarding how to send information securely from a GOSH email account to be disseminated to staff. This should include how to password protect attachments and how to securely send password information.</p> <p>b) Guidance regarding safe transfer of information to be included in email policy for the trust</p> <p>c) Learning from information governance breaches made using email to be disseminated trust wide via a member of the executive team.</p> <p>d) Training slide regarding safe transfer of information by email to be included in mandatory Information Governance training at GOSH.</p> <p>e) Module regarding safe data transfer to be included Good Clinical Practice 'GCP' training as part of a mandatory research course. This will be attended by all staff undertaking a clinical research project</p> <p>Staff must be made aware of their responsibilities regarding information sharing and information governance.</p> <p>a) Mandatory annual information governance training to continue to be implemented as a requirement for all GOSH staff to complete.</p> <p>b) Ensure that staff are aware of any relevant changes as a result of GDPR.</p>	Safe transfer of information should always be paramount when sending data between different sites. Consideration should be given to whether information requires encryption, the email addresses used are secure according to the sensitivity level of patient data being sent. Whilst consideration of these factors should be carried out by staff, they must also be given the tools to transfer information securely.

Has patient care been safe in the past?

Learning from closed Serious Incidents and Never Events

Learning from closed/de-escalated SIs/Never Events in July – September 2018 (7):

Ref:	Summary:	Root Cause:	Action to Remedy Root Cause:	Trust Wide Learning:
2018/11980	The patient was being cared for on the Cardiac Intensive Care Unit post operatively and developed a grade 3 Pressure Ulcer.	If the combined mandatory risk assessment (pre-operative skin assessment) had been carried out on admission the correct bed could have been ordered in advance of the procedure for the patient to be nursed on post operatively. This may have avoided the development of the pressure ulcer. The patient also needed to be turned regularly and frequency would be dependent on GS regardless of the bed/mattress.	<p>Ensure that all patients are nursed on appropriate bed</p> <p>a) Meeting to be convened to review current bed and mattress provision – availability, access to specialist equipment, repair, maintenance, replacement. Contract supervision for maintenance of beds.</p> <p>Ensure skin assessments and nutritional assessments (combined mandatory risk assessment) take place within 6 hours of admission and are clearly documented in the medical notes</p> <p>a) Review and update combined mandatory risk assessment in line with NHSE changes and update any associated policies. Add section to document previous pressure areas Staff to document GS once per shift where PU already identified. Submit updated risk assessment to nursing board and associated policies to Policy Approval Group. Review and update teaching package. Discuss at sisters/charge nurse forum. Launch and audit.</p> <p>Further training for staff on Pressure Ulcer Prevention and maintaining skin integrity</p> <p>a) Review core training material and adapt for CICU specific patients. Progress offer by CICU matron to establish 0.5 WTE TVN post for cardiac wards. Review GOSH TVN capacity and demand and make recommendations for future investment.</p> <p>Staff to be familiar with all equipment to avoid pressure ulcers and frequency of turns.</p> <p>a) Monitor manual handling training compliance. Ensure X 2 Manual Handling training posts are recruited to.</p> <p>Staff training on types of beds and new beds for different patient weights.</p> <p>a) Staff to have familiarisation sessions with types of beds and mattresses available and which patients they are suitable for.</p> <p>Highlight importance of accurate documentation in Carevue e.g. site where aderma applied, turns etc.</p> <p>a) Ensure lessons are learned from this investigation in terms of the importance of good standards for nursing documentation through education sessions..</p> <p>Ensure patients with LD have LD involvement and hospital passport updated if required.</p> <p>a) Ensure staff are aware of LD team and support available and how to make any necessary referrals. SOP/flowchart to be developed. Work with Electronic Patient Record Team to ensure staff can make referrals to the team via the EPIC system.</p> <p>Ensure documentation in theatre of any pressure areas pre (from pre op checklist) and post operatively and effective handover is carried out post operatively.</p> <p>a) Use of the peri operative care plan to document skin status on arrival, removal, transfer to recovery and at handover to ward. Use of guidance from the National Safety Standards for Invasive Procedures addressing handovers.</p>	All patients must have combined mandatory risk assessment completed on admission.

Are we responding and Improving?

Patient and Family Feedback: Red Complaints

Red Complaints in July - September 2018

No of new red complaints declared in April-June 2018:

2

No of re-opened red complaints in April-June 2018:

0

No of closed red complaints in April-June 2018:

1

New Red Complaints declared July – September 2018 (2)

Ref	Opened Date	Report Due	Description of Complaint	Divisions Involved	Exec Lead	Division Lead
18/038	07/08/18	30/10/18	Parents raise concerns regarding care at GOSH and two other Trusts. Patient arrived with a bleed on the brain but surgery was unsuccessful and patient died.	JM Barrie	Medical Director	GM
18/041	30/08/18	04/10/18	Patient's mother raises concerns about the frequency of monitoring of patient's spine. Specifically, she complains that patient was not appropriately followed up and his scoliosis progressed to the extent that the surgical outcome was not as good as it should have been. She also raises concerns that when problems were found, fast track surgery (within 3 months) was promised but it was 5 months.	Spinal	Medical Director	Service Manager, Neurosciences



The child first and always

Are we responding and Improving?

Patient and Family Feedback: Learning from Red Complaints

Learning from closed red complaints in July – September 2018 (2):

Ref:	Summary of complaint:	Outcomes/Learning:
17/069	Father of a deceased patient raised concerns about care provided in the three days before her death. Specifically, that staff were unresponsive to the family's concerns and the patient's changing condition.	The investigation concluded that the care provided was appropriate and that staff appropriately monitored, reviewed and responded to the patient's deterioration. However, the investigation highlighted inadequate communication and record-keeping. In response to this staff briefings are being held with all staff highlighting the importance of good communication issues, use of interpreters and record keeping.
18/004	Mother of patient raised concerns about the failure to diagnose a dislocated hip, and the subsequent delay in treatment.	Serious Incident investigation highlighted failings in communication following an incidental finding of a dislocated hip. The investigation found inadequate processes to highlight unusual or concerning findings and also that telephone calls from the patient's family were not responded to. <ul style="list-style-type: none">Learning actions/outcomes included:<ul style="list-style-type: none">Changes to the automated radiology reporting processes so that significant/ unexpected findings are identified as priority reports to consultants;Review of SOP including criteria for phoning through unexpected findings;Review of clinical consultant job plans to ensure appropriate allocation of time for administrative tasks;Implementation of process for responding to patient telephone calls amongst the administrative teams, and new messaging system to ensure timely and appropriate response to queries;EPIC will also enable 'red light' of images, monitoring of whether scan results have been accessed, and wider distribution of imaging results to clinical teams.



Comparison of PALS cases received by the Trust during July 17/18

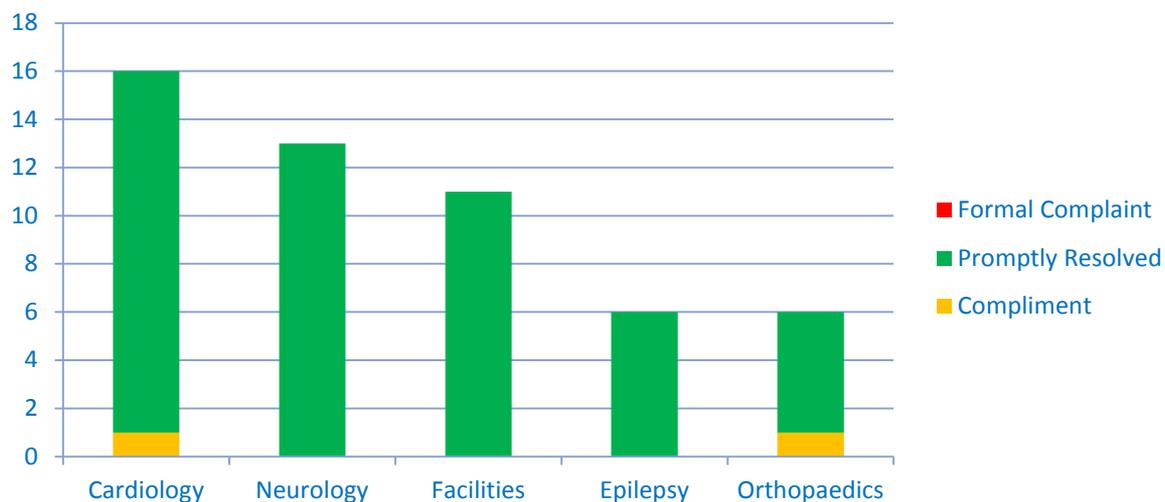
Table showing Pals cases by grading comparing July 17/18 in comparison to the previous month June 18.

Cases - Month	07/17	06/18	07/18
Promptly resolved	76	151	116
Complex cases	15	2	0
Escalated to formal complaints	0	1	1
Compliments about specialities	1	9	5
*Special cases	2289	0	0
Total	2381	163	122

*See Appendix at the end for definitions

*Date range for July 2017 & July 2018

Graph showing the top 5 specialities of Pals cases classified by category.



Top 5 specialities and themes arising in PALS cases received July 17/18

Specialities - Month	07/17	06/18	07/18
Cardiology	8	8	16
Neurology	2	3	13
Facilities	2	0	11
Epilepsy	5	3	6
Orthopaedics	6	1	6

Themes for the top five specialities	07/17	06/08	07/18
Outpatient (Cancellation; Failure to arrange appointment; poor communication, franking of letters)	20	15	24
Lack of communication (lack of communication with family, telephone calls not returned; incorrect information sent to families, transport)	27	52	24
Staff attitude (Rude staff, poor communication with parents, not listening to parents)	1	6	10
Referrals (Waiting times; Advice on making a NHS referral; advice on making an IPP referral)	5	20	8
Admission/Discharge (Cancellation; waiting times to hear about admissions; lack of communication with families, Accommodation)	5	6	7

Comparison of PALS cases received by the Trust during Aug 17/18

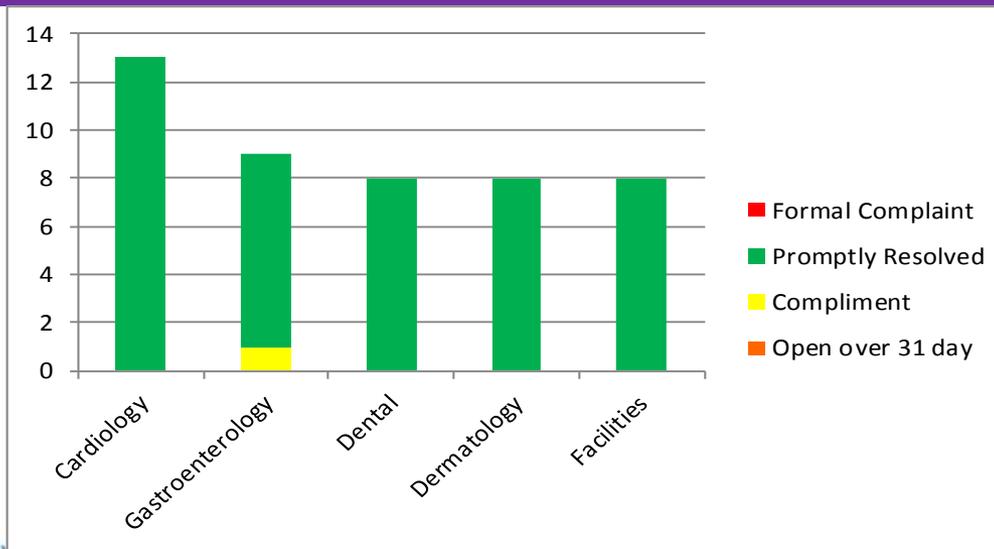
Table showing Pals cases by grading comparing Aug 17/18 in comparison to the previous month Jul 18

Cases - Month	08/17	07/18	08/18
Promptly resolved	94	116	125
Complex cases	19	0	0
*Escalated to formal complaints	0	1	1
Compliments about specialities	0	5	3
*Special cases	45	0	0
Total	158	122	129

See Appendix at the end for definitions

*Date range for Aug 2017 & Aug 2018

Graph showing the top 5 specialities classified by category. (**Red case not in the top 5*)



Top 5 specialities and themes arising in PALS cases received August 17/18

Specialities - Month	08/17	07/18	08/18
Cardiology	9	17	13
Gastroenterology	6	3	9
Dental	6	3	8
Dermatology	3	0	8
Facilities	4	10	8

Themes for the top five specialities	08/17	07/18	08/18
Outpatient (Cancellation; Failure to arrange appointment; poor communication, franking of letters)	19	23	33
Lack of communication (lack of communication with family, telephone calls not returned; incorrect information sent to families, transport)	50	31	37
Staff attitude (Rude staff, poor communication with parents, not listening to parents)	8	20	8
Support & Listening (Communication, Emails, Letters, social media)	46	1	1
Admission/Discharge /Referrals (Waiting times; Advice on making a NHS referral; advice on making an IPP referral, cancellation; waiting times to hear about admissions; lack of communication with families, Accommodation)	11	14	8

Are we responding and improving?

Learning from Friends and Family Test- Inpatient Data



Data Quality Kite-Mark

Inpatient Results July 2018

Inpatient Results August 2018

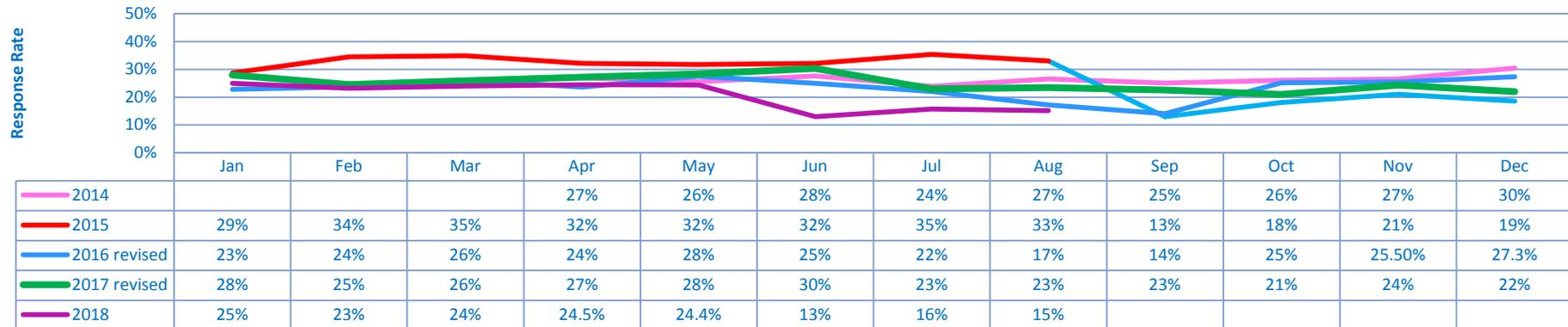
July 2018

Overall FFT Response Rate = 16%
Overall % to Recommend = 97%

August 2018

Overall FFT Response Rate = 15%
Overall % to Recommend = 97%

FFT Responses over time



The percentage response rate has dropped since the introduction of the new online system. The Patient Experience Team are working closely with the wards to increase this.

July 2018 Top 3 Themes (by % of overall comments)

August 2018 Top 3 Themes (by % of overall comments)

Positive Themes:

No +ve comments | Total No. comments

Always Helpful

248 | 660

Always Expert

110 | 660

Always Welcoming

110 | 660

Negative Themes:

No -ve comments | Total comments

Environment & Infrastructure

22 | 660

Access / Admission / Discharge / Transfer

21 | 660

Catering & Food

4 | 660

Positive Themes:

No +ve comments | Total No. comments

Always Welcoming

96 | 712

Always Helpful

226 | 712

Always Expert

133 | 712

Negative Themes:

No -ve comments | Total comments

Environment & Infrastructure

34 | 712

Access / Admission / Discharge / Transfer

12 | 712

Catering & Food

10 | 712

Are we responding and improving?

Learning from Friends and Family Test- Outpatient Data



Data Quality Kite-Mark

Narrative:



The percentage to recommend in Outpatients has improved slightly in August compared with July.
The total number of feedback received in outpatients in August was 829.
96% were completed by Adults and Young People, 4% by younger patients.

Outpatient Results July 2018

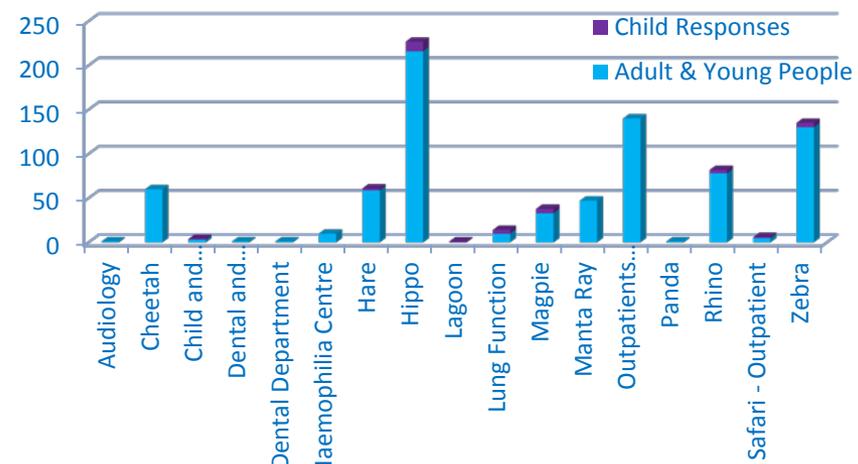
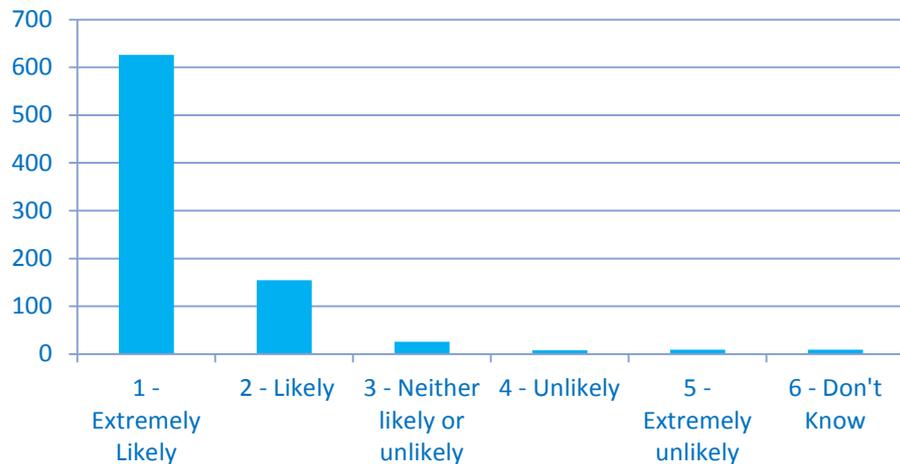
Outpatient Results August 2018

July 2018

Overall % to Recommend = 93.8%
833 Responses in July 2018

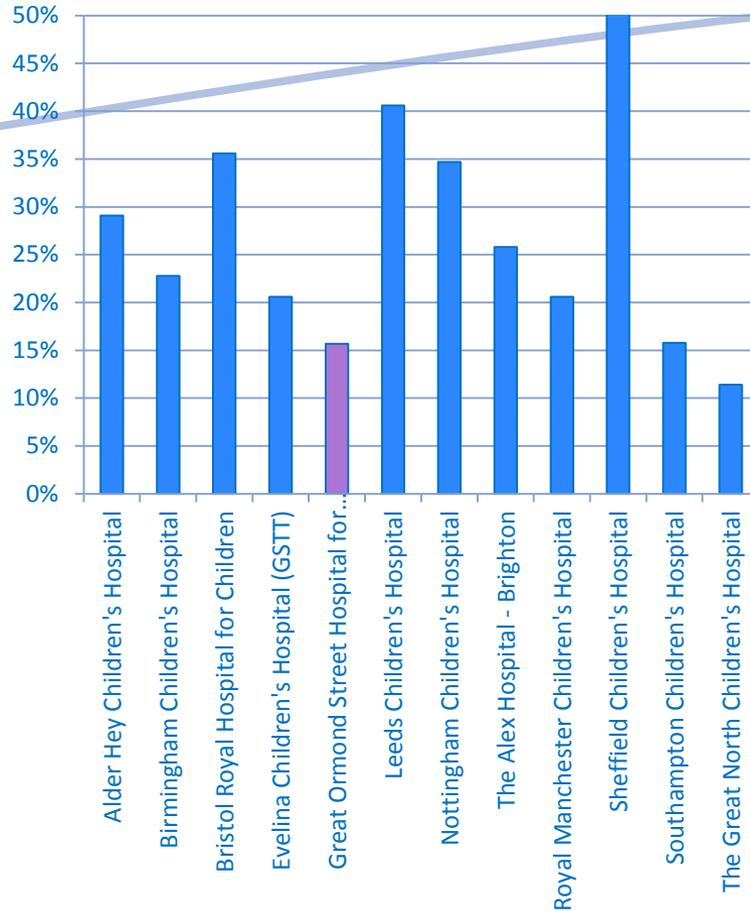
August 2018

Overall % to Recommend = 94.8%
829 Responses in August 2018

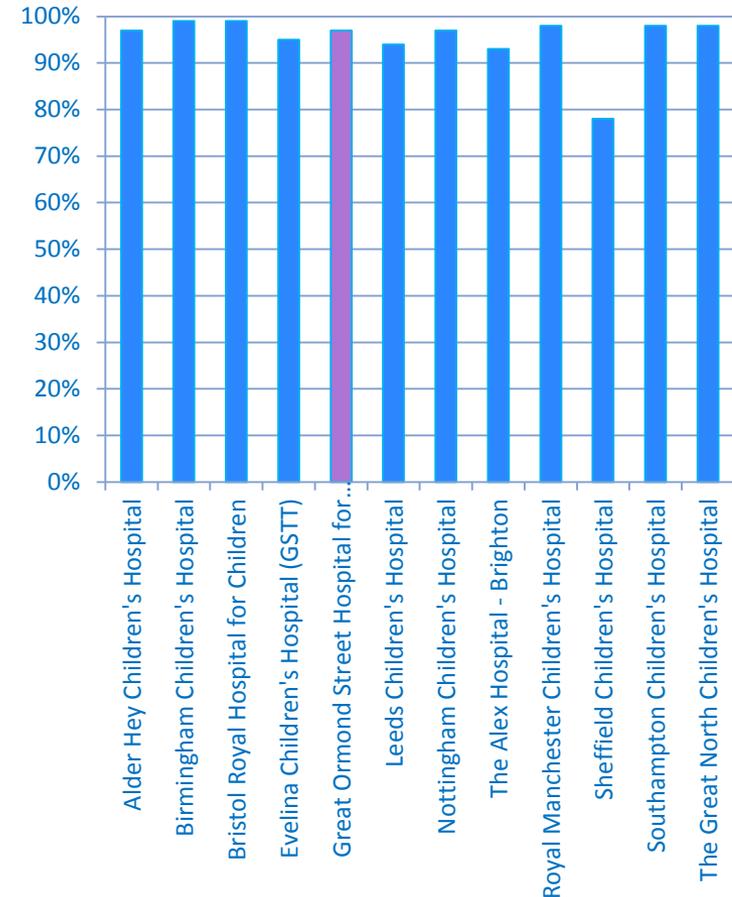


Data from NHS Choices – July 2018

Response Rates



Percentage to Recommend



Are we responding and improving?

Learning from Friends and Family Test



Below is a snapshot of some of the positive feedback received via FFT during the reporting period. Feedback is shared with the relevant teams for dissemination.

Parent / Carer Feedback

Parent/Carer Feedback

My son was referred to ENT for glue ear & had an operation and insert grommets and remove adenoids. That operation has completely changed his life. Previously he was thought to have autism. The sudden explosion in his social communication skills following his operation was extraordinary to see. He is now a radically different, chatty, social and cheerful little boy having previously been unresponsive and introverted. The ENT team here have literally changed our lives. Thank you! (Rhino)

The whole service was amazing everyone was really nice and helpful, very happy. What a warm feeling. Thank you to all you amazing people, your doing a brilliant job at Great Ormond Street. Thank you! (Walrus)

Great care. Very friendly and trustworthy staff. Amazing hospital!

During our stay the staff members here have already been very supportive, caring, friendly and very efficient. Thank you to all the team who have made our stay the best it could be. (Koala)

Very friendly, patient and engaged brilliantly with our child. (Manta Ray)

(Staff name) is amazing and brilliant. She is always positive, happy and I love it when I come in and she is our nurse, I'm using this as a feedback form as having her has really helped put me/us at ease. She is helpful and really supportive. GOSH is very lucky to have her. Please feed back to her (NICU).



Are we responding and improving?



Learning from Friends and Family Test- 'You Said, We Did' Feedback

'You Said'

We
did

Below is a snapshot of some of the negative feedback received via FFT during the reporting period and the subsequent actions taken. There is a process in place for the management of negative feedback to ensure that this is acted upon appropriately.

Bumblebee Ward

1. Lack of care from the team for the patient
2. Not quick enough to respond to the needs of the patient for e.g. (changing and tidying bed and cleaning)
3. Nurses do not co-operate (do not have the spirit of teamwork)
4. Intentional neglect

I will be writing a detailed report/letter to the Qatar Health Office so they can avoid working with this hospital or this ward specifically, as the patient should be treated with respect (father of the patient)

I have fed back to the ward team the information I received from (Patient Names) family, I also got some feedback from the hospitality team regarding the issues that they raised. As a team we have been looking at strategies such as "shift buddies" to ensure patients are covered in the absence of an allocated nurse. I have drafted a letter which I will send to the family and I plan to call the family as well to feedback

Tom Kennedy - Matron

Lab Samples Project

Project aim: To significantly reduce the number of lab sample rejections by November 2019.

Project Initiation and Leadership:

Project start: July 2018. Executive Sponsor: Nicola Grinstead.

Background: An audit revealed that in 2017 approximately 4900 patient samples were rejected due to pre-analytical errors. Rejected samples can result in delayed diagnoses, treatment and discharge from hospital, impacting on patient experience.

What are we trying to accomplish?

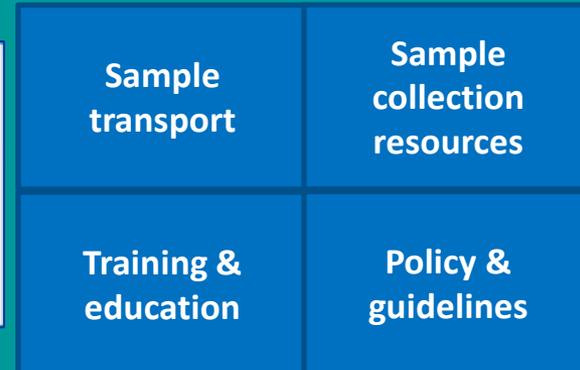
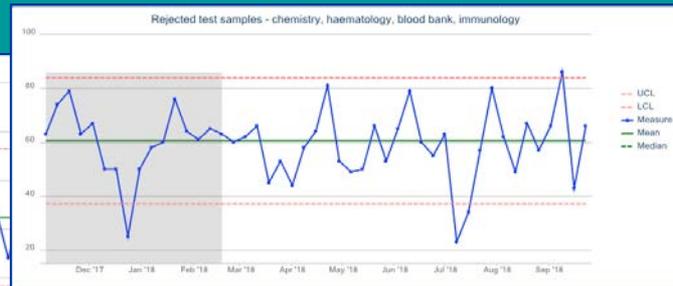
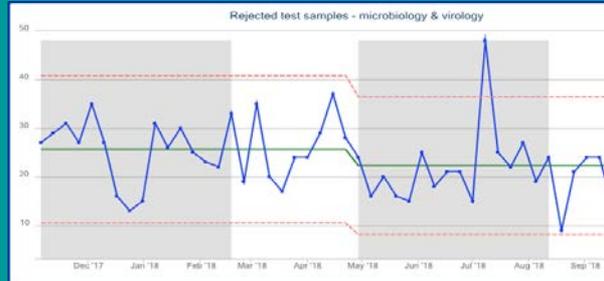
- Reduced incidence of repeated sample collection
- Improved patient experience
- Effective mechanisms for information sharing and troubleshooting
- Improved access to data on rejections for ward staff
- Reduced wastage of resources

How will we know that a change is an improvement?

- Sustained reduction in the total number of rejected samples
- Reduced transport time
- Reduced number of lost/missing samples reported

What change can we make that will result in improvement?

- Steering group established with representation from key stakeholders
- 4 key work-streams identified:



Next steps

- Establish working groups for each work-stream
- Review reasons for rejection data

- Review of policies, guidelines and SOPs
- Trial of alternative resources - smaller coagulation bottle, alternative NPA container, alternative butterfly needles

Are we responding and improving?

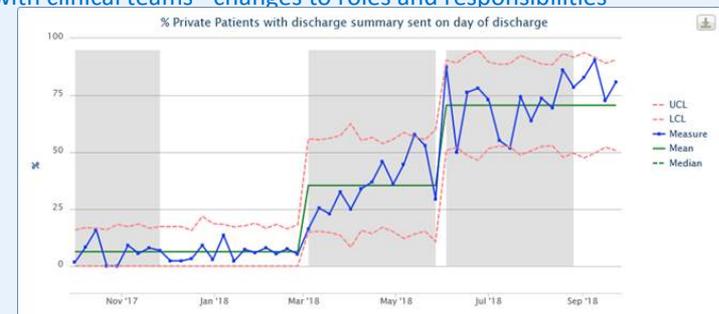
Quality Improvement Project Status Update (with Executive sponsorship)

Project	Project Aims	Project Leads	Project Timescales and Progress
PEWS	To Implement PEWS across all inpatient wards at GOSH by April 2018.	<p>Executive Sponsor- Alison Robertson (Chief Nurse)</p> <p>Medical Lead - Mark Peters (ITU Consultant Intensivist)</p> <p>Nursing Lead – Sarah Newcombe (Chief Nursing Information Officer)</p>	<p><u>Progress to date:</u></p> <ul style="list-style-type: none"> Changes to PEWS were made on the 1st August 2018. This was based on clinical feedback that included; <ul style="list-style-type: none"> ➢ Realignment of the type of alerts staff receive ➢ Original Temperature chart was re-instated ➢ Addition of ‘oral’ as a selectable temperature site ➢ ‘Watcher’ status added for patients on end of life care ➢ Ward beds matched against those on Nervecentre with the addition of ‘virtual’ beds in some areas to support patient flow. The PEWS project is set to close at the end of October 2018. The Resus team have agreed to take over PEWS and it will be reviewed as part of the ‘Deteriorating Patient’ projects. PEWS measures will be reviewed in context of ensuring they are fit-for-purpose when used operationally e.g. Nursing dashboard.
Extravasation	To reduce the incidence of extravasation injury and repeated cannulation at GOSH by 30 March 2019	<p>Executive Sponsor- Chief Nurse</p> <p>Clinical Lead- Consultant Anaesthetist</p>	<p><u>Progress to date:</u></p> <ul style="list-style-type: none"> Review of publications and current practice at other paediatric centres (including international) to identify best practice in securing and dressing cannulas VHP Framework & Tool implemented in all wards excluding ICUs Working with EPR to ensure Epic supports project interventions Best practice checklist for cannulation trolley and VHP developed On-going PDSA pilot of cannulation training pathway for junior doctors Review and consolidation of all policy, procedure and care bundle related to IV access underway Coordination of cannulation education now led by SIM team – focus on signing off more assessors across Trust to improve ability to sign-off competent staff Working with plastics to improve referral form for Epic Piloting of VAF system paused whilst recruitment of team underway (system to log referrals to VAF team to enable prioritisation and oversight from CSP team.

Are we responding and improving?

Quality Improvement Project Status Update (with Executive sponsorship)

Project	Project Aims	Project Leads	Project Timescales and Progress
Transition	<p>To enable clinicians to start all young people a Transition Plan by the age of 14 in line with NICE recommendations</p> <p>Ensure young people and their families are adequately prepared for the move to adolescent or adult health services</p>	Executive Sponsor- Chief Nurse	<p>On-going project</p> <p><u>Progress to date:</u></p> <ul style="list-style-type: none"> • Growing Up, Gaining Independence (GUGI) programme developed • eCOF reporting tab scheduled to go live w/c 8.9.18 • Family information sheets being formatted/illustrated • GUGI Part 2 template sent to all specialties • TIM attending specialty meetings <p><u>Next steps:</u></p> <ul style="list-style-type: none"> • Further information videos for YP and families • Staff training needs analysis • Template for 'Welcome to the XYZ service at GOSH' to include information about age limit of service and set expectations from outset developed to send to specialties • Transition Policy update • Develop sustainability plan
GOSH clinical app development	To develop an app to improve access to information on GOSH quality and safety tools to new and current clinical staff	Project Leads QI - Maria Banaghan and Duncan Shepherd	<p><u>Progress to date:</u></p> <ul style="list-style-type: none"> • Prototype mobile application developed by two UCL Computer Science students Incorporating 'safety toolkit' of GOSH quality and safety tools (e.g. Sepsis 6 protocol, vessel health framework), training videos, ICU induction toolkit and guidelines. <p><u>Next steps:</u></p> <ul style="list-style-type: none"> • Alpha version of app due to be demoed at Drive launch • Improving the user experience when using the application, and developing a content management function that will allow content growth within the App, at future points. • Discussion on long term aim of app and possible expansion as a wider app to include GOSH policies and guidelines
IPP Flow – discharge summaries	To improve the number of IPP discharge summaries completed on the day of discharge	Divisional Lead – Chris Rothenbach QI Lead – Maria Banaghan	<p><u>Progress to date:</u></p> <ul style="list-style-type: none"> • Improvement from June 2018 , from 45% to 73% of discharge summaries completed on the day. • Process review with clinical teams - changes to roles and responsibilities





Integrated Quality Report

Mr Matthew Shaw, Medical Director

Alison Robertson, Chief Nurse

December 2018

(covering October 2018)



Safety

Care/
Experience

Outcomes/
Effectiveness

Improvement

Has patient care been safe in the past? Measures where we have no concerns	Page 3-5
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Are we responding and improving? Patient and family feedback; learning from closed red complaints	Page 13
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Are we responding and improving? Learning from friends and family test data- outpatient data	Page 18
Are we responding and improving? Friends and family test updates/ benchmarking	Page 19
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Are we responding and improving? Friends and family test- 'you said', we did	Page 21
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Has patient care been safe in the past?

Measures – summary

This slide contains an overview of some of the key measures monitored within the Trust; these will be considered by exception. Where there are measures/trends of concern, a slide containing a deep dive of that information will be included in the report.

Measures for self reporting systems do not always have a direct correlation between the data and safety; e.g. an increase in reporting may not always be a result of an unsafe environment but instead as a result of a good reporting culture which in turn can improve safety via learning.

Please see appendix 1 for the methodology used for the measures below.

Measure	Comment
<p>Non-2222 patients transferred to ICU by CSPs**</p> <p>** patients should be transferred to ICU before they have an arrest where possible which would indicate the early identification of a deterioration prior to an arrest.</p>	<p>From September to April 2018 there was a statistically significant increase – a run of 8 consecutive months above the previous process mean. This increase did not sustain and the current mean is still 7.1 transfers per month. In July 2018 there were 6 unplanned ICU transfers, in August there were 16 (an outlier – being investigated by the resus team), in September there were 10 and in October there were 9, all within expected limits.</p>
<p>Cardiac arrests**</p>	<p>Overall, the data remains stable for this measure at 1.4 cardiac arrests per month; this has remained stable since 2015 with the exception of one outlier in January 2017. The Trust had zero cardiac arrests from March 18 to May 18, however there were 2 recorded in June (both in theatres). There were 2 cardiac arrests in July 2018 (one on Leopard, one on Chameleon), 2 in August (one on Chameleon and one on XMRI), 1 in September (on Bear) and 0 in October. Although the count of cardiac arrests remains stable, there has been a statistically significant reduction in the number of cardiac arrests outside ICU per 1000 bed days (see further slides for details).</p>
<p>Respiratory arrests**</p> <p>**The figures within the Integrated Quality Report includes arrests within all areas outside of ICUs (including day case Wards, day units, outpatient areas and non-clinical areas e.g. main reception) whilst the Safe Staffing Report arrest data only refers to arrests on in-patient Wards. The data will therefore differ between the two reports as the Integrated Quality Report includes additional areas.</p>	<p>The data remains stable for this measure at 2.67 respiratory arrests per month; this has remained stable since June 2015 (when there was a decrease) with the exception of an outlier in November 2015 and August 2017 (both high). The most recent 4 months indicate no change – there were 4 respiratory arrests outside ICU in July, 3 in August, 1 in September and 0 in October 2018.</p>

Has patient care been safe in the past?

Measures – summary

This slide contains an overview of some of the key measures monitored within the Trust; these will be considered by exception. Where there are measures/trends of concern, a slide containing a deep dive of that information will be included in the report.

Measures for self reporting systems do not always have a direct correlation between the data and safety; e.g. an increase in reporting may not always be a result of an unsafe environment but instead as a result of a good reporting culture which in turn can improve safety via learning.

Please see appendix 1 for the methodology used for the measures below.

Measure	Comment
Never Events	The last Never Event was on 23 rd March 2018, meaning there have been no never events in the previous two quarters. The mean time between never events is unchanged at 220 days, with the baseline for this data taken from 2010 until 2014. The Never Event declared in March 2018 was for retained foreign object while the previous never event in October 2017 was for wrong site surgery.
Serious Incidents** **by date of incident not declaration of SI	There has been a recently identified increase in the monthly number of serious incidents (Sis). From February 2018 to October 2018 the mean is 2.33 SIs per month, an increase on the previous monthly mean of 0.76 per month (based on a baseline between September 2016 and January 2018, which was a statistically significant reduction compared to the previous mean). There were 3 SIs reported in July, 3 in August, 2 in September but none in October 2018. The increase is yet to be sustained.
Mortality	<p>There has been a recently identified decrease (improvement) in the monthly inpatient mortality rate per 1000 discharges. The previous baseline mean of 6.3 inpatient deaths per 1000 discharges remained stable up to and including November 2017. However, from December 2017 there has been a run of points below the mean and therefore a statistically significant reduction – the current rate is 4.8 inpatient deaths per 1000 discharges. This improvement is yet to be sustained. The figures for July, August, September and October 2018 were 4.99, 5.07, 4.92 and 7.25 inpatients deaths per 1000 discharges, respectively.</p> <p>Over 80% of GOSH inpatient deaths are on ICU, and ICU deaths must be risk adjusted to properly determine a trend. Raw survival/mortality rates do not take account of severity of illness and case mix so outcome data needs to be adjusted to take these factors into account. All ICU data is submitted, after risk adjustment, to the national Paediatric Intensive Care Audit Network (PICANET). This process will allow any trends or outlier performance to be determined. Internal monitoring of Variable Life Adjusted Plots (VLAD) from January – June 2017 showed an increase in the number of deaths on PICU compared to expected. A comprehensive internal review of cases did not suggest any obvious patterns or concerns about the quality of care in PICU/NICU, and no single cause that could explain the trend. GOSH has been informed by PICANET it will not be a statistical outlier for 2017 and the full PICANET data for the calendar year 2017 is due to be published on 31 March 2018. The most recent VLAD data suggests that the negative trend has not continued.</p>

Has patient care been safe in the past?

