

**Meeting of the Trust Board
Thursday 7 February 2019**

Dear Members

There will be a public meeting of the Trust Board on Thursday 7 February 2019 at 1:30pm 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	1:30pm
Declarations of Interest All members are reminded that if they have any pecuniary interest, direct or indirect, in any contract, proposed or other matter which is the subject of consideration at this meeting, they must disclose that fact and not take part in the consideration or discussion of the contract, proposed contract or other matter, nor vote on any questions with respect to it.				
2.	Delivery of the Research Hospital (with a focus on the Zayed Centre for Research)	Director of Research and Innovation/ Mr Paulo De Coppi, Consultant	Presentation	
2.	Minutes of Meeting held on 5 December 2018	Chairman	I	1:45pm
3.	Matters Arising/ Action Checklist	Chairman	J	
4.	Chief Executive Update	Chief Executive	K	1:50pm
	<u>STRATEGY and RISK</u>			
5.	Patient Story	Chief Nurse	L	2:10pm
7.	GOSH Operational Plan 2019/20	Acting Chief Operating Officer/ Chief Finance Officer	N to follow	2:40pm
	<u>PERFORMANCE</u>			
8.	Integrated Quality Update Report – 31 December 2018	Acting Medical Director/ Chief Nurse	P	2:55pm
9.	Learning from Deaths Mortality Review Group - Report of deaths in Q2 2018/2019	Acting Medical Director	Q	3:10pm
10.	Integrated Performance Report - 31 December 2018	Acting Chief Operating Officer	R	3:20pm
11.	Finance Update – 31 December 2018	Chief Finance Officer	S	3:35pm

	ASSURANCE			
12.	CQC Readiness Update	Acting Medical Director	T	3:45pm
13.	Well Led Assessment Action Plan	Chief Executive	1	3:55pm
14.	Safe Nurse Staffing Report (November and December 2018)	Chief Nurse	U	4:10pm
	GOVERNANCE			
15.	Corporate Governance Update	Company Secretary	V	4:20pm
16.	Board Assurance Committee reports <ul style="list-style-type: none"> • Quality and Safety Assurance Committee update – January 2019 meeting • Audit Committee – January 2019 • Finance and Investment Committee Update – December 2018 	Chair of the Quality and Safety Assurance Committee Chair of the Audit Committee Chair of the Finance and Investment Committee	W X Y	4:35pm
17.	Code of Conduct for Board Directors	Company Secretary	Z	5:00pm
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 Wednesday 3 April 2019 in the Charles West Room, Great Ormond Street, London, WC1N 3JH.				

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**DRAFT Minutes of the meeting of Trust Board on
5th December 2018**

Present

Sir Michael Rake	Chairman
Dr Peter Steer	Chief Executive
Lady Amanda Ellingworth	Non-Executive Director
Mr James Hatchley	Non-Executive Director
Mr Chris Kennedy	Non-Executive Director
Ms Kathryn Ludlow	Non-Executive Director
Mr Akhter Mateen	Non-Executive Director
Professor Rosalind Smyth	Non-Executive Director
Mr Matthew Shaw	Medical Director
Ms Alison Robertson	Chief Nurse
Ms Helen Jameson	Interim Chief Finance Officer
Ms Nicola Grinstead	Deputy Chief Executive
Ms Alison Hall	Acting Director of HR and OD

In attendance

Mr Matthew Tulley	Director of Development
Ms Cymbeline Moore	Director of Communications
Dr Anna Ferrant	Company Secretary
Ms Victoria Goddard	Trust Board Administrator (minutes)
Dr Sophia Varadkar*	Chief of Service, Brain Directorate
Mr Martin Tisdall*	Consultant Neurosurgeon
Mr James Scott*	Head of Strategy and Planning
Ms Claire Williams*	Interim Head of Patient Experience and Engagement
Josephine*	Former GOSH patient
Dr John Hartley*	Director of Infection Prevention and Control
Ms Polly Hodgson*	Interim Deputy Chief Nurse
Dr Renee McCulloch	Guardian of Safe Working

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

** Denotes a person who was present by telephone

124	Apologies for absence
124.1	No apologies for absence were received.
125	Declarations of Interest
125.1	No declarations of interest were received.
126	Minutes of Meeting held on 27th September 2018
126.1	The minutes were approved by the Board.
127	Matters Arising/ Action Checklist
127.1	The actions taken since the last meeting were noted.