Measures – summary

This slide contains an overview of some of the key measures monitored within the Trust; these will be considered by exception. Where there are measures/trends of concern, a slide containing a deep dive of that information will be included in the report.

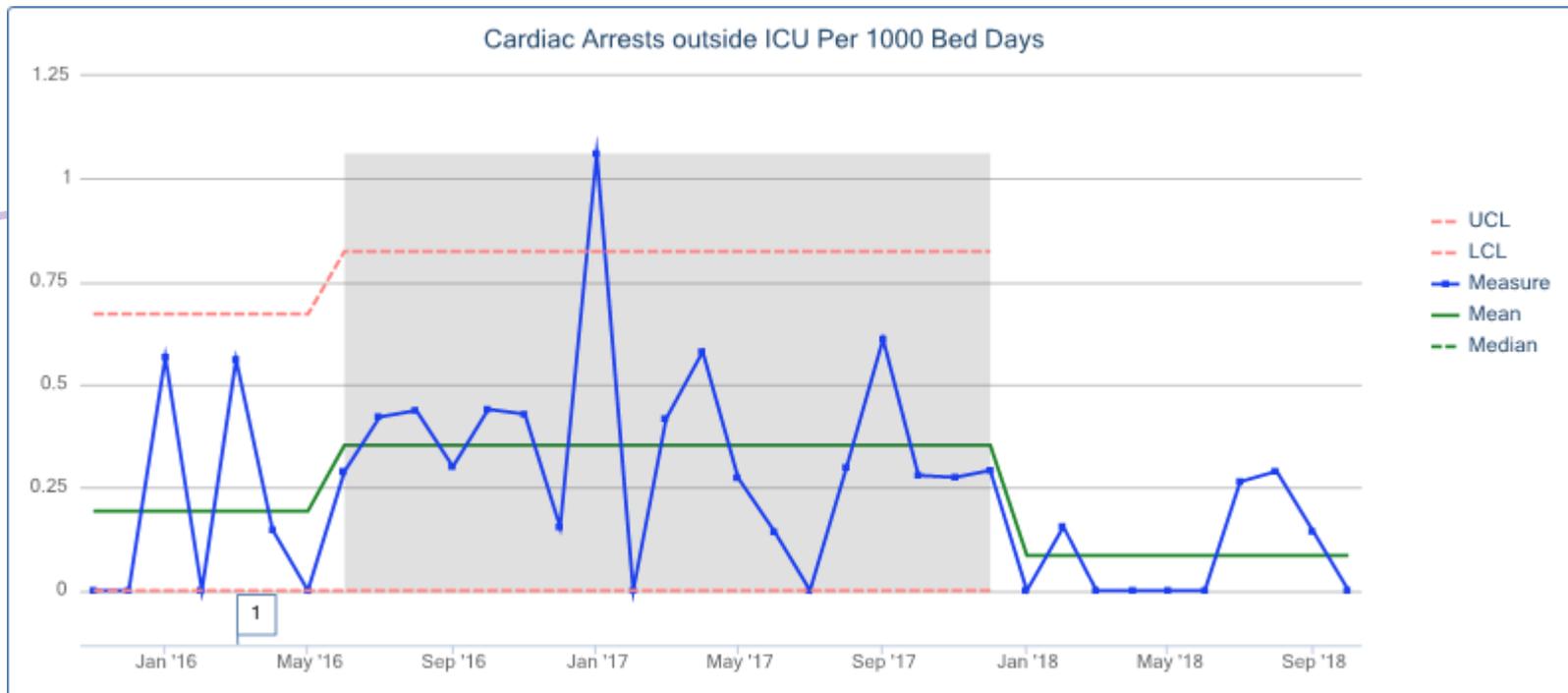
Measures for self reporting systems do not always have a direct correlation between the data and safety; e.g. an increase in reporting may not always be a result of an unsafe environment but instead as a result of a good reporting culture which in turn can improve safety via learning.

Please see appendix 1 for the methodology used for the measures below.

Measure	Comment			
Hospital acquired pressure ulcers reported (category 2+)	There has been a recently identified statistically significant reduction in the number of hospital acquired pressure ulcers reported. Starting in March 2017 (identified in August 2018 as 14 of 17 consecutive points were below the previous baseline mean), there was a reduction from 6.67 per month to 5.06 per month – this has been sustained. The figures for July, August and September 2018 are as below:			
	July 2018	August 2018	September 2018	October 2018
Category 2 hospital acquired pressure ulcers	5	12	7	7
Category 3 hospital acquired pressure ulcers	1	0	0	1
Category 4 hospital acquired pressure ulcers	0	0	0	0
GOSH-acquired CVL infections	We have identified a reduction in the measure of CVL infections per 1000 line days. This reduction started in January 2017 and has been sustained – the current baseline mean from January 2017 to January 2018 shows a rate of 1.38 CVL infections per 1000 line days, compared to a previous mean of 1.78 CVL infections per 1000 line days. Since this reduction, the CVL infection rate per 1000 line days has remained stable and within normal variation, with 0.81, 1.27, 1.17 and 0.93 CVL infections per 1000 line days recorded in July, August, September and October 2018 respectively.			
The number of PALS cases	The number of PALS cases reported per month remains stable, with an average of 145. Since the outliers in summer 2017 (June and July), the process is currently in normal variation; there have been no runs, trends or recent outliers identified. There were 129 cases in July 2018, 136 cases in August, 116 cases in September and 139 cases in October 2018 – these are all within expected limits based on previous baseline data.			

Has patient care been safe in the past?

Measures – highlights/exception



Measure	Comments
Cardiac arrests outside ICU per 1000 bed days**	There has been a recently identified statistically significant reduction in the number of cardiac arrests outside ICU per 1000 bed days. The current mean is 0.09 cardiac arrests per 1000 bed days, a reduction on the previous mean of 0.35 per 1000 bed days, which was taken from a baseline period between June 2016 and December 2017. The current improvement is yet to be sustained but is a significant improvement.

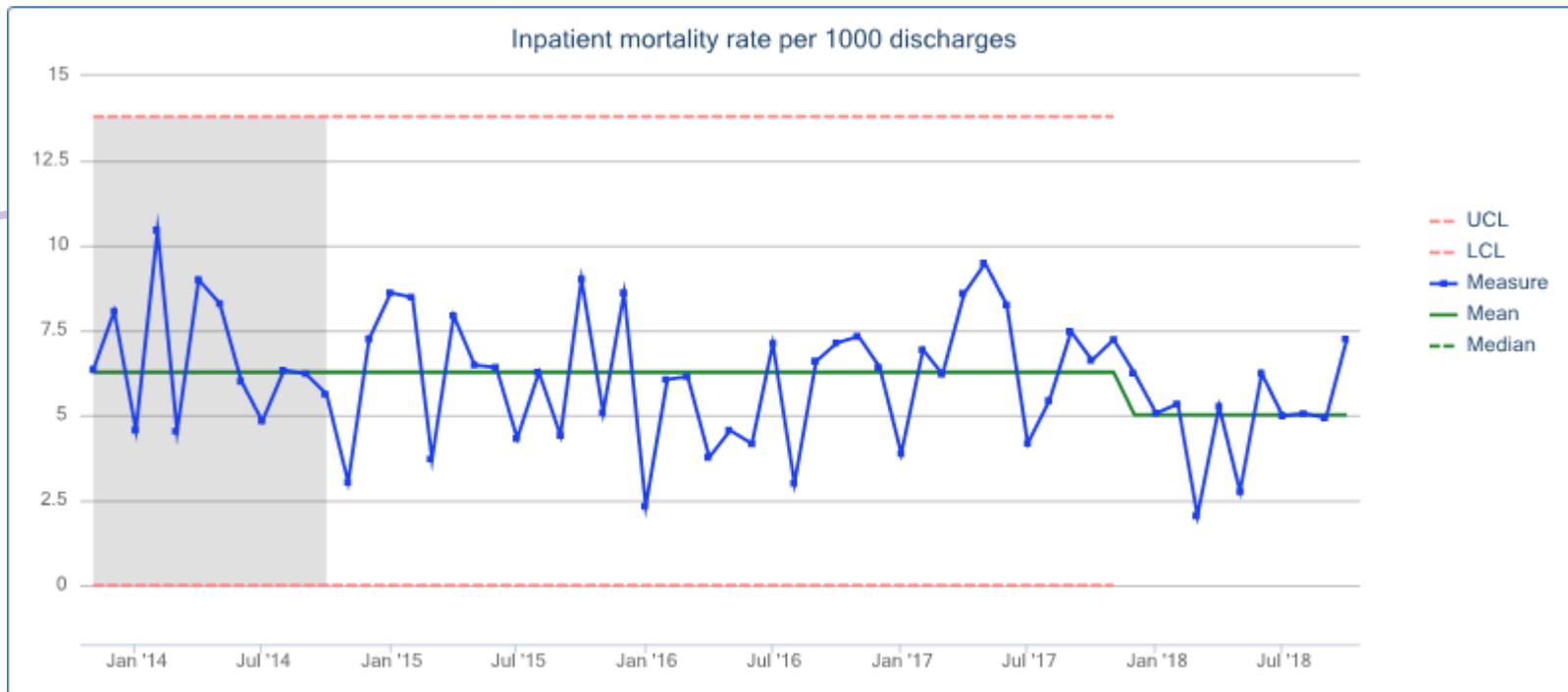
Has patient care been safe in the past?

Measures – highlights/exception

Great Ormond Street
Hospital for Children



NHS Foundation Trust



Measure	Comments
Mortality	There has been a recently identified decrease (improvement) in the monthly inpatient mortality rate per 1000 discharges. The previous baseline mean of 6.3 inpatient deaths per 1000 discharges remained stable up to and including November 2017. However, from December 2017 there has been a run of points below the mean and therefore a statistically significant reduction – the current rate is 4.8 inpatient deaths per 1000 discharges. This improvement is yet to be sustained.

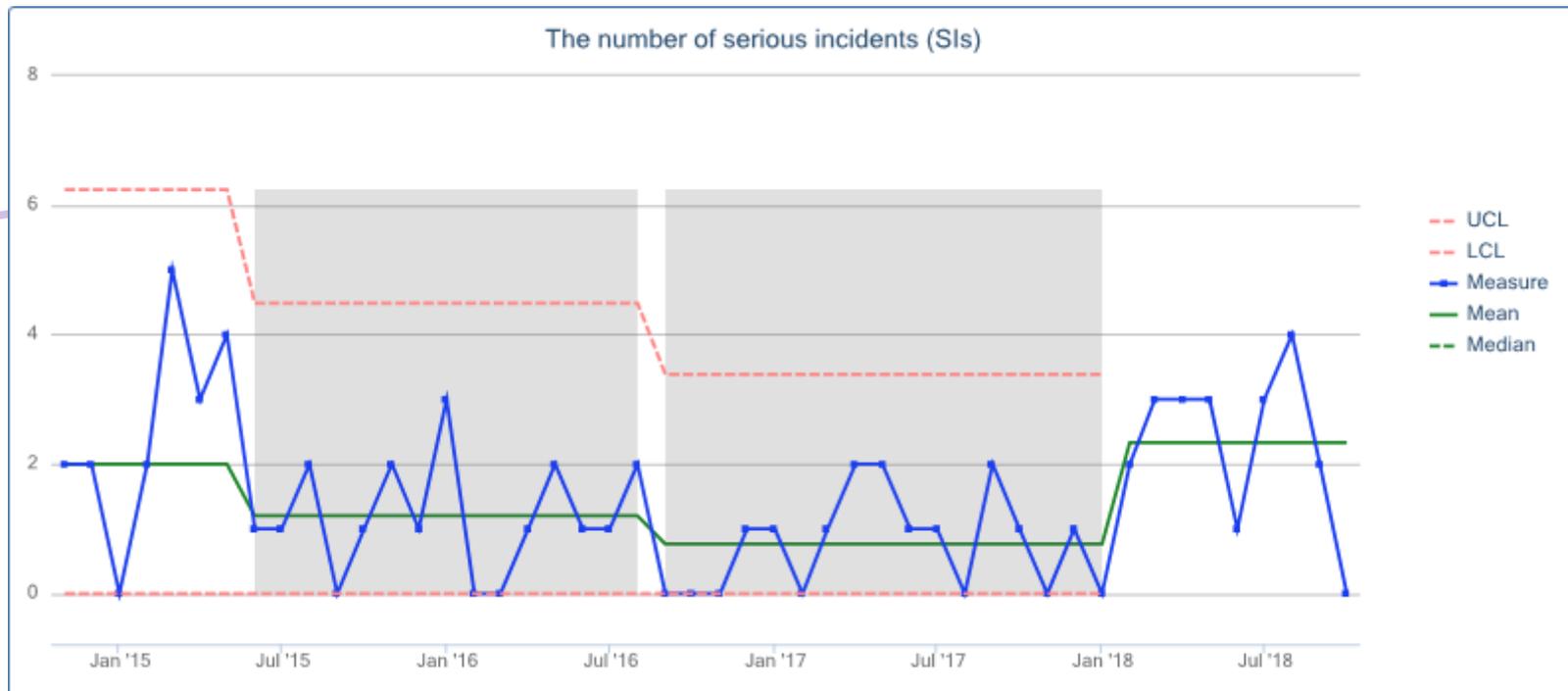
Has patient care been safe in the past?

Measures – highlights/exception

Great Ormond Street
Hospital for Children



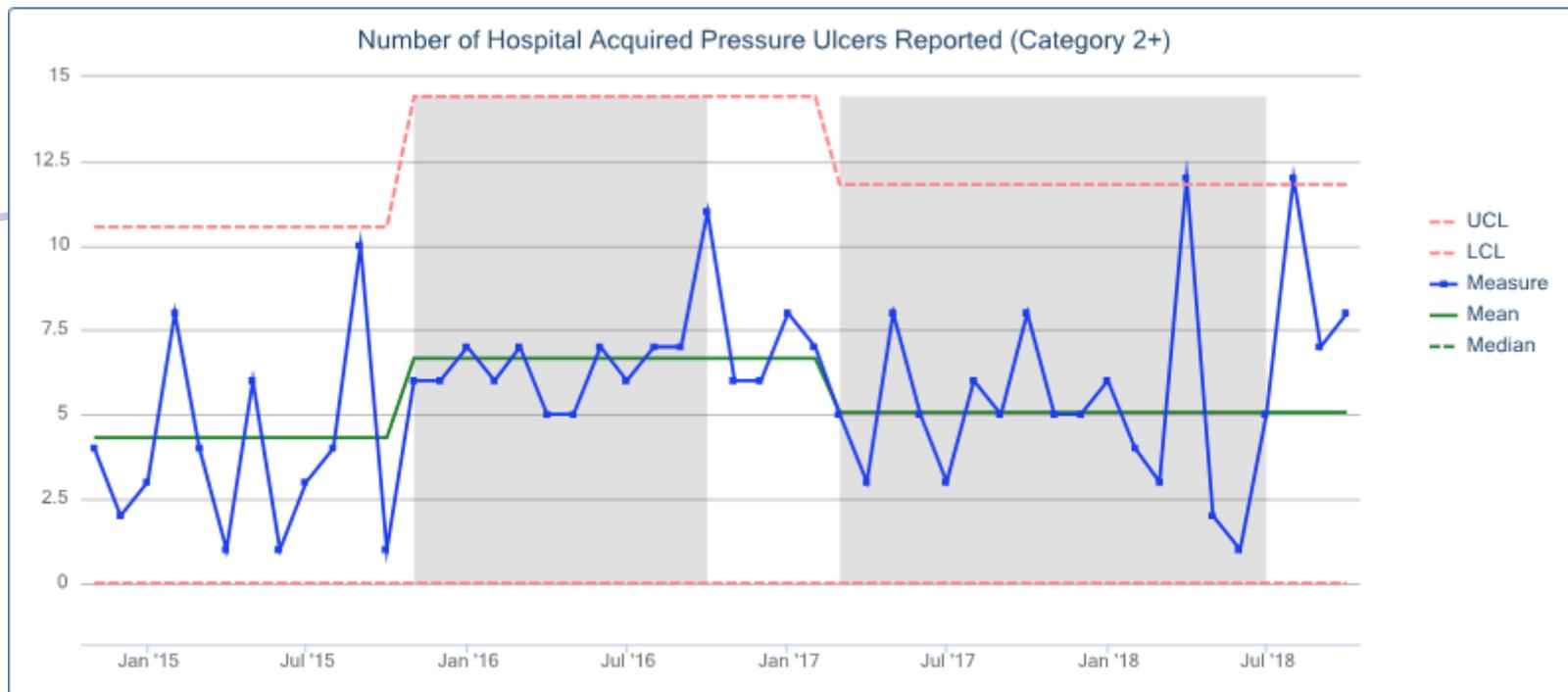
NHS Foundation Trust



Measure	Comments
<p>Serious Incidents**</p> <p>**by date of incident not declaration of SI</p>	<p>There has been a recently identified increase in the monthly number of serious incidents (Sis). From February 2018 to September 2018 the mean is 2.50 SIs per month, an increase on the previous monthly mean of 0.76 per month (based on a baseline between September 2016 and January 2018, which was a statistically significant reduction compared to the previous mean). The increase is yet to be sustained.</p>

Has patient care been safe in the past?

Measures – highlights/exception



Measure	Comments
Hospital acquired pressure ulcers reported (category 2+)	There has been a recently identified statistically significant reduction in the number of hospital acquired pressure ulcers reported. Starting in March 2017 (identified in August 2018 as 14 of 17 consecutive points were below the previous baseline mean), there was a reduction from 6.67 per month to 5.06 per month – this has been sustained.

Has patient care been safe in the past?

Learning from closed Serious Incidents and Never Events

Serious Incidents and Never Events in October 2018

No of new SIs declared in October 2018:	1	No of new Never Events declared in October 2018:	0
No of closed SIs/ Never Events in October 2018:	3	No of de-escalated SIs/Never Events in October 2018:	0

New SIs/Never Events declared in October(1)

STEIS Ref	Incident Date	Date Report Due	Description of Incident	Directorates Involved	Senior Responsible Officer (SRO)	Patient Safety Manager	Executive Sign Off	Divisional Contact
2018/24654	20/08/18	09/01/19	Unexpected complication following procedure	Heart and Lung	Medical Director	Lead Patient Safety Manager	Medical Director	Chief of Service

Learning from closed/de-escalated SIs/Never Events in October 2018 (3):

Ref:	Summary:	Root Cause:	Action to Remedy Root Cause:	Trust Wide Learning:
2018/16218	<p>Patient admitted to hospital for a cardiac procedure. Following surgery, the patient was admitted to CICU. Two days post surgery, the patient returned to theatre due to a collection in the neck which required drainage. During this, a mark over the patient's coccyx/sacrum was noted to be worsening and had blackened. The patient was turned to relieve pressure and aderma was applied. A referral to Plastic was made as there was no tissue viability service over the weekend period. The patient was not reviewed by plastic for another two days and the area was subsequently graded 1. The patient was being nursed on a foam mattress as no air dynamic mattresses were available however this was changed after the patient was reviewed by the Plastic team who also advised the patient to be turned 2 hourly and to continue with aderma. The mattress was changed to a dolphin mattress the following day.</p>	<p>If the combined mandatory risk assessment (pre-operative skin assessment) had been carried out on admission the correct bed could have been ordered in advance of the procedure for the patient to be nursed on post operatively. This may have avoided the development of the pressure ulcer. The patient also needed to be turned regularly and frequency would be dependent on GS regardless of the bed/mattress.</p>	<ul style="list-style-type: none"> Ensure that all patients are nursed on appropriate bed Ensure skin assessments take place within 6 hours of admission Ensure nutritional assessments take place within 6 hours of admission and are clearly documented in the medical notes. Training and competency for staff on Pressure Prevention Policy Staff to be familiar with all equipment (hoists etc.) to avoid pressure ulcers and frequency of turns according to GS. Staff training on types of beds and new beds for different patient weights as CICU patients are often underweight and this patient was malnourished. Importance of accurate documentation in Carevue for skin cares Ensure patients with LD have LD involvement and hospital passport updated if required. Ensure documentation in theatre of any pressure areas pre (from pre op checklist) and post operatively and effective handover is carried out post operatively 	<p>All patients must have combined mandatory risk assessment completed on admission.</p>

Has patient care been safe in the past?

Learning from closed Serious Incidents and Never Events

Learning from closed/de-escalated SIs/Never Events in October 2018 (3):

Ref:	Summary:	Root Cause:	Action to Remedy Root Cause:	Trust Wide Learning:
2018/17571	<p>A box of 50mg/ml Fentanyl in a Ward controlled drug (CD) cupboard was opened for use for a patient on another Ward. The drugs subsequently underwent their daily and weekly checks and no discrepancies were noted. Five days later, the box was accessed again to remove a vial for a patient on the Ward and it was noted that two vials in the box were empty. The plastic had been peeled back, the glass vial top had been snapped and the liquid removed, there was a needle mark in the plastic. These vials had then been replaced into the box and put back into the CD cupboard. There was residue in the bottom of both vials suggesting there had been drug in the vial. There was no evidence of a spillage and the box was not damaged.</p>	<p>The panel felt that it is unlikely that the cause of the disappearance will ever be discovered and no individuals have been identified as under suspicion. The possibility of staff removing the Fentanyl has been explored and the staff at the timeline/root cause analysis meeting agreed that it appeared to be deliberate and devious behaviour that may have caused the drugs to go missing and an attempt was made to avoid early detection by replacing the empty vials into the box. Staff carrying out the daily and weekly checks were probably only counting the vials in the box and not removing them from the box to perform the daily and weekly checks so this also avoided detection at the earliest point. The possibility of a breakage prior to the box being opened was also discussed, either by dropping or manufacturing issue, although there was no evidence of leakage into the plastic or damage to the box from liquid was seen although over a long period of time the liquid could have evaporated. The Senior Responsible Officer for the investigation noted that it would be impossible to prevent the issue of CDs going missing unless there was a more secure method of storing controlled drugs. There are no plans currently to change these wards to intelligent storage (Omniceil) which does require ID badge or fingerprint technology to access the storage unit.</p>	<ul style="list-style-type: none"> • Provide further training for clinical staff in relation to Trust Policy on the management of controlled drugs and associated regulations, such as not leaving the cupboard unattended, ensuring the controlled drug key is kept on a separate key ring • Medicines Ordering and Storage Policy and Medicines Administration Policy to be reviewed and updated as more detail required on recording of daily and weekly checking of CDs, ensure vials are pulled out of boxes to be counted, standardised method of measuring CDs, key holding and access to keys. • Change the ward CD register to a theatre style CD register to enable staff to record the time and date of the regular CD checks and also to provide space for the staff to record their signature and print their name. Obtain signature list for all staff who access CDs • Each ward area should have a high level access security group to ensure that only those staff that need to enter medication rooms have swipe access to do so. Special consideration will need to be taken as to how bank nursing staff will be able to access medication rooms on wards they are working on • The panel wanted to acknowledge in the report that these wards do not have intelligent storage but the Trust is progressing towards having intelligent storage for all wards. • Trust security strategy should be reviewed to ascertain position re usage of mobile CCTV on an ad hoc basis in more areas • Ensure that the three monthly Trust audit of CD registers is carried out, documented and any actions arising from the audit are followed up. The ward pharmacist should also carry out regular checks of the CD register and highlight any discrepancies to the ward sister. Ward sisters should also monitor entries in the CD register for poor practice. • Pharmacy diary to be introduced on wards so that stock issues and orders can be noted and checked by pharmacy throughout the shift to ensure that the ward maintains a stock of all drugs required. 	<p>All clinical staff should ensure they are aware of their responsibilities in relation to management of controlled drugs</p>

Has patient care been safe in the past?

Learning from closed Serious Incidents and Never Events

Learning from closed/de-escalated SIs/Never Events in October 2018 (3):

Ref:	Summary:	Root Cause:	Action to Remedy Root Cause:	Trust Wide Learning:
2018/17096	A dose of oral morphine was administered to the patient and approximately one hour and twenty minutes later she began to demonstrate signs of respiratory compromise and deteriorated. It was later noted that the dose of morphine was prescribed incorrectly, and that this was not identified by the nursing staff when checking and administering the drug.	On the balance of probabilities the investigating panel feels that the oral morphine overdose contributed significantly to the patient's unexpected deterioration. The patient was showing signs of becoming unwell over the afternoon so it is recognised that there may have been other factors which also contributed to the deterioration. There were errors in both the prescription and administration of the medication, contributed to by a number of systemic factors	<ul style="list-style-type: none"> • Ensure that all ways of prescribing morphine include the dose prompt and calculator, and ensure that no further protocols/ sets are created on the Electronic Prescribing System. This should include a review of the current protocols and remove any that are not in use • Communicate to anaesthetic staff that prescriptions made from Friday evenings will not have a routine pharmacy check until the Monday morning • Electronic Prescribing pharmacist to look into the feasibility of end date for 'as required' prescriptions- this would enable anaesthetists to limit the time a medication would be available for post-operatively • Teaching sessions for the Chameleon nursing team regarding indications for opiate administration and conversion of small doses or may involve conversion of micrograms and milligrams • Review beds and staffing for Ward at weekends to ascertain whether nursing levels need to be increased if beds cannot be closed • Theatres Management team to continue reviewing demand and wait time for emergency lists • Additional training regarding Sepsis 6 recognition and pathway for Chameleon nursing and SNAPS medical staff • Ensure learning from Serious Incidents informs ongoing Trust wide Sepsis work • PEWS working group to consider whether additional teaching is required in relation to completing observations and escalation during downtime • Requirements for post anaesthetic apnoea monitoring to be reviewed including training and equipment resource required 	Ensure that all ways of prescribing morphine include the dose prompt and calculator, and ensure that no further protocols/ sets are created on the Electronic Prescribing System. This should include a review of the current protocols and remove any that are not in use

Are we responding and Improving?

Patient and Family Feedback: Red Complaints

Red Complaints in October 2018

No of new red complaints declared in October 2018:

0

No of re-opened red complaints in October 2018:

0

No of closed red complaints in October 2018:

1

Learning from closed red complaints in October 2018 (1):

Ref:	Summary of complaint:	Outcomes/Learning:
18/014	Concerns about delay in treatment on the ward and about coordination of care across specialty teams for complex patients.	The complaint prompted a comprehensive review of the ward to improve coordination of care and consultant review, increase awareness of escalation processes and reviews of staffing to ensure appropriate cover and support. An audit of ward round attendance and documentation has taken place and General paediatricians attend morning ward round to help co-ordinate care between specialties. Wednesday morning Grand Round also review complex patients. Physician associate to be hired for ward.



Are we responding and Improving?

Patient and Family Feedback: Closed Complaints October 2018

Complaint

Ref 18-014

Concerns about delay in treatment on the ward and about coordination of care across specialty teams for complex patients.

Ref 18-026

Parent raised concerns that the team failed to diagnose their child with cancer during a previous admission to GOSH. Parent concerns were not listened to. A swab was left inside patient during surgery.

Ref 18-043

Family felt the full treatment options were not discussed with them and they had a number of questions and concerns regarding the clinical options.

Ref 18-044

Family felt that lead clinician was giving up on their daughter following discussions of potential withdrawal of treatment in the future.

Learning/Outcome

The complaint prompted a comprehensive review of the ward to improve coordination of care and consultant review, increase awareness of escalation processes and reviews of staffing to ensure appropriate cover and support. An audit of ward round attendance and documentation has taken place and General paediatricians attend morning ward round to help co-ordinate care between specialties. Wednesday morning Grand Round also review complex patients. Physician associate to be hired for ward.

A detailed response explained that the investigation found no evidence that cancer was present during the previous admission. Parent was offered assure that their concerns had been listened to and documented.

The response explained the different options discussed and why the doctor made the recommendation they did which was deemed the safest option. An appointment was booked to discuss clinical care.

Explanation given that further surgery was not possible, but treatment was not being withdrawn. The clinical team and family are working with the palliative care team. A meeting with the family, clinical team and complaints manager took place to talk through the response.

Are we responding and Improving?

Patient and Family Feedback: Closed Complaints October 2018

Complaint

Ref 18-045

Delay in patient being shown to bed-space, in treatment being started and being discharged home. Concerns were also raised regarding the attitude of staff.

Ref 18-046

Concerns raised regarding the behaviour of a consultant who refused further treatment due to patient being under multiple teams (private and NHS) in UK and another country outside the EU.

Ref 18-048

Parents raised concerns about a lack of personal cares provided to their child and felt judged as they were only able to visit on the weekend. Concerns were also raised about the environment and that their child's admission was longer than expected.

Ref 18-051

Delay in admission for PEG replacement. Concerns raised about the poor communication around the admission date.

Ref 18-052

There was a delay in virology results being sent by clinic letter and a delay in treatment starting at another hospital as a result.

Learning/Outcome

An apology and explanation was offered for the delays and the family's experience during the admission. It was an exceptionally busy day and the bed space required cleaning.

Patient had surgery abroad which consultant considered unsafe. Response explained concerns around safety and that all treatment should either be managed in one location, or with full co-operation and collaboration between both teams.

Letter sent apologising for distress caused by this experience. Personal care should have been provided and there was poor documentation around this. GOSH has recently launched a Trust wide program focusing on core cares. Response explained why the patient was not fit for discharge.

PEG needed replacement but was not initially urgent. When this became urgent, patient was admitted immediately.

Found that virology testing was done in a routine oncology clinic which did not follow routine practice. Therefore there was no urgent method of communication in place at that time. Patient was admitted to the local hospital but this was not communicated to GOSH; thus non urgent timeframes were applied. Learning has been shared including reminders of the correct process to be followed.

Comparison of PALS cases received by the Trust during October 17/18

Table showing Pals cases by grading comparing October 17/18 in comparison to September 18

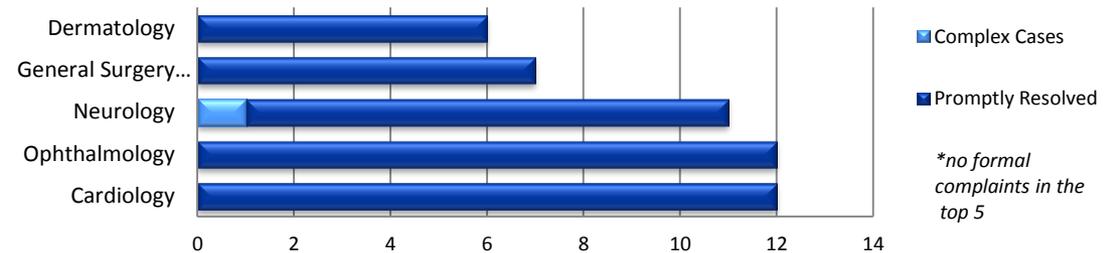
Cases	10/17	09/18	10/18
Promptly resolved	127	102	131
Complex cases	33	5	6
Escalated to formal complaints	0	3	4
Compliments about specialities	2	2	0
*Special cases	0	0	0
Total	162	112	141

*See Appendix at the end of report for definitions

Date range for Oct 2017 & Oct 2018

Top 5 Specialties arising in PALS cases received	10/17	09/18	10/18
Cardiology (*inc POTS concerns)	9	1	18*
Ophthalmology	8	7	12
Neurology	15	6	11
General Surgery (SNAPS)	8	6	7
Dermatology	6	5	6

Graph showing top 5 specialities by category*



Themes for the top five specialties	10/17	09/18	10/18
Outpatient (Cancellation; Failure to arrange appointment; poor communication, franking of letters)	23	21	18
Lack of communication (lack of communication with family, telephone calls not returned; incorrect information sent to families, transport)	24	26	38
Staff attitude (Rude staff, poor communication with parents, not listening to parents)	9	8	14
Transport (Eligibility, delay in providing transport, failure to provide transport)	10	4	7
Admission/Discharge /Referrals (Waiting times; advice on making a NHS referral; advice on making an IPP referral, cancellation; waiting times to hear about admissions; lack of communication with families, accommodation)	14	29	10

Are we responding and improving?

Learning from Friends and Family Test- Inpatient Data



Data Quality Kite-Mark

Inpatient Results September 2018

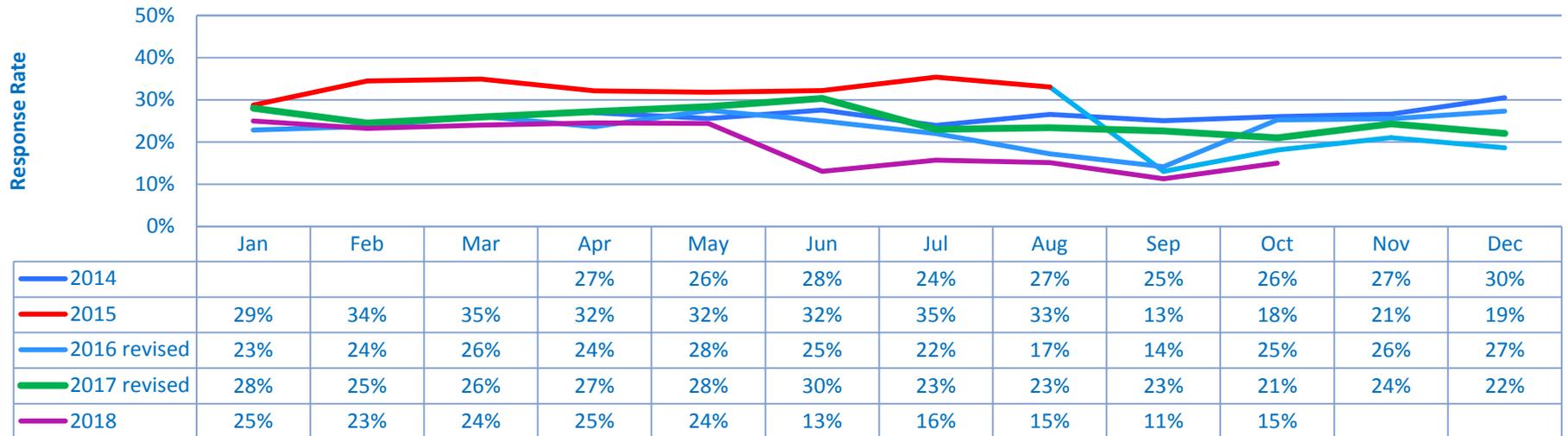
Inpatient Results October 2018

September 2018

Overall FFT Response Rate = 11%

October 2018

Overall FFT Response Rate = 15%



September 2018 Top 3 Themes (by % of overall comments)

Positive Themes:

Always Helpful

Always Welcoming

Always Expert

Negative Themes:

Environment & Infrastructure

Housekeeping

Access / Admission / Discharge / Transfer

October 2018 Top 3 Themes (by % of overall comments)

Positive Themes:

Always Helpful

Always Welcoming

Housekeeping / Cleanliness

Negative Themes:

Environment & Infrastructure

Always Expert

Access / Admission / Discharge / Transfer

Are we responding and improving?