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128	Chief Executive Update
128.1	<p>Dr Peter Steer, Chief Executive gave an update on the following matters:</p> <ul style="list-style-type: none"> • Professor Faith Gibson, Deputy Chief Nurse for Research had been awarded a lifetime achievement award from the International Society for Paediatric Oncology. The Board congratulated Professor Gibson. • Dr Steer thanked Ms Helen Jameson, Chief Finance Officer for her work on the consolidation of genetics laboratories across North Thames. He said that the work was complex however following negotiation, engagement around adult cancer had been agreed by GOSH's partners. Work was now taking place to ensure that an adequate budget was in place. • GOSH continued to work with the Children's Alliance around the challenge associated with the proposed changes to the Market Forces Factor (MFF). If the changes were introduced the Children's Alliance would face a challenge of approximately £27 million in the first year of a three to five year programme. Sir Michael Rake, Chairman emphasised the potential damage to paediatric services nationally.
129	Board Assurance Committee reports
129.1	<u>Audit Committee – October 2018 including Audit Committee effectiveness review results</u>
129.2	Mr Akhter Mateen, Chair of the Audit Committee presented the update and confirmed that it had been provided to the Council of Governors at its November meeting. The Committee had undertaken a deep dive into the power outage which had occurred in August 2018 and the Trust's external auditors presented their draft plan for 2019/20. The Committee noted that the internal audit report on safeguarding had received a rating of significant assurance with minor improvement potential.
129.3	Mr Mateen drew attention to the results of the audit committee effectiveness review results and requested that a greater number of recipients completed the survey in future years.
129.4	<u>Quality and Safety Assurance Committee update – October 2018 meeting including QSAC Committee effectiveness review results</u>
129.5	Lady Amanda Ellingworth, Chair of the Quality and Safety Assurance Committee said that discussion had taken place about the way in which the committee worked following the completion of the effectiveness review. Discussion had taken place about the importance of ensuring there was sufficient time on the agenda for free flowing discussion to take place both about the matters on the agenda and other emerging issues.
129.6	<u>Finance and Investment Committee Update – October and November 2018</u>
129.7	Mr James Hatchley, Chair of the Finance and Investment Committee said that the committee had considered the redevelopment of the estate and the assumptions underpinning the Long Term Financial Model (LTFM). It was noted that there had been some deterioration in the financial position in months 6 and 7 however plans were in place to ensure that the Control Total was met. There remained a gap in

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129.8	<p>the Better Value programme, however the committee acknowledged the success of the programme in 2018/19 when compared with previous years.</p> <p>Mr Hatchley said that the committee had begun to look at 'magic number' reports which showed performance on a directorate basis to show any areas of underperformance. Mr Chris Kennedy, Non-Executive highlighted that these reports were helpful when the information provided was on a detailed rather than average basis.</p>
130	Council of Governors' Update – September and November 2018
130.1	Sir Michael Rake, Chairman said that pre-meetings between the Chair and Council continued to take place prior to the Council of Governor meetings which was helpful. He confirmed that the Council had approved the appointment of Mr Matthew Shaw as Chief Executive and had appointed Professor Rosalind Smyth as a Non-Executive Director on the Board as an appointed NED for a further one year at an extraordinary meeting in November 2018.
131	Revised Standing Financial Instructions and Scheme of Delegation
131.1	Ms Helen Jameson, Chief Finance Officer said that the Scheme of Delegation and Standing Financial Instructions had been updated in line with the Trust's governance arrangements. Updates had been made as a result of the change of procurement providers, the new directorate structure, the new vacancy approval process and changes to the tendering rules. It was confirmed that the documents had been reviewed by the Audit Committee and had been recommended to the Board for approval.
131.2	Ms Jameson suggested that in future the documents should be updated in line with the updates to the standing orders and constitution and reported that a shortened version would be produced for use internally.
132	Register of Seals
132.1	The Board endorsed the use of the Company Seal.
133	GOSH Operational Plan 2019/20 – planning process and guidance update
133.1	In June 2018, the Government had 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%. The NHS would be required to develop a Long Term Plan for a ten year period up to 2029 and NHS England and NHS Improvement had written to all providers to set out the approach that would be taken to operational and strategic planning to ensure organisations were able to make the necessary preparations for implementing the NHS Long Term Plan. Full planning guidance had not yet been published.
133.2	Mr Akhter Mateen, Non-Executive Director queried whether information on the precise impact of the Market Forces Factor had been received and Ms Jameson said that a planning tariff would be issued in the week of 10 th December 2018 and it was unlikely that further changes would be made before the final tariff was issued. Ms Jameson said that the full impact had not yet been shared with the Trust and changes to CQUIN, Provider Sustainability Fund (PSF) and funding for agenda for change had not been shared. A consultation would begin in January