Learning from Friends and Family Test- Outpatient Data



Data Quality Kite-Mark

Narrative:



Outpatient teams have worked really hard to increase the response rates throughout October. October responses totalled 990, an increase of 40%

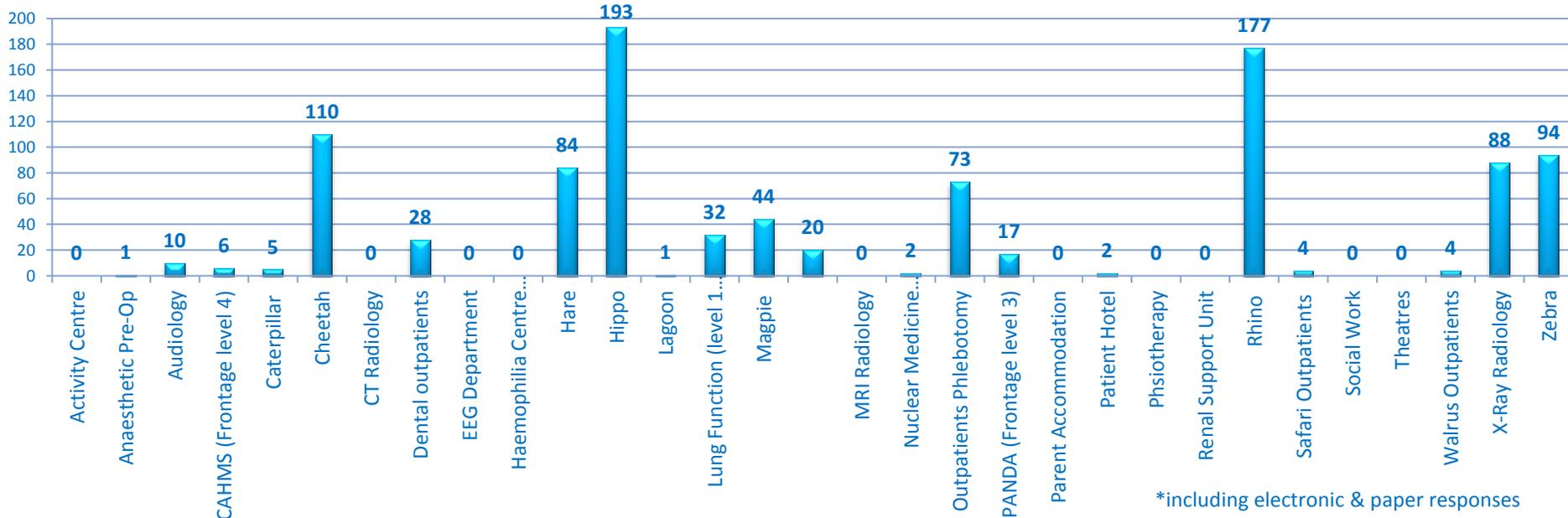
The Patient Experience Team ran a FFT competition throughout October alongside Open House Week.
Highest number of online responses – Cheetah
Highest number of FFT entries – Hippo

Outpatient Results September 2018*

Overall % to recommend 93.8%
709 Responses

Outpatient Results October 2018*

Overall % to Recommend = 95.6%
990 Responses

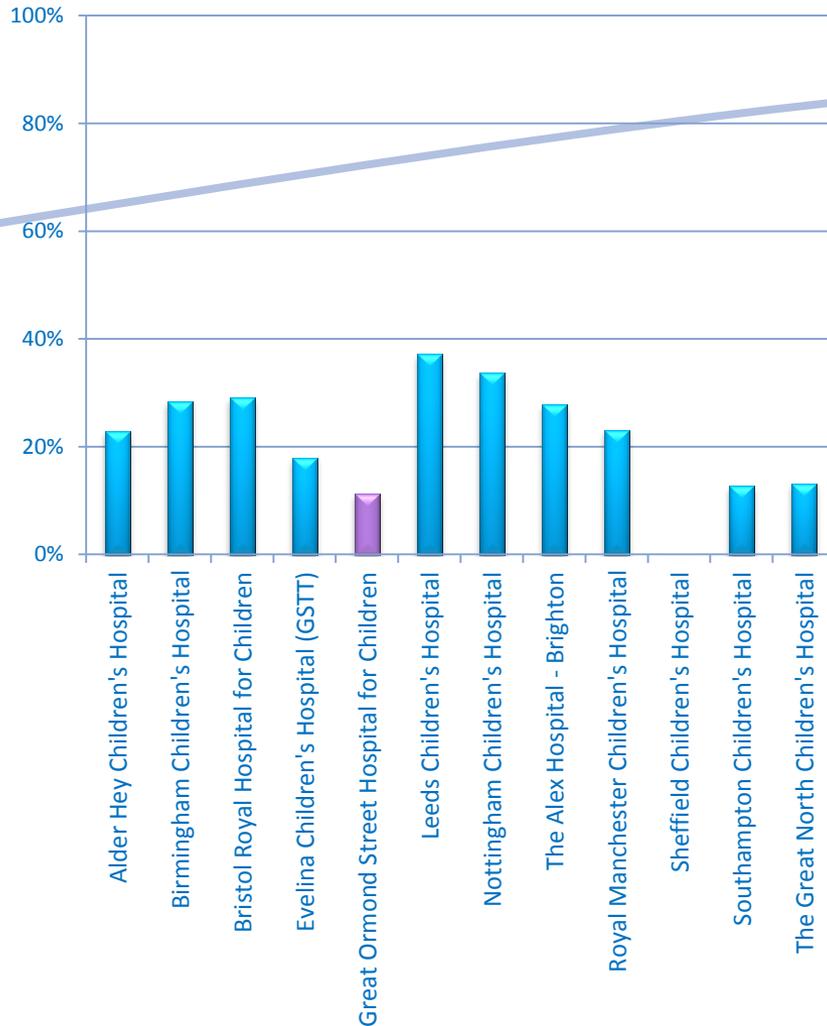


Are we responding and improving?

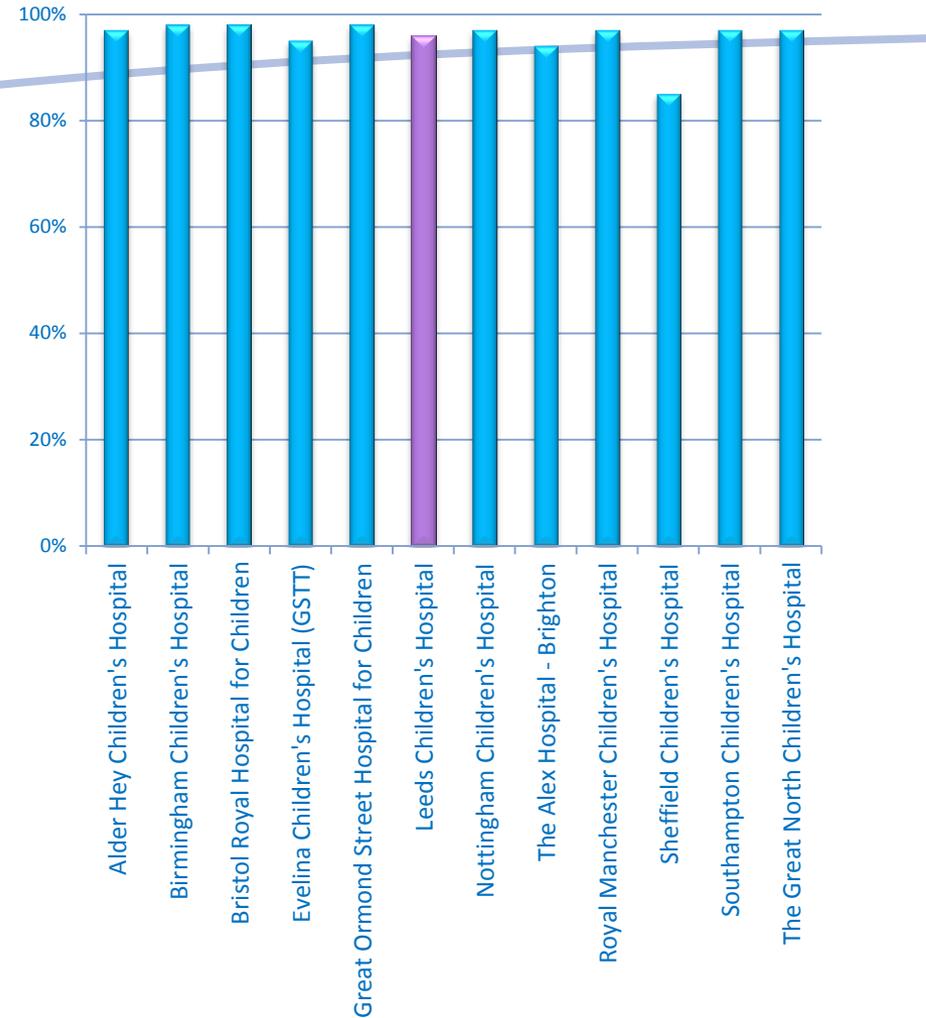
Benchmarking

Data from NHS Choices – September 2018

Response Rates



Percentage to Recommend



Are we responding and improving?

Learning from Friends and Family Test



Below is a snapshot of some of the positive feedback received via FFT during the reporting period. Feedback is shared with the relevant teams for dissemination.

Parent / Carer Feedback

"The consultant was very thorough, she was very helpful with giving us the information we need for the transition to UCLA. In general the staff made our day very satisfied and comfortable". Hare Ward

"The staff and facilities at Great Ormond St are always amazing. It's always a great atmosphere and the staff are always helpful. I strongly recommend GOSH to anyone, It's a phenomenal institution that the UK should be proud of it!" Rhino Ward

"I find GOSH a place of safety and support for my child and me. Everyone who works here is really helpful and full of understanding." Cheetah Ward

"Thank you to the staff in Nightingale Ward for the care and attention you gave my son before and after his surgery. **ALL** staff are positive, good humoured and reassuring at all times. A big thanks to the Housekeeper, for bringing me a much needed cup of tea!!" Nightingale Ward

"We encountered [staff name] on a number of occasions during our 3 1/2 week stay. (staff name) was the kindest, sweetest, most gentle nurse. She was my daughter's favourite and loved seeing her/interacting with her. She made us both feel at ease (my daughter had to have enemas and was so nervous & embarrassed). Really enjoyed getting to know her. She is an outstanding nurse who really made a difference to my daughter." Chameleon Ward



Are we responding and improving?



Learning from Friends and Family Test- 'You Said, We Did' Feedback

'You Said'

We did

Below is a snapshot of some of the negative feedback received via FFT during the reporting period and the subsequent actions taken. There is a process in place for the management of negative feedback to ensure that this is acted upon appropriately.

"Not enough chairs in Rhino!"

Property Services will replace chairs and will see if the Commissioning team can recommend some chairs to purchase for the area.

Short notice cancellations in the Dental Department

Management and the Dental Team are working to rectify this as soon as possible.

During October, the Patient Experience Team experienced delays in wards / departments responding to the feedback to inform 'You Said, We Did' updates.

Once a month, the updates will be published on Great Ormond Street Twitter feed, commencing Friday 30 November 2018.

Lab Samples Project

Project aim: To significantly reduce the number of lab sample rejections by November 2019.

Project Initiation and Leadership:

Project start: July 2018. Executive Sponsor: Nicola Grinstead.

Background: An audit revealed that in 2017 approximately 4900 patient samples were rejected due to pre-analytical errors. Rejected samples can result in delayed diagnoses, treatment and discharge from hospital, impacting on patient experience.

What are we trying to accomplish?

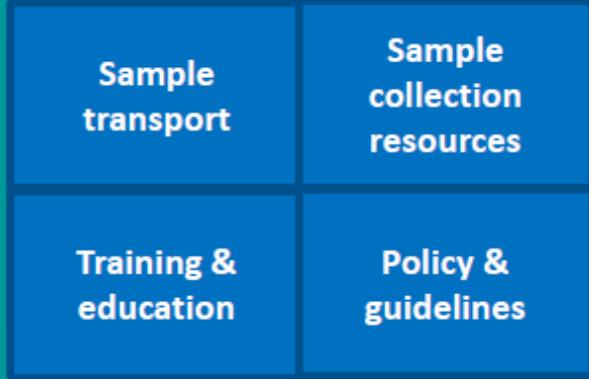
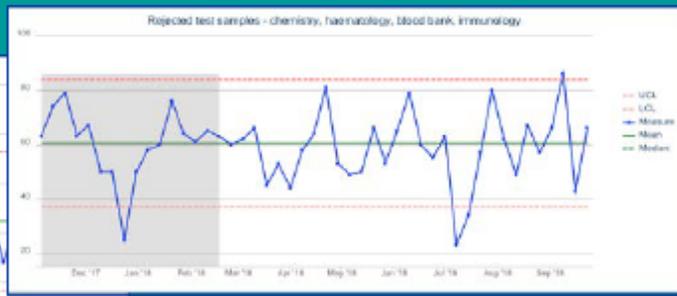
- Reduced incidence of repeated sample collection
- Improved patient experience
- Effective mechanisms for information sharing and troubleshooting
- Improved access to data on rejections for ward staff
- Reduced wastage of resources

How will we know that a change is an improvement?

- Sustained reduction in the total number of rejected samples
- Reduced transport time
- Reduced number of lost/missing samples reported

What change can we make that will result in improvement?

- Steering group established with representation from key stakeholders
- 4 key work-streams identified:



Next steps

- Establish working groups for each work-stream
- Review reasons for rejection data

- Review of policies, guidelines and SOPs
- Trial of alternative resources - smaller coagulation bottle, alternative NPA container, alternative butterfly needles

Are we responding and improving?

Quality Improvement Project Status Update (with Executive sponsorship)

Great Ormond Street Hospital for Children



NHS Foundation Trust

Project	Project Aims	Project Leads	Project Timescales and Progress
Reducing pre-analytical lab sample rejections	To significantly reduce the number of pre-analytical patient sample rejections by November 2019	Executive Sponsor- Deputy Chief Executive Project Leads- Pathology Lead Quality and Risk Manager And Laboratory Manager	<u>Progress to date:</u> <ul style="list-style-type: none"> Project leads and sponsor confirmed. Project aim and documents agreed. Steering group established. Baseline data for rate and reasons for rejection, as well as transport time have been gathered. Dashboards now automated. Working groups for sample collection resources, training and sample transport established. New 9pm porter collection has improved evening sample transport times <u>Next steps:</u> <ul style="list-style-type: none"> Trial of Multifly needle in Outpatients Improving blood culture transport time on Robin & Fox Change to GOSH order of draw guideline Targeted training for sample collection technique Neonates data review + intervention planning
PEWS	To replace the Children's Early Warning System (CEWS) with the Paediatric Early Warning System (PEWS) for wards across GOSH by March 2018	Executive Sponsor- Chief Nurse Medical Lead- Consultant Intensivist Nursing Lead- Clinical Site Practitioner	<u>Progress:</u> The project aim has now been achieved key messages have been shared at meetings across the Trust e.g. Nursing Board and GMSC. <u>Next steps:</u> Governance of PEWS ; data review and monitoring is yet to be agreed. There is agreement that there is joint nursing/ medical responsibility regarding governance, but the meeting / board that this will be reviewed on a monthly basis has yet to be determined. Nursing Board agreed to the development of a ward dashboard for ward managers/ matrons to proactively monitor Early Warning Dashboard <ul style="list-style-type: none"> To support operational handover, an 'Early Warning Dashboard' is being developed that will combine specific PEWS and Sepsis measures in a user friendly manner. The dashboard will allow staff to proactively review data associated with identifying clinical deterioration and develop tailored action plans to improve recognition and treatment within their area.

Are we responding and improving?

Quality Improvement Project Status Update (with Executive sponsorship)

Great Ormond Street Hospital for Children



NHS Foundation Trust

Project	Project Aims	Project Leads	Project Timescales and Progress
Transition	<p>To enable clinicians to start all young people a Transition Plan by the age of 14 in line with NICE recommendations</p> <p>To ensure GOSH to meets the requirements of NICE Transition Guidelines published February 2016</p>	<p>Executive Sponsor- Chief Nurse</p>	<p>On-going project</p> <p><u>Progress to date:</u></p> <ul style="list-style-type: none"> GUGI section on Intranet GUGI web-pages GUGI recording tab on eCOF GUGI recording tab on EPR ready for Go Live Working with GOSH Arts/YPF on resource to support families to cope with emotional impact of moving on from GOSH TIM attending Specialty meetings <p><u>Next steps:</u></p> <ul style="list-style-type: none"> Trust-wide launch All information to be made available on external web-site Continued development of Specialties/subspecialties GUGI 2 information Develop GUGI monitoring reports for Specialty/Divisional/Executive teams Ongoing discussions re sustainability plan
Extravasation	<p>To reduce the incidence of extravasation injury and repeated cannulation attempts at GOSH by 30th March 2019</p>	<p>Executive Sponsor- Chief Nurse Clinical Lead- Consultant Anaesthetist</p>	<p><u>Progress to date:</u></p> <ul style="list-style-type: none"> Review of current and best practice in peripheral IV access in literature (policy & guidelines), and across paediatric centres completed Junior doctor training using SIM being tested - approx. 5/month attending Anaesthetic A/ H review has been completed – no evidence of additional workload since introduction of VHP tool Working with EPR to ensure Epic supports project interventions Review of provision of vascular access and phlebotomy at GOSH, linking in with Lab samples project Trust-wide one week audit of all venepuncture & cannulation activity is being planned for Dec 3rd -10th.

Appendix 1

Methodology for key Trust measures

Measure	Methodology	
Never Events	Never events are defined here - https://www.england.nhs.uk/ourwork/patientsafety/never-events/	
Non-2222 patients transferred to ICU by CSPs	Unplanned non-2222 patient transfers to ICU, admitted as deteriorating patients from ward areas by the CSP team.	
Cardiac and respiratory arrests	<p>Cardiac arrests outside of ICU: The monthly number of cardiac arrests outside of ICU wards (recorded from calls made to the 2222 Clinical Emergency Team). Cardiac arrests are defined by any patient requiring cardiac compressions and/or defibrillation. Cardiorespiratory arrests count towards the cardiac arrests total, not the respiratory arrests total.</p>	<p>Respiratory arrests outside of ICU: The monthly number of respiratory arrests outside of ICU wards (recorded from calls made to the 2222 Clinical Emergency Team). Respiratory arrest is defined by any patient requiring bag mask ventilation. (Previous to May 2013 this was defined as any patient requiring T-piece and/or Bag Valve Mask.) Cardiorespiratory arrests count towards the cardiac arrests total, not the respiratory arrests total.</p>
Mortality	The inpatient mortality rate per 1000 discharges. The numerator is the number of patients who die whilst inpatients at GOSH. The denominator is the number of inpatients who are discharged each month. Day case admissions (as specified by a patient classification of 2 or 3) are excluded from the denominator. CATS patients who are not admitted to GOSH are excluded from this measure.	
Serious Incidents	<p>This is the monthly count of serious incidents (SIs), by date of incident (as opposed to date incident was reported). A serious incident is defined as an incident that occurred in relation to care resulting in one of the following:</p> <ul style="list-style-type: none"> • Unexpected or avoidable death of one or more patients, staff visitors or members of the public. • Serious harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm • Allegations of abuse • One of the core sets of 'Never Events' <p>http://www.england.nhs.uk/ourwork/patientsafety/serious-incident/</p>	
GOSH-acquired CVL infections per 1000 line days	<p>The definition for this measure is complex and can be found here: http://goshweb.pangosh.nhs.uk/clinical_and_research/qi/Infection%20Prevention%20and%20Control/CVL%20Infection/Pages/default.aspx</p>	

Trust Board 5th December 2018	
Regular report on Infection Prevention and Control	Paper No: Attachment U
Submitted by: Dr John Hartley DIPC	
Aims / summary: To update the Board on Infection Prevention and Control issues and current plans	
Action required from the meeting Board support for actions and feedback.	
Contribution to the delivery of NHS Foundation Trust strategies and plans: Minimising infection is a central component of the Trust goal of zero harm	
Financial implications Failure to prevent or control infections leads to harm and cost.	
Who needs to be told about any decision? Infection prevention and control is responsibility of all staff.	
Who is responsible for implementing the proposals / project and anticipated timescales? Clinical and Corporate Directorates Infection Prevention and Control Team. On going.	
Who is accountable for the implementation of the proposal / project? Director of Infection Prevention and Control	

**Regular DIPC Infection Prevention & Control Report to Trust Board
2018 - 2019
Update at 26/11/2018**

Three top achievements since last report:

1. Developed and introduced a new audit process for clinical care bundles, including hand hygiene. First audit day was 12/11/2018, output awaited.
2. KPMG audit of infection control standards and governance arrangements – Draft report found ‘significant assurance with minor improvement opportunities’. Final report to follow.
3. Employment of new ID consultant, antimicrobial pharmacist and microbiology consultant should strengthen, among other things, antimicrobial stewardship

Three significant ongoing risks

1. Environment and equipment cleaning – recently agreed OCS have implemented improvement plan, but monitoring required; plans approved for refurbishment of endoscopy decontamination unit (estimated completion may 2019) but not medical equipment decontamination unit (re-submission to CIG planned for Dec 2018); quality of sterile services reprocessing has fallen, action plan in place.
2. Failure to implement standard and transmission based infection prevention and control procedures at all times, especially with increase in respiratory and enteric viruses
3. Successful transfer of information systems to RL Solutions and EPIC

Report

1. Infection Prevention and Control (IPC) team

Issue: **Maintaining data and electronic infection prevention management system**

Control process– Working with new (fixed term) data manager on short term solutions and with RL Solutions and EPIC to implement new systems; but risk of non-completion

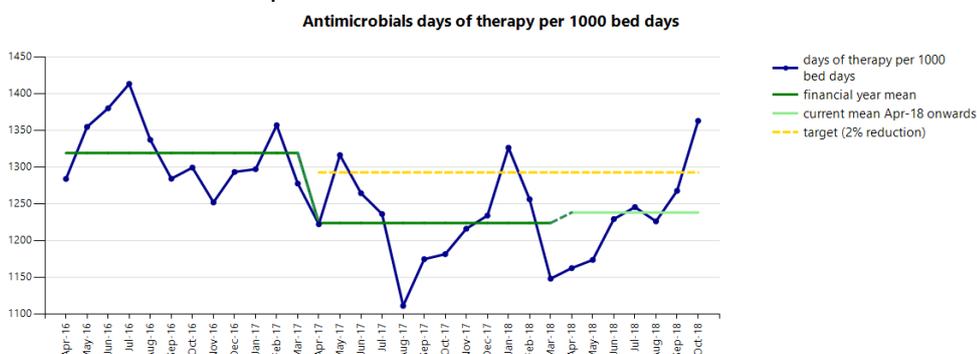
Issue: **Insufficient staff to maintain input in to all development projects**

Potential resolution: Additional funding proposed by DPS for IPC nurse time has not been agreed.

Action: Staffing review planned with new Directorate team.

2. Antibiotic stewardship –

Antimicrobial consumption: recent increase



Action: While this increase in consumption may reflect current clinical case mix, the recently strengthen AMS service will be closely addressing the issue.

3. Health care associated infection (HCAI) statistics

HCAI Mandatory national reporting:

	2018/19 after 7 months		Last financial year 2017/18	
	Developed while in hospital	Admitted with	Developed while in hospital	Admitted with
MRSA bacteraemia	2	0	1	2
MSSA bacteraemia	9	7	11	9
E. coli bacteraemia	8	4	12	6
P. aeruginosa bact	8	2	6	7
Klebsiella sp. bact	8	2	16	2
C. difficile infection	3	0	12	6

HCAI non-mandatory internal reporting – infection and significant colonisation:

	2018/19 after 7 months		Last financial year 2017/18	
Infection:				
GOS acquired CVC related bacteraemia	1.4 / 1000 line days (40 episodes)		1.6 / 1000 line days (82 episodes)	
	Developed in hospital	Admitted with	Developed in hospital	Admitted with
Respiratory viral infection	124	209 (winter to come)	159	359
Enteric viral infection	167	189	237	286
Colonisation:				
MRSA colonisation	13	105	9	200
MDR GN (non CPO) colonisation	32	78	55	172
Carbapenemase producing (CPO) GN	1	14	0	23
Vancomycin resistant enterococci	15	17	38	27
MDR GN = Multi antibiotic resistant gram negative 'alert' organism ; CPO = carbapenemase producing organism				

Issue: Children, their families and staff, are a frequent reservoir of viral infections and antimicrobial resistant organisms. Cross-colonisation and cross-infection is not fully controlled.

Control activity: Maintaining a clean environment; and compliance with individual risk assessment and implementation of standard and transmission based precautions.

Risk: Environmental cleanliness was less assured; compliance not 100%

Assurance: Worked with cleaning partner to improve cleaning. Change in audit process to improve reliability in data and empowerment for local teams to drive improvement, if needed.

4. Major outbreaks or preventable high risk exposure events. 2018/19

Date	Organism and issue	Ward	Outcome
2018/19	Pulmonary TB in staff member		Staff and patients screened. No patient infection detected. No active staff infection.
2018/19	oxa48 Klebsiella pneumonia cross transmission	PICU	No other cases identified at time.
2018/19	Enteric virus transmission	Lion/Giraffe/Elephant	Controlled without ward closure

Oct			
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5. Infection prevention and control regular audits and data display

A new audit process has been developed; first audit day was Nov 12th.

Verbal update of process and outcomes will be given to Board as data entry not yet complete.

6. Estate and facilities – issues

a. Cleaning – there have been difficulties this year, with an improvement notice served on supplier. Principle issues were around training and supervision. This notice has recently been satisfactorily closed, with detailed monitoring to follow.

b. Decontamination – risk present due to age of endoscopy decontamination unit and non-compliant medical equipment decontamination unit.

Mitigation – Endoscopy unit: continuity plan now negotiated for emergency off-site endoscopy service, if needed; unit refurbishment project has been agreed, with expected completion May 2019. MEDU – risk remains significant as new unit plans not agreed. Re-submission to CIG required Dec 2018.

Off-site sterile services department – currently there is a fall in quality and an action plan has been put in place.

7. IPC Training - At

	At 23/11/2018	15/03/2018
Trust compliance with level 1 training	94%	98
Trust compliance with level 2 training	87%	82%

Actions: Compliance has increased but not reached target yet for level 2.

Directorates need to monitor and continue to improve compliance.

8. Infection Prevention and Control Committee – Other items of discussion and developments from recent meetings

1. Major modification in use of face masks for personal protection (moving from FFP2's to FFP3's and surgical masks) – not complete. New fit testing technology on trial.
2. Implementation of new isolation strategy in outpatients – Progress was made with toy strategy, but still awaiting Directorate finance for change from curtains to screens. Policy being developed, capital bid for modifications submitted.
3. Reduction of glove use – the 'gloves are off' campaign was successfully launched and glove use has reduced. Surveillance is underway to see if skin care improves.
4. Need to review IPCC attendees to ensure representation from all new Directorates without excessive increase in committee size.
5. A new GOSH/ICH genetically modified organism safety committee has been established with formal reporting to ICH but also to IPCC.

J C Hartley
Consultant Microbiologist and DIPC

26/11/2018

Trust Board 5th December 2018	
<p>Learning from Deaths. Mortality Review Group - Report of deaths in Q1 2018/2019</p> <p>Submitted by: Mr Matthew Shaw, Medical Director Andrew Pearson, Clinical Audit Manager; Dr Isabeau Walker, Consultant Anaesthesia & co-chair of the MRG</p>	Paper No: Attachment V
<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 is an executive summary of a report that was reviewed at the Patient Safety and Outcomes Committee on the 28th September.</p> <p>The Trust Learning from Deaths Policy mandates that mortality reviews occur within 12 weeks of death, this is in line with national guidance. At the time of writing, there is one case where a review has not been completed by the MRG within the timeframes. This is because the review cannot be completed until post mortem investigations have been completed. The Learning from Deaths report for Q2 2018/19 is on the agenda for the January 2019 Patient Safety and Outcomes Committee.</p> <p>The Child Death Review Statutory Guidance was published in October 2018. A plan and resources will require development to ensure the Trust is able to meet the additional requirements of this guidance</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>	

Attachment V

Mortality Review Group: Report of deaths in Q1 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.

The National Quality Board (NQB) National Guidance on Learning from Deaths requires trusts to have a policy for reviewing and learning from deaths and for this to be available on the trust website. The Trust published an interim policy in March 2018 and is still awaiting publication of HM Government Child Death Review Statutory Guidance. Once the Child Death Review guidance is published, further work will be required to assess any changes required, and develop a plan to meet any additional requirements. The inclusion criteria for the cases reviewed by the MRG will be reviewed upon publication of that guidance.

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 draft 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 April and 30th June 2018

Headlines

The MRG reviews continue to highlight the excellent care provided by the multidisciplinary teams at GOSH for children, young people and their families, including at the end of life.

Twenty children died at GOSH between 1st April and 30th June 2018. 20 children. Case record reviews have been completed for 18 patients. Two cases cannot be reviewed until notes can be made available following post mortem.

Of the 18 cases reviewed:

- One case had a modifiable factor in the child's care at GOSH that may have contributed to vulnerability, ill health or death (influence score 2¹).
- There was one case where the review team felt that there had been a modifiable factor in the child's care outside GOSH that may have contributed to vulnerability, ill health or death (influence score 2¹).
- The table below provides a summary of the deaths that occurred during the quarter using NHS England reporting guidance and guidance included in the draft HM Government Child Death Review Statutory Guidance.

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

Total number of inpatient deaths at GOSH between 1st April and 30 th June 2018	20
Number of those deaths subject to case record review by the MRG	18 ²
Number of those deaths investigated under the serious incident framework and declared as serious incidents	0 ³
Number of deaths where a modifiable factor was identified at GOSH with an influence score of 2	1
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	4
Number of deaths of people with learning disabilities that have been reviewed	4
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 Nurse Consultant for Learning Disabilities is the lead at GOSH for notifying deaths and coordinating requests for information.

Period of deaths covered	N of notifications required by GOSH	N of notifications made	N of outstanding notifications
May 2017 to June 2018	5	5	0

Learning points for deaths occurring in Q1 2018/19

The following general learning points have been derived from the 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 to continuously improve the care provided for patients.

Cardiac conditions, non-cardiac surgery

- *Teams should be aware of 'red flag' cardiac conditions when children present for non-cardiac surgery, particularly where the patient is referred to GOSH from another hospital. This includes patients with single ventricle physiology, shunt-dependent pulmonary circulation (e.g. modified Blalock-Tausig (mBT) shunt), cardiomyopathy, severe pulmonary hypertension, left ventricular outflow obstruction (e.g. aortic stenosis), cyanosis, and children awaiting cardiac surgery. Multidisciplinary discussions should take place prior to all non-cardiac operations in these complex patients.*
- *It is helpful to conduct a systematic handover when care is transferred between specialty teams, particularly in a child with complex disease who is deteriorating acutely.*

Undiagnosed metabolic condition in a child born outside the UK

- *A child with learning disability, myopia, tall stature and scoliosis presented with seizures and was found to have a new diagnosis of homocystinuria. This is an inherited metabolic condition that is amenable to treatment, usually diagnosed on newborn blood spot screening. Children with multiple unexplained abnormalities under the care of different hospitals may have a unifying metabolic diagnosis that has been missed, particularly in communities where consanguineous marriage is common. A child born outside the UK may not have been subject to a newborn screening programme.*

² Two cases cannot be reviewed until notes can be made available following post mortem.

³ Additional documentation about the one case is being reviewed by the Lead Patient Safety Manager, in order that a decision can be made by the EIRM as to the appropriate level of safety investigation to take place at GOSH.

Errors with completion of the MCCD

- *Eight out of ten Medical Certificate of Cause of Death (MCCD) reviewed were completed appropriately. In one case, Trisomy 21 had been omitted from the MCCD.*
- *The MCCD is an important legal document that should be completed by a doctor who attended the patient in their last illness, generally taken as a doctor who cared for the patient during the last 14 days of their life. The MCCD should be completed promptly, legibly, and should be factually correct, not omitting relevant information. Abbreviations should be avoided.*
- *Section 1a relates to the direct immediate cause of death, with each subsequent line going back through the sequence of events so that the last line of section 1 refers to the root cause that explains all the conditions in the lines above. Section 2 of the cause of death is for any other conditions contributing to the death, for example a chronic condition.*
- *A neonatal death certificate should be used where a child dies within the first 28 days of life.*

Documentation/communication – better, but definitely still room for improvement

- *In 17/18 cases documentation was deemed excellent or good. However, in one case there were no medical entries in the patient's notes for four days. Medical teams need to make entries in the patient's medical record on a daily basis for all in-patients.*
- *A patient received cardiopulmonary resuscitation with a 'do not resuscitate' order in place. DNAR orders must be documented clearly in the medical record; it is also important to make sure that all members of the ward team are made aware of this, for instance at routine handovers.*
- *It is essential to log all referrals promptly in EDM, including e-mail referrals, particularly for complex patient managed by multiple different teams.*
- *A team highlighted a concern about medication administered by the parents that had been part of an experimental treatment received overseas. There is a Trust Policy for parent administered medication, and it is important to involve the Chief Pharmacist and the Medical Director, particularly if the nature of the medication is unknown.*

Please note that these are learning points from case reviews and do not replace Trust policies and guidelines.

17th September 2018

Dr Isabeau Walker, Consultant Anaesthetist & Co-Chair of MRG; Andrew Pearson, Clinical Audit Manager

Mortality Review Group
Quarterly Reporting Schedule 2018 - 2019

Quarter	Deaths to be reported	MRG time timeframes to have review cases for the quarter (12 weeks after death)	Quarterly report due to be presented at next following PSOC (papers deadline)	Date presented	Trust Board
Q1 18/19	1 st April 2018 – 30 th June 2018	2 nd September	Friday 28 th September 2018	Friday 28 th September 2018	Pending Dec 18
Q2 18/19	1 st July 2018 – 30 th September 2018	23 rd December [MRG is on 17 th Dec]	9 th January 2019 Paper deadline is 31 st December (will need to write by 20th December)		Next Trust Board is 7 th February – papers deadline is 29 th January 2018
Q3 18/19	1 st October 2018 – 31 st December 2018	26 th March 2019	10 th April 2019 Papers deadline is Tuesday 2 nd April		
Q4 18/19	1 st January 2019 – 31 st March 2019	24 th June 2019	Weds 10 th July 2019 Tues 2 nd July papers deadline		

Trust Board 5th December 2018	
Integrated Performance Report: October 2018 (Reporting Month 7 2018/19)	Paper No: Attachment W
Submitted by: Nicola Grinstead, Deputy Chief Executive / Peter Hyland, Director of Operational Performance and Information	
Aims / summary The Integrated Performance Report (IPR) is focused on the key areas/ domains in line with the CQC, in order to be assured that the Trust's services are delivering to the level our patients & families, Trust Board and our commissioners & regulators expect. The indicators included are those that have been recommended by the Trust Board, Clinical Divisions and other relevant parties. It is expected that these will evolve and iterate overtime. The narrative provides provide more detail / analysis from the IPR of those indicators not meeting the required standards or where they warrant further mention. In addition, this report included a deep dive related to improve the Trust theatre utilisation, as well as a report detailing the Kite Marking scores for the Trust Performance Report.	
Action required from the meeting Board members to note and agree on actions where necessary	
Contribution to the delivery of NHS Foundation Trust strategies and plans All the indicators within the IPR contribute to the delivery of either regulatory or commissioner requirements, and as such are aligned to the objectives and strategy of the Trust	
Financial implications For indicators that have a contractual consequence there could be financial implications for under-delivery	
Who needs to be told about any decision? Where appropriate and applicable: Internal stakeholders, NHS Improvement and NHS England Special Services Commissioners	
Who is responsible for implementing the proposals / project and anticipated timescales? Each Domain / Section has a nominated Executive Lead	
Who is accountable for the implementation of the proposal / project? As above	



Integrated Performance Report

Nicola Grinstead, Deputy CEO
December 2018
(Month 7 2018/19)

The child first and always

Executive Summary	Page 3
Integrated Performance Dashboard	Appendix I
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 Well Led	Page 11 – 17
 Effective	Page 18
 Productivity	Page 19 – 20
 Our Money	Page 21
Appendix I: Integrated Performance Dashboard	Attached
Appendix II: Data Quality – Overview	Attached
Appendix III: Definitions	Attached

December 2018 (Month 7 2018/19)

The Trust Integrated Performance Report (IPR) is designed to focus on the key areas/ domains below, in order to be assured that our services are delivering to the level our patients & families, Trust Board and our commissioners & regulators expect.

The domains are consistent with the Care Quality Commission and cover:

- Caring
- Safe
- Responsive
- Well-led
- Effective

The IPR additionally includes further indicators and metrics with regard to Our Money (Finance), Data Completeness and Productivity. These indicators are those that have been recommended by the Trust Board, Clinical Divisions and other relevant parties. The IPR is attached as an appendix to this supporting narrative. As per previously for other elements this report and narrative should continue to be looked at in conjunction with the Quality and Safety Report and Finance Report.

At the time of writing the Trust Board report, Month 7 (October 2018) data was available, with key national submission deadlines being met and data reviewed in time for inclusion.



Friends & Family Test (FFT)

Headlines via the Performance Report for these measures are:

- Continued positive recommendation responses for those undertaking the Inpatient FFT (97.79% in October compared to 98.07% in September)
- The rate (%) of those responding (for Inpatients) has continues to be challenging for the Trust. Following the introduction of the electronic system the average response rate has been 13.5%, October performance has seen 12.54%, the contributing factors have been described in previous reports. Contextually based on data submitted in over the last 3 months the Trust is an outlier in the FFT response rate nationally which stands at 24%, with the Trust's peers having an average of 36% response rate.

Please note that following discussions the Trusts internal response rate target has been reviewed and amended to 25% (previously 40%)

Response Mode of Collection	Apr	May	June	July	Aug	Sept	Oct
Paper	796	830	445	546	512	358	539
Online Survey	0	0	5	2	7	4	11
Total	796	830	450	548	519	362	550
GOSH Response Rate	24.54%	24.34%	13.01%	15.71%	15.03%	11.28%	12.54%
National Rate	24.4%	25.1%	24.8%	24.8%	24.6%	24.2%	NP

A comprehensive overview and assessment of the Inpatient FFT delivery is provided in the Integrated Quality and Safety Report, tracking response rates over time and also in comparison to other organisations. This is reviewed and assessed in the relevant Trust Committees, and Divisional Nursing leads provide regular updates at their monthly Divisional Performance meetings.

Access to Healthcare for people with Learning Disabilities

The Trust continues to report compliance with this requirement against the measure outlined in the supporting appendix which provides an overview of the definitions for each indicator.





Number of Complaints received in month

This indicator has been introduced to the Trust Board Dashboard from this month and requested to provide additional quality measures. This indicator provides the number of complaints received during the reporting period.

For the month of October the Trust received 18 complaints, these are split into the following services:-

Gastroenterology – 3, Neurology – 2, Oncology – 2, Orthopaedic Surgery – 2, Surgery – 1, Cardiology – 1, Cardiac Surgery -1, Physiotherapy – 1, PICU – 1, Plastic Surgery – 1, CAMHS – 1, Pharmacy – 1 and Health Records – 1,

Each complaint is reviewed as per the Trust policy. At the end of October , 18 complaints were open with oldest being from June 2018 in CAMHS, the draft response has been received and being reviewed.

*

Number of overdue RCA's

This indicator construction and content is currently being agreed and will be available in future reports



Serious Incidents and Never Events

As confirmed in the Performance Dashboard and in the Quality & Safety Report, there was one serious incident and zero never events reported in October. Year to date the Trust has reported 17 Serious Incidents and zero never events.

645 Incidents have been reported in October, this is a new indicator within the Board report. Further detail is provided in the Quality and Safety report.

Healthcare Associated Infections (HCAIs)

Incidents of C. Difficile

The Trust reported two cases of C Diff in October, with a year to date total of three. The Trust's total allowance for 2018/19 is 14 cases which is set nationally.

Incidents of MRSA

The Trust did not report any incidents of MRSA in October. However, one MRSA case was reported on Eagle ward in September taking the year to date position to two. A full RCA has been completed.

CV Line Infections

October performance was 1.01 against 1.6 per 1000 line days compared to September when the Trust reported 1.28 per 1000 line days. All incidents have or will be investigated by the lead nursing staff with involvement from the Infection Control team. Please see the Quality & Safety report for further detail.

WHO Surgical Checklist Completion (> 98%)

The Trust continues to not deliver against the 98% standard, for the month of October the Trust achieved 93.29% for the data collected on PIMs. This is a slight increase from September when the Trust reported 93.22%. The average this financial year is 93.45%.

However, as part of the NatSSIPs project the week-long trust-wide observational audit indicated the Trust continues to have excellent compliance with team brief and sign-in, time out and sign out had positive data collection at 96% and 95% respectively but has room for improvement. The weak point is debrief at 54% and work continues within divisions to improve this and is overseen by the Medical Director.

Hospital Acquired pressure / device related ulcer: Grade 3 & above

The Trust reported one patient with a grade 3 pressure ulcer in October on Caterpillar within IPP. Further details are provided in Quality & Safety report.