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	2018 with final tariffs being issues in March or April 2018.
134	A 'deep dive' analysis of neuroscience: developing a strategy
134.1	Dr Sophie Varadkar, Chief of Service for the Brain Directorate said that Neuroscience at GOSH had been a growing area for a number of years and with the refresh of the Trust strategy a deep dive review had been undertaken of the directorate's strategy. Meetings had been held with over 90 staff within the directorate and feedback received was that although there was a strong core ethos of multidisciplinary team (MDT) working within Neuroscience, a wide ranging approach to a strategy was required as it was a diverse and complex area. Aspirations of how teams wanted to move forward were primarily related to rare disease and highlighted the importance of MDT working. Dr Varadkar added that almost all clinical staff had honorary contracts with the UCL GOS Institute of Child Health and therefore it was vital to support its PhD and taught programmes.
134.2	Dr Varadkar emphasised the importance of continuing to build capacity and said work was taking place to review how the team worked regionally with existing networks and partnerships. Challenges were around the provision of junior doctors and work was on-going with the nursing team to develop an advanced nursing practitioner role.
134.3	The team was working at the forefront to pioneer and drive developments in clinical assessment, diagnostics and treatment and would therefore continue to work with drugs in advance of NICE approval or their being commissioned by the NHS. Dr Varadkar said that the Board had been supportive of this work previously and the team would continue to require this.
134.4	Sir Michael Rake, Chair asked to what extent teams were able to use drugs prior to NICE approval. Dr Varadkar said that drugs could be used through formal clinical trials or through the expanded access programme for compassionate ethics use. She said that the support of the clinical ethics services was key in these cases. Mr Martin Tisdall, Consultant Neurosurgeon said that in terms of medical devices if they were unlicensed they must be used within the research framework.
134.5	Ms Alison Robertson, Chief Nurse welcomed the inclusive approach that had been taken to developing the strategy. She highlighted that many patients had a number of specialties involved in their care and queried how a family knew who their child's lead clinician was. Dr Varadkar agreed that this was key and said that it was dependent on the patient's lead service. She said the Clinical Nurse Specialist role was vital as this would generally be the professional that families liaised with. Mr Tisdall said that many patients had well established pathways in which it was clear which team was leading.
134.6	Action: Dr Peter Steer, Chief Executive agreed that the use of novel therapies would continue to be a key issue for the Board and suggested a deep dive take place on the process that the Trust undertook to begin using the drug Nusinersen. He said that work was taking place on this with the Children's Alliance. Mr Matthew Shaw, Medical Director said that in some rare diseases the Trust had an element of discretion in the use of drugs. For example where a drug was licensed for use in adults rather than children and it was not possible to begin a trial due to the rarity of the condition the Trust could make a balanced decision where there was no previous research. He added that the Trust's financial position would also impact the ability to make these decisions.