Responsive



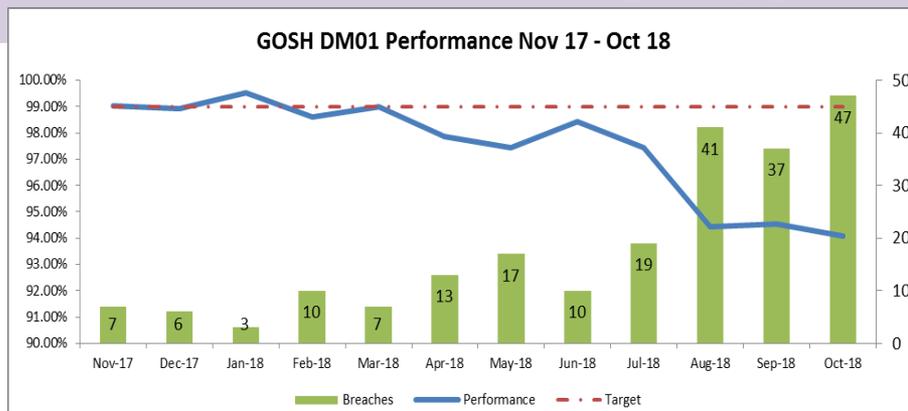
Diagnostics (99% < 6 weeks) – April 2018 position

In October, the Trust underachieved against the standard of 99% for patients accessing the 15 diagnostic modalities within 6 weeks of referral / request at 94.07%, this is a deterioration from September (94.53%). The Trust has underachieved against this standard since February 2018, as previously reported this is a challenging standard for the Trust due to the low denominator and permitted breach numbers. However, the number of breaches for October remain significantly high compared to previous months.

As shown in the table opposite, the overall number of breaches for October was 47 (increase of ten from September). Breaches occurred in Audiology (3), CT (1), Dexa (2), MRI (15), Non Obstetric Ultrasound (14), Cystoscopy (2), Gastroscopy (6), Urodynamics (1), Cardiac MRI (2) and Clinical Neurophysiology (1).

As previously reported the Audiology incorrect administrative process has been quickly rectified resulting in the decrease of breaches in that modality. The increase in the remaining breaches are disappointingly mainly due to administrative staff not following the Trust's standard operating procedure (SOP) for offering reasonable notice to patients or processes in requesting information, this has resulted in 28 breaches. This has been addressed via reiteration of the SOP to the booking teams and additional intervention by the directorate senior management team. Four were due to late requests into Radiology, six were due to equipment failure, two were complex patients and four patients were unable to proceed on the day.

Contextually when comparing GOSH nationally, out of 182 Providers reporting against the standard (NHS and Independent sector) 109 in September were delivering 99% or better (it must be noted that 12 of these trusts reported a waiting list of less than 100 and a number are also providers just offering certain specific diagnostics, rather than a full range).



Modality	Breach	No Breach	Grand Total	%
Body, Bones & Mind	9	93	102	91.18%
Colonoscopy	1	1	1	100.00%
Cystoscopy	2	17	19	89.47%
Gastroscopy	6	43	49	87.76%
Urodynamics - pressures & flows	1	32	33	96.97%
Brain	1	31	32	96.88%
Neurophysiology - peripheral neurophysiology	1	31	32	96.88%
Heart & Lung	2	74	76	97.37%
Cardiology - echocardiography	1	1	1	100.00%
Magnetic Resonance Imaging	2	21	23	91.30%
Respiratory physiology - sleep studies	0	52	52	100.00%
Operations & Images	32	510	542	94.10%
Barium Enema	0	7	7	100.00%
Computed Tomography	1	55	56	98.21%
DEXA Scan	2	20	22	90.91%
Magnetic Resonance Imaging	15	219	234	93.59%
Non-obstetric ultrasound	14	209	223	93.72%
Sight & Sound	3	38	41	92.68%
Audiology - Audiology Assessments	3	38	41	92.68%
Grand Total	47	746	793	94.07%

Cancer Wait Times

At the time of writing the report for the month of September 2018 the Trust reported one breach against the 31 Day Subsequent Treatment – Surgery standards, this was due to the patient being unwell on the day. For all other indicators applicable to the Trust performance is at 100%. Indicative performance for October indicates compliance against all standards.

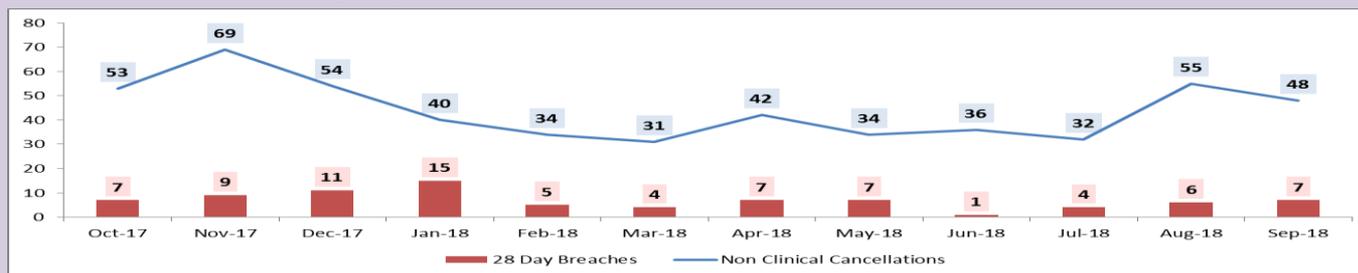




Last minute non-clinical hospital cancelled operations (and associated 28 day breaches)

Reported in the dashboard are the monthly breakdowns for this quarterly reportable indicator.

For month of September 2018, the Trust reported a slight improvement in performance the number of patients cancelled, however, for the quarter as a whole is 23 higher than the previous quarter (135 v 112). There were 48 last minute non-clinical hospital cancelled operations, compared to 55 in August 2018. The areas contributing most to these were Cardiology/Cardiac Surgery (17), Radiology (18) and Surgery (4). The main reasons recorded for September are List Overrun (13), Emergency Case (12) and Ward Bed Unavailable (12).



The Trust reported seven last minute cancelled operations within 28 days of the cancellation in September, (compared to six in August). Four Cardiology/Cardiac patients, one Ophthalmology patient, one Surgery patient and one Urology 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 reported no patient being cancelled for an urgent operation for the last five consecutive months.





Mental Health Identifiers

Mental Health Identifiers: Data Completeness

The Trust is nationally required to monitor the proportion of patient accessing Mental Health Services at the Trust that have a valid NHS number, date of birth, postcode, gender, GP practice and commissioner code. Within this area the Trust consistently meets the 97% standard with 99.50% of patients having valid data in September.

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 significantly improved collating ethnicity for patients accessing mental health services, with 60.64% (+18.04%) in October having a valid ethnic code. This is continues to be addressed with operational teams via weekly monitoring, refreshed training and focused Data Assurance work.

Patients with a valid NHS Number

% of patients with a valid NHS Number Inpatients and Outpatients

This indicator has been added the Dashboard for 2018/19 following agreement with NHSE the content of Schedule 4 of the NHS Contract. Nationally the Trust is monitored against achieving 99% of patients having a valid NHS Number across all services being accessed. As the report depicts for both Inpatients and Outpatients this is below the standard, nationally the average for both indicators is above 99%. Work is being undertaken to understand the drivers underpinning the data.



Workforce Headlines

- **Contractual staff in post:** Substantive staff in post increased to 4600.2 FTE (full-time equivalent) in October. This is 228.1 FTE (5.2%) higher than the same month last year.
- **Unfilled vacancy rate:** The Trust vacancy rate for October reduced to 1.8% (81 FTE), well below the Trust target of 10%. Nursing vacancies decreased to 88 FTE (5.5%) as a large cohort of Junior Band 5 nurses joined the Trust.
- **Turnover** is reported as voluntary turnover. Voluntary turnover increased in October to 14.7% which is above target but has reduced since August, and is expected to continue reducing over the next few months. Relocation and promotion were the most common reported leaving reason. Total turnover (including Fixed Term Contracts) also increased to 17.5%
- **Agency usage** for 2018/19 (year to date) stands at 1.07% of total paybill, which is below the local stretch target, and is also well below the same month last year (2.2%). Human Resources Business Partners continue to work with the divisions and corporate areas to address local pockets of agency usage. The target for 2018/19 remains 2% of total paybill.
- **Statutory & Mandatory training compliance:** In October the compliance across the Trust was 92%. 2 Directorates with below target compliance are being offered support. The target for 2018/19 remains 90%.
- **Sickness absence** remains below target at 2.4% and below the London average figure of 2.8%. During 2018, the Trust will implement an integrated rostering system. The system will support improvements in the accuracy of absence reporting, which may lead to fluctuations in reported rates. The 2018/19 target remains 3%
- **Appraisal/PDR completion** The non-medical appraisal rate has reduced to 81% since August and remains below the Trust target, however the Trust continues to benchmark well. Reminders of expired appraisals are being sent to managers. Consultant appraisal rates have reduced slightly to 83%. Targets this year remain at 90%.





Trust KPI performance October 2018

Metric	Plan	October 2018	3m average	12m average
Voluntary Turnover	14%	14.7%	14.9%	14.2%
Sickness (12m)	3%	2.4%	2.4%	2.4%
Vacancy	10%	1.8%	3.3%	3.5%
Agency spend	2%	1.1%	1.1%	1.4%
PDR %	90%	81%	86%	85%
Consultant Appraisals	90%	83%	84%	84%
Statutory & Mandatory training	90%	92%	92%	91%

Key:
■ Achieving Plan ■ Within 10% of Plan ■ Not achieving Plan



Directorate (Clinical) KPI performance October 2018

Metric	Plan	Trust	Blood, Cells & Cancer	Body, Bones & Mind	Brain	Heart & Lung	Medicine, Therapies & Tests	Operations & Images	Sight & Sound	IPP
Voluntary Turnover	14%	14.7%	17.0%	14.3%	10.7%	16.1%	11.5%	10.4%	18.2%	23.9%
Sickness (12m)	3%	2.4%	2.6%	2.3%	2.3%	2.7%	1.9%	2.3%	2.8%	3.4%
Vacancy	10%	1.8%	-7.1%	-3.6%	2.0%	7.1%	-10.9%	4.7%	14.3%	16.0%
Agency spend	2%	1.1%	0.1%	0.2%	0.0%	0.2%	3.1%	0.9%	1.8%	0.0%
PDR %	90%	81%	85%	79%	91%	74%	84%	77%	72%	95%
Stat/Mand Training	90%	92%	90%	92%	90%	88%	93%	93%	91%	97%

Key:

- Achieving Plan
- Within 10% of Plan
- Not achieving Plan



Directorate (Corporate) KPI performance October 2018

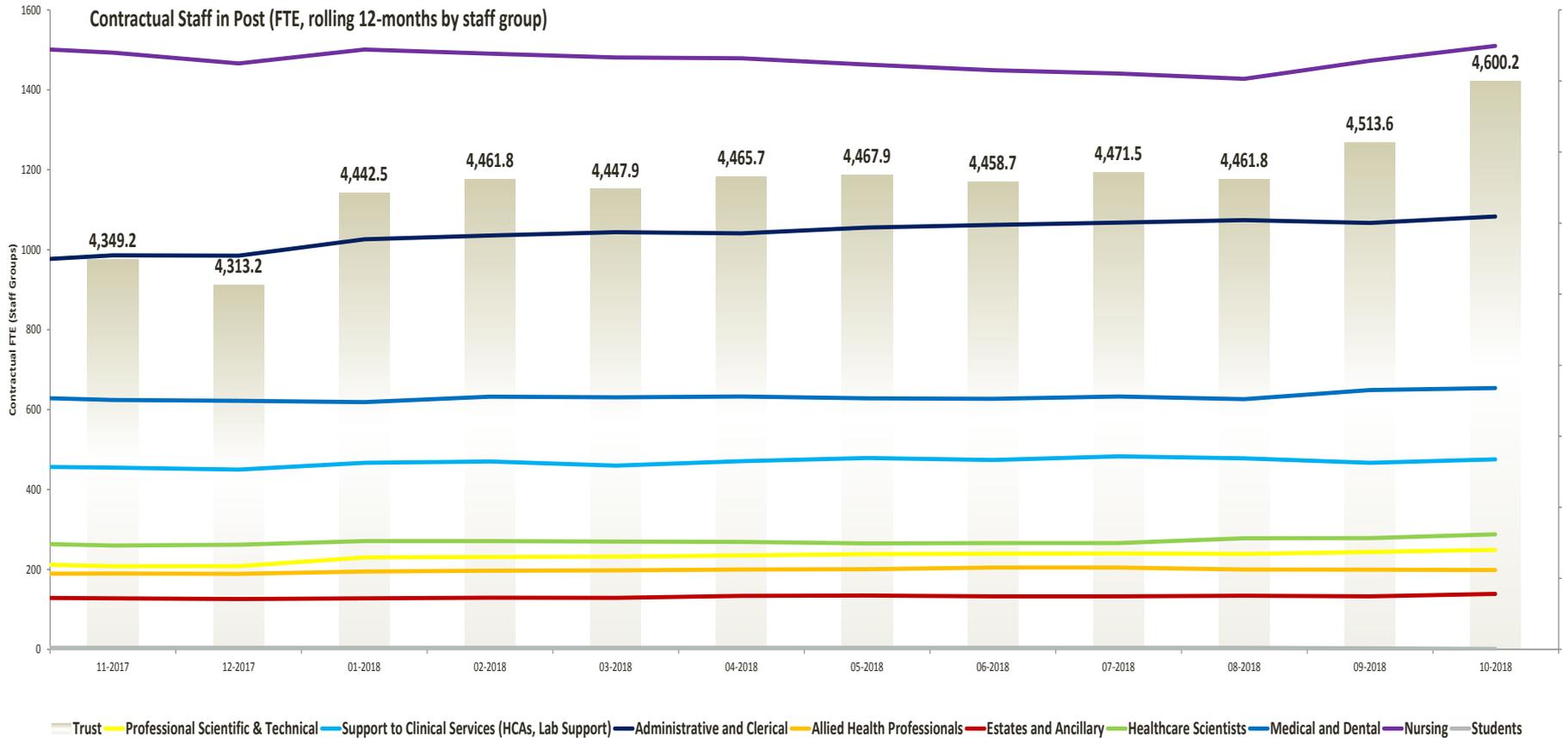
Metric	Plan	Trust	Clinical Operations	Corporate Affairs	DPS	Finance	HR&OD	Medical Director	Nursing & Patient Experience	Research & Innovation
Voluntary Turnover	14%	14.7%	17.4%	20.9%	13.3%	12.5%	21.9%	14.5%	12.9%	25.3%
Sickness (12m)	3%	2.4%	2.0%	0.1%	2.3%	1.3%	4.0%	0.8%	1.3%	2.3%
Vacancy	10%	1.8%	-12.0%	-30.9%	19.5%	22.3%	13.7%	9.0%	-4.8%	-70.8%
Agency spend	2%	1.1%	0.7%	-0.3%	1.8%	4.7%	8.9%	0.0%	0.9%	0.3%
PDR %	90%	81%	82%	77%	92%	79%	85%	55%	80%	79%
Stat/Mand Training	90%	92%	100%	83%	95%	98%	97%	94%	95%	96%

Key:

- Achieving Plan
- Within 10% of Plan
- Not achieving Plan



Substantive staff in post by staff group





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 Delivery and Performance Group 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 Divisions / Directorates.

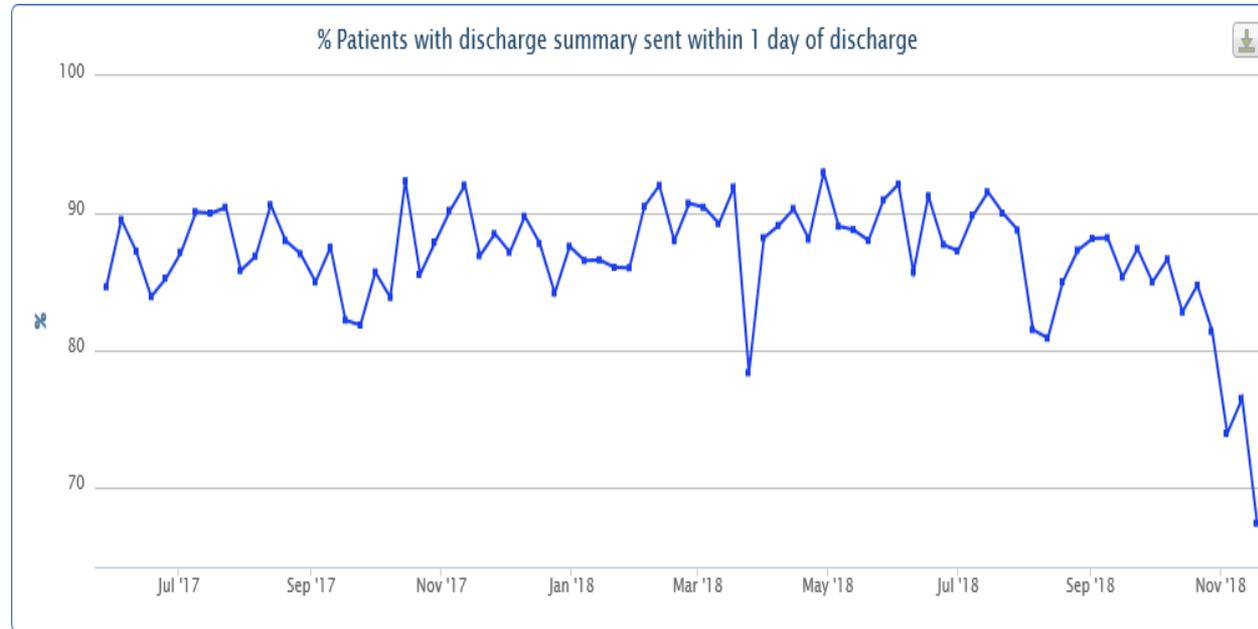


Discharge Summaries

As is evident from the SPC chart and the dashboard, performance in this area continues to fluctuate. For October 2018, the position was 85.51% sent within 24hrs of discharge, which is a deterioration from September performance (87.31%). As per definitions of this metrics, the expectation for the Trust is to send all discharge summaries within 24 hours.

The Clinical Directorates continue to keep this as an areas of focus and challenge, and reported such in monthly performance meetings. It should also be noted that 93% of patients and referrers receive a discharge summary within 48 hours of discharge

Some of the on going actions in place in divisions include daily reminders to HoCS/SM/fellows to complete the DS within 24 hours, weekly reports generated and sent to the Service and Ward Clerks, ensure discharges flagged as exclude are clinically validated and documented. There is also a lack of adequate junior doctor clinical cover between all specialties which is impacting this measure. In some instances recruitment to posts has been unsuccessful on a number of occasions, work with HR and senior clinical leads is ongoing.



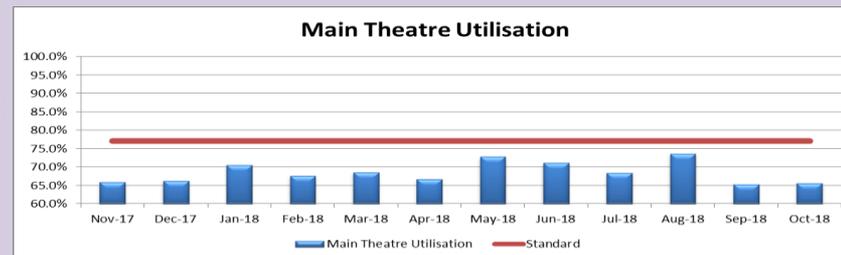
Clinic Letter Turnaround times

For September (as this indicator is reported a month in arrears), there has been a deteriorated in performance in relation to 14 day turnaround, 69.53% from 70.66% in August. For those sent within 7 working days, performance has also reduced, 43.91% from 44.91% in August. Some of the actions in place to improve performance are operational teams focusing on identifying where delays in the process reside within each specialty and implementing actions e.g. targeting sign off where weekly reminders for clinical teams to sign of letters are circulated, providing remote access to clinicians so they can sign off letters electronically, create and administer a robust monitoring system for administrators to be used on a weekly basis to check the upload and downloading of letters, clinic letter turnaround being part of service reviews, and extra admin time to work through the backlog of letters in specific areas.



Utilisation of main theatres has significantly decreased in October to 65.6% from 73.6% (August). Specialties with utilisation above 70% are Plastic Surgery (78%), ENT (77%), Dental (73%), Urology (72%), and Ophthalmology (70%). Areas of concern Spinal Surgery (57.6%), SNAPS (64.8%) and Neurosurgery (63.6%).

The main drivers for deterioration are being investigated by the operational teams. Work which remains ongoing includes addressing delays with consenting and clerking of patients, continuing to target specialties that do not fully utilise capacity or book to over 100% and reducing data quality errors.



Beds

The metrics supporting bed productivity are to be improved for future months, however for now, reflect occupancy and (as requested) the average number of beds closed over the reporting period.

Occupancy: For the reporting period of September, occupancy has returned to previous levels of above 80% to 81.5%. This indicator and methodology is currently under-review as part of the statutory returns work being completed to support EPR implementation.

Bed closures: There has been a further increase in the average number of beds closed in October (35) compared to 29 in August, the reasons recorded are linked to staffing. This was mainly due to Sky having an average of 6 beds closed and Butterfly an average of 5 beds closed. Robin, Fox, Koala and Bumblebee all had average of 4 beds closed. PICU/NICU average of 4 beds.

Activity

Trust activity: October activity for day case discharges, outpatient attendances are above the same reporting period for last year ytd, critical care bed-days and overnight discharges remain below the same reporting period ytd. Further detail will be provided within the Finance Report.

Long stay patients: This looks at any patient discharged that month with a length of stay (LOS) greater than 100 days, and the combined number of days in the hospital. For October, the Trust reported 13 patients discharges that had amassed a combined LOS of 2,459 days of which 1906 are attributable to critical care. The patients with 200 days plus LOS were Cardiac, CAMHS and SNAPS. The clinical coding of the admissions relate to the patients having many having complex conditions and comorbidities warranting that LOS.



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.

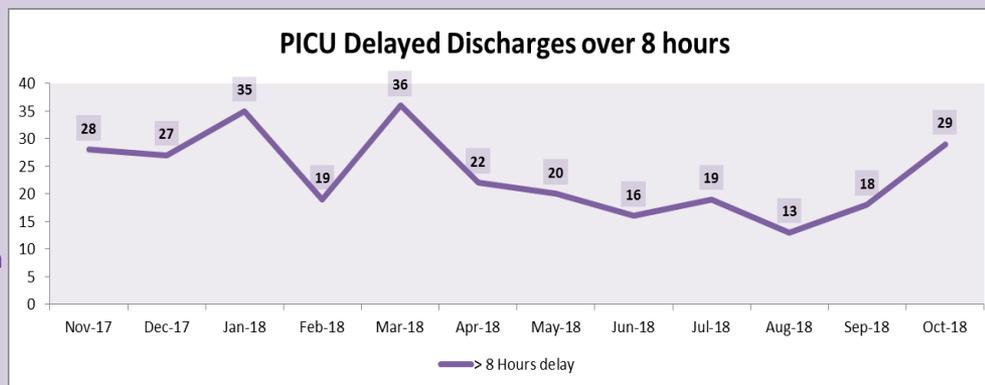
CATS PICU/NICU Refusals: The number of CATS referral refusals into PICU/NICU from other providers during October has significantly increased to 25 from a September position of eleven. Compared to the first seven months of 17/18 (71 refusals) the number of refusals is 79 (+8) in 18/19. During April – October 2018 the Trust received 199 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
Q1 18/19	27	112	24.1	6.27
Q4 17/18	No Data	No Data	No Data	No Data
Q3 17/18	99	226	43.8	19.8
Q2 17/18	32	148	21.6	7.14

PICU Emergency Readmissions: Readmissions back into PICU within 48 hours is two for the month of October. During April to October 2018 seven patients have been re-admitted to the department.

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. October has seen 29 total delays over 8 hours reported compared to 18 in September. Over the last 8 months, 25% of patients have been delayed due to accessing another Provider, and 75% accessing a bed internally within the hospital.





Summary

This section of the IPR includes a year to date position up to and including October 2018 (Month 7). In line with the figures presented, the Trust has a YTD Control Total Surplus of £8.1m which is £0.9m behind plan. The Trust is generating a YTD surplus of £1.7m which is £0.9m behind plan.

- Clinical Income (exc. International Private Patients and Pass through Income) is £1.1m higher than plan
- Non Clinical revenue is £2.1m higher than plan
- Private Patients income is £0.8m higher than plan
- Staff costs are £1.8m higher than plan
- Non-pay costs (excluding pass-through costs) are £3.3m higher than plan

Appendix I – Integrated Performance Dashboard

Please see attached covering all the domains in line with this supporting narrative

Appendix II – Data Quality Kite-Marking

Please find attached the supporting DQ Kite-marking for each of the reportable indicators within the Trust Board report

This is in line with previous updates provided to the Board and Trust Audit Committee, which assesses each of the indicators for:

- Accuracy
- Validity
- Reliability
- Timeliness
- Relevance
- Audit
- Executive Judgement

Any areas where there is insufficient assurance an action plan is needed or is in place, approved and signed off for the relevant SRO / Executive lead for that metric. These will then be monitored by the SRO and then re-assessed at a set point in the year.

A more detailed summary is provided as part of the dashboard.

Appendix III – Definitions

Please see attached the supporting definitions and methodologies for each of the metrics reported upon

	Aug-18	Sep-18	Oct-18	Trend	Plan	NHS Standard
Caring						
Access to Healthcare for people with Learning Disability				→		
% Positive Response Friends & Family Test: Inpatients	96.72%	98.07%	97.79%	↓		95%
Response Rate Friends & Family Test: Inpatients	15.03%	11.28%	12.54%	↑		25%
% Positive Response Friends & Family Test: Outpatients	94.21%	93.60%	95.66%	↑		95%
Number of complaints received in month	7	8	18			
Number of open RCAs	TBC	TBC	TBC			

	Aug-18	Sep-18	Oct-18	Trend	Plan	NHS Standard
Safe						
Number of Incidents	Reported Open	608	596	645		
Serious Patient Safety Incidents (date reported on STEIS)	In-month	0	4	1		
	YTD	12	16	17		
Never Events	In-month	0	0	0	→	0
	YTD	0	0	0	→	0
Incidents of C. Difficile	In-month	0	1	2	↓	
	YTD	0	1	3	↓	
C.Difficile due to Lapses of Care	In-month	0	0	0	→	0%
	YTD	0	0	0	→	
Incidents of MRSA	In-month	0	1	0	↑	0
	YTD	1	2	2	→	0
CV Line Infection Rate (per 1,000 line days)		1.40	1.28	1.01	↑	1.6
WHO Checklist Completion		92.27%	93.22%	93.29%	↑	98%
Arrests Outside of ICU	Cardiac Arrests	2	1	0	↑	5
	Respiratory Arrests	3	1	0	↑	
Total hospital acquired pressure / device related ulcer rates grade 3 & above		0	0	1	↓	0

	Aug-18	Sep-18	Oct-18	Trend	Plan	NHS Standard
Responsive						
Diagnostics: Patients Waiting <6 Weeks	94.44%	94.53%	94.07%	↓		99%
Cancer 31 Day: Referral to First Treatment	100%	100%		→		85%
Cancer 31 Day: Decision to Treat to First Treatment	100%	100%		→		96%
Cancer 31 Day: Decision to Treat to Subsequent Treatment - Surgery	100%	83%		↓		94%
Cancer 31 Day: Decision to Treat to Subsequent Treatment - Drugs	100%	100%		→		98%
Cancer 62 day: Consultant Upgrade of Urgency of a referral to first treatment	100%	100%		→		
Last Minute Non-Clinical Hospital Cancelled Operations	55	48		↑		
Last Minute Non-Clinical Hospital Cancelled Operations: Breach of 28 Day Standard	6	7		↓		0
Urgent Operations Cancelled for a 2nd Time	0	0	0	→		0
Same day / day before hospital cancelled outpatient appointments	1.37%	1.27%	1.54%	↓		
RTT: Incomplete Pathways (National Reporting)	92.85%	92.24%	92.19%	↓		92%
RTT: Number of Incomplete Pathways (National Reporting)	<18wks	4896	5279	5501	↑	-
	>18wks	377	444	466	↓	-
RTT: Incomplete Pathways >52 Weeks - Validated	6	5	2	↑		0
RTT: Incomplete Pathways >40 Weeks - Validated	20	18	11	↑		0
Number of unknown Internal Referrals	1	2	1	↑		-
RTT clock starts External Referrals	910	416	562	↓		-
RTT: Total Number of Incomplete Pathways Known/Unknown	<18 weeks	5792	5681	6042	↑	-
	>18 weeks	392	458	488	↓	-

	Aug-18	Sep-18	Oct-18	Trend	Plan	NHS Standard
Data Completeness						
Mental Health Identifiers: Data Completeness	99.12%	99.25%	99.50%	↑		97%
Mental Health Ethnicity Completion - % - No NHSE Reference	42.60%	60.64%	60.64%	↓		90%
% of Patients with a valid NHS number - No NHSE Reference	Inpatients	92.6%	TBC	TBC		99%
	Outpatients	93.5%	TBC	TBC		

Trend Arrow Key (based on 2 most recent months' data)

↑	Improvement	On / above target
→	Consistent trend	Below target
↓	Deterioration	No target

	Aug-18	Sep-18	Oct-18	Trend	Plan	NHS Standard
People, Management & Culture: Well-Led						
Sickness Rate	2.41%	2.42%	2.40%	↑		3%
Turnover	Total	17.6%	17.7%	17.5%	↑	18%
	Voluntary	15.2%	14.8%	14.7%	↑	14%
Appraisal Rate	Non-Consultant	86.0%	79.0%	81.0%	↓	90%
	Consultant	84.0%	84.0%	83.0%	↓	
Mandatory Training		93.0%	92.0%	92.0%	→	90%
% Staff Recommending the Trust as a Place to Work: Friends & Family Test						61%
Vacancy Rate	Contractual	4.8%	3.4%	1.8%	↑	10%
	Nursing	7.9%	4.0%	1.3%	↑	
Bank Spend		6.1%	5.9%	6.2%	↓	
Agency Spend		1.07%	1.08%	1.07%	↑	2%

	Aug-18	Sep-18	Oct-18	Trend	Plan	NHS Standard
Effective						
Discharge Summary Turnaround within 24hrs	84.11%	87.31%	85.51%	↓		100%
Clinic Letter Turnaround within	7 working days	44.26%	43.91%	-	↓	
	14 working days	70.66%	69.53%		↓	100%
Was Not Brought (DNA) Rate NHS (exc Telephone Contacts)		8.92%	8.89%	8.41%	↑	7.73%

	Aug-18	Sep-18	Oct-18	Trend	Plan	NHS Standard
Productivity						
Main Theatres	Theatre Utilisation	73.6%	65.3%	65.6%	↑	77%
Outside Theatres	Theatre Utilisation	50.0%	55.4%	56.4%	↑	77%
Trust Beds	Bed Occupancy	79.7%	85.0%	81.5%	↓	
	No of available beds	406	406	406	↓	
Average number of trust beds closed	Wards	29	33	35	↓	
	ICU	6	8	5	↑	

	Aug-18	Sep-18	Oct-18	Trend	Plan	NHS Standard
Activity (NHS & PP)						
Refused Admissions	Cardiac refusals	1	3	7	↓	
	PICU / NICU refusals	7	11	25	↓	
Number of PICU Delayed Discharges	Internal 8 - 24 hours	2	1	3	↓	
	Internal 24 hours+	4	11	16	↓	
	External 8 - 24 hours	0	3	1	↑	
	External 24 hours+	7	3	9	↓	
	Total 8 - 24 hours	2	4	4	→	
	Total 24 hours+	11	14	25	↓	
PICU Emergency Readmissions < 48 hours		2	0	2		
Daycase Discharges (YOY comparison)	In-month	2,453	2,324	2,608	↑	2,345
	YTD	12,102	14,426	17,034		15,833
Overnight Discharges (YOY comparison)	In-month	1,421	1,272	1,441	↑	1,426
	YTD	7,240	8,512	9,953		10,069
Critical Care Beddays (YOY comparison)	In-month	1,096	847	1,203	↑	1,150
	YTD	5,250	6,097	7,300		7,473
Bed Days >=100 Days	No. of patients	10	8	13	↓	9
	No. of beddays	1,614	1,332	2,459	↓	3,220
Outpatient Attendances (All) (YOY comparison)	In-month	21,260	21,261	24,037	↑	22,329
	YTD	110,744	132,005	156,042		149,196

	Aug-18	Sep-18	Oct-18	Trend	YTD	Variance
Our Money						
Control Total	2.4	0.0	2.3	↑	9.0	(0.9)
Forecast outturn control total	12.5	12.5	12.5	→	12.1	0.4
Debtor Days (IPP)	195.0	206.0	213.0	↓	120.0	(93.0)
Quick ratio (Liquidity)	1.8	1.8	1.9	↑	1.6	0.2
NHSI KPI Metrics	1	1	1	→	1	0.0

KITE MARKING SUMMARY SEPTEMBER 2017*

Domain	Lead	Total Count	Sufficient Assured		Insufficient Assured		Yet to be Assured		Action Plans Req'd	Action Plans Outstanding		Action Plans Over Due	
			Count	%	Count	%	Count	%		Count	%	Count	%
			Caring	Juliette Greenwood, David Hicks	49	35	71.4%	0		0.0%	14	28.6%	0
Safe	Juliette Greenwood, David Hicks	70	61	87.1%	2	2.9%	7	10.0%	2	2	100%	2	100%
Responsive	Nicola Grinstead	98	65	66.3%	33	33.7%	0	0.0%	14	3	21%	4	29%
People, Management & Culture: Well-Led	Ali Mohammed	63	45	71.4%	9	14.3%	9	14.3%	5	0	0%	0	0%
Effective	Nicola Grinstead	28	16	57.1%	12	42.9%	0	0.0%	4	0	0%	4	100%
Productivity	Nicola Grinstead	98	65	66.3%	33	33.7%	0	0.0%	14	4	29%	10	71%
Our Money	Loretta Seamer	49	48	98.0%	1	2.0%	0	0.0%	1	0	0%	1	100%
Grand Total		455	335	73.6%	90	19.8%	30	6.6%	40	9	23%	21	53%

*To be reviewed December 2017

Domain	Metric	Accuracy	Validity	Reliability	Timeliness	Relevance	Executive Judgement	Action Plan Req'd	Action Plan in Place	Action Plan Due Date
Caring	Access to Healthcare for people with Learning Disability	3	3	3	3	3	3	NK	NK	
Caring	% Positive Response Friends & Family Test: Inpatients	1	1	1	1	1	1	N	N/A	N/A
Caring	Response Rate Friends & Family Test: Inpatients	1	1	1	1	1	1	N	N/A	N/A
Caring	% Positive Response Friends & Family Test: Outpatients	1	1	1	1	1	1	N	N/A	N/A
Caring	Number of Complaints	1	1	1	1	1	1	N	N/A	N/A
Caring	Number of Complaints -Red Grade	1	1	1	1	1	1	N	N/A	N/A
Caring	Mental Health Identifiers: Data Completeness	3	3	3	3	3	3	NK	NK	
Safe	Total hospital acquired pressure / device related ulcer rates grade II & above	1	1	1	1	1	1	N	N/A	N/A
Safe	Reported cases of MRSA bacteremia to the Public Health England mandatory reporting system	1	1	1	1	1	1	N	N/A	N/A
Safe	Reported cases of Clostridium difficile associated disease to the Public Health England mandatory re	1	1	1	1	1	1	Y	N	
Safe	Serious Patient Safety Incidents	1	1	1	1	1	1	N	N/A	N/A
Safe	Never Events	1	1	1	1	1	1	N	N/A	N/A
Safe	C.Difficile due to Lapses of Care	1	1	1	1	1	1	Y	N	
Safe	CV Line Infection Rate (per 1,000 line days)	1	1	1	1	1	1	N	N/A	N/A
Safe	WHO Checklist Completion	3	3	3	3	3	3	NK	NK	
Safe	Cardiac Arrests Outside of ICU	1	1	1	1	1	1	N	N/A	N/A
Safe	Respiratory Arrests Outside of ICU	1	1	1	1	1	1	N	N/A	N/A
Responsive	RTT: Incomplete Pathways >52 Weeks (Validated)	2	2	2	1	1	2	Y	Y	On-going through DQ Dashboard
Responsive	RTT: Incomplete Pathways >52 Weeks (Unvalidated)	2	2	2	1	1	2	Y	Y	On-going through DQ Dashboard
Responsive	RTT: Incomplete Pathways (Over 18 Weeks)	2	1	2	1	1	2	Y	Y	On-going through DQ Dashboard
Responsive	RTT: Number of Incomplete Pathways (Under 18 Weeks)	2	1	2	1	1	1	Y	Y	On-going through DQ Dashboard
Responsive	Number of unknown RTT clock starts (Internal Referrals)	1	1	1	1	1	1	Y	Y	On-going audits
Responsive	Last Minute Non-Clinical Hospital Cancelled Operations: Breach of 28 Day Standard	1	1	1	1	1	1	Y	N	
Responsive	Number of unknown RTT clock starts (External Referrals)	1	1	1	1	1	1	Y	Y	On-going audits
Responsive	Same day / day before hospital cancelled appointments	1	1	1	1	1	1	Y	Y	Audits not yet started
Responsive	Diagnostics: Patients Waiting >6 Weeks	1	1	1	1	1	1	Y	N	
Responsive	Cancer 31 Day: Decision to Treat to First Treatment	2	1	2	1	1	1	Y	Y	Audits not yet started
Responsive	Cancer 31 Day: Decision to Treat to Subsequent Treatment - Surgery	2	1	2	1	1	1	Y	Y	Audits not yet started
Responsive	Cancer 31 Day: Decision to Treat to Subsequent Treatment - Drugs	2	1	2	1	1	1	Y	Y	Audits not yet started
Responsive	Last Minute Non-Clinical Hospital Cancelled Operations	1	1	1	1	1	1	Y	N	
People, Management & Culture: Well-Led	Sickness Rate	2	2	1	1	1	3	Y	Y	01-Jul-18
People, Management & Culture: Well-Led	Turnover - Total	1	1	1	1	1	3	NK	NK	
People, Management & Culture: Well-Led	Turnover - Voluntary	1	1	1	1	1	3	NK	NK	
People, Management & Culture: Well-Led	Appraisal Rate	2	1	1	2	1	3	Y	Y	01-Jul-18
People, Management & Culture: Well-Led	Mandatory Training	1	1	1	1	1	3	Y	Y	
People, Management & Culture: Well-Led	% Staff Recommending the Trust as a Place to Work: Friends & Family Test	1	1	1	1	1	3	NK	NK	
People, Management & Culture: Well-Led	Vacancy Rate	2	1	1	1	1	3	Y	Y	31-Mar-18
People, Management & Culture: Well-Led	Bank Spend	2	1	1	1	1	3	Y	Y	01-Jul-18
People, Management & Culture: Well-Led	Agency Spend	2	1	1	1	1	3	Y	Y	01-Jul-18
Effective	Discharge Summary Turnaround within 24hrs	1	1	1	1	1	2	Y	Y	31-Jul-17
Effective	Clinic Letter Turnaround within # - 7 working days	2	2	2	1	2	1	Y	Y	31-Jul-17
Effective	Clinic Letter Turnaround within # - 14 working days	2	2	2	1	2	1	Y	Y	31-Jul-17
Effective	Was Not Brought (DNA) Rate NHS (exc Telephone Contacts)	1	1	1	1	1	1	Y	Y	31-Jul-17
Productivity	Excess Beddays >=100 days - number of patients	1	1	1	1	1	2	Y	N	
Productivity	Excess Beddays >=100 days - number of beddays	1	1	1	1	1	2	Y	N	
Productivity	Critical Care Beddays	1	1	1	1	1	2	Y	Y	31-Aug-17
Productivity	Outpatient Attendances (All)	1	1	1	1	1	2	Y	Y	31-Jul-17
Productivity	Overnight Discharges	1	1	1	1	1	2	Y	Y	31-Jul-17
Productivity	Theatre Utilisation (NHS UO4) - Main theatres	2	2	2	1	2	2	Y	Y	31-Jul-17
Productivity	Average numbers of beds closed - Wards	1	1	1	1	1	2	Y	Y	31-Aug-17
Productivity	Daycase Discharges	1	1	1	1	1	2	Y	Y	31-Jul-17
Productivity	Average numbers of beds closed - ICU	1	1	1	1	1	2	Y	Y	31-Aug-17
Productivity	Theatre Utilisation (NHS UO4)	2	2	2	1	2	2	Y	Y	31-Jul-17
Productivity	Bed Occupancy	1	2	2	1	2	2	Y	Y	31-Jul-17
Productivity	Number of Beds	2	1	2	1	1	1	Y	Y	31-Aug-17
Productivity	Cardiac Refusals	1	1	1	1	1	1	Y	N	
Productivity	PICU/NEICU Refusals	1	1	1	1	1	1	Y	N	
Our Money	Net Surplus/(Deficit) v Plan	1	1	1	1	1	1	N	N/A	N/A
Our Money	Forecast Outturn v Plan	1	1	1	1	1	1	N	N/A	N/A
Our Money	P&E Delivery	1	1	1	1	1	1	N	N/A	N/A
Our Money	Pay Worked WTE Variance to Plan	2	1	1	1	1	1	Y	Y	01-Aug-17
Our Money	Debtor Days (DPP)	1	1	1	1	1	1	N	N/A	N/A
Our Money	Quick Ratio (Liquidity)	1	1	1	1	1	1	N	N/A	N/A
Our Money	NHS KPI Metrics	1	1	1	1	1	1	N	N/A	N/A