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134.7	Mr Chris Kennedy, Non-Executive Director noted that other Trusts had procured an Intraoperative MRI (iMRI) a number of years before GOSH and queried how the Trust could better horizon scan for these significant investments. Mr Tisdall said that discussion about iMRI had started in 2010 and some of the issues were around space. He added that neurosurgery had tripled the throughput of surgery over ten years with the same number of beds and in the absence of a strategy and this had the potential to place substantial pressure particularly on nursing staff. He said that it was important to consciously strategise and plan for the future.
134.8	Lady Amanda Ellingworth, Non-Executive Director asked for a steer on GOSH's national position in terms of Neuroscience and whether there was anything more that could be done to support the national picture. Dr Varadkar said that GOSH was the leading national centre both clinically and academically and this had led to an expansion in scope of the team in order to fill gaps due to lack of services elsewhere nationally. She said it was important to continue to work collaboratively with commissioners in order to do this.
135	Patient Story - JH
135.1	The Board received a patient story from Josephine who attended the Board meeting to discuss her experiences as a GOSH patient under the epilepsy team from 2011–2018.
135.2	Josephine gave the following feedback on what she found helpful whilst in hospital: <ul style="list-style-type: none"> • Josephine enjoyed the food and the catering staff were extremely kind • The play team were excellent and catered appropriately for Josephine's age • Nurses were very helpful • Volunteers made her feel welcome
135.3	Josephine said that she felt that improved wifi and more information about financial support such as food vouchers would have been helpful. It was noted that the Trust's wifi had recently been substantially improved.
135.4	Lady Amanda Ellingworth, Non-Executive Director asked about Josephine's experience of transition away from GOSH and Josephine said that she was still able to speak to her Consultant Neurosurgeon Mr Martin Tisdall and to her GP. Mr Tisdall said that Josephine would not have experienced transition in its traditional form as it was not anticipated the Josephine would require further care.
136	Integrated Quality Update Report – 31 October 2018
136.1	Mr Matthew Shaw, Medical Director said that future reports would include more trend data and reduced narrative. He said that the first report in this format would be reviewed by the Quality and Safety Assurance Committee in January 2019.
136.2	It was noted that there had been an improvement in the monthly inpatient mortality rate per 1000 discharges from a baseline of 6.3 to 4.92 in September which was a statistically significant reduction. Mr Shaw said that as predicted there had been a statistically significant increase in the number of Serious

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136.3	<p>Incidents as a result of a lower threshold for declaring a serious incident.</p> <p>Ms Alison Robertson, Chief Nurse said that there was new Interim Head of Patient Experience and Engagement who was keen to review the way in which patient experience data was presented to enable better triangulation of themes. Friends and Family Test response rates had been discussed at Directorate Performance Reviews and weekly response rates were being sent to teams to review which had led to an improvement in performance, although as a whole the trust had not achieved their overall response rate target.</p>
137	Learning from Deaths Mortality Review Group - Report of deaths in Q1 and Q2 2018/2019
137.1	Mr Matthew Shaw, Medical Director said that the Child Death Review Statutory Guidance had been published in October 2018 and a plan was being developed, including the resources required, to implement the guidance.
137.2	Lady Amanda Ellingworth, Non-Executive Director noted that there had been five deaths of patients with learning disabilities and asked for a steer of how representative this was of the number of patients in the Trust. Mr Shaw said that it was challenging to calculate the overall number of patients with learning disabilities however he felt that five deaths was likely to be under representative of the patient population.
137.3	Mr Chris Kennedy, Non-Executive Director asked if the quality of communication with bereaved families was reviewed and Mr Shaw said that the Trust had an excellent bereavement team and good feedback was received. Ms Alison Robertson, Chief Nurse said that a regular survey on the action the Trust took when a family was bereaved was undertaken.
137.4	Professor Rosalind Smyth, Non-Executive reiterated the request to make a distinction in the report between patients whose deaths came as a result of a decision to withdraw treatment and other deaths. Mr Shaw said that this would be done, however the standard report requirements specified that all deaths must be equitably reviewed as a whole.
138	Infection Prevention and Control Report
138.1	Dr John Hartley, Director of Infection Prevention and Control said that a positive audit day for hand hygiene had taken place which had enabled teams to ask questions, learn the process and develop action plans for outcomes. The outcome of the audits was in line with the results of the smaller audits and required additional focus however the way of working was positive.
138.2	The Trust's contracted cleaning supplier had implemented the recently agreed improvement plan which was being monitored and improvements were also required to the Trust's facilities for medical equipment decontamination.
138.3	Mr James Hatchley, Non-Executive Director asked if IPC data was benchmarked against other Trusts nationally and Dr Hartley said that GOSH used a process of continuous improvement rather than comparison with others. He added that he felt GOSH had good surveillance in comparison to other paediatric Trusts.
138.4	Sir Michael Rake, Chair asked for further information on the issue with facilities for