TRUST BOARD PERFORMANCE DASHBOARD: KPI DEFINITIONS

Measure	Definition	Standard	Calculation formulae	Reporting Frequency
 Access to Healthcare for people with Learning Disability	Covers the NHS Standard for organisations to meet the 6 criteria for people with a learning disability: 1. Does the NHS foundation trust have a mechanism to identify and flag patients with learning disabilities and protocols that ensure pathways of care are reasonably adjusted to meet the health needs of these patients? 2. Does the NHS foundation trust provide readily available and comprehensible information to patients with learning disabilities about the following criteria? • Treatment options? • Complaints procedures? • Appointments? 3. Does the NHS foundation trust have protocols to provide suitable support for family carers who support patients with learning disabilities? 4. Does the NHS foundation trust have protocols to routinely include training on providing healthcare to patients with learning disabilities for all staff? 5. Does the NHS foundation trust have protocols to encourage representation of people with learning disabilities and their family carers? 6. Does the NHS foundation trust have protocols to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports?	Yes	Does the service meet the six criteria for meeting the needs of people with a learning disability, based on recommendations in Healthcare for all (DH 2008):29?	Quarterly
Caring	% Positive Response Friends & Family Test: Inpatients	>95%	Numerator: respondents who would be extremely likely or likely to recommend the service Denominator: total respondents	Monthly
	Response Rate Friends & Family Test: Inpatients	>40%	Numerator: Total number of patients that have completed the FFT Questionnaire. Denominator: Total number of patients eligible to respond.	Monthly
	% Positive Response Friends & Family Test: Outpatients	>95%	Numerator: respondents who would be extremely likely or likely to recommend the service Denominator: total respondents	Monthly
	Mental Health Identifiers: Data Completeness	>97%	Denominator for NHS number, DOB, postcode, gender, GP practice: count of distinct patients in that submission Numerator: does the patient have a valid NHS number, DOB, postcode, gender, GP practice Denominator for Commissioner Code: Count of referrals in submission Numerator: Does each referral have a valid commissioner code. All denominators and numerators are added up to create the overall Monitor measure	Monthly
Effective	 Discharge Summary Turnaround within 24hrs	100%	Numerator: number of discharge summaries sent for eligible patients within 24 hours Denominator: total number of discharge summaries required for eligible patients	Monthly
	Was Not Brought (DNA) Rate NHS (exc Telephone Contacts)	8.36%	Numerator: number of non-attendances Denominator: total number of expected attendances	Monthly
	Clinic Letter Turnaround within 7 Working Days	100%	Numerator: number of clinical letters sent for eligible patients within 7 working days Denominator: total number of matching clinical letters for eligible patients on Clinical Documents Database	Monthly

Measure	Definition	Standard	Calculation formulae	Reporting Frequency		
 Diagnostics: Patients Waiting >6 Weeks	The percentage of patients waiting greater than 6 Weeks for a Diagnostic Test at the given month end census date based on the National DM01 Key 15 groupings	99%		Monthly		
Cancer 31 Day: Decision to Treat to First Treatment	The percentage of patients receiving first definitive treatment from diagnosis within 31 days	96%		Monthly		
Cancer 31 Day: Decision to Treat to Subsequent Treatment - Surgery	The percentage of patients receiving subsequent treatment of surgery for new cases of primary or recurrent cancer within 31 Days	94%		Monthly		
Cancer 31 Day: Decision to Treat to Subsequent Treatment - Drugs	The percentage of patients receiving subsequent treatment of drugs for new cases of primary or recurrent cancer within 31 Days	98%		Monthly		
Last Minute Non-Clinical Hospital Cancelled Operations	Count the number of last minute cancellations by the hospital for non clinical reasons in the quarter. Last minute means on the day the patient was due to arrive, after the patient has arrived in hospital or on the day of the operation or surgery.			Monthly		
Last Minute Non-Clinical Hospital Cancelled Operations: Breach of 28 Day Standard	Count of the number of patients that have not been treated within 28 days of a last minute cancellation	0		Monthly		
Responsive	RTT: Incomplete Pathways (National Reporting)	Patients waiting below 18 Weeks on an Incomplete RTT Pathway at month end with a known clock date (i.e. clock start and no stop) expressed a percentage	92%	Numerator: number of patients waiting below 18 weeks Denominator: total number of patients waiting	Monthly	
	RTT: Total Number of Incomplete Pathways (National Reporting)	Under 18 Weeks	Patients waiting below 18 Weeks on an Incomplete RTT Pathway at month end with a known clock date (i.e. clock start and no stop).	Total number of patients waiting below 18 weeks	Monthly	
		Over 18 Weeks	Patients waiting above 18 Weeks on an Incomplete RTT Pathway at month end with a known clock date (i.e. clock start and no stop).	Total number of patients waiting above 18 weeks	Monthly	
	RTT: Incomplete Pathways >52 Weeks	Validated	Patients waiting 52 Weeks and above on an Incomplete RTT Pathway waiting at month end with a known clock date (i.e. clock start and no stop)	0	Total number of patients waiting 52 weeks and above	Monthly
	RTT: Number of Unknown Clock Starts	Internal Referrals	Patients referred internally within Great Ormond Street where the RTT Clock Start Date cannot be verified	Total number unknown clock starts from an internal referral	Monthly	
		External Referrals	Patients referred by other organisations to Great Ormond Street where the RTT Clock Start Date cannot be verified	Total number unknown clock starts from an external referral	Monthly	
	RTT: Total Number of Incomplete Pathways	Under 18 Weeks	Patients waiting below 18 Weeks on an Incomplete RTT Pathway at month end with a known and unknown clock date (i.e. clock start and no stop)	Total number of patients waiting below 18 weeks	Monthly	
		Over 18 Weeks	Patients waiting above 18 Weeks on an Incomplete RTT Pathway at month end with a known and unknown clock date (i.e. clock start and no stop)	Total number of patients waiting above 18 weeks	Monthly	
	 Serious Patient Safety Incidents	Serious Incidents include acts or omissions in care that result in; unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm - including those where the injury required treatment to prevent death or serious harm, abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services.	N/A	Total number of Serious Patient Safety Incidents reported in month.	Monthly	
	Never Events	Never Events are serious incidents that are wholly preventable Never Events include incidents such as wrong site surgery, retained instrument post operation or wrong route administration of chemotherapy	0	Total number of Never Events reported in month.	Monthly	
Incidents of C. Difficile	This is the number of C.Difficile infections that have been reported in the Trust, regardless of whether they are hospital acquired and/or categorised as infection due to lapses of care.	0	Total number of C. Difficile infections that have been reported in month, in the Trust.	Monthly		

	Measure	Definition	Standard	Calculation formulae	Reporting Frequency
SAFE	C.Difficile due to Lapses of Care	The types of issues which would result in the infection being considered to be associated with a lapse in care could be any case where there was evidence of transmission of C. difficile in hospital such as via ribotyping of the infection indicating the same strain is involved, where there were breakdowns in cleaning or hand hygiene, or where there were problems identified with choice, duration, or documentation of antibiotic prescribing. It must be noted that none of these would indicate that the infection was definitely caused by the provider organisation, only that we cannot state that best practice was followed at all times	0	Total number of C. Difficile infections that have been reported in the Trust.	Monthly
	Incidents of MRSA	This is the number of MRSA infections that have been reported in the Trust, regardless of whether they are hospital acquired and/or categorised as infection due to lapses of care.	0	Total number of MRSA infection the have been reported in the Trust in month.	Monthly
	CV Line Infection Rate (per 1,000 line days)	Rate of GOSH acquired central venous catheter related bacteraemia per 1000 line days.	1.6	Numerator: Number of GOS acquired CVC related infections in month x 1,000 Denominator: Monthly Number of line days in month.	Monthly
	Arrests Outside of ICU	The monthly number of cardiac and respiratory arrests outside of intensive care units.	5 (total)	Total number of cardiac and total number of respiratory arrests that have occurred outside ICU in the reportable month. Cardiorespiratory arrests count towards the cardiac arrests total, not the respiratory arrests total.	Monthly
	Total hospital acquired pressure / device related ulcer rates grade III & above	Total number of hospital acquired pressure/device related ulcers (Grade 3 SUPERFICIAL ULCER, full thickness skin loss, damage/necrosis to subcutaneous tissue, Grade 4 DEEP ULCER, extensive destruction, damage to muscle, bone or supporting structures).	N/A	Monthly number of hospital acquired pressure/device related ulcers, Grade III or above.	Monthly
People, Management & Culture: Well-Led	 Sickness Rate	The sickness rate is based on the number of calendar days lost to sickness as a percentage of total available working calendar days (for either the 12-month period or the month).	3%	Numerator: Number of calendar days lost to sickness Denominator: Total available working calendar days.	Monthly
	Total Turnover	Turnover represents the number of employees that the Trust must replace as a ratio to the total number of employees across the Trust (excluding junior doctors).	18%	Numerator: All employees that the Trust must replace (excluding Junior Doctors) Denominator: Total amount of employees across the Trust (excluding Junior Doctors).	Monthly
	Turnover Rate	Voluntary Turnover represents the number of employees that the Trust must replace (due to: Flexi Retirement, Mutually Agreed Resignation, Pregnancy or Retirement due to Ill Health/Retirement Age) as a ratio to the total number of employees across the Trust (excluding junior doctors).	14%	Numerator: All employees that the Trust must replace due to voluntary resignation (Excluding Junior Doctors) Denominator: Total amount of employees across the Trust (excluding Junior Doctors).	Monthly
	Appraisal Rate	This indicators shows the percentage of substantive employees that have had their Performance and Development Review (PDR) appraisal.	90%	Numerator: Number of staff members with a complete PDR Denominator: Total number of staff members eligible for a PDR.	Monthly
	Mandatory Training	This indicators shows the percentage of substantive employees that have completed the necessary mandatory training courses on GOLD LMS.	90%	Numerator: Number of staff members who have successfully completed all the necessary training courses for their role. Denominator: Total number of substantial staff members.	Monthly
	% Staff Recommending the Trust as a Place to Work: Friends & Family Test	This is an indicator of the overall satisfaction of staff members working in the Trust and how likely they are to recommend GOSH as a place to work to their friends and family.	61%	Numerator: Total number of staff members that have indicated that they are likely or very likely to recommend the Trust as a place to work. Denominator: Total number of patients that have completed the Staff FFT questionnaire	Quarterly
	Vacancy Rate	This indicator shows the percentage of unfilled vacancies within the Trust.	10%	Numerator: Established FTE Denominator: Actual Budget FTE	Monthly
	Bank Spend	Total amount spent on temporary staff from the GOSH Staff Bank	N/A	Numerator: Total amount that has been spent on Bank staff. Denominator: Total pay bill.	Monthly
	Agency Spend	Total amount spent on agency staff as a percentage of the total pay bill.	2%	Numerator: Total amount that has been spent on Bank staff. Denominator: Total pay bill.	Monthly

	Measure	Definition	Standard	Calculation formulae	Reporting Frequency
Our Money	 Net Surplus/(Deficit) v Plan	Variance between YTD Net Surplus/(Deficit) - Excluding Capital Donations and Impairments compared to YTD Plan Surplus/(Deficit) - Excluding Capital Donations and Impairments			Monthly
	Forecast Outturn v Plan	Variance between Forecast month 12 Net Surplus/(Deficit) - Excluding Capital Donations and Impairments compared to Annual Plan as at month 12 Surplus/(Deficit) - Excluding Capital Donations and Impairments			Monthly
	P&E Delivery	Actual YTD recurrent savings delivered v YTD Planned Savings			Monthly
	Pay Worked WTE Variance to Plan	Variance between worked WTE in period and plan WTE in period			Monthly
	Debtor Days (IPP)	IPP Debtors / Total Sales x365			Monthly
	Quick Ratio (Liquidity)	Cash + Receivables divided by current liabilities			Monthly
	NHS KPI Metrics	Composite metric based on performance against plan of the following NHS Improvement Measures: <ul style="list-style-type: none"> • Liquidity • Capital Service Coverage • I&E Margin • Variance in I&E Margin as % of income • Agency Spend • Each measure is rated 1 to 4 (and RAG rated 1 Green, 2 Amber and 3/4 Red) 			Monthly
Productivity	 Theatre Utilisation (NHS UO4)	Theatre Utilisation based on the percentage of original scheduled session hours that were used for operating	77%		Monthly
	Bed Occupancy	KH03 definition- day and night occupied bed days divided by total no of available bed days			Monthly
	Number of Beds	KH03 definition of total number of available beds			Monthly
	Average Number of beds closed	Average number of day and night beds closed in the reporting month.			Monthly
	Refused Admissions	Admissions refused due to non clinical reasons. Data excludes refusals based on medical grounds and refusals to a GOSH ICU/Ward that were accepted to a different GOSH ICU/Ward			Monthly
	Trust Activity: Trust activity (Daycase discharges, Overnight Discharges, Critical Care bed days and OP attendances)	Discharges based on spells. Overnight discharges include elective, non elective, non elective non emergency and regular attenders. OP attendances include both new and follow up. Critical care bed days include elective, non elective and non elective non emergency.			Monthly
	Excess Bed Days >=100 days	No of patients with an extra ordinary length of stay (100 days+) at the end of the reporting period.			Monthly

Trust Board 5 December 2018	
Better Value Update	Paper No: Attachment X
Submitted by: Nicola Grinstead, Deputy Chief Executive	
Aims / summary This paper provides an update on Better Value programme delivery over the first seven months of the year (M7) and summarises the current position and actions being taken to ensure a full £15m programme is delivered by year end. It notes that after mitigation, the programme is reporting on-track delivery of £7.8m as at M7 with the Trust currently forecasting delivery of the total programme value of £15m by year end. Considerable progress has been made in fully developing the programme; nearly £14m has now been identified and the remaining gap subject to final work-up has reduced to just over £1m. This work is overseen by the Better Value Programme Board and subject to oversight by the Finance and Investment Committee and the Quality and Safety Assurance Committee.	
Action required from the meeting The Board is asked to note the M7 position against the 2018-19 Better Value programme and note the actions underway to secure delivery of the £15m programme by year end as well as the work begun to scope the programme for the year to come.	
Contribution to the delivery of NHS Foundation Trust strategies and plans The Better Value Programme is a significant contributor to the Trust's overall financial strategy and plans. Delivery of the £15m Better Value target this year 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.	
Financial implications Included within the overall Trust financial position.	
Who is responsible for implementing the proposals / project and anticipated timescales? Deputy Chief Executive & individual project / programme leads with support of Programme Office.	
Who is accountable for the implementation of the proposal / project? Deputy Chief Executive.	

Better Value Programme Update Report

December 2018

1) 2018-19 BETTER VALUE PROGRAMME M7 DELIVERY UPDATE				
Delivery against plan	Before mitigation: £4.7m	A	After mitigation: £7.8m	G
Programme Delivery	<p>After mitigation, the Better Value programme is reporting delivery of £7.8m as at the end of M7. This is in line with the initial phased plan for the programme. The Trust is projecting that the full £15m target will be achieved at year-end although it is anticipated that – as for previous years – some slippage of schemes likely to take longer to become fully-established will be mitigated by other actions over the course of the year. Up to M7, non-recurrent expenditure reductions, vacancy factor and increased patient care activities have contributed significantly - c£3m - towards the Better Value target.</p>			
2) PROGRESS TO SIGN OFF FINAL FULLY-SCOPED PLAN DURING PERIOD				
Programme sign off	This Reporting Period:	A	Last Reporting Period:	A
RAG Reason	<ul style="list-style-type: none"> Opportunities of £13.7m (before risk adjustment) have been found and there remains a gap of c. £1.3m against the full £15m target. The majority of the gap (£1.2m) relates to cross organisational schemes. The local 2.5% schemes are now almost fully-identified and the gap has largely been eliminated from the £359k level reported at the last board meeting due to directorates continuing to scope new ideas and a finalisation of the carry forward value from the 2017/18 programme. Unless rapid progress is made to close the remaining gap in the programme, the challenge will increase substantially as we are now well in to Q3. Exiting 2018-19 without a fully established Better Value programme will also potentially result in a need to further increase the 'ask' in 2019-20. 			
RAG Recovery Action Plan	<ul style="list-style-type: none"> Work continues with the divisions, finance and scheme leads to get remaining programme documentation completed for all identified schemes, including Quality Impact Assessments where applicable to close down the programme as a matter of urgency. Progress is overseen at the (weekly) business planning meetings chaired by the Deputy CEO, reported and discussed at the (fortnightly) Operational Performance & Delivery Group, and overseen by the (6-weekly) CEO chaired Better Value Programme Board. 			
Progress Summary	<ul style="list-style-type: none"> All corporate directorates have identified their 2.5% target in full. Since the change to the new structure the directorate local 2.5% gap now stands at £100k, a significant improvement from that reported at the last board meeting. Directorates are confident this gap will be eliminated. A number of cross-organisational programmes have identified their complete target including ICT enabled, nursing workforce and patient placement. For the cross-organisational programme, there has been good progress made in developing a robust procurement programme, overseen by a newly established Procurement Transformation Board. A new combined flow programme is being developed to take forward work already commenced on productive theatres and patient placement – the new programme will be considered by the Quality Improvement Committee and included in a future briefing to the Board. The impact of the existing theatres programme is on the agenda for the next meeting of the Finance and Investment Committee. 			

3) FINANCIAL OVERVIEW – PROGRAMME IDENTIFICATION		
2.5% local scheme plans which are identified at budget code level	£6.485m	
Additional 2.5% local schemes being worked up (not yet got budget codes)	£1.497m	
Total 2.5% local scheme identified	£7.982m	
Remaining gap against 2.5% local target	£0.100m	
Cross organisational plans now identified at budget code level	£2.613m	
Additional cross organisational plans still being worked up	£3.117m	
Total cross organisational scheme identified	£5.730m	
Remaining gap against cross organisational schemes target	£1.188m	
Total programme identified to-date	£13.712	
<p>Better Value schemes valued at c. £13.7m have been identified; there remains a gap in the scoping of the cross-organisational schemes, as further identified below. The Finance and Investment Committee also receive a summary analysis of the anticipated risk of financial delivery of these schemes which suggests that the current value of the programme including risk adjustments would indicate that a prudent forecast of the likely year-end delivery – before mitigation – would be in the region of £11.8m (ie a risk adjustment of c.£3.2m). This reflects both the fact that some schemes have yet to be finalised, as well as a reliance upon additional income in some areas (for example commercial/IPP and for schemes related to improving flow). After taking this into consideration, the Trust is currently forecasting that other mitigations will enable it to deliver its financial control total for the year.</p>		

4) GAP ANALYSIS – CROSS ORGANISATIONAL SCHEMES																
	Identified	Gap														
Cross organisation schemes - FLOW <table border="1"> <tr> <td>XC Outpatients</td> <td></td> </tr> <tr> <td>Improving clinic utilisation</td> <td></td> </tr> <tr> <td>XC Theatres</td> <td></td> </tr> <tr> <td>Various incl reducing list overruns, increased use of APOA, starting first case on time, scrubs dispensing machine</td> <td></td> </tr> <tr> <td>XC Patient Placement</td> <td></td> </tr> <tr> <td>Reduce number of admissions cancelled due to bed unavailability, increase utilisation of Nightingale Ward</td> <td></td> </tr> </table>	XC Outpatients		Improving clinic utilisation		XC Theatres		Various incl reducing list overruns, increased use of APOA, starting first case on time, scrubs dispensing machine		XC Patient Placement		Reduce number of admissions cancelled due to bed unavailability, increase utilisation of Nightingale Ward		Outpatients £0.159m Theatres £0.597m P Placement £0.800m	Outpatients £0.016m Theatres £0.203m P Placement £0.000m		
XC Outpatients																
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Cross organisational schemes - WORKFORCE <table border="1"> <tr> <td>XC NURSING</td> <td></td> </tr> <tr> <td>Review of bank rates</td> <td></td> </tr> <tr> <td>New ROI recruitment campaign arrangements</td> <td></td> </tr> <tr> <td>XC OTHER WORKFORCE</td> <td></td> </tr> <tr> <td>Review of study leave and Mandatory Training</td> <td></td> </tr> <tr> <td>Temporary staffing</td> <td></td> </tr> <tr> <td>Staff overpayments</td> <td></td> </tr> </table>	XC NURSING		Review of bank rates		New ROI recruitment campaign arrangements		XC OTHER WORKFORCE		Review of study leave and Mandatory Training		Temporary staffing		Staff overpayments		Nursing £0.392m Medical £0.133m Other workforce £0.225m	Nursing +£0.042m Medical £0.217m Other workforce £0.125m
XC NURSING																
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Cross organisational schemes – PROCUREMENT, NON PAY, WASTE XC Procurement Procurement savings from PPIB and AdviseInc dashboard	Procurement £1.300m	Procurement £0.00m Diagnostics £0.300m
Cross organisational schemes – PHARMACY & MEDICINES MGT XC Medicines Management Nitrofurantoin switch from oral suspension to tablets	Medicines Management £0.323m	£0.077m
Cross organisational schemes – COMMERCIAL XC IPP Overseas opportunities from Saudi Arabia, Kuwait, Egypt Additional craniofacial, spinal and urology activity Other commercial (R&D, Education & Training) HEE paediatric dementia project Orchard Therapeutics data agreement phases 1 & 2	IPP £0.450m Other £0.180m	IPP £0.550m Other £0.170m
Cross organisational schemes – ICT ENABLED (NON EPR) XC ICT Video interpreting service Dr Doctor SMS messaging service Insourced network services Single transcription service Contribution from DRIVE Reduce computer hardware budgets pan trust	£0.371m	+£0.046m
Cross organisational schemes – CODING XC Coding Ensuring accurate and complete coding	£0.500m	£0.000m

Taking each of the main cross-organisational areas and progress against target is set out below:

Flow

The **theatres programme** has identified c.£600k with a gap now at c.£200k. The primary focus is on reasons for cancellation on the day, on planned versus actual theatre session utilisation, including late starts, and on improving future planning and booking performance. Whilst the programme has identified and agreed a methodology for tracking benefits with finance colleagues, the programme is almost entirely income focussed and as such represents a risk; 1) if the activity per speciality is below the planned level and 2) if the commissioners refuse to pay for the additional work undertaken. The theatres programme and its progress are overseen by the theatres programme board and these arrangements are currently being reviewed to follow the recent clinical operations restructure.

The **patient placement** programme has identified its target in full with plans to roll out systematic use of estimated date of discharge, ensure the right information is available to support decision making through a central planning tool and booking system, and improve the use of tools to predict loads on wards and enable more intelligent scheduling. The major risk, similar to the theatres programme, is that benefits accrue from increased income. Again, work is currently underway to refresh this programme post directorate-restructure, with an accelerated rollout of a 'control hub' approach including improved information and escalation arrangements to and from the daily bed meetings.

Outpatients have a small gap of £16k following a thorough review which identified numerous opportunities to improve clinic utilisation (with associated income risks as above). There is work underway to refresh this programme in to a more pathway-aligned approach looking at pre, peri and post phases of an out patient's journey in order to maximise efficiencies in each area and to better monitor the progress of each work stream.

Workforce

The **nursing workforce** group has identified its full £350k target for 2018/19 in full through a principal scheme aimed at reducing an enhancement paid to some bank staff. This scheme went live in August 2018, will contribute c. £340k in year with the remainder covered through a reduction in recruitment agency spend. The rollout of this scheme has been controversial and its impact is subject to close oversight, including a future planned deep-dive at the Quality and Safety Assurance Committee.

Work has commenced with the medical director on **medical workforce** plans, with two schemes identified and in workup currently, valued at **£133k**. These relate to an over accrual for CEA awards and the application of the STP pan London bank rates. There will remain a gap however of over £200k against the target.

The **HR&OD** team is continuing work to finalise proposals for meeting the **workforce other** target and there are projected significant savings associated with improved costs for the trust bank service. However, these benefits are unlikely to be realised until the new financial year.

Procurement

Good progress has been made since the last board update and the transfer of the PPS service to a new shared service agreement with GSTT has now taken place. GSTT have already provided much of the ground work in identifying the c. £1.3m target and since the summer, the procurement programme has already delivered **actual saving of £324k**. Further refinement of the identified opportunity areas is currently taking place but the expectation is that this will be concluded within the next few weeks and focus will shift to actual delivery of the remaining target in full.

A target for **reduced unnecessary ordering of diagnostic investigations** is considered to pose a higher risk, especially in advance of EPIC implementation, and is subject to further discussion with the medical director. However, a small contribution may be possible from a new QI supported project to reduce pre-analytical errors – the project team to oversee this work has met several times since August and will be rolling out its work over the remainder of the year.

Pharmacy/Medicines Management

To date two schemes have been identified (£323k) that the team is confident of delivering as noted above. The principle scheme (£250k) is associated with savings identified by the recently-established Medical Director Led Innovation and Development Group. Further work is being undertaken to close the remaining gap as part of the Hospital Pharmacy Transformation Programme led by the chief pharmacist with some PMO support.

Commercial/IPP

As noted in the last update to the board the commercial cross-organisation target remains an area of high risk, although the IPP division has reported good progress towards meeting its control total as at M7. These schemes will continue to be overseen by the Commercial Oversight Group.

5) PLANNING FOR 2019/20

Considerable focus is being placed on the development of the Better Value programme for next year. The size of the challenge is anticipated to increase sharply, in large part as a result of changes to the national tariff proposed by NHS England and NHS Improvement. Reductions to specialist top-up payments and market forces factor adjustments are predicted to result in an additional c.£10m challenge for GOSH next year, with further reductions in future years. The resulting savings target for the organisation is likely to be in excess of 5% of influencable spend; a target which is high compared to historic delivery, one which some other providers have been able to meet successfully, but one which is very much dependent upon transformational and fundamental change rather than reliance upon a plethora of smaller scale and sometimes opportunistic initiatives.

The scale of the challenge for next year has been the subject of recent discussion at the Finance and Investment Committee, which requested further detail before the approach that it would recommend for adoption over the coming year can be confirmed. The timing of that decision is of the essence, in that a programme of the potential scale described above will require very rapid development and sign-off, if it

is to be ready for successful implementation from the start of the new financial year.

The work to develop the Better Value programme for next year has already begun as part of the recently-launched business planning process – although without confirmation of the exact financial target - with an initial session already held to identify potential areas for investigation over coming weeks, and an upcoming event planned for the senior (clinical and managerial) leadership team in mid-December. Progress updates will be provided to future meetings of the Finance and Investment Committee and Board.

NEXT STEPS AND RECOMMENDATION

The Board is asked to note the M7 position against the 2018-19 Better Value programme and note the actions underway to secure delivery of the £15m programme by year end as well as the work begun to scope the programme for the year to come.

**Board Finance Report
5th December 2018**

Month 07 2018/19 Finance Board Report	Paper No: Attachment Y
Submitted by: Helen Jameson, Chief Finance Officer	Attachment Board Finance Report M07

Key Points to take away

1. The Trust is required to achieve an overall control total that is agreed with NHSI annually. The Trust is behind of its control total by £0.9m in Month 7 which is a further decline from M6. In order to support the Trust's position, £1.6m has been released from contingency YTD.
2. The Trust is ahead of its income target by £4.0m (excluding pass through) at Month 7. NHS Clinical Income remains ahead of plan by £1.1m YTD though performance has slowed considerably over the last 2 months. The position is supported by continued strong performance for IPP activity and increased income for research trials in month.
3. Pay was overspent YTD by £1.8m due to the £1.6m that relates to the implementation of the national Agenda for Change pay award (the expenditure is within pay but under NHSI requirements, we have to account for the funding under income); the Trust is £0.2m overspent YTD when this is excluded. There was an increase in the establishment in month for the September intake of nursing recruits. Bank spend was largely in line with the historic trend.
4. Non pay is £3.2m overspent year to date (excluding pass through). This predominantly relates to the provision for bad debt increasing in the month relating mainly to IPP income and further driven by non-pay Better Value savings not being delivered in line with the original plan.
5. The Trust is forecasting a breakeven position at the year end to the control total. It is anticipated that the income under delivery seen in the last two months will recover and that there will be further non recurrent benefits to pay and non-pay that will help deliver the position.

Introduction

This paper reports the Trust's Financial Position as at the end of October 2018 (Month 7). The Trust is required to achieve an overall control total surplus of £12.1m for the year which is an increase from 2017/18. In order to achieve this, the Trust must deliver additional income over and above the prior year and achieve the Better Value program of £15m. The Trust is currently reporting a £0.9m adverse deficit to the control total but is forecasting to recover and be in line with the control total at year end. In order to achieve this, a number of non-recurrent adjustments have been made in M6 and M7 to support the Trust's position including the release of £1.6m of contingency.

Financial Position – Summary Points

NHS & other clinical revenue (excluding pass through) is favourable to plan by £1.1m YTD though the level of income over-performance has been dropping in recent months; NHS income was as a consequence £0.7m behind plan in month. The main services that are behind include SNAPs, trauma and orthopaedics and cardiac surgery. The reasons for the reduced activity

include a lack of available beds which have led to lists being cancelled and there have been specific patient needs on certain wards that have limited patient flow.

Private patient income is £0.8m ahead of plan YTD and was on plan in M7. There continues to be significant over-delivery of income in a number of areas including cardiac and PICU / NICU.

Non-clinical Income is £2.1m favourable to plan YTD and £1.8m favourable in month. This predominantly relates to the AfC pay award funding of £1.6m and the increase in research activity that was seen in month. This is offset by better value targets held against non-clinical income which are being delivered through other means.

Pay is overspent by £1.8m YTD which includes the additional costs associated with the AfC pay award of £1.6m. If this is excluded the pay budget is overspent by £0.2m. The Trust had 118 newly qualified nurses start on the 24th of September of which now all are within the establishment and reflected within the pay costs. The Trust is currently below the NHSI agency cost ceiling that it agrees as part of its annual plan.

Non-Pay expenditure (excluding pass through) is overspent by £3.2m YTD. This is due to increased costs associated with the additional research activity and the further increase to the impairment of receivables associated with private patient income of £0.6m. There are also Better Value targets held within non-pay that are not being delivered in line with the plan; these are partly offset by the release of £1.6m of the Trust contingency YTD.

Financial Forecast – Summary Points

The Trust forecasts continue to be reviewed and in M7, the new directorate management teams completed their first returns for the new structure and hence in a number of areas,. These will be discussed further with operational teams during the month. The Trust is forecasting to achieve break even in line with its control total target by year end. This includes the full release of the central contingency and the realisation of a number of non-recurrent benefits in year that will be required to hit the Trust's control total.

Statement of Financial Position – Summary Points

Indicator	Comment														
NHSI Financial Rating	Four of the five KPI's are green in month; the only area that is amber is for the control total which is adverse to plan by £0.9m. The forecast outturn is also amber as it is being forecast in line with plan.														
Cash	<p>The closing cash balance was £54.1m, £6.3m higher than plan.</p> <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>(0.9)</td> </tr> <tr> <td>Inventories – higher than plan</td> <td>(0.6)</td> </tr> <tr> <td>Trade and other Receivables – higher than plan</td> <td>(1.1)</td> </tr> <tr> <td>Trade and Other Payables - higher than plan</td> <td>3.5</td> </tr> <tr> <td>Capital expenditure – lower than plan</td> <td>5.4</td> </tr> <tr> <td>Increase to cash position</td> <td>6.3</td> </tr> </tbody> </table>	Variance/movement	Cash variance vs plan YTD (£m)	EBITDA – lower than plan	(0.9)	Inventories – higher than plan	(0.6)	Trade and other Receivables – higher than plan	(1.1)	Trade and Other Payables - higher than plan	3.5	Capital expenditure – lower than plan	5.4	Increase to cash position	6.3
Variance/movement	Cash variance vs plan YTD (£m)														
EBITDA – lower than plan	(0.9)														
Inventories – higher than plan	(0.6)														
Trade and other Receivables – higher than plan	(1.1)														
Trade and Other Payables - higher than plan	3.5														
Capital expenditure – lower than plan	5.4														
Increase to cash position	6.3														
NHS Debtor Days	NHS Debtor days in month was 7 days which remains within target. 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 increased from 206 days to 213 days.														

Creditor Days	Creditor days increased in month from 21 days to 24 days but are still in line with plan.
Inventory Days	Drug inventory days decreased in month from 7 to 5 days. Non-Drug inventory days fell slightly in month from 74 to 73 days.
Action required from the meeting	
<ul style="list-style-type: none"> To note the Month 7 Financial Position 	
Contribution to the delivery of NHS / Trust strategies and plans	
The delivery of the financial plan is a key strategic objective to ensure we have sufficient funding to meet the needs of our delivery of care.	
Financial implications	
The Trust has achieved its control total in Q1 and Q2 leading to the receipt of £2.6m of PSF funding to date. Missing the Control Total would result in the loss of the PSF which is back ended to the remainder of the financial year. £5m of PSF funding remains to be delivered in the second half of the financial year for 2018/19 without which, the Trust will struggle to achieve financial balance.	
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 7 2018/19

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FINANCIAL PERFORMANCE

	In month			Year to date			Full Year Forecast	
	Plan	Actual	RAG	Plan	Actual	RAG	F'cst	RAG
INCOME <i>incl. passthrough</i>	£41.7m	£41.8m	●	£274.2m	£277.5m	●	£477.0m	●
PAY	£21.9m	£22.4m	●	£152.0m	£153.7m	●	£266.6m	●
NON-PAY <i>incl. passthrough</i>	£15.2m	£15.6m	●	£103.6m	£106.1m	●	£181.5m	●
CONTROL TOTAL	£3.2m	£2.3m	●	£9.0m	£8.1m	●	£12.1m	●

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 7, the Trust position is £0.9m adverse to the planned control total; the Trust position would have been worse without the release of £0.5m of contingency in month which brings the YTD release up to £1.6m. YTD income is £3.3m favourable to plan including pass through income (which is £0.8m adverse to plan). YTD Pay costs are £1.7m adverse to plan due to the £1.6m AIC pay award and research costs driven by greater activity within R&I in month. Non-pay is £2.5m adverse to plan due to an increase in the impairment of receivables related to the private patient activity and increased costs associated with the additional research activity.

INCOME BREAKDOWN RELATED TO ACTIVITY

Income breakdown Year to Date	Plan (£m)	Actual (£m)	Var (£m)	RAG
NHS & Other Clinical Revenue	£164.1m	£165.2m	£1.1m	●
Pass Through	£37.4m	£36.6m	(£0.8m)	●
Private Patient Revenue	£36.7m	£37.5m	£0.8m	●
Non-Clinical Revenue	£36.0m	£38.1m	£2.1m	●
Total Operating Revenue	£274.2m	£277.5m	£3.3m	●

RAG: on or favourable to plan = green, 0-5% adverse to plan = amber, 5%+ adverse to plan = red

AREAS OF NOTE:

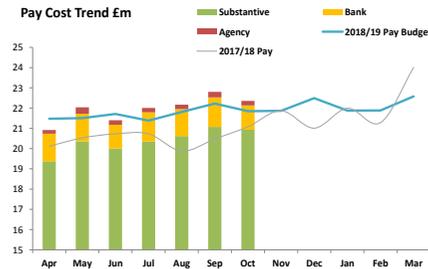
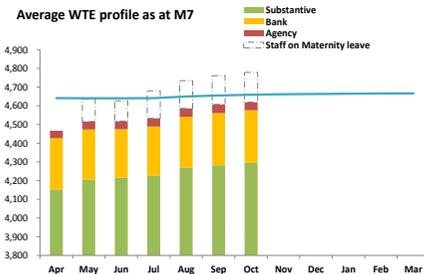
Operating revenue remains favourable to plan YTD although a number of clinical areas had low NHS activity in Month 6 and 7; the main area of under-performance was within elective care. YTD non-clinical income is £2.1m ahead of plan which is driven by the £1.6m AIC pay review income and £3.4m of research income above plan offset by the Better Value target that is being achieved through NHS income. IPP income in month 7 was lower than the previous two months but overall remains ahead of plan.