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138.5	<p>medical equipment decontamination and Dr Hartley said that this was primarily a space issue however he felt this was a priority for GOSH. Ms Helen Jameson, Chief Finance Officer agreed that space was an issue and confirmed that this would be discussed again at the next Capital Investment Group meeting.</p> <p>Action: Discussion took place about the importance of benchmarking and it was agreed that it would be further discussion at the Quality and Safety Assurance Committee.</p>
139	Integrated Performance Report - 31 October 2018
139.1	Ms Nicola Grinstead, Deputy Chief Executive said that the first performance reviews with the new clinical operations directorates had taken place in the last week of November running across two days. The new structure had led to direct contact in the meetings with more layers of staff in teams and the consecutive reviews enable themes to be highlighted between directorates. Ms Grinstead added that the directorate performance at the review meetings had been excellent with teams demonstrating their understanding of their scorecards and the improvement actions in place.
139.2	Ms Grinstead highlighted that the Trust continued for a tenth consecutive month to report compliance against the 92% referral to treatment standard which was excellent.
139.3	Mr Akhter Mateen, Non-Executive Director noted that there had been slippage against the PDR target. Ms Grinstead said that this continued to be a focus for teams, as did mandatory training compliance which had been achieved. She said that a large number of newly qualified nurses had been appointed towards the end of 2017 leading to managers needing to undertake a large number of PDRs in a short timeframe.
139.4	Mr Mateen highlighted that IPP debtor days had deteriorated and asked what action was being taken. Ms Helen Jameson, Chief Finance Officer said that no payments had been received in October however discussions were taking place with one territory about receiving a £3million payment to prevent the debt from growing and future discussions would also include the possibility of increasing the payment in order to reduce the debt. Mr Mateen said that it was important that the financial year was closed without a further increase in IPP debt.
139.5	Sir Michael Rake, Chair noted that there was a 23% turnover rate in IPP as well as a high staff sickness rate and no agency spend. He asked for further information about this and Ms Alison Robertson, Chief Nurse said that the team reported sickness very accurately and it was likely that when a new system for monitoring sickness was introduced other directorates would rise to be more in line with IPP. Ms Grinstead agreed and added that the team had done a useful piece of work about the positive contributors to staff retention.
139.6	Mr James Hatchley, Non-Executive Director highlighted the deteriorating trends of theatre utilisation and bed closures and emphasised that this was key to meeting activity targets.
139.7	<u>Progress with Better Value Programme</u>
139.8	Ms Grinstead said that substantial work was taking place with local teams to revise schemes and increase savings that had not materialised in other areas.

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	She said that optimism that the target would be reached remained high although it continued to be challenging. Ms Grinstead added that accountability for schemes was clear under the new directorate structure.
139.9	Work was now taking place on the programme for 2019/20 however the scale of savings required was not yet known. Mr Chris Kennedy, Non-Executive Director suggested that there should be a culture of continuously developing potential schemes which were being risk adjusted rather than targeting a specific figure.
139.10	Professor Rosalind Smyth, Non-Executive Director expressed some concern that it was possible that the Trust's cash would be used in the development programme as this could be required to fill gaps in the Better Value programme. Mr Mateen highlighted that the cash spend would be over a number of years and said he felt there was more that could be done in terms of opportunities for cost improvement over the same timeframe. Ms Grinstead said it was vital to consider the lead in time required for schemes to come to fruition and Ms Robertson said it was important to consider the Board's appetite for making and supporting difficult decisions around savings.
139.11	Action: It was agreed that further discussions would take place at the Finance and Investment Committee about a Better Value plan over three years including tracking large investments such as Epic and the anticipated associated savings.
140	Finance Update - 31 October 2018
140.1	Ms Helen Jameson, Chief Finance Officer said that the as of 31 st October 2018 the Trust was £900,000 behind plan. NHS activity remained below plan and therefore income in month was £700,000 below plan. The Trust continued to forecast breakeven against the control total.
141	Review of the Assurance and Escalation Framework
141.1	Dr Anna Ferrant, Company Secretary said that a summary of the assurance and escalation framework was being presented for information and work was taking place to update the document in light of the changes which had been made over the year including the introduction of a Guardian of Safe Working and work on Freedom to Speak Up and the Board Assurance Framework.
141.2	Action: Mr James Hatchley, Non-Executive Director said that safety was a key issue within a number of areas of the framework and queried whether this and data quality should have separate headings. It was agreed that this would be considered as part of the review of the framework.
142	CQC Inspection Action Plan
142.1	Mr Matthew Shaw, Medical Director said that the Trust was on track to deliver the milestones set out in the action plan arising from the planned CQC inspection in January 2018. The Board agreed to take part in a mock well led inspection supported by NHS Improvement.
142.2	Mr Shaw said that work was taking place on staff engagement such as walkrounds however there was more to be done.
143	Safe Nurse Staffing Report (September and October 2018)

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143.1	Ms Alison Robertson, Chief Nurse said that the Trust as a whole had remained within the recommended parameters for 'actual' versus 'planned' hours for nursing and care staff however there was one directorate which was below the recommended parameters in September and one in October. Ms Robertson said that this could be as a result of staff sickness or staff having been moved to different areas as appropriate. Two directorates had been above the recommended parameters in September.
143.2	It was confirmed that no unsafe shifts had been reported in either September 2018 or October 2018.
143.3	Work would take place to review the number of patients outside ICU who were being nursed on a 1:1 or 1:2 ratio. Ms Robertson said that whilst it was anticipated that this would be high due to the complexity and acuity of GOSH patients, it was important to ensure that this was accurate and appropriate.
143.4	The vacancy rate for October 2018 was 1.3% as a result of a cohort of newly qualified nurses starting in post in September 2018. Work would take place to review establishments following the clinical directorate restructure to support teams to be clear about their establishments and budgets. Turnover remained higher than other organisations at 16.6% for October and the Trust had joined the NHS Improvement retention collaborative which would provide support and access to good practice examples.
143.5	Mr Akhter Mateen, Non-Executive Director queried whether the exit survey asked staff which organisation they were moving to. Ms Polly Hodgson, Interim Deputy Chief Nurse confirmed that exit interviews did take place and the questions were continually revised. She highlighted that GOSH was the largest training Trust in the country for paediatric nurses which would contribute to staff turnover and the workforce was comparatively young and accordingly more likely to move between organisations. Ms Alison Hall, Acting Director of HR said that consideration was being given to undertaking full surveys rather than waiting until staff were leaving.
143.6	<u>Annual Nursing Establishment Review</u>
143.7	Ms Robertson said that the review had been discussed at the Operational Planning and Delivery Group and Nursing Board. She had met with the Deputy Chief Nurse for NHS Improvement who had agreed to review the report with a view to giving feedback as to how the Trust could improve analysis and assurance to the Trust Board.
143.8	Radiology had been undertaking a lot of positive nurse-led work and Ms Robertson said that if this continued it would be necessary to review their establishment. Although the Trust wide vacancy rate was 1.3% there were areas with a substantially higher rate which would require focus such as CICU, PICU and NICU.
144	Report from the Guardian of Safe Working
144.1	Dr Renee McCulloch, Guardian of Safe Working presented the quarterly report and said that progress had been made in the role since it had been established but highlighted that exception reporting was not well integrated into medical working practice. It was confirmed that this was a national issue and a meeting of