PEOPLE

	M7 Plan Av. WTE	M7 Actual Av. WTE	Variance
PERMANENT	4,631.1	4,297.1	334.0
BANK	20.1	278.9	(258.9)
AGENCY	8.1	43.8	(35.7)
TOTAL	4,659.2	4,619.8	39.4

AREAS OF NOTE:

Since M4 the average cost of the Trust WTE's has risen as a result of paying AIC back pay. In M5, the Cardiac Business Case provided further budgeted posts although a number remain unfilled. A key change in-month has been the number of substantive nursing posts filled; this has risen from 1,413 in M6 to 1,504 in M7 due to newly qualified nurses entering post. The calculations exclude 158.6 contractual WTE's on maternity leave within the Trust.



CASH, CAPITAL AND OTHER KPI'S

Key metrics	Plan	Actual
Cash	£47.8m	£54.1m
IPP Debtor days	120	213
Creditor days	30	24
NHS Debtor days	30	9

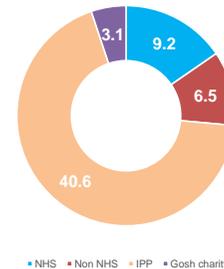
Capital Programme	YTD Plan M7	YTD Actual M7	Full Year Fcst
Total Trust-funded	£13.8m	£8.4m	£23.2m
Total Donated	£28.7m	£21.9m	£38.7m
Grand Total	£42.4m	£30.3m	£61.9m

NHSI metrics	Plan M7	Actual M7
CAPITAL SERVICE COVER	1	1
LIQUIDITY	1	1
I&E MARGIN	1	1
VAR. FROM CONTROL TOTAL		2
AGENCY		1
TOTAL		1

AREAS OF NOTE:

- Cash held by the Trust is higher than plan by £6.3m.
- The capital programme is £12.1m behind plan (£5.4m Trust funded and £6.7m donated) due to slippage on a number of IT and Estates projects
- The forecast capital expenditure outturn is reviewed and updated monthly on a scheme by scheme basis. The forecast outturn for trust funded capital expenditure is £4.8m lower than plan. The two most significant projects contributing to this are the Medical Equipment Decontamination Unit (MEDU) and the Phase 4 project development. Charity funded expenditure outturn is forecast at £6.2m lower than plan. The two most significant projects contributing to this are the Sight and Sound Hospital and Southwood Courtyard developments.
- NHSI metrics are on plan apart from variance to the control total; this is showing as below plan as result of the Trust being £0.9m adverse to its control total YTD at M7.
- Total IPP debt is £40.6m; of which £30.5m is overdue as at 31 October 2018. The provision for IPP debt is £9.8m

Net receivables breakdown (£m)



Annual Budget	Income & Expenditure	2018/19								Rating	Notes	2017/18		
		Month 7				Year to Date						YTD Actual	CY vs PY	
		Budget	Actual	Variance		Budget	Actual	Variance					Variance	
(£m)	(£m)	(£m)	%	(£m)	(£m)	(£m)	%	(£m)	(£m)	%				
280.59	NHS & Other Clinical Revenue	24.83	24.12	(0.71)	(2.86%)	164.14	165.23	1.09	0.66%	G	1	162.00	3.23	1.99%
63.49	Pass Through	5.77	5.02	(0.75)	(13.00%)	37.39	36.64	(0.75)	(2.01%)	G	2	38.30	(1.66)	(4.33%)
63.55	Private Patient Revenue	5.40	5.17	(0.23)	(4.26%)	36.70	37.53	0.83	2.26%	G	3	32.70	4.83	14.77%
62.93	Non-Clinical Revenue	5.72	7.48	1.76	30.77%	35.96	38.10	2.14	5.95%	G	4	30.40	7.70	25.33%
470.56	Total Operating Revenue	41.72	41.79	0.07	0.17%	274.19	277.50	3.31	1.21%	G		263.40	14.10	5.35%
(260.28)	Permanent Staff	(21.65)	(20.93)	0.72	3.33%	(150.58)	(142.75)	7.83	5.20%	G		(130.70)	(12.05)	(9.22%)
(0.50)	Agency Staff	(0.04)	(0.22)	(0.18)	(450.00%)	(0.29)	(1.64)	(1.35)	(465.52%)	G		(3.00)	1.36	45.33%
(1.87)	Bank Staff	(0.16)	(1.21)	(1.05)	(656.25%)	(1.08)	(9.33)	(8.25)	(763.89%)	G		(9.90)		0%
(262.65)	Total Employee Expenses	(21.85)	(22.36)	(0.51)	(2.33%)	(151.95)	(153.72)	(1.77)	(1.16%)	R	4	(143.60)	(10.12)	(7.05%)
(13.48)	Drugs and Blood	(1.22)	(1.05)	0.17	13.93%	(7.87)	(7.24)	0.63	8.01%	G		(7.50)	0.26	3.47%
(41.45)	Other Clinical Supplies	(3.47)	(4.17)	(0.70)	(20.17%)	(24.31)	(24.39)	(0.08)	(0.33%)	A		(24.40)	0.01	0.04%
(60.62)	Other Expenses	(4.78)	(5.31)	(0.53)	(11.09%)	(34.05)	(37.86)	(3.81)	(11.19%)	R		(33.60)	(4.26)	(12.68%)
(63.49)	Pass Through	(5.77)	(5.02)	0.75	13.00%	(37.39)	(36.64)	0.75	2.01%	G		(37.90)	1.26	3.32%
(179.04)	Total Non-Pay Expenses	(15.24)	(15.55)	(0.31)	(2.03%)	(103.62)	(106.13)	(2.51)	(2.42%)	R	5	(103.40)	(2.73)	(2.64%)
(441.69)	Total Expenses	(37.09)	(37.91)	(0.82)	(2.21%)	(255.57)	(259.85)	(4.28)	(1.67%)	R		(247.00)	(12.85)	(5.20%)
28.87	EBITDA (exc Capital Donations)	4.63	3.88	(0.75)	(16.20%)	18.62	17.65	(0.97)	(5.21%)	R		16.40	1.25	7.62%
(16.79)	Owned depreciation, Interest and PDC	(1.41)	(1.56)	(0.14)	(10.19%)	(9.58)	(9.51)	0.08	0.80%	G	7	(9.40)	(0.11)	(1.13%)
12.08	Control total	3.22	2.32	(0.89)	(27.79%)	9.04	8.14	(0.89)	(9.88%)	R		7.00	1.14	16.34%
(11.60)	Donated depreciation	(0.99)	(0.95)	0.03	3.44%	(6.52)	(6.48)	0.0	0.51%	G		(4.40)	(2.08)	(47.36%)
0.48	Net (Deficit)/Surplus (exc Cap. Don. & Impairments)	2.23	1.37	(0.86)	(38.57%)	2.52	1.66	(0.86)	(34.13%)	R		2.60	(0.94)	(36.15%)
(2.52)	Impairments	0.00	0.00	0.00	0.00%	0.00	0.00	0.00	0.00%	G		0.00	0.00	0%
44.97	Capital Donations	4.81	3.20	(1.61)	(33.47%)	28.65	21.94	(6.71)	(23.42%)	R	6	13.00	8.94	68.77%
42.93	Adjusted Net Result	7.04	4.57	(2.47)	(35.09%)	31.17	23.60	(7.57)	(24.29%)	R		15.60	8.00	51.28%

Plan Annual	Directorates	2018/19								Rating
		Month				Year to Date				
		Budget	Actual	Var	Var %	Budget	Actual	Var	Var %	
(£m)	(£m)	(£m)	%	(£m)	(£m)	(£m)	%			
14.32	Blood Cells & Cancer	1.45	1.94	0.49	33.79%	8.60	9.35	0.75	8.72%	G
21.57	Body Bones & Mind	2.11	1.54	(0.57)	(27.01%)	12.70	10.59	(2.11)	(16.61%)	R
18.71	Brain	1.78	1.83	0.05	2.81%	11.14	13.04	1.90	17.06%	G
52.74	Heart & Lung	4.77	4.37	(0.40)	(8.39%)	31.20	32.09	0.89	2.85%	G
(19.14)	Medicines Therapies & Tests	(1.51)	(1.26)	0.25	16.56%	(10.97)	(10.70)	0.27	2.46%	G
(30.68)	Operations & Images	(2.52)	(2.43)	0.09	3.57%	(17.79)	(17.73)	0.06	0.34%	G
9.98	Sight & Sound	1.12	0.96	(0.16)	(14.29%)	5.96	6.62	0.66	11.07%	G
24.88	International Private Patients	2.05	2.02	(0.03)	(1.46%)	14.67	12.46	(2.21)	(15.06%)	R
1.87	Research And Innovation	0.33	0.23	(0.10)	(30.30%)	0.95	1.79	0.84	88.42%	G
(82.17)	Corporate/Other	(6.36)	(6.88)	(0.52)	(8.18%)	(47.42)	(49.37)	(1.95)	(4.11%)	R
12.08	Control total	3.22	2.32	(0.90)	(27.95%)	9.04	8.14	(0.90)	(9.96%)	R



RAG Criteria:
 Green Favourable YTD Variance
 Amber Adverse YTD Variance (< 5%)
 Red Adverse YTD Variance (> 5% or > £0.5m)

Summary

- In month the Trust is reporting an adverse position to the control total (£0.9m). Activity and income have remained below plan in M7 although YTD income is still offsetting under delivery within the Better Value Program. This is partially offset with the release of £1.6m of contingency YTD.

Notes

- NHS & other clinical revenue (excluding pass through) is favourable to plan by £1.1m YTD though this largely driven by increased activity in the first half of the year which has not been seen in the last two months. M6 & M7 activity was below plan in a number of specialties but is expected to exceed planned levels for the remainder of the year and therefore ensure the Trust meets its control total.
- Private Patient income has fallen in M7 from historic highs in M5 and M6 but is still remains above plan.
- Other non-clinical income is £2.1m favourable YTD. The income for the AFC pay award leads to a £1.6m favourable variance and in M7 research income is £1.9m favourable to plan due to increased grant activity.
- YTD pay is adverse to plan by £1.8m due to the additional cost of the AFC pay award of £1.6m which is unplanned, as per guidance, and the pay costs associated with increased Research activity. (these are offset by increased income, above). There are a number of vacancies across the Trust which are being partially filled by bank and agency staff which carry a premium over equivalent substantive posts.
- Non pay (excluding pass through) is £2.5m adverse to plan YTD due to increased costs associated with the increased research activity and the further impairments of receivables for IPP income. These are partially offset by the release of £1.6m YTD of contingency.
- Income from capital donations is £6.7m less than plan due to slippage on a number of donated projects. These include in particular the Cardiac Cath Lab as the project start date is delayed to Feb 2019 to coincide with the replacement of MR number 4.

Full Year Actual 2017/18 (£m)	31 Oct 2018		Internal Forecast		Rating	
	Income & Expenditure	Annual Budget	Full-Yr	Variance to Plan		
						(£m)
280.64	NHS & Other Clinical Revenue	280.59	284.46	3.87	1.36%	G
64.33	Pass Through	63.49	62.22	(1.27)	(2.04%)	
57.26	Private Patient Revenue	63.55	63.65	0.10	0.16%	G
59.65	Non-Clinical Revenue	62.93	66.67	3.74	5.61%	G
461.88	Total Operating Revenue	470.56	477.00	6.44	1.35%	
(231.99)	Permanent Staff	(260.28)	(247.83)	12.45	(5.02%)	
(4.38)	Agency Staff	(0.50)	(2.88)	(2.38)	82.64%	
(17.34)	Bank Staff	(1.87)	(15.86)	(13.99)	88.21%	
(253.71)	Total Employee Expenses	(262.65)	(266.57)	(3.92)	1.47%	R
(12.37)	Drugs and Blood	(13.48)	(12.65)	0.83	(6.56%)	G
(43.66)	Other Clinical Supplies	(41.45)	(41.28)	0.17	(0.41%)	G
(61.97)	Other Expenses	(60.62)	(65.35)	(4.73)	7.24%	R
(64.33)	Pass Through	(63.49)	(62.22)	1.27	(2.04%)	
(182.33)	Total Non-Pay Expenses	(179.04)	(181.50)	(2.46)	1.35%	R
(436.04)	Total Expenses	(441.69)	(448.07)	(6.38)	1.42%	R
25.84	EBITDA (exc Capital Donations)	28.87	28.93	0.06	0.21%	G
(15.93)	Owned Depreciation, Interest and PDC	(16.79)	(16.85)	(0.06)	0.36%	
9.91	Control total	12.08	12.08	0.00	0.01%	G
(9.30)	Donated depreciation	(11.60)	(11.60)	0.00	0.00%	
0.61	Net (Deficit)/Surplus (exc Cap. Don. & Impairments)	0.48	0.48	0.00	(633.33%)	
(2.81)	Impairments	(2.52)	(2.52)	0.00	0.00%	
24.65	Capital Donations	44.97	38.72	(6.25)	(16.15%)	
22.45	Adjusted Net Result	42.93	36.68	(6.25)	(17.05%)	

Notes

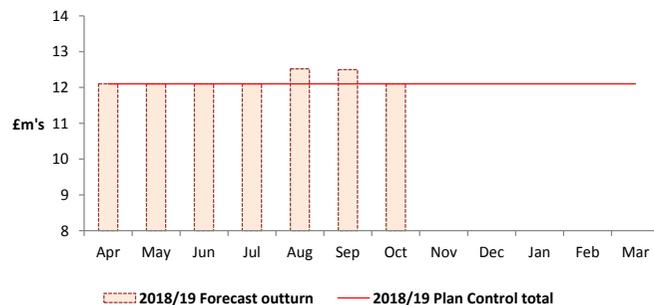
Summary

- The Trust is forecasting a year end position that breaks even with the Trust control total of a £12.1m surplus. This is a deterioration on the position that was reported in Month 6.
- Forecasts continue to be updated on a monthly basis and month 7 is the first time they have been worked up in the new directorate structure.
- Following the low activity in M6 & M7 work is continuing to be undertaken to develop future activity plans.

Notes

- NHS Clinical income is forecast to be £3.9m favourable to plan excluding pass through, this assumes the reduced income in M6 & M7 will be recovered by year end.
- Private patient income is forecast to be £0.1m favourable to the plan which is a reduction from the M6 forecast of £1.8m. IPP have indicated a slight improvement to the plan while the clinical divisions have revised down the estimates, principally in PICU/NICU/CICU due to reduced activity for the remaining months.
- Pay is forecast to be £3.9m adverse to plan by the year end which is a £1.6m improvement from M6. The adverse variance is due to the additional AfC pay review payments to staff which is offset by income. The increased spend within the final months of the year is related to new starters.
- Non-pay is forecast to be £3.7m adverse at the year end excluding pass through which lines up with last months forecast. The higher than planned spend reflects increases in the level of impairments for IPP debt and increased costs associated with increased research.
- The forecast assumes full achievement of the Provider Sustainability Fund (£7.6m) and the full release of the contingency. The Trust has fully achieved its control total in Q1 and Q2 and is planning to breakeven at the year end.

Control total - Plan vs Forecast outturn



RAG Criteria:
Green Favourable
Variance to plan
Amber Adverse
Variance to plan (< 5%)
Red Adverse Variance
to plan (> 5% or >
£0.5m)

Summary by Point of Delivery excluding pass through & CQUIN

Point of Delivery	Activity plan	Activity actual	Activity variance	Income plan £000's	Income actual £000's	Income variance £000's	RAG YTD Variance	Ave price per plan	Ave price received	Ave price var %	Price variance £000's	Activity variance £000's
Day Case	12,609	11,081	(1,528)	£14,856	£15,520	£664	G	£1,178	£1,401	18.9%	£2,471	(£1,807)
Elective	8,272	8,096	(176)	£38,279	£35,931	(£2,348)	R	£4,628	£4,438	(4.1%)	(£1,538)	(£810)
HDU Bed Days	2,031	1,884	(147)	£1,496	£1,832	£336	G	£737	£972	31.9%	£443	(£107)
Highly Specialised Services	10,928	11,116	188	£17,816	£17,342	(£474)	A	£1,630	£1,560	(4.3%)	(£778)	£304
Inpatient excess bed days	5,033	4,025	(1,008)	£2,888	£2,268	(£620)	R	£574	£563	(1.9%)	(£44)	(£576)
ITU Bed Days	6,685	5,766	(919)	£19,442	£18,161	(£1,281)	R	£2,908	£3,150	8.3%	£1,395	(£2,676)
Non NHS Clinical Income	990	1,613	623	£2,585	£2,837	£252	G	£2,611	£1,759	(32.6%)	(£1,374)	£1,626
Non-Elective	958	1,072	114	£10,563	£11,929	£1,366	G	£11,026	£11,128	0.9%	£109	£1,257
Other Nhs Clinical	37,175	38,292	1,117	£29,238	£32,312	£3,074	G	£786	£844	7.4%	£2,221	£853
Outpatients	95,272	94,892	(380)	£23,965	£24,003	£38	G	£252	£253	0.4%	£95	(£57)
Total	179,953	177,836	(2,117)	£161,128	£162,135	£1,007	G	£895	£912	1.9%	£3,000	(£1,993)

Summary

Income is favourable to plan excluding pass through and CQUIN due to a higher case mix resulting from higher value activity (£3.0m) offset by a decreased volume of activity (£2.0m). The adverse activity variance is primarily driven by the continued under-performance within ITU vs. the original plan. Case mix in month is down and has been partially offset by increased volumes resulting in an improvement in the activity variance but a deterioration in the income variance.

The key year to date variances are summarised below:-

Elective is £2.3m adverse to plan excluding excess bed days and this is due to an activity variance of (£0.8m) and a price variance of (£1.5m). This has increased from the month 6 variance of £1.7m. The key areas contributing to the activity under-performance are paediatric surgery, paediatric trauma & orthopaedics and cardiac surgery where additional assumed planned activity for business cases is not being delivered along with an under-performance for nephrology inpatient admissions.

ITU bed days (PICU, CICU & NICU) have an adverse variance of £1.3m (£1.1m M6). The unfavourable activity variance of £2.7m is a result of reduced activity levels for PICU & CICU however this is partially offset by a favourable price variance of £1.4m for all locations that is due to us delivering value below the block activity.

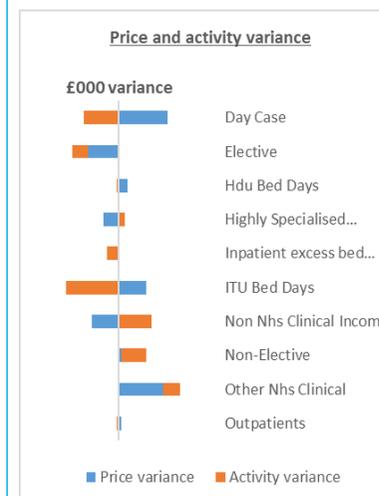
Highly specialised services contain a mix of low volume, high cost and high volume, low cost services and this can cause volatility in the price and activity variances from month to month. The year to date activity variance is largely the result of ECMO being below plan.

Non-elective (£1.4m favourable) driven by increases in paediatric surgery, nephrology and respiratory medicine activity.

Other NHS clinical income (£3.1m favourable) This includes:-

- Flex to freeze estimated movement £350k
- Additional funding for delivery cystic fibrosis second line screening £42k
- Prior year benefit of £135k between year end and final activity values

Outpatients has a small adverse variance of (£28k) with a favourable activity variance driven by increased recording of radiology attendance

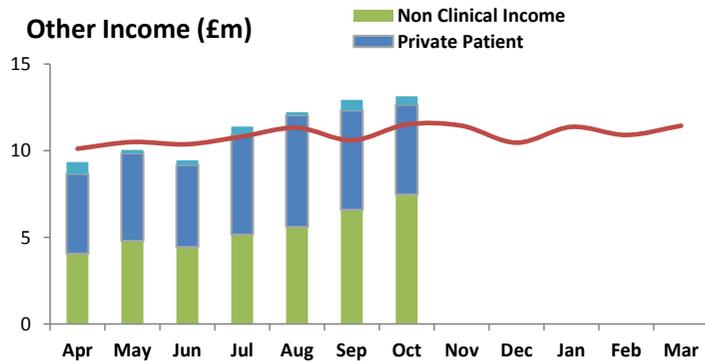


RAG Criteria:

Green Favourable Variance to plan
Amber Adverse Variance to plan (< 5%)
Red Adverse Variance to plan (> 5%)

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	£63,545	£5,395	£5,173	(£222)	£36,697	£37,531	£834	G	
Non NHS Clinical Income	£4,396	£393	£481	£88	£2,585	£2,895	£310	G	
Non-NHS Clinical Income	£67,941	£5,788	£5,654	(£134)	£39,282	£40,426	£1,144	G	
Education & Training	£8,676	£723	£617	(£106)	£5,061	£4,753	(£308)	A	
Research & Development	£22,530	£2,049	£3,908	£1,859	£13,269	£16,687	£3,418	G	
Non-Patient Services	£771	£70	£65	(£5)	£454	£439	(£15)	G	
Commercial	£1,603	£146	£134	(£12)	£944	£872	(£72)	A	
Charitable Contributions	£6,248	£568	£811	£243	£3,680	£3,905	£225	G	
Other Non-Clinical	£23,097	£2,168	£1,942	(£226)	£12,550	£11,440	(£1,110)	R	
Non Clinical Income	£62,925	£5,724	£7,477	£1,753	£35,958	£38,096	£2,138	G	



RAG Criteria:
Green Favourable YTD Variance
Amber Adverse YTD Variance (< 5%)
Red Adverse YTD Variance (> 5% or > £0.5m)

Summary

- Private patient income is £0.8m favourable to plan YTD. Revenue within Cardiac Surgery, Neurology, ENT and PICU is above plan; although this is being offset by lower activity within Gastro, Haematology and Cancer. PICU has seen an uplift in activity due to the low volume of NHS work undertaken YTD which is being used to provide additional IPP capacity. Reduced activity in the first quarter of the year led to the closure of Hedgehog ward; however this re-opened in M4 due to increased demand after Ramadan and remains open. M7 is showing £0.2m adverse driven by lower than planned bed days on the IPP wards.
- Research income is £1.8m above plan in month due to increased grants and recognition of the income associated with the achievement of milestones within current grants. A number of grants have also been recognised in the accounts. This is in line with month 6 which was up by £1.6m (though much of this income is offset with equivalent cost).
- Other Non-Clinical income is £1.1m adverse YTD. This is due to the income received to fund the AfC pay award for which £1.6m has been received YTD and this is not budgeted for (in line with NHSI guidance). However this is offset by the Trust wide income better value targets being included here within the Trust annual plan, but being delivered primarily through additional NHS income.

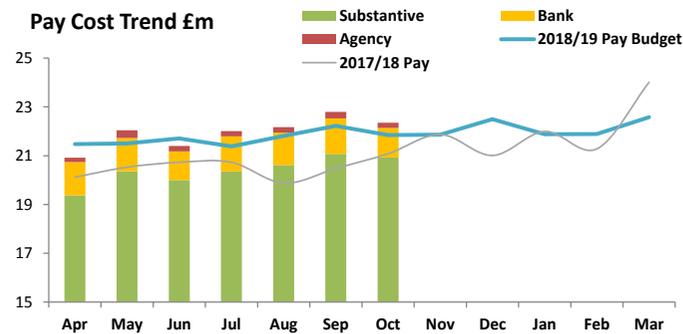
Workforce Summary for the 7 months ending 31 Oct 2018

*WTE = Worked WTE, Worked hours of staff represented as WTE

£m including Perm, Bank and Agency	2018/19 plan			2018/19 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)	28.7	1,132.1	43.4	26.7	1,078.0	42.5	1.9	54.0	1.4	0.6	G
Consultants	30.4	355.4	146.6	29.4	335.5	150.1	1.0	19.9	1.7	(0.7)	G
Estates & Ancillary Staff	2.3	130.1	30.8	2.4	125.8	32.0	(0.0)	4.3	0.1	(0.1)	G
Healthcare Assist & Supp	5.6	315.1	30.7	5.1	286.2	30.6	0.5	28.9	0.5	0.0	G
Junior Doctors	14.8	354.3	71.5	15.1	328.5	78.6	(0.3)	25.8	1.1	(1.4)	A
Nursing Staff	45.6	1,595.0	49.0	45.0	1,543.6	50.0	0.6	51.4	1.5	(0.9)	G
Other Staff	0.3	8.7	54.0	0.1	4.7	50.0	0.1	4.0	0.1	0.0	G
Scientific Therap Tech	28.0	916.2	52.4	27.2	874.1	53.3	0.8	42.1	1.3	(0.5)	G
Total substantive and bank staff costs	155.7	4,806.8	55.5	151.0	4,576.3	56.6	4.7	230.5	7.5	(2.8)	G
Agency	0.3	8.1	61.8	1.6	43.8	64.1	(1.3)	(35.7)	(1.3)	(0.1)	R
Total substantive, bank and agency cost	156.0	4,814.9	55.5	152.7	4,620.1	56.6	3.3	194.8	6.3	(3.0)	G
Reserve*	(4.0)	(155.4)	0.0	1.0	0.0	0.0	(5.1)	(155.4)	(5.0)	(0.0)	R
Total pay cost	152.0	4,659.5	55.9	153.7	4,620.1	57.0	(1.7)	39.4	1.3	(3.0)	R
Remove Maternity leave cost				(1.8)			1.8			1.8	G
Total excluding Maternity Costs	152.0	4,659.5	55.9	151.9	4,620.1	56.4	0.1	39.4	1.3	(1.2)	G

*Plan reserve includes WTEs relating to the better value programme

Pay Cost Trend £m



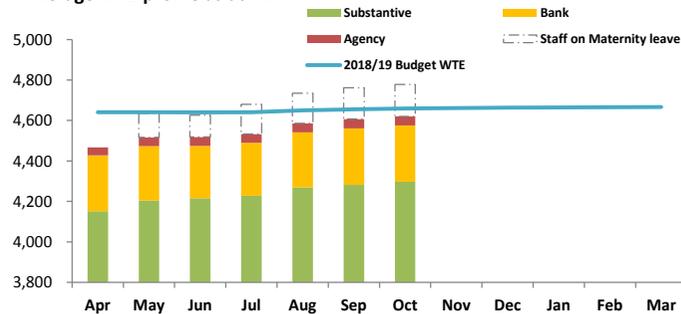
RAG Criteria:

Green
Favourable
Variance to plan
Amber Adverse
Variance to plan
(< 5%)
Red Adverse
Variance to plan
(> 5% or >
£0.5m)

Summary

- YTD actual pay spend is £153.7m which is £1.7m adverse to plan. A key contributor to this overspend is the additional pay in relation to the AfC Pay Award (£1.6m); the equivalent funding has been provided for but is captured within Non-Clinical Revenue. Without AfC payments, Trust pay spend would be £0.1m adverse to plan due to pay better value targets that are not being achieved (offset by additional income at a Trust-wide level).
- The table above does not include 158.6 contractual WTE for staff on maternity leave which cost £1.8m YTD. If this cost is excluded then the average cost per WTE is 0.8% higher than plan.
- Substantive staff are £4.7m below plan due to vacancies across the various staff groups, however these are being partly offset by agency costs of £1.6m, predominantly within PICU & Pharmacy and the unallocated pay better value schemes on the Reserve lines.
- 118 newly qualified nurses started on 24th September and in Month 7 are fully represented in the accounts. This is the first month they are fully represented in the WTE.
- We are not forecasting to breach the agency ceiling set by NHSI and the Trust is currently below the YTD agency ceiling.

Average WTE profile as at M7



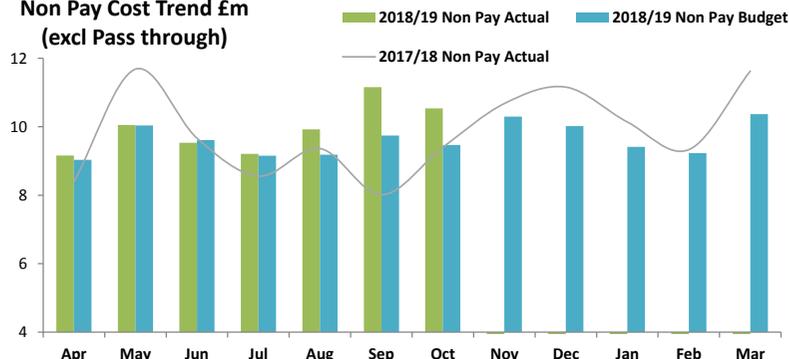
Non-Pay Costs (excl Pass through) YTD				RAG YTD Actual variance
	Budget (£m)	Actual (£m)	Variance	
Drugs Costs	6.66	6.15	0.51	G
Blood Costs	1.21	1.09	0.12	G
Business Rates	2.31	2.21	0.10	G
Clinical Negligence	4.13	4.13	0.00	G
Supplies & Services - Clinical	24.31	24.39	(0.07)	A
Supplies & Services - General	2.21	3.08	(0.87)	R
Premises Costs	19.26	18.63	0.63	G
Other Non Pay	6.14	9.82	(3.67)	R
Total Non-Pay costs	66.23	69.49	(3.26)	R
Depreciation	11.77	11.66	0.10	G
PDC Dividend Payable	4.38	4.54	(0.16)	A
Total	82.37	85.69	(3.32)	R

Top 5 YTD Clinical* Non Pay overspends by Speciality (£m)			
	YTD 2018/19 Budget (£k)	YTD 2018/19 Actual (£k)	Variance (£k)
Genetics	1,716	2,108	(392)
Theatre	5,148	5,539	(391)
Nephrology	1,732	2,109	(377)
Cardiac Critical Care	1,013	1,333	(320)
Audiology	921	1,034	(113)

Top 5 YTD Clinical* Non Pay underspends by Speciality (£m)			
	YTD 2018/19 Budget (£k)	YTD 2018/19 Actual (£k)	Variance (£k)
Critical Care Barrie	2,291	1,916	376
Neuromuscular	616	269	347
Haematology/Oncology	2,296	2,048	248
Cardiac Serv	2,817	2,620	198
Snaps	493	300	193

RAG Criteria:
Green Favourable YTD Variance
Amber Adverse YTD Variance (< 5%)
Red Adverse YTD Variance (> 5% or > £0.5m)

Non Pay Cost Trend £m (excl Pass through)



Summary

- YTD non-pay excluding pass through in 2018/19 is adverse to plan by £3.2m. A key driver is the YTD increase in the impairment of receivables to £2.4m. This is driven by the delayed payment of the increasing private patient income and drives the Other Non Pay variance along with the better value targets being delivered elsewhere.
- Non Pay overall is up in month compared to the first 5 months due to increased costs within Research due to increased grants and activity and increased catering costs.
- Premises costs are underspent mainly driven by changes to software maintenance contracts.

Top 5 clinical over/under spends

There has been an overspend in selected clinical non-pay areas including:

- **Theatre** - overspends are driven by an increase in higher value related spinal metal and implant non-pay costs YTD and other surgical speciality growth. There are also noted high value spends for medical and surgical equipment across theatres.
- **Genetics** - higher than plan Next Generation Sequencing and lab consumables linked to the Genetics reconfiguration
- **Cardiac Critical care** - This overspend is driven by ECMO related expenditure which in previous years has been offset by over performing critical care income.
- **Nephrology** - Mainly driven by drugs spend in line with activity over-performance versus plan.
- **Audiology** - Mainly driven by spend on devices in line with over-performance on activity versus plan.

There have also been a number of underspends within clinical non-pay areas including:

- **Critical Care Barrie** - underspends due to NHS activity volume shortfall against plan driven by low referrals.
- **Neuromuscular** – Under Services from Other NHS Bodies there were benefits relating to miscoding from 17-18. The speciality continues to underspend on splints, braces and drugs.
- **SNAPS** - consumables underspend due to lower activity.
- **Haematology/Oncology** - underspend mainly due to a positive variance against drug costs, in line with an under-performance on activity.
- **Cardiac Service** - underspent by £0.2m due to delays in opening of Alligator Ward.

*Clinical non-pay excludes passthrough

31 Mar 2018 Audited Accounts £m	Statement of Financial Position	YTD Plan 31 Oct 2018 £m	YTD Actual 31 Oct 2018 £m	YTD Variance £m	Forecast Outturn 31 Mar 2019 £m	YTD Actual 30 Sep 2018 £m	In month Movement £m
463.29	Non-Current Assets	493.65	481.68	(11.97)	501.22	479.25	2.43
85.92	Current Assets (exc Cash)	98.35	96.02	(2.33)	82.18	98.53	(2.51)
55.69	Cash & Cash Equivalents	47.81	54.10	6.29	55.79	53.65	0.45
(69.95)	Current Liabilities	(74.07)	(73.53)	0.54	(67.20)	(77.71)	4.18
(5.51)	Non-Current Liabilities	(5.14)	(5.21)	(0.08)	(4.88)	(5.25)	0.04
529.44	Total Assets Employed	560.61	553.06	(7.55)	567.11	548.47	4.59

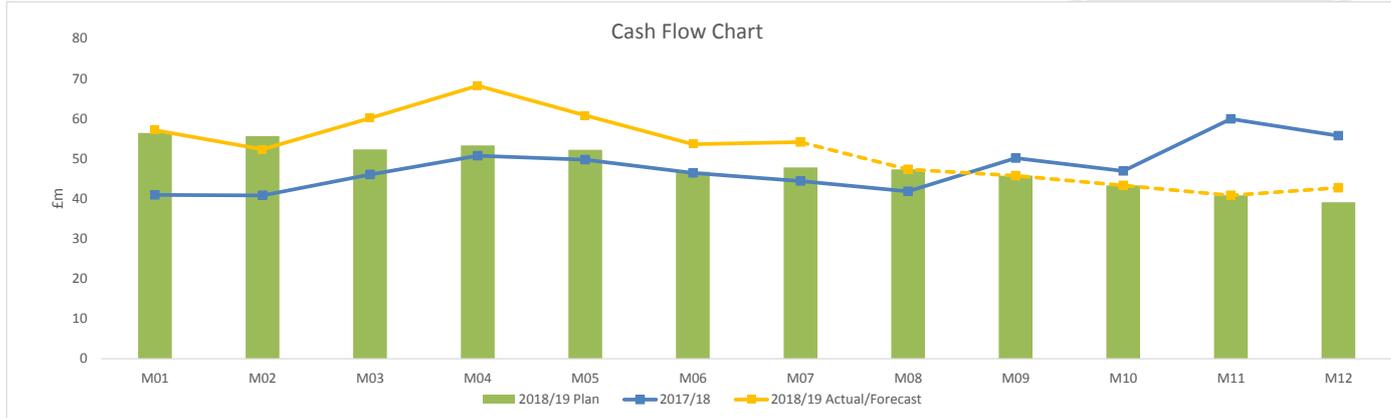
31 Mar 2018 Audited Accounts £m	Capital Expenditure	YTD Plan 31 Oct 2018 £m	YTD Actual 31 Oct 2018 £m	YTD Variance £m	Forecast Outturn 31 Mar 2019 £m	RAG YTD variance
5.81	Redevelopment - Donated	12.72	6.47	6.25	13.84	R
9.06	Medical Equipment - Donated	2.44	3.68	(1.24)	8.84	R
9.78	ICT - Donated	13.49	11.79	1.70	16.03	A
24.65	Total Donated	28.65	21.94	6.71	38.71	A
6.99	Redevelopment & equipment - Trust Funded	5.10	2.75	2.35	6.08	R
1.61	Estates & Facilities - Trust Funded	1.90	0.44	1.46	2.24	R
4.73	ICT - Trust Funded	6.76	5.21	1.55	14.85	A
13.33	Total Trust Funded	13.76	8.40	5.36	23.17	A
37.98	Total Expenditure	42.41	30.34	12.07	61.88	A

31-Mar-18	Working Capital	30-Sep-18	31-Oct-18	RAG	KPI
19.00	NHS Debtor Days (YTD)	7.0	9.0	G	< 30.0
189.00	IPP Debtor Days	206.0	213.0	R	< 120.0
27.70	IPP Overdue Debt (£m)	27.4	30.5	R	0.0
5.00	Inventory Days - Drugs	7.0	5.0	G	7.0
70.00	Inventory Days - Non Drugs	74.0	73.0	R	30.0
35.00	Creditor Days	21.0	24.0	G	< 30.0
70.3%	BPPC - NHS (YTD) (number)	45.3%	42.9%	R	> 95.0%
43.3%	BPPC - NHS (YTD) (£)	79.8%	80.4%	R	> 95.0%
89.3%	BPPC - Non-NHS (YTD) (number)	82.6%	83.8%	R	> 95.0%
85.0%	BPPC - Non-NHS (YTD) (£)	89.2%	90.1%	G	> 95.0%

RAG Criteria:

NHS Debtor and Creditor Days: Green (under 30); Amber (30-40); Red (over 40)
 BPPC Number and £: Green (over 90%); Amber (85-90%); Red (under 85%)
 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)

Cash Flow Chart



Comments:

- The capital programme is £12.1m behind plan (£5.4m Trust funded and £6.7m donated). The following Trust funded programmes have slipped against plan; Network/Wi-Fi hardware (£0.5m); various estates projects (£1.5m); Phase 4 (£0.8m) and MEDU (£0.6m).
- Cash held by the Trust is higher than plan by £6.3m. The increase was largely as a result of lower than planned expenditure on Trust funded capital projects (£5.4m).
- Total Assets employed at M07 was £7.5m lower than plan as a result of the following:
 - Non current assets totalled £461.7m (£12.0m less than plan largely as a result of the slippage on Estates and IT projects);
 - Current assets excluding cash less Current liabilities totalled £22.5m (£1.8m lower than plan).
 - Cash held by the Trust totalled £54.1m (£6.3m higher than plan)
 - Non current liabilities totalled £5.2m (£0.1m higher than plan)
- Overdue IPP debt increased in month to £30.5m (£27.4m in M6). This largely relates to debt from Embassies which has increased by £1.7m in month.
- IPP debtor days increased from 206 days to 213 days.
- The cumulative BPPC for NHS invoices (by number) decreased in month. The percentage by value of invoices paid improved slightly since M06.
- The cumulative BPPC for Non NHS invoices (by number and value) improved slightly since M06.
- Creditor days increased in month to 24 days but this remains within target of 30 days.

Trust Board 5 December 2018	
Assurance and Escalation Framework Review	Paper No: Attachment Z
Submitted by: Anna Ferrant , Company Secretary	For Information
<p>Aims / summary</p> <p>As part of the Trust's preparation for foundation trust status in 2012, Deloitte conducted an independent review of Monitor's Quality Governance Framework. One of the recommendations was to develop and maintain an Assurance and Escalation Framework (AEF).</p> <p>The Framework is a document which describes the responsibility and accountability for the Trust's governance structure and systems through which the Board receives assurance or escalated concerns/ risks related to quality of services, performance targets, service delivery and achievement of strategic objectives. The framework describes how the Trust's policies, procedures, quality systems and organisational learning are monitored through an effective committee structure.</p> <p>The framework is currently subject to review and update. The slides attached provide a summary of the areas covered by the framework and the actions underway. The framework supports the Trust's response to the 'Well Led' criteria. A final version of the framework will be submitted to the Board for approval at the end of Q4 2018/19.</p>	
<p>Action required from the meeting</p> <p>To note the areas covered by the AEF and that a final version of the framework will be brought to the Board in late Q4 2018/19, following consultation with relevant teams and committees.</p>	
<p>Contribution to the delivery of NHS Foundation Trust strategies and plans</p> <p>A robust and effective governance framework supports delivery of the Trust's strategic objectives.</p>	
<p>Financial implications</p> <p>None.</p>	
<p>Who needs to be told about any decision?</p> <p>The Operational Performance and Delivery Group (OPDG) will be consulted on the updated framework. The Risk Assurance and Compliance Group (RACG) will consider and recommend the AEF to the Board for final approval.</p>	
<p>Who is responsible for implementing the proposals / project and anticipated timescales?</p> <p>Company Secretary</p>	
<p>Who is accountable for the implementation of the proposal / project?</p> <p>Chief Executive.</p>	

Attachment Z

Update on review of Assurance and Escalation Framework

Anna Ferrant, Company Secretary

Purpose of report

What is the Assurance and Escalation Framework?

What does it cover and why is it important?

Elements of the Assurance and Escalation Framework

- Where we are now?
- What are our development plans?
- Next steps?

What is the Assurance and Escalation Framework (AEF)?

The aim of the AEF is:

- To ensure the organisation is able to effectively and responsively identify, monitor, escalate and manage concerns and risks to the Trust meeting its organisational objectives and regulatory requirements

It achieves this by encapsulating (in one document) all GOSH's:

- Quality governance structures
- Systems for receiving assurance
- Processes for staff, patients, families, visitors and other stakeholders to escalate issues or risks

The elements of the Assurance and Escalation Framework are below and expanded upon within this report.



What does it cover and why is it important?

Ensures the objectives, requirements and expected standards of services (clinical and non-clinical) across the Trust are clearly articulated and communicated to staff

Maintains effective and responsive systems and processes to identify issues, concerns and opportunities for improvement, informed by information from internal and external sources

Ensures a variety of forums and systems for staff, patients, families and other stakeholders to escalate concerns or risks which could threaten delivery of the organisation's corporate objectives, service delivery or patient safety

Maintains fair and transparent systems and processes to respond to risks and performance issues, including holding teams and individuals to account where required

Managing a proactive and comprehensive system of internal controls and external reviews, to provide assurance that each the Trust's systems and processes are working individually and collectively.

Provides proactive assurance to the Trust Board, patients, families and external stakeholders that GOSH has mechanisms in place to provide safe, high quality and sustainable services.

Also provides retrospective/reactive assurance that the Trust Board had a robust framework in place and did everything reasonably practicable in the event of a serious incident.



Strategy and planning process

Overview of element

- The Trust has in place clear **strategic objectives, operational plans** and supporting strategies that clearly articulate the Trust's objectives, requirements and performance standards.

What we do around strategic objectives

- We have clear objectives through our mission to put 'The child first and always', supported by our 'Always Values'
- Priorities identified in Spring 2017 with staff and Council, along with our mission, vision, enablers and our 'Always Values' are presented in our 'strategy house' – Fulfilling our potential.
- This forms a framework that teams across the Trust and leadership team, use to plan against and make decisions.
- Progress against these objectives are reported on regularly.

What we do around organisational planning

- The Performance Management Framework (outlined in more detail on the next slide) provides the process through which the strategic objectives are translated into specific activities to achieve the Trust's strategic objectives.
- The PMF ensures that, from 'ward to Board', for each objective and indicator, there is clear accountability for performance and that this is approved and monitored by a designated individual or group.
- These objectives and accountabilities are articulated in the annual (Trust-wide) operational plan, and are cascaded through the organisation in Divisional and Departmental plans, service plans and individuals' performance appraisals.



Performance Management

Overview of element

- The Trust has a range of frameworks and policies in place that outline how the Trust's performance objectives and standards will be met, reviewed and managed

The Integrated Performance report

- The Integrated Performance report is used to provide the external update as well as the update internally to Trust Board
- Integrated quality report?
- Report provide an overview of RAG rated performance against 57 different indicators split into seven sections 'loosely' based on the CQC domains, replicated across organisational wide reporting: Caring, Safe, Responsible, People, Management & Culture: Well Led, Effective, Productivity, Our Money
- Performance review and discussion takes place at various committees across the organisation at all levels: Local reviews, Speciality reviews, Divisional Performance reviews, Operational Performance and Delivery Group and Executive Management team, Trust Board, Council of Governors, Audit Committee, Finance and Investment Committee, Quality and Safety Assurance Committee.

Individual performance plans

- The Trust's performance appraisal process requires staff to link their individual duties and responsibilities to the Trust's strategic objectives and Always Values.



Policy Framework

Overview of element

- Outline and administer the minimum governance considerations and requirements for Trust policies

Role of the Policy Approval Group

- The Corporate Affairs Team manages the Trust's policy management system. It works with the Policy Approval Group (PAG) to ensure that all Trust policies are 'in date', fit for purpose and compliant with the Trust policy template.

Actions

- To improve policy compliance, the Corporate Affairs Team :
 - Provides regular reports to the Executive Team and Risk, Assurance and Compliance Group listing the dates of policies in the Trust
 - Frequent chasing of Policy authors
 - Reviews policies at an early stage to ensure compliance with the policy template (consistency)
 - Provides a list of commonly observed errors and omissions for authors to check against, increasing the likelihood of first time approval by the PAG.



Risk Management Framework

Overview of element

- The Trust has a comprehensive and established Risk Management Strategy that
- sets out the way risks are systematically managed.
- Provides an integrated framework for
 - decision-making
 - escalation and
 - ensuring that all reasonable action is taken to identify, assess and manage risks in a consistent and transparent way.

Risk management strategy

- Standard content of a risk management strategy includes:
 - Committees' roles in risk management
 - How the Trust will create and review the Board Assurance Framework (BAF)
 - How the Trust will create and review the Trust Wide Risk Register
 - Incident reporting and management
 - Risk assessment and reporting.

Actions

- The Risk Management Strategy is under review to reflect the new Divisional structure.



Accountability Framework

Overview of element

- The Trust has Board, Executive, Divisional and Committee Structures in place.
- Teams and individual roles have been deliberately designed to deliver specific functions and services.
- Every member of staff's responsibilities and duties are articulated in a job description

Action: Structure and governance standards review

- The new Operational Team structure was published on 1st October 2018 following a comprehensive consultation and engagement programme of work.
- A refresh of the Trust's committees, sub-committees and groups will be initiated aiming to be complete by the end of January 2019. The purpose of this review will be to ensure:
 - the assurance committees are effectively reporting to Board.
 - the current committee structure below Board is fit for purpose.
 - all committees/ groups are fulfilling their duties consistent with their terms of reference (also subject to review).
 - duplication of effort is reduced between committees.

Compliance Framework

Overview of element

- The Trust has a Compliance Framework that is under review. It will ensure on-going compliance with statutory and regulatory requirements through integrated, rigorous and proactive structures, policies and practices.

Compliance register

- The lynchpin of the Compliance Framework is the Compliance Register which will be managed by the Clinical Governance and Compliance Manager within the Medical Director's team.
- The RACG will also review the Compliance Register and receive reports on completed and imminent compliance inspections.



Escalation Framework - Staff

Overview of element:

- Promoting a culture of being open and comfortable to raise concerns is a prerequisite to improving patient safety and ensuring the quality of healthcare

What we are doing to promote a culture of openness and transparency

- GOSH encourages all staff to abide by the Being Open and Duty of Candour Policy
- The Trust has a strong culture of incident reporting via the Quality and Safety Team
- The Trust's whistleblowing guidance (Raising Concerns in the Workplace Policy) provides the framework by which members of staff can raise concerns about safety and quality if they feel issues or concerns are not addressed.
- The Trust has a Freedom to Speak Up Guardian and issues raised are reported to the QSAC and annually to the Trust Board.
- Guardian for Safe Working oversees the safe working of the junior doctors in e.g. around concerns about patient safety due to excess working hours and non-compliant rotas.
- The safeguarding team is a source of specialist advice and support, working closely with the GOSH Social Work Service on any potential safeguarding concerns.

What are we doing to promote staff engagement

- The Trust is committed to meaningful and effective communication with its staff
- Individual members of staff are encouraged to raise with their manager any matters of concern about the delivery of care. There are numerous mechanisms for this including: Datix incident reporting, staff surveys, Raising Concerns in the Workplace Policy and the Grievance Policy
- Established the Staff Partnership Forum.

What we are planning to do

- Safety Reliability and Improvement Programme - Speaking up for Safety: a programme that trains and supports staff to speak up when faced with potential safety concerns. Training will be begin to all Staff with a pilot in October 2018.
- New Staff Forums for groups with protected characteristics such as BAME, Disabilities, LGBT plus and others.

Escalation Framework – Patients, Parents and carers



Escalation
Framework

Overview of element:

- Promoting a culture of being open and comfortable to raise concerns is a prerequisite to improving patient safety and ensuring the quality of healthcare

What are we doing to promote Patient and Family Experience and Engagement

- The Patient and Family Experience and Engagement Committee (PFEEC) oversees the quality and effectiveness of patient engagement across the Trust. It has parents and Governors in attendance. It receives reports on the mechanisms in place to listen to the feedback and experiences of our patients and families and to plan improvements in collaboration.
- The Patient Experience team:
 - Facilitates involvement in a range of national surveys
 - Monitors and reports on the Friends and Family Test
 - Facilitates the Young Person Forum (YPF), to engage young people between 10 and 21 to feedback into service improvements. National YPF forum, hosted the first ever meeting with YPFs across the country
 - Organises Trust listening events: last one in 2016, Executives, parents and patients. Invited topics through social media and discussed the top 4.
 - Supports local ward engagements
 - PALS team reactively receives queries and proactively engages through volunteers on wards

What we will be doing

- Planning to host panels with the patient experience team in the Lagoon to engage with patients and parents on their experiences



Assurance Framework

Overview of element:

- The Trust has in place a range of internal controls and external reviews.

Internal and external audit

- The Audit Committee is responsible for reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical).
- To provide the necessary assurance, a range of internal audits are conducted. Some are "traditional" or "cyclical", others are targeted as and when the Audit Committee or QSAC identifies issues
- The recommendations from internal audits, as well as being reported to the Divisional lead for the area audited, a log of the recommendations will be reported to the Risk, Assurance and Compliance Group for monitoring.

External inspections, accreditations and submissions

- The schedule of external inspections and submissions is recorded in the compliance register
- Assurance information from external inspections, in particular any recommendations arising from them, is reviewed at the Risk, Assurance and Compliance Group.
- Of particular focus at present is the response to the CQC inspection in January 2018 and the Trust-wide well-led inspection.

Learning from incidents and events

- The Patient Safety and Outcomes Committee (PSOC), shares learning across clinical teams.
- The PSOC ensures that any thematic concerns arising from complaints and incidents are considered and learned from.

Special reviews

- The Trust may become aware of complex or systemic performance or quality issues that require specialist and/or additional resources to fully address. In these instances the Executive Team, as the key group responsible for the day-to-day management of the Trust may commission new projects or engage short term external expertise to mitigate performance and quality issues.

Trust Board 5th December 2018	
CQC Update	Paper No: Attachment 1
<p>Submitted by: Salina Parkyn, Head of Quality and Safety Matthew Shaw, Medical Director</p>	
<p>Aims / summary This is an update paper regarding compliance within the Trust in reference to the CQC inspections.</p> <p>The inspection report highlighted non-compliance with Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance. The regulation was not being met as the report outlined that “Clinicians did not always have access to each patient’s medical history and clinical notes before carrying out a procedure.” Immediate action was taken, the action plan was complete and as part of that action plan an audit was required.</p> <p>The CQC have confirmed that this has been closed and the Trust is now compliant in this area.</p> <p>The Clinical Governance and Compliance Manager has now commenced in post. Meetings with the Medical Director, Head of Quality and Safety and the Service lines to monitor action plans have taken place. These will continue in 2019 and will aim to build relationships including responsibility and accountability following the Directorate restructure.</p> <p>The Chief Nurse and the Company Secretary will continue to work together on the Well-led action plan.</p>	
<p>Action required from the meeting To note the report and support the work ongoing.</p>	
<p>Contribution to the delivery of NHS Foundation Trust strategies and plans Fundamental to the delivery of Trust strategies and plans.</p>	
<p>Financial implications None</p>	
<p>Who needs to be told about any decision? Medical Director</p>	
<p>Who is responsible for implementing the proposals / project and anticipated timescales? Head of Quality and Safety</p>	
<p>Who is accountable for the implementation of the proposal / project? Medical Director</p>	



CQC Update paper – December 2018

Matthew Shaw, Medical Director
Salina Parkyn, Head of Quality and Safety

Planned CQC inspection carried out in January 2018

2 core services
Surgery and Outpatients
Well-Led

Approximately Annual CQC Inspections to Follow

CQC aims to inspect at least once between June 2017 and Summer 2019 using their current approach, and approximately annually after that.

Organisational Changes

Matthew Shaw and Alison Robertson commenced as Medical Director and Chief Nurse in Spring 2018
Trust Directorates re-structured from October 2018

Future Change

Recruitment under way for Chief Executive and Director of HR positions

Organisational Changes

Accountability and responsibility for CQC transferred from the CEO office to Medical Directors office in July 2018.
Clinical Governance and Compliance Manager commenced post November 2018

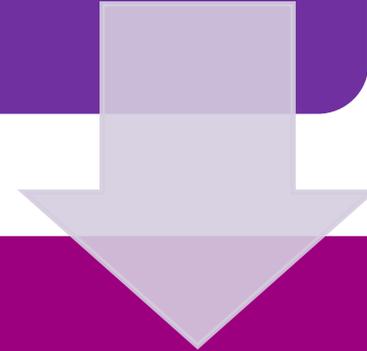
Planning for CQC Readiness

Continued meetings with Service Lines
Internal assessments against CQC ratings
Preparations for mock inspections
Monitoring and escalation of action plan

Update September 2018

Many aspects of the service are performing well; including the Bereavement service. Following a review meeting it has been agreed that there will be some focused areas for improvement as follows:

- Best practice decision making for end of life (RESPECT program)
- Team dynamics impacting on culture and well-led



Progress as of November 2018

RESPECT to be rolled out via Quality Improvement.

The Executive Lead for the project is Alison Robertson, Chief Nurse

Internal work continues on service dynamics

Learning from Deaths framework is being reviewed

ICUs Update September 2018:

The ICU's have been highly engaged. Recognition that there are gaps around policy and there will be challenges as PICU and NICU begin to work more autonomously. The consultants have allocated the ICU standards to individual consultants to plan for the next visit.

Pharmacy Update September 2018

A new Chief Pharmacist has started in post. Issues have been discovered with the management of CD's, oversight of medicines safety and the pharmacy environment. These and other issues will take time to resolve. The pharmacy transformation board has oversight of the work plan.

Update November 2018

Work continues to rectify gaps identified and the action plan was scrutinised at a recent meeting with the service line. Work in underway to staffing issues across this area and will review skill mix including reviewing GOLD training and competencies

Update November 2018

A Medicine Safety Committee has been created, chaired by the Chief Pharmacist, which will report to the Patient Safety and Outcomes Committee (PSOC). The first meeting has been held and a schedule of meetings and reporting has been agreed.

A Medicines Safety quality improvement project has been agreed which will be monitored via the Quality Improvement Committee (QIC)

OPD Update September 2018:

Outpatients have continued to make good progress following the CQC visit. The Outpatients Improvement Group continues to see good progress.

Radiology Update September 2018

Radiology were inspected separately last year by the IRMER aspect of CQC. There is clear governance around completion of the action plan.

Progress as of November 2018

Work continues in the department with good progress.
Next meeting with the Service line to be scheduled for January 2019

Progress as of November 2018

Update meetings continue to take place
Updated IRMER regulations scoped; discussions held with LEaD to address wider radiation training requirements
Chief of Service meeting with Consultants to discuss leadership, accountability and responsibility

Transition Update September 2018:

The Trust has had a committed focus on Transition which has previously been presented at Board. The programme of work continues until April 2019 with evidence of improvement and good practice.

Surgery Update September 2018

Areas for focus include: PIMS recording the use of the WHO Checklist, having a plan for all surgical services, sharing of learning from Serious Incidents and improvement of RAGS (in some surgical areas).

Progress as of November 2018

Trust mapped against CQC Transition Inspection Framework (2016)
Growing Up Gaining Independence framework: Comms Team fine-tuning Trust-wide launch strategy
GUGI 1 Family/YP information sheets ready
GUGI pages on Intranet ready
eCOF recording tab ready
GUGI Internet pages ready

Progress as of November 2018

The improvement notice issued by the CQC regarding the availability of medical records prior to surgery has been removed. The Trust submitted additional information to highlight actions taken by the Trust and service improvements to the CQC who have agreed to close the action

Next Steps (September 2018):

- Meeting with NHSI by MD/ND to understand the ask of well-led
- Employment of a band 7 co-ordinator
- Organise and conduct two CQC mock inspections in January and July 2019; inviting external parties to help with the inspection.
- Set up a well-led inspection practice by NHSI. NHSI have agreed to help in our preparation by performing a mock inspection of our well led element.
- CN/MD joint walkarounds- planned for September 2018
- Meeting specialty service lines on a regular basis to ascertain their readiness
- Engaging Deputy Chiefs of Service in order to embed learning, quality and safety into the Directorates
- Training of more staff to be CQC inspectors in order to improve skill levels
- To have a centrally held quality improvement plan for the whole hospital which will be a live updated document so we understand where we are at any time.
- Communication plan needed to communicate the Trust's expectation and plan for CQC readiness

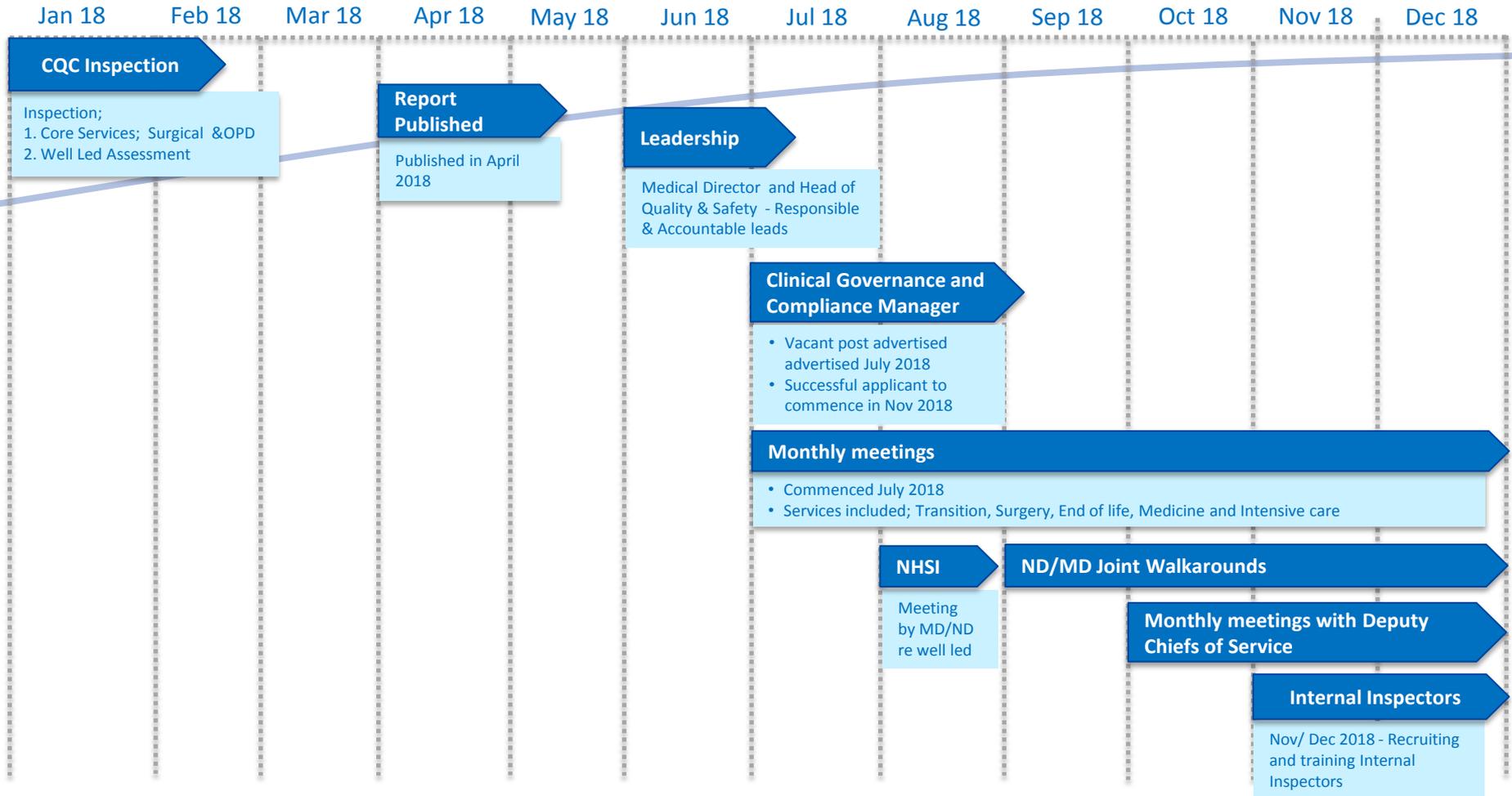
Progress (November 2018):

- Completed
- Completed- post holder commenced November 2018
- NHS Improvement have agreed to attend the mock inspections. Planning to begin in December 2018.
- In progress- currently this is being planned for September 2019
- Commenced and on-going
- Commenced and on-going; ToRs to be drafted
- Meetings have been scheduled with the Deputy CoS's; an on-going agenda has been agreed
- Meeting scheduled to discuss training of staff; plan to roll out across Trust once core staff trained
- Partially in place; medicines management and end of life care have been added and work continues
- Communication plan to be drafted and consulted on in January 2019

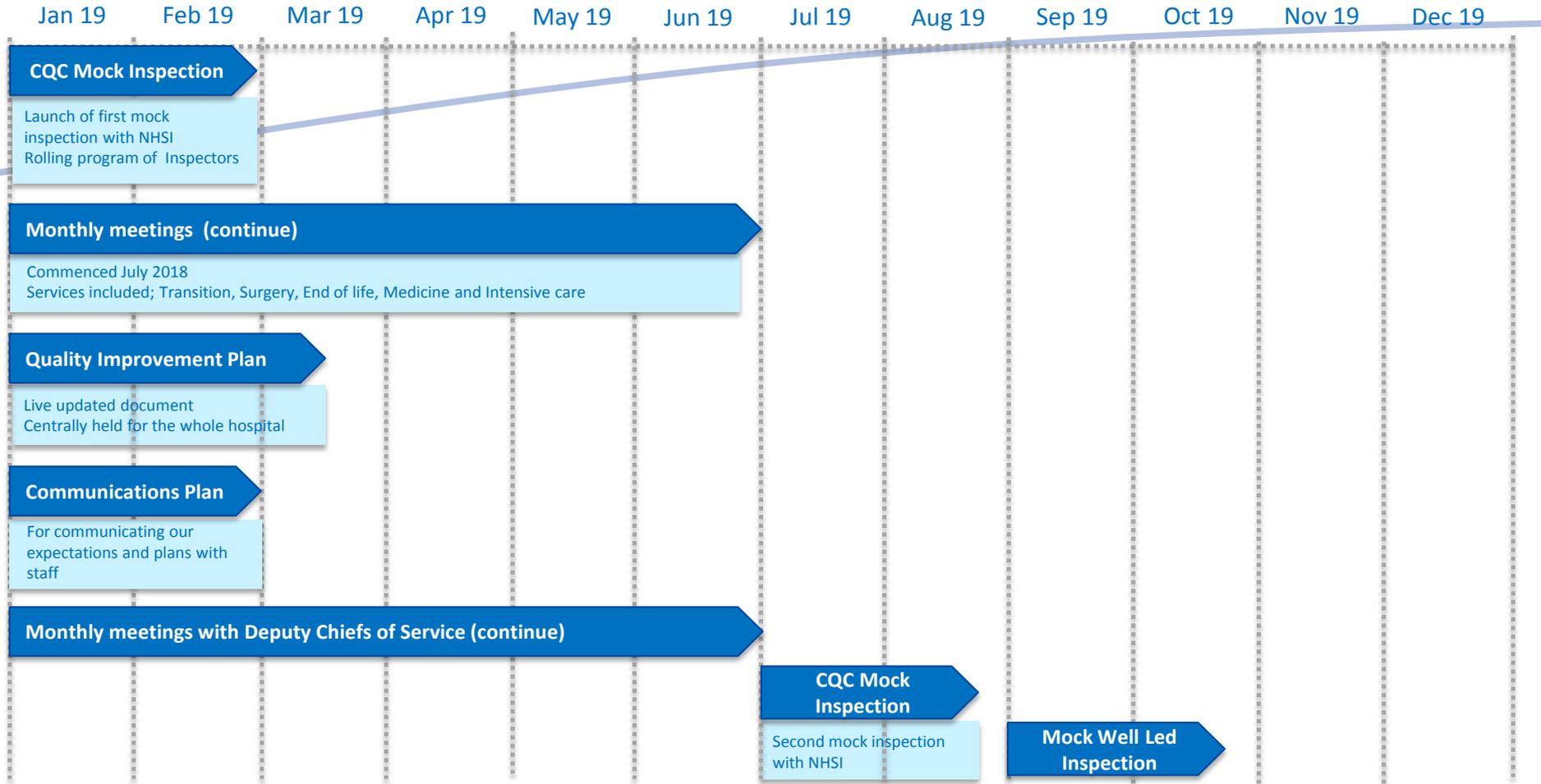
Internal assessment: **Needs improvement**

- Great work since inspection:
 - Restructure, Freedom to Speak Up Guardian , engaging with the wider hospital network of North London and with Regulators and Commissioners.
- Well Lead focus at Exec meetings, Strategy day and Board development.
- There have been further changes to the Executive team since the report plus two new NEDs joining the board.
- More work in needed in areas such as:
 - Workforce plan, Organisational Development Plan, Quality Improvement Plan

Great Ormond Street Action Plan – CQC Well Led Assessment (January 2018)



Great Ormond Street Action Plan – CQC Well Led Assessment (January 2018)



- Work is continuing regarding CQC compliance within the Trust. The new Clinical Governance and Compliance Manager has started and will be working to ensure CQC readiness
- Meetings have been set for January 2019 to review possible integrated governance solutions for the Trust in order to better collate and manage compliance information and evidence
- It has been reported in the HSJ that more Trusts could face prosecution for safety breaches
- The Gosport Report and Learning from Gosport Report (response published by the Government) have been reviewed to establish key areas of learning applicable to the Trust and how to embed the learning

The Board is asked to

- acknowledge the paper and the current position
- support a proactive plan to be CQC ready

Trust Board
5th December 2018

**Safe Nurse Staffing Report for
 September/October 2018**

Paper No: Attachment 2

Submitted by: Alison Robertson, Chief Nurse.

Aims / summary

This report provides the Board with an overview of the Nursing workforce during the month of September and October 2018 and is set out in line with the National Quality Board (NQB) Standards and Expectations for Safe Staffing published in 2016.

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.

Action required from the meeting

To note the information in this report on safe staffing including:

1. The assurance of the safe staffing levels on the inpatient wards for September and October
2. The number of Newly Qualified Nurses who started in September
3. Overall the nursing vacancy rate is 1.3% well below the Trust target of 10%, however 3 directorates; IPP, Sight and Sound and Body, Bones and Mind have a vacancy rate of over 10%.
4. Turnover peaked in September at 17.% and continues to be above the Trust target of 14%
5. The challenges regarding retention and the initiatives proposed to address this situation.

Contribution to the delivery of NHS Foundation Trust strategies and plans

Safe levels of nurse staffing are essential to the delivery of safe patient care and experience.

Financial implications

Already incorporated into 18/19 Division budgets.

Who needs to be told about any decision?

Divisional Management Teams
 Finance Department
 Workforce Planning

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

Chief Nurse; Assistant Chief Nurses and Head of Nursing

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

Chief Nurse; Divisional Management Teams



Safer Staffing Report September/October 2018

The child first and always

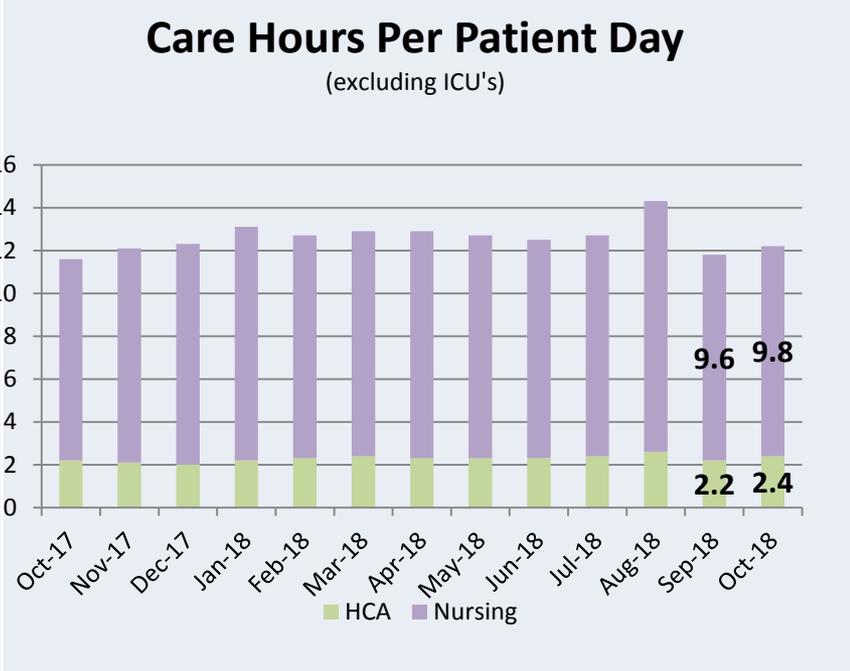
Always



Nursing & HCA Safe Staffing- September/October 2018

Definition	Trend	Comments																												
<p>Actual vs Planned Hours shows the percentage of Nursing & Care staff who worked (including Bank) as a percentage of planned care hours in month. The National Quality Board recommendations are the parameters should be between 90-110%.</p>	<p>Unify Actual vs Planned Hours</p> <table border="1"> <caption>Unify Actual vs Planned Hours Data</caption> <thead> <tr> <th>Month</th> <th>Percentage</th> </tr> </thead> <tbody> <tr><td>Oct-17</td><td>90%</td></tr> <tr><td>Nov-17</td><td>102%</td></tr> <tr><td>Dec-17</td><td>98%</td></tr> <tr><td>Jan-18</td><td>108%</td></tr> <tr><td>Feb-18</td><td>92%</td></tr> <tr><td>Mar-18</td><td>98%</td></tr> <tr><td>Apr-18</td><td>99%</td></tr> <tr><td>May-18</td><td>103%</td></tr> <tr><td>Jun-18</td><td>104%</td></tr> <tr><td>Jul-18</td><td>107%</td></tr> <tr><td>Aug-18</td><td>111%</td></tr> <tr><td>Sep-18</td><td>104.4%</td></tr> <tr><td>Oct-18</td><td>100%</td></tr> </tbody> </table>	Month	Percentage	Oct-17	90%	Nov-17	102%	Dec-17	98%	Jan-18	108%	Feb-18	92%	Mar-18	98%	Apr-18	99%	May-18	103%	Jun-18	104%	Jul-18	107%	Aug-18	111%	Sep-18	104.4%	Oct-18	100%	<p>Actual vs Planned Hours: - On average across the Trust the actual nursing hours available were within the recommend parameters for both months; in September it was 104.4% of actual hours vs planned and in October it was 100%. However there was one Directorate, Brain, which was just below the recommended parameters at 88.7% in September and one Directorate, Blood, Cells and Cancer at 87% in October. Heart and Lung and Blood Cells and Cancer were slightly above the recommended parameter at 113.2% and 111.7% respectively in September. No unsafe shifts were reported for either of these months.</p>
Month	Percentage																													
Oct-17	90%																													
Nov-17	102%																													
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Oct-18	100%																													

Care Hours Per Patient Day (CHPPD) - CHPPD is calculated by adding the hours of registered nurses and healthcare support workers available in a 24 hour period and dividing the total by the number of patients at midnight. CHPPD is reported as a total and split by registered nurses and 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.

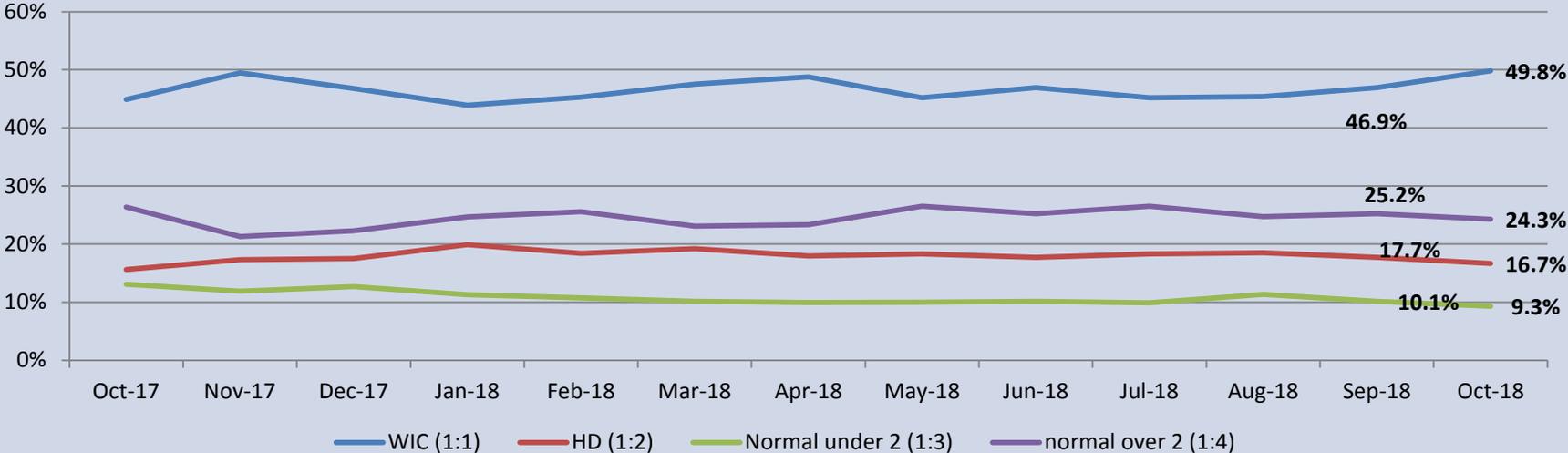


CHPPD for October was 12.2. This is higher than in September (11.8) and the same month last year (11.6).

This figure is an indication of “care” hours given to patients, so if the total was 24, that indicates every patient received 1:1 nursing, the figures for October indicate that patients received, on average 1:2 nursing.

Though these figures give a more granular detail of nursing staff available for the number of patients they cannot be taken in isolation. A number of measures and strategies are taken to ensure safe staffing is maintained, for example, closing beds or moving staff from one ward to another.

Patient Acuity (PANDA)



PANDA acuity data measures patient dependency based on the actual acuity and dependency of children. These are the following categories that are evaluated:

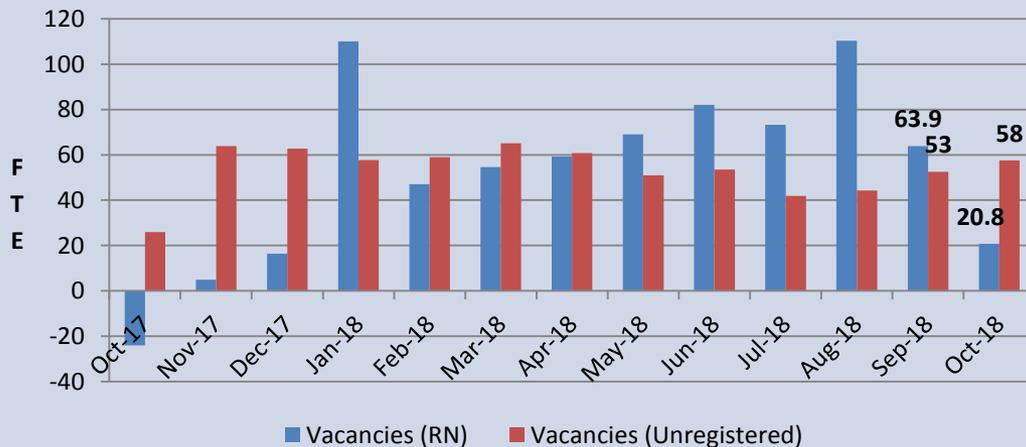
- Normal dependency Under 2 Years - 1 Nurse: 3 Patients
- Normal dependency Over 2 Years - 1 Nurse: 4 Patients
- Ward High Dependency (HD) - 1 Nurse: 2 Patients
- Ward Intensive Care (WIC) - 1 Nurse: 1 Patient

The trend in patient acuity requiring a nurse to patient ratio of 1:1 or 1:2 level of care has been consistent over the last few months and is currently reporting at 67% which is higher than October 2017 (61%). Patients with normal dependency of 1:3 and 1:4 were 33% of the total reported in October. This is a trend that is continually reviewed and discussed to ensure that correct numbers and skill mix of staff are available for the needs of the wards and departments.