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	Guardians of Safe Working had shown that there was very little standardisation of practice across Trusts. Dr McCulloch said that work was required to be clear and about roles and responsibilities within teams and this was beginning. A deep dive into the junior doctor workforce was required to establish expectations of junior doctors and the Trust.
144.2	It was confirmed that rotas were compliant however Dr McCulloch said it was not possible to monitor each Junior Doctor's working pattern. Work was taking place to consider the management of medical workforce risks and the actions that could be taken when there were rota gaps as well as how to measure progress.
144.3	Professor Rosalind Smyth, Non-Executive Director expressed some concern at the lack of assurance that could be provided. She said that this was a good opportunity for GOSH to lead and emphasised the extent to which the Trust depended on Junior Doctors and the responsibility for providing high quality training. She asked for further information about the anticipated outcomes of the deep dive. Mr Matthew Shaw, Medical Director said that they key issue was around modernisation of the workforce. He said that fewer junior doctors were going into paediatrics and the Trust's dependency on this group was increasing. Work was taking place to establish nursing roles that could be developed to support doctors however there were some activities which could only be undertaken by Doctors. Feedback had been received that substantial pressure was placed on registrars at night and Mr Shaw said that the nursing team was far more developed in terms of thinking around recruitment and retention and a similar approach to the safe staffing model should also be taken for doctors.
144.4	Dr McCulloch said that recent junior doctor appointees had tended to be from different countries than had traditionally been recruited at the Trust and their expectations of training had been different. She said it was important to support these individuals and added that training was often dependent on Junior Doctors seeking out opportunities.
144.5	Action: It was agreed that the next report would include the actions that were being taken to modernise the workforce.
144.6	Action: Mr Chris Kennedy, Non-Executive Director said that it was difficult to get a sense of the current position from the report and requested that some context and trend information was provided in future reports.
145	Any other business
145.1	There were no items of other business.

TRUST BOARD – PUBLIC ACTION CHECKLIST
February 2019

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
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.	AT	October 2019	Noted for future Board workplan (update on outcome of restructure for reporting to Board in October 2019)
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	To be discussed in light of changes to the work-plan of the Quality and Safety Assurance Committee (QSAC)
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.	HJ, AT	February 2019	Verbal update at meeting
134.6	05/12/18	Dr Peter Steer, Chief Executive agreed that the use of novel therapies would continue to be a key issue for the Board and suggested a deep dive take place on the process that the Trust undertook to begin using the drug Nusinersen.	SS	TBC	Date for this deep-dive to be determined
138.5	05/12/18	Discussion took place about the importance of benchmarking in infection and prevention and control and it was agreed that it would be further discussion at the Quality and Safety Assurance Committee.	AR	April 2019	To be considered for the April QSAC meeting
139.11	05/12/18	It was agreed that further discussions would take place at the Finance and Investment Committee about a Better Value plan over three years which including tracking large	AT	February 2019	To be considered by the Finance and Investment Committee

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Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
		investments such as Epic and the anticipated associated savings.			
141.2	05/12/18	Mr James Hatchley, Non-Executive Director said that safety was a key issue within a number of areas of the assurance and escalation framework and queried whether this and data quality should have separate headings. It was agreed that this would be considered during the review of the framework.	AF	March 2019	Noted for update and review to the Framework
144.5	05/12/18	It was agreed that the next Guardian of Safe Working report would include the actions that were being taken to modernise the workforce.	MS	March 2019	Noted for next Guardian of Safe Working report
144.6	05/12/18	Mr Chris Kennedy, Non-Executive Director said that it was difficult to get a sense of the current position from the Guardian of Safe Working report and requested that some context and trend information was provided in future reports.	MS	March 2019	Noted for next Guardian of Safe Working report

Attachment K

Trust Board 7th February 2019	
Chief Executive Report Submitted by: Matthew Shaw, Chief Executive	Paper No: Attachment K
Aims / summary Update on key operational and strategic issues.	
Action required from the meeting For noting.	
Contribution to the delivery of NHS Foundation Trust strategies and plans <ul style="list-style-type: none"> • Compliance with CQC Well-Led framework • Delivery of trust strategy 'Fulfilling Our Potential' 	
Financial implications <ul style="list-style-type: none"> • None (business as usual) 	
Who needs to be told about any decision? Not applicable	
Who is responsible for implementing the proposals / project and anticipated timescales? CEO and executive colleagues	
Who is accountable for the implementation of the proposal / project? CEO	

Attachment K

CQC inspection and Well Led

The Care Quality Commission (CQC) wrote to the trust on the 2nd January 2019 to advise that an inspection of the trust's 'well-led' performance and at least one core service would be carried out within six months. We contacted the CQC to advise them that this will coincide with the implementation of our Electronic Patient Record Programme, an essential transformation programme which will have a significant impact on our operations. The CQC considered this information and have advised that the inspection will take place after the roll-out phase (i.e. towards the end of the year) to prevent additional pressures being placed on our patient services.

The executive and governance teams have updated the trust's Well Led action plans to ensure that any outstanding areas for improvement are closed as soon as possible. An item is included on the Board agenda.

Exec team changes and proposed board changes

Nicola Grinstead, Deputy Chief Executive, left the Trust at Christmas. I would like to thank Nicola for the contribution she has made to the running of the Trust and to wish her every success in the future.

Andrew Taylor assumed the role of Acting Chief Operating Officer to lead our clinical operations and we envisage he will remain in this role for a period of six months, after which time the post will be recruited to on a permanent basis. I am extremely grateful to Andrew for his support to maximise continuity and stability at a time when we, along with the rest of the NHS, are under pressure operationally and are preparing to introduce our Electronic Patient Record.

Following my appointment to the CEO post, we requested expressions of interest from the GOSH consultant body to assume the role of Interim Medical Director. I'm delighted that Dr Sanjiv Sharma, our Deputy Medical Director for Medical and Dental Education since January 2016 has taken on this post. Recruitment for the substantive Medical Director post is ongoing.

We have announced the appointment of our new Director of HR and Organisational Development, Caroline Anderson. We are looking forward to welcoming her on 18th March 2019 and offer huge thanks to Alison Hall who is doing a tremendous job covering the role.

These changes to our executive team provided an ideal opportunity to consider the structure and function of the board. The Corporate Governance paper outlines some important proposals to strengthen our breadth of expertise and improve our effectiveness. As well as mandating a board assurance committee to address workforce and education issues, we are also proposing that the board considers:

- the appointment of a non-voting Associate Non-Executive Director with expertise in workforce issues, people management and cultural change to bolster our skills in an area that presents very real and relentless challenges for all NHS organisations.
- the appointment of a non-voting director, reporting directly to the CEO, with expert knowledge in the field of NHS digital transformation (for example, a Chief Information Officer/Chief Clinical Information Officer/Chief Research Information Officer). This is a highly specialised and rapidly evolving area and this expertise will help us ensure that our decision-making is informed by a professional who has oversight on how to maximise the use of data and technology to benefit our patients.

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Exec team development and ways of working

The executive team kicked off the New Year with a planning session to map out the key projects and programme across the year. As a result of this work we have refreshed our executive work plan and are developing an annual board schedule to ensure that key decisions come to board at the optimum time to expedite progress. We are also investigating the use of software packages to track our progress across various programmes, share updates across teams in real-time and improve oversight and communication.

We are working on an Executive and Board Development Programme to build on key elements within the Well Led Framework, including the Key Lines of Enquiry 1 (Leadership capacity and capability to deliver high-quality, sustainable care) Key Line of Enquiry 2 (Clear vision and strategy for high-quality, sustainable care with robust delivery plans) and Key Line of Enquiry 3: (Culture of high quality, sustainable care).

This programme is being co-designed with the King's Fund. For the executive team it will involve a programme of 360 appraisal and workshops on team effectiveness with a developmental focus on 'learning while doing'. For the Board we propose to develop a programme of masterclasses delivered by experts to broaden our knowledge base and apply this learning to decision-making on high priority issues including organisational strategy, cultural change, innovation and sustainability. We will be inviting the chair and non-executive directors to take part in informal telephone conversations with the programme leads to allow them to take stock of your views in shaping the programme.

GOSH 3-5 year transformation and Long Term Strategy

We are establishing two concurrent programmes to build on and develop previous work done on the GOSH strategy – 'Achieving Our Potential'.

The implementation plan for the strategy will be owned by an internal steering group which will operationalise it and monitor progress as well as scoping the hospital's ongoing needs to achieve transformation for key services within a 3-5 year timeline. The membership and terms of reference for this group is being considered by the Acting COO with support from our Programme Management Office.

Alongside this deliberate approach to operationalising 'Fulfilling Our Potential', we are also developing a six month plan to develop the long term vision for GOSH, addressing key unresolved questions about the future development of our services and our place in the healthcare system. This process will involve consultation with external stakeholders, GOSH clinical experts, the Board, Council of Governors and staff groups on issues including the NHS Long Term Plan, clinical networks, cardiac services, urgent care, mental health and transition. The consultation will help shape a set of strategic