Recruitment & Retention

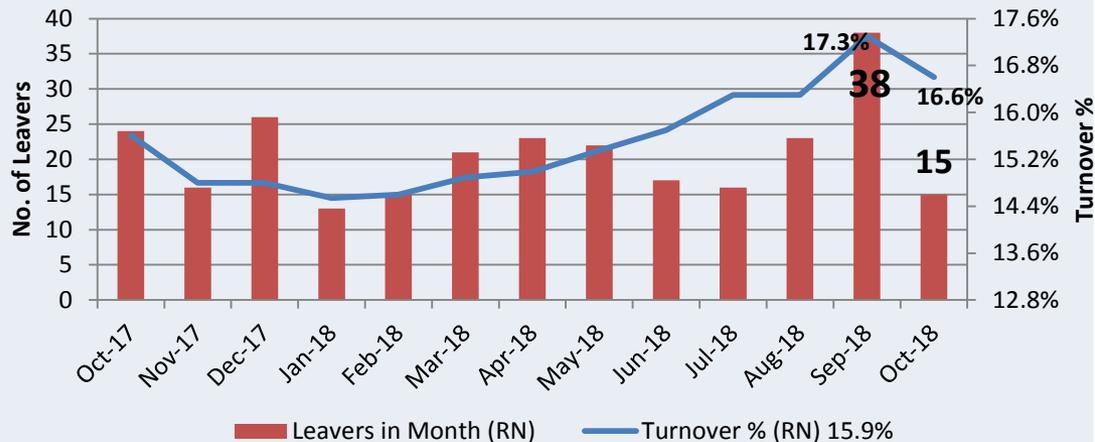
Comments

Vacancies & Pipeline



The RN Vacancy rate for October was 1.3% (20.8 WTE), which was a decrease from the previous month (4%: 63.9 WTE), and is well below the set Trust target of 10%. This was due to the cohort of Junior Band 5 nurses that commenced in the Trust in late September. A further assessment centre has been arranged in Dublin in December to interview a cohort of student nurses who will be qualifying in January 2019. Whilst the overall vacancy factor is only 1.3% a number of ward have a higher vacancy rate, namely International Private Patients, Sky Ward, PICU/NICU and CICU (with the opening of Alligator Ward), recruitment plans are being developed to address these specific areas. Further work is also required to fully understand the establishment for Theatre as historically any service growth has relied on the use of Bank staff.

Voluntary Turnover & Leavers



Turnover decreased in October from it's September peak (17.3%) to 16.6% but remains above target of 14%. Approximately 50% of the leavers identified accommodation issues as being a contributor to their decision making process. There is a Trust wide recognition of a need to review the provision of Trust accommodation and this work is currently being undertaken in conjunction with HR and the Charity. As part of the ongoing retention strategy a Band 5/6 a Marketplace is taking place in December to highlight some of the issues that affect turnover. This day has been arranged in collaboration with the Advisory Board Company, who will be running seminars to discuss key issues including; building resilience in nurses and providing psychological support. The review of the Clinical Nurse Specialists and Advanced/ Trainee Nurse Practitioners is ongoing and is identifying how to utilise this resource effectively within the Trust.

Nursing & HCA Safe Staffing- September/October 2018

Nursing Workforce Metrics by Division: September

Division	Actual vs Planned %	CHPPD (exc ICUs)	RN Vacancies %	RN Vacancies (FTE)	Turnover %	Sickness %	Maternity %
Blood, Cells & Cancer	111.7%	12.6	0.23%	0.1	17.7%	3.3%	4.0%
Body, Bones & Mind	107.1%	10.5	12.0%	5.4	13.7%	2.9%	4.0%
Brain	88.7%	12.3	33.3%	27.3	10.8%	3.0%	6.8%
Heart & Lung	113.2%	14.7	10.9%	2.3	19.4%	3.3%	2.6%
International & PP	95.4%	10.7	31.1%	28.2	23.1%	3.3%	3.8%
Operations & Images	-	-	0.8%	1.5	9.0%	3.5%	2.7%
Sight & Sound	-	-	13.9%	4.3	26.8%	1.9%	4.9%
Trust	104.4%	11.8	4.0%	63.9	16.6%	3.1%	3.6%

Nursing & HCA Safe Staffing- September/October 2018

Nursing Workforce Metrics by Division: October

Division	Actual vs Planned %	CHPPD (exc ICUs)	RN Vacancies %	RN Vacancies (FTE)	Turnover %	Sickness %	Maternity %
Blood, Cells & Cancer	87.8%	10.9	-4.9%	-10.25	17.4%	3.3%	3.8%
Body, Bones & Mind	107.6%	12.2	-11.0%	-24.7	13.7%	2.9%	4.1%
Brain	90.0%	12.8	-4.3%	-5.3	10.8%	3.0%	6.9%
Heart & Lung	110.8%	12.9	-0.1%	-0.3	19.4%	3.3%	3.4%
International & PP	102.3%	12.4	25.2%	27.8	23.1%	3.3%	4.9%
Operations & Images	-	-	0.8%	1.5	9.0%	3.5%	1.9%
Sight & Sound	-	-	13.9%	4.3	26.8%	1.9%	3.8%
Trust (*)	100%	12.2	1.3%*	20.8*	16.6%*	3.1%*	3.9%*

Successes

- Junior Sister/Charge Nurse job description and person specification agreed at the Workforce Advisory Board (WAB). This new role is part of the retention strategy to prepare senior ward nurses for the role and responsibilities expected of a Ward Sister.
- Visible Leadership- feedback from Junior Band 5's reported that they have been very well supported.
- A 'Longer Career' Nursing Marketplace Engagement Event took place on 18th September: Excellent feedback was received, staff felt valued.
 - High numbers registered for the Equiniti pension seminars- 80 staff members from different age groups attend these sessions.
- A Healthcare Support Worker Assessment day was held on 4th September with excellent engagement from Ward Managers. In total 14 candidates were successfully recruited.
- 118 Junior Band 5's were welcomed to the Trust on 24th September.
- Nurse Recruitment Open day took place 16th October, receiving positive feedback from attendees.
- 49 candidates have been shortlisted who will attend a Junior Band 5 assessment days in November.

Challenges.

- Although the cohort of 118 newly qualified nurses started in the Trust in September, there is a period where they are supernumerary whilst they attend Trust and local induction and undertake local training to gain the required competencies and skills. These nurses have started to be included in the staffing numbers from the middle of October.
- A number of beds have been closed over the last two months to ensure safety, these closures have been closely monitoring by the Nursing Director of Operations and the Flow Managers, in conjunction with the Matrons and Heads of Nursing, on a daily basis.
- The higher vacancy rates for IPP, Sky Ward and the Intensive Care Units. Specific recruitment plans are being developed for these areas to address the shortfall in nursing numbers.
- Turnover rate of nurses continues to be above the Trust target. The Trust has joined the NHS Improvement Support Programme and will be attending the first conference in November 2018.

Trust Board 5th December 2018	
Annual review of nursing establishment at Gt Ormond Street Hospital for Children	Paper No: Attachment 3
Submitted by: Alison Robertson, Chief Nurse.	
Aims / summary	
<p>In May 2018 guidance was published by the NQB – <i>Safe, sustainable and productive staffing. An improvement resource for children and young people’s inpatient wards in acute hospitals</i> This guidance provides an updated set of NQB expectations for nurse staffing to help Trust boards make local decisions that will deliver high quality care for patients within the available staffing resource. This includes the recommendation: - <i>2.1.1 Boards should carry out a strategic staffing review every 12 months as NQB recommends, aligned to the operational and business planning process, or more frequently if changes to services are planned.</i></p> <p>This reports provides the detail on the methodology used to review current ward establishments and if any adjustments need to be made to the current budgeted establishments.</p>	
Action required from the meeting	
<p>To note the information in this report including:</p> <ol style="list-style-type: none"> 1. The review has confirmed that the establishments for the current services and activity are fundamentally correct with the exception for theatres and radiology where further scrutiny and discussion needs to occur to better understand their staffing requirements. 2. There is always continuous scrutiny and reporting of safe staffing monthly, utilising the information provided from the rostering systems, the Patient Information Management system (PIMS), review of datixs and incidents and professional judgment. 3. The process to change nursing establishments will continue to be made through the Trust business case approval process or the annual business planning cycle. 	
Contribution to the delivery of NHS Foundation Trust strategies and plans	
Having the correct nursing establishments are essential to the delivery of safe patient care and experience	
Financial implications	
Additional budget maybe required once further scrutiny has taken place to better understand the Theatre nurse staffing requirements.	
Who needs to be told about any decision?	
Divisional Management Teams Finance Department Workforce Planning	
Who is responsible for implementing the proposals / project and anticipated timescales?	
Chief Nurse; Assistant Chief Nurses and Head of Nursing	
Who is accountable for the implementation of the proposal / project?	
Chief Nurse; Divisional Management Teams	

**Annual review of nursing establishments at
Great Ormond Street Hospital for Children NHS Foundation Trust**

1. Introduction

- 1.1 In May 2018 guidance was published by the NQB – *Safe, sustainable and productive staffing. An improvement resource for children and young people’s inpatient wards in acute hospitals*. This guidance provides an updated set of NQB expectations for nurse staffing to help Trust Boards make local decisions that will deliver high quality care for patients within the available staffing resource. There are no new actions from this report for the Trust. This paper includes the recommendation: *(2.1.1) Boards should carry out a strategic staffing review every 12 months as NQB recommends, aligned to the operational and business planning process, or more frequently if changes to services are planned.*
- 1.2 It is clear from the guidance that Trust Boards are expected to take full responsibility for the quality of care provided to patients and as a key determinate of quality take full responsibility for nursing staff capacity and capability. This paper focuses on the former.

2. Context

- 2.1 In order to give assurance that safe care is provided, a Safe Staffing Report, for inpatient wards, is presented at each Trust Board, in line with national requirements. The report includes information on staffing levels, Care Hours Per patient Day (CHPPD), patient acuity and action undertaken regarding staff reallocation if needed. This annual report provides further information to meet the recommendations and requirements as mentioned in 1.1.
- 2.2 Changes or deficiencies in the nursing workforce can have a detrimental impact on the quality of care. Patient outcomes and particularly safety are improved when organisations have the right people, with the right skill in the right place at the right time. This has been highlighted consistently in numerous reports strategies and inquiries.
- 2.3 From May 2016 Trusts began reporting monthly CHPPD data to NHS Improvement. When looking at this information locally alongside other patient outcome measures, trusts will be able to identify how they can change and flex their staffing establishment to improve patient outcomes and improve productivity. It is still anticipated that in the future the reporting of CHPPD will replace the current method of looking at the nurse to patient ratios and is now published on the new Model Hospital website. The Model Hospital is a digital information service provided by NHS Improvement to support the NHS to identify and realise productivity opportunities and supports Trusts to identify and tackle unwarranted variation.

3. Defining Staffing levels

3.1 Currently there is no national guidance on what the CHPPD should be for specialist children's hospitals. Thus, in the absence of a national mandate the use of evidence based tools have been used along with professional judgement to inform staffing levels as in previous reviews. There are a number of published standards and tools available to define staffing levels but there are only two which relate to the care of children and young people; Defining staffing levels for Children's and Young People's services (Royal College of Nursing, July 2013), Paediatric Intensive Care Standards (PICs, 2015) and Safe, Sustainable and Productive Staffing; An improvement resource for children and young people's inpatient wards in acute hospitals (NQB May 2018) are widely used and endorsed.

The RCN categories are:

- Normal dependency Under 2 Years - 1 Nurse: 3 Patients
- Normal dependency Over 2 Years - 1 Nurse: 4 Patients
- High Dependency - 1 Nurse: 2 Patients
- Intensive Care, (including ward Intensive care) - 1 Nurse: 1 Patient
- Enhanced Intensive Care - 2 Nurses: 1 Patient (this includes children requiring ECMO or renal replacement therapies).

3.2 The Paediatric Intensive Care Society (PICs) Standards (Version: 5: 2015) recommends that the nurse to bed ratio should be 7.06 WTE per Intensive care bed. However on greater scrutiny of their calculations there does appear to be an error, when this error was corrected and the calculation reworked the nurse to bed ratio works out to be 6.8 WTE. This adjusted ratio has been adopted by the Trusts' Intensive Care Units.

3.3 In addition to the above standards the Paediatric Acuity and Nurse Dependency (PANDA) Tool is also widely used across GOSH to determine patient acuity which helps to inform safe staffing levels. It should be noted that the nurse numbers calculated within PANDA are not used to inform the nurse establishments as the algorithms used within the system over estimate the nursing requirements.

4.0 Safe Staffing Reports (UNIFY) and Care Hours Per Patient Day (CHPPD)

4.1 The Trust submits monthly safe staffing data to NHS England, statistics are published on NHS Choices, and the Trust Board receives these figures monthly as part of the Safe Staffing Report. The Trust monthly overall fill rate i.e. hours worked expressed as a % of planned hours for this period should fall between 90% - 110%. These are the parameters considered acceptable for safe staffing levels. These figures don't include staff working supernumerary shifts eg. new starters during their orientation period. For the past year all monthly returns reported an overall fill rate falling between the recommended parameters.

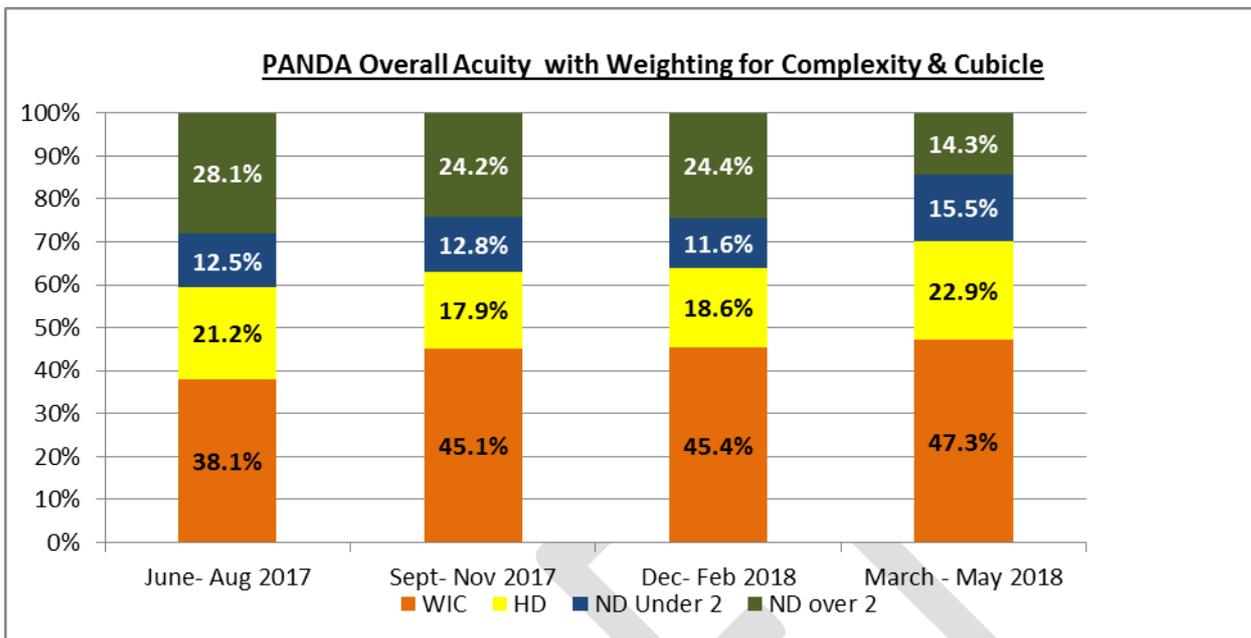
4.2 CHPPD is calculated by adding the hours of registered nurses and healthcare support workers available in a 24 hour period and dividing the total by the number of patients at midnight. CHPPD is reported as a total and split by registered nurses and HCAs to provide a complete picture of care and skill mix.

- 4.3 The introduction of CHPPD for nurse and HCAs in the inpatient setting was the first step towards developing a tool that could contribute to a review of staff deployment and a more efficient use of manpower resources. As with other indicators, CHPPD should never be viewed in isolation but as part of a local quality dashboard, that includes patient outcome measures alongside workforce and finance indicators. In March this year the Trust agreed to purchase and implement a new rostering system, HealthRoster. HealthRoster is a widely used e-rostering system within the NHS and is intended to deliver a proven, intelligent, end-to-end staff management system based on one consolidated view of all staff groups and all staff types, whether substantive, bank or agency. This should improve the efficiency and fairness of roster management across the Trust, providing managers and staff with easy to use systems to manage staff deployment and linked to Bank Partners, to ensure lower Bank and Agency usage. Managers will be able to monitor usage of annual leave, study leave and sickness more efficiently and effectively as the information is current.
- 4.4 SafeCare, a component tool of HealthRoster brings the workforce and patients information together in a single view allowing the Trust to better match real-time staffing levels to actual patient acuity, via PANDA, to give nursing managers, at all levels, a clear and updated view of patient demand. This will improve existing processes to ensure safe staffing levels across the Trust.
- 4.5 CHPPD data is also uploaded monthly and published on NHS Choices.

5.0 Methodology

- 5.1 This year's annual review included all inpatient wards and, for the first time, departments including theatres, radiology, outpatient and day-care units. All wards and departments establishments both budgeted and actual were reviewed and agreed by each Ward Manager, Team Leader, Matrons and the Assistant Chief Nurse for Workforce and finally the Divisional Assistant Chief Nurses. As part of the review quality measures such as complaints, DATIX reports and PALS reports received on safe staffing were reviewed alongside ward incidents. Activity, dependency and occupancy data was also reviewed to see if there were any major changes that would require a change to the establishment. This data was also underpinned by professional judgment to inform and determine safe establishments on GOSH wards.
- 5.2 Table 1 provides a breakdown of PANDA data for the period June 2017 to May 2018; this information shows that patient dependency and acuity increased from September 2017. This increase is linked to the opening of the Premier Inn Clinical Building (PICB) and the increase in cubicle capacity this building provides. This increase in cubicles capacity was factored into the nursing establishments required to staff this new clinical environment.

Table 1.



5.3 Patient dependency and acuity has remained fairly consistent over the last 3 quarters and as no other concerns were raised to the Assistant Chief Nurse (Workforce) with regards to the budgeted establishments, no other additional posts are being requested following this review except for those noted in Section 8.2 and for future planned service development.

6.0 Current Staffing

6.1 Whilst the budgeted establishments are currently sufficient the recruitment and retention of suitably trained and skilled staff remains a challenge. There have been new initiatives and campaigns launched since February 2017 to attract both new and experienced nurses. Since Sept 2017, over 400 newly qualified nurses have joined the nursing workforce. From the 215 cohort of newly qualified nurses who started in September 2017 a total of 36 nurses have now left the Trust a turnover of 16.7%.

6.2 Across the Trust, the current nursing vacancy rate (June 2018) is 4.7%, this year's intake of newly qualified Band 5 nurses is 145, with the majority planning to start in September. Currently the annual attrition rate for nursing staff rate is 16.87 % which is slightly down from last year. Nurse sickness for the last year to July 2018 is 3.0%, similar to the previous year.

6.3 Within the budgeted establishment there is a 22% uplift to compensate for factors that can effect staffing levels including sickness and holidays, it is only when this factor has been breached should the ward staff request Bank or agency staff. Bank Partners has 1751 nurses and HCAs enrolled on their system, an increase of 194 from the last report (1484 substantive registered staff, and 267 non substantive staff of which 64 are HCA's). The current shift fill rate is circa 89.3% for the last 12 months. Our reliance on

third party agency staff has decreased to less than 1%, well below the national agency cap.

- 6.4 A comprehensive recruitment and retention plan has been developed with a number of key work streams including; career pathways; secondment opportunities and fast track internal transfer process. This plan has been presented at the Operational, Delivery and Performance Group (OPDG), Nursing Board and Trust Board.
- 6.5 In line with a national strategic framework to develop the healthcare support workforce 'Talent for Care'. The Trust has recently made changes to the recruitment and training of the unregistered workforce, (Clinical Band 2-4 roles). This is to ensure consistency and uniformity in their deployment across the Trust and to ensure these roles are in line with this new Talent for Care framework. In the last year the turnover rate is similar to the Registered Nurses at 16.25%, sickness rate at 4.73% and the vacancy rate is 13.09%, which equates to 29 WTE. A further assessment centre is taking place in September 2018 to recruit more healthcare support workers.
- 6.6 The Trust is a pilot site for the new Nursing Associate role which is a 2 year training programme, the first cohort started in January 2017. The evaluation report of the Nursing Associate test sites is currently being reviewed and the outcomes will be reported in due course.

7.0 Findings

Following the review there are 3 areas identified as not having the correct establishment for the activity/ acuity. These were;

- **Theatres: -**
Theatres have not previously been included in the annual review of establishments and there is evidence of changes in workload and activity over time. The additional Referral to Treatment Time (RTT) work has become business as usual as has a lot of the additional International Private Patient work. If activity is planned to be maintained at this current level then the establishment in Theatres will require a review as the current staffing levels are below what is required to deliver the current theatre activity.

This is evidenced by nursing spend on Bank staff in 2017-18, which was in excess of £1.2 million, which equates to an overspend of £0.9 million when the vacancy factor is accounted for. It is recommended that, as a matter of some urgency, the establishment is reviewed against predicted bank spend so that posts can be converted and moved into the establishment. Calculations would suggest that the theatre nursing establishment is showing a shortfall of between 15 and 20 WTE. Work to ascertain what the current establishment should be for theatres is currently underway. A recruitment plan specifically designed for theatres will then be developed.

- **Radiology: -**
Radiology services are expanding, especially the use of the nurse led sedation service. This service is growing as it provides more effective and efficient patient pathway with improved patient experience, if levels of activity continue to rise then a review of the

current establishment, to accommodate future growth, will be required. This growth should inform any future business plan.

- **HDU's/Expanded Services/New Wards.**

Throughout the process of this review it has become evident that there are planned developments or changes to certain wards and departments. There is a concern that these service developments may go ahead without a systematic review of staffing requirements. Bank lines are often utilised to support new developments which can prove to be difficult to fill and is a more unpredictable way of maintaining safe staffing levels.

It is strongly recommended that workforce plans are included in any business cases and that an associated recruitment plan is put in place ahead of time to maximize the opportunities to fill substantive posts. In the new directorate structures the Heads of Nursing and Patient Experience will be accountable for ensuring that nursing requirements are calculated and included in future business cases. The Chief Nurse will also maintain oversight and sign off of all workforce plans associated with service change. The Assistant Chief Nurse for Workforce will be responsible for supporting the service to develop and deliver a recruitment plan.

8.0 Conclusion and Recommendations

- 8.1 A comprehensive review of nurse establishments has been conducted to ensure staffing levels are able to meet the national recommendations to ensure that safe, quality care is provided. The methodology was slightly changed from previous reviews to include departments including theatres, radiology, outpatient and day-care units.
- 8.2 The recommended areas for either increase or further scrutiny are theatres, radiology and any ward based areas with planned service developments that are without workforce plans as part of their business cases. Heads of Nursing and Patient Experience should meet with the directorate general manager to review any current business cases to decide whether or not further work is required.
- 8.3 This paper gives assurance to the Trust Board that GOSH, has appropriate nursing establishments to deliver safe staffing levels and systems in place to manage the demand for nursing staff shortfalls (with the exception of those areas identified above).
- 8.4 There is no room for complacency as recruitment and retention of suitably trained nursing staff remains a challenge especially in International Private Patient directorate, Sky Ward and PICU/NICU and the opening of additional cardiac surgery capacity on Alligator Ward. There is a need to stabilise the workforce by continuing with the current Recruitment and Retention Action Plan especially in regard to Band 6 practitioners. There has been a high level of collaborative work between Workforce, Education and HR to develop these pathways, to ensure the Trust is viewed as a place of choice to work with many varied career opportunities Recruiting Health Care Assistants in line with the national strategic Talent for Care framework will continue.
- 8.5 Currently, there is a comprehensive review underway to fully understand and appreciate the roles of the Clinical Nurse Specialists and the Advanced, Trainee and Nurse Practitioners. This resource is significant within the Trust and as the nursing and junior

doctor numbers decline, this is an opportunity to look forward and plan for the future nursing workforce requirements to ensure services are safe and sustainable.

- 8.6 Any further changes to ward establishments should be made through the business planning approval process to ensure any changes are financially viable. All nursing workforce plans should be signed off by the directorate Heads of Nursing and Patient Experience and the Chief Nurse Office.
- 8.7 In line with the National Quality Board recommendations an additional establishment review will be undertaken in 6 months. This review will take into account the new directorate structure and the establishments agreed with the new Heads of Nursing. These reviews will take place during November and December 2018.

9.0 Future Developments

- 9.1 Following the roll out of a number of new national programmes including; Nursing Associates, for which GOSH was a pilot site; the introduction of nursing undergraduate apprenticeship programme and Advance Clinical Practitioners (ACPs) a detailed skill mix review will need to be undertaken to ensure we have the right nursing workforce that accounts for these developments and that the right education and training is in place to support them.
- 9.2 The Trust is currently rolling out a new rostering system, Healthroster a component of this system is software called SafeCare which allows wards to compare staffing levels and skill mix with actual patient demand. This software will interface between the new rostering system and the PANDA system. This new system will provide greater visibility of required versus actual staffing highlighting hotspots as well as areas that could help. There are plans to interface this system with EPIC in the future, which may result in the Trust moving away from the PANDA system altogether. Further work will take place to review what the impact of this will be.
- 9.3 The plan is to undertake the next full establishment review in August/September 2019 to align with the business planning cycle.
- 9.4 The Trust has joined the NHS Improvement Retention Direct Support Programme and representatives from the Trust attended the first conference in November 2018.
- 9.4 New guidance has been published by NHS Improvement (2018), '*Developing workforce safeguards – supporting providers to deliver high quality care through safe and effective staffing*'. This guidance sets out a number of new recommendations including; all Trusts are required to have an annual workforce plan that is multidisciplinary, evidence-based, integrated with; finance and activity and performance plans. Trust's compliance will be assessed through the Single Oversight Framework (SOF) and Trusts will be asked to include a specific workforce statement in their annual governance statement.

Appendix 1: Nursing Establishment June 2018

Division	Ward	Band 7		Band 6		Band 5 d		Band 4 Funded Establishment	Band 3 Funded Establishment	Band 2 Funded Establishment	Total Funded Establishment	
		Established Bed No.s	Funded Establishment	Establishment	Funded Establishment	Establishment	Funded Establishment					
C h a r l e s W e s t	Leopard	14	1	8.8	29.23			0	4.92	1	43.95	
	Bear	24	1.8	18.58	35.89			7	3	1	66.27	
	Walrus	N/A	2	6.4	3.5			2	2	0.5	16.4	
	Kangaroo	7	1.5	5	11.73			2.5	8.67	0	29.4	
	CICU	19 Flex to 21	8.7	60.48	68.43			1.6	3	0	142.21	
	NICU	10	6.3	22.95	27.49			0	2	0	68.74	
	PICU	17 flex to 20	9.8	40.85	52.76			0	1	0	104.41	
	Elephant	13	1	7	17			0	5.38	0	30.38	
	Fox	10	1	9	24			0	5	0	39	
	Giraffe	7	1	7	11			0	3	0	22	
	Lion	11	1	7	14			0	4	0	26	
	Pelican	10	3.51	5.5	9			1	4	0	23.01	
	Safari	N/A	1	7	4			0	5	1	18	
	Robin	10	1	8	20			0	5	0	34	
	Outpatients	N/A	2	2	6.17			1	24.89	0	36.06	
	IPP	Bumblebee	21	1	11	25			0	10	0	47
		Butterfly	18 + 4 D/C	1	7.83	28.17			1	9	0	47
Caterpillar		N/A	0	1	2			0	6	0	9	
J M B a r r i e	Hedgehog	10	1	5.46	13.61			1	6	0	27.07	
	Radiology	NA	3	14	8.5			3	1		29.5	
	APOA	N/A	1	2.5	0			1	1	1	6.5	
	Eagle	15	1.62	17.28	23			2	8	2	51.9	
	Kingfisher	13	2	5.9	9.81			0.92	4.61	0	23.24	
	Rainforest Gastro	8	1	6	10			0.5	4	0	29.5	
	Rainforest Endo/ Met	8	1	4.84	10.76			1	4	0	21.6	
	Mildred Creak	10	0	4.7	9			5	2.61	0	21.31	
	Starfish/ Ranu	N/A	1	2	2			0	2	0	7	
	Koala	12	2	18.2	36.1			0	5.2	2	61.5	
	Panther ENT	14	1	9	14.6			1	5	0	30.6	
	Sky	18	2	12.4	29			1	8.6	0	53	
	Panther Urology	10	1	6	14			0.5	4	0	25.5	
	Chameleon	10	1	10	21			0	4	0	36	
	Urodynamics	N/A	2	2.6	0			1	0	0	5.6	
	Woodpecker/ Nightingale	N/A	2	6	12			0	5	0	25	
	Theatres	13 Theatres	10.5	42	24.8			4	6		87.3	
CRF	N/A	9	20	2			4	1		36		
Trust Total:		265	86.73	424.27	629.55			42.02	177.88		1380.95	

Trust Board 5th December 2018	
Guardian of Safe Working report Submitted by: Dr Renée McCulloch, Guardian of Safe Working	Paper No: Attachment 4
Aims / summary This report is the third quarter report to the Board regarding Junior Doctor working practice at GOSH. This report covers the period 1 st July to 30 th September 2018 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 Dr Sanjiv Sharma, Deputy Medical Director for Medical & Dental Education Sarah Ottaway, Head of Medical HR & PGME Services	
Who is accountable for the implementation of the proposal / project? Matthew Shaw, Medical Director	

**Trust Board Report
Guardian of Safe Working
1st July – 30th September 2018**

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

The GOSW champions the importance of safe and appropriate working hours, training & education and general wellbeing for all junior doctors as all have a direct effect on the quality and safety of patient care.

3. GOSH Junior Doctor Rotas

- 3.2.** There are 45 different rota patterns currently in place within the Trust. All GOSH rotas are compliant with the 2016 TCS.
- 3.3.** Number of Trust Doctors as of 31 September 2018 = 174
Number of Training Doctors as of 30st September 2018 = 151
- 3.4.** The **overall vacancy rate** across junior doctor rotas as of 31/09/2018 is **11.4% with 32.4 FTE vacant out of a total of 284 rota slots**. The national 18% fall in Paediatric ST1 applications since 2015 represents a workforce crisis in paediatrics (RCPCH Jan 2018).
- 3.5. Rota Gaps** (due to unfilled positions and sickness) put significant pressure on the system and result in doctors working over hours and not accessing training and education opportunities.
- 3.6.** The MEGGA/HO rota has been highlighted as a particular risk by the junior doctors who requested a meeting with the GOSW- work volume is high and there is potential patient safety concern, although no incidents reported. A response meeting was held on October 31st to consider various options for increasing SpR numbers – several are currently under consideration.
- 3.7.** As of the 30st September 2018 the following junior doctor posts were vacant:

Specialty	Rota grade	Rota establishment	Vacant posts	Vacancy rate %
Neurology	SHO	4	1	25
Orthopaedic Surgery	SHO	3	2	66.6
Urology	SHO	4	2	50
Plastic Surgery	SHO	3	2	66.6
ENT	SHO	2	1	50
General Surgery	SHO	6	3	50
Orthopaedic	SpR	7	1	14.3
Gastroenterology	SHO	3	1	33.3
Megga 2	SpR	7	2	28.5
Ham/Onc (ICI)	SpR	8	2	25
CATS	SpR	9	2	22
ICON	SpR	8	1	12.5
ECMO	SpR	7	2	28.5
Cardiothoracic Surgery	SpR	8	1	12.5
Respiratory	SpR	8	2	25
Ophthalmology	SpR	3	1	33.3
Radiology	SpR	5	1	20
Dermatology	SpR	3	1.4	46.6
International Private Patients	SpR	14	4	28.6

4. Exception Reports

- 4.2.** Exception reporting is the contractually mandated mechanism used by doctors to inform the Trust when their day-to-day work and educational opportunities varies significantly and/or regularly from the agreed work schedule. From June 2018 ALL GOSH junior doctors (training doctors on the 2016 contract and Trust doctors on local TCS) can exception report
- 4.3.** The purpose of exception reports (ERs) is to ensure prompt resolution and / or remedial action to ensure that safe working hours are maintained.

4.4. Numbers of ERs July to September incl. 2018

Date:	Number of ERs	Number of Episodes	No closed / completed
01-07 to 31-09 2018	16	28	10/16

4.5. Exception Report Outcomes:

Exception Report Outcomes (Per Episode- some have >1 outcome) July to September 2018 incl.					
Compensation with payment	TOIL	Work Schedule review	Further information	Pending ES meeting	Level 1 review
5	3	-	1	6	1

4.6. Exception Report by Specialty and Grade

Exception Reports July to Sept 2018: Details by Specialty, Grade and Reason					
Specialty	Rota grade		ERs: hours	ERs: educational opportunities	ERs: missed breaks
	SHO	SpR / Fellow			
Gastroenterology		4	4		
Endocrine		1	1		
CAMHS		1	1		
Rheumatology		1	1		
Neurology		4	3	1	
Surgery	5		5		
Total	5	11	15	1	

4.7. Exception Report Themes: The predominant themes behind the extra hours being worked are:

- **Rota gaps** "I have converted to night shift at very short notice to cover a gap on the rota for night shifts".
- **Work flow & volume:** "I was covering 3 different areas- internal referrals, outliers, nutrition. I had to stay back longer to ensure all the work was done"
- **Staying late to complete clinical duties** "Had to stay longer as received many external calls that needed to be sorted out: discussed with consultant. Then communicated to local teams, organised admission...document on EDM".

5. Compliance with 2016 TCS

- 5.2. The existing reporting systems makes it impossible to determine whether doctors are working beyond the limits set out in schedule 3 of the 2016 TCS:
- 5.3. Recording and assimilation of extra bank hours in conjunction with scheduled working hours is not undertaken.
- 5.4. ER system is not used consistently and universally by all doctors
- 5.5. The existing Allocate software does not support longitudinal data collection comparison against individual doctor's working rotas so unable to determine 'breaches' unless manually checked.

6. Fines and Payments

No 'Higher' fines have been levied by GOSW against non-compliant departments. **This is not to say that GOSH departments are compliant.** Unless the doctors report all their hours (including bank duties) on every shift across several weeks the GOSW cannot determine these breaches.

7. Junior Doctors' Forum and Engagement

GOSW is positively engaged with the junior doctors via a number of routes and meetings. The JDF is working well but attendance numbers are generally low although quality of discussion is high and actions constructive.

8. Rest Facilities

Lack of access to rest facilities have been highlighted as an issue for doctors across the Trust and escalated to the Clinical Operations team and the Medical Director's Office. GOSW and the JDF are surveying doctor's access to rest facilities for every rota level.

9. Speciality Focus

- 9.2. Through ER information and personal reporting GOSW has identified specific specialities that require further support and is working alongside the teams to improve rotas, examine work flow systems and processes and facilitate access to learning opportunities.

10. Locums - Bank and Agency use

- 10.2. Below is a breakdown of locum (bank and agency) usage across junior doctor rotas, for the period 1 July to 31 September 2018.

Speciality / Rota	Number of Shifts	Cost
Cardiology SHOs	24	£10,408
Cardiology SpRs	14	£7,492
Cardiothoracic SpRs	38	£23,026
CATS	57	£34,023
CICU	70	£55,460
Haematology/Oncology	162	£82,088
Intensivists	3	£3,187
MEGGA	278	£80,226
Neurology	123	£45,984
NeuroResp Nights	9	£5,909
Neurosurgery	70	£32,259
NICU PICU ICON	94	£75,502
Ortho Spinal SpRs	34	£10,027
Private Divisional Medical	160	£70,599
Respiratory Medicine	20	£5,227
Rheumatology	58	£25,358
Spinal	1	£505
Surgery SHOs (inc. ENT, Surgery, Urology, Orthopaedics)	271	£103,577
Grand Total	1486	£670,854

11. Externality

- 11.2. GOSH GOSW attended NHS Employers National GOSW conference in September – benchmarking with other Trusts, GOSH has achieved considerable ER numbers and positive change.
- 11.3. BMA hosted a Pan London GOSW networking meeting in September chaired by GOSH Guardian to encourage sharing of good practice and discussion re challenges
- 11.4. NHS Improvement are reviewing the standardisation and data capture of ER – GOSH GOSW has contributed evidence and feedback

12. **Progress:** The GOSW and medical director's office has supported several new initiatives to address current challenges.

- 12.2. 'Junior Doctor's Recruitment and Modernisation Working Group' ('dashboard development', forward forecast of gaps and JD medical workforce strategy development).
- 12.3. Surgical SHO Support Meetings (MD Office and GOSW)
- 12.4. Rest facilities- issue raised at LNC and commitment for support from the GOSH charity; commitment by GOSH to support the national sleep charter
- 12.5. Assessment and Management of medical workforce risk – in development: a risk stratification tool to enable an operational response to junior doctor rota gaps (ensuring 'safe doctor' numbers')
- 12.6. Hospital at Night Working Group – currently in development
- 12.7. Associate Medical Director for Modernising the Medical Workforce – post in development

13. Summary

- 13.2. Assurance of compliance with the 2016 contract: GOSH rotas are theoretically compliant however rota gaps directly affect compliance and safety in addition to education and training opportunities.
- 13.3. Exception reporting is being used appropriately and constructively but is not well integrated into medical working practice. When used proactively it is a valuable safety tool and can provide a constructive framework to evaluate junior doctor working practice.
- 13.4. The MEGGA /HO rota has been highlighted as a particular risk and action is being taken to modify the number of doctors allocated to this on call work stream.
- 13.5. Strategy and process that modernises the Junior Doctor working experience at GOSH, addressing the local and national challenges of the paediatric medical workforce, are now being addressed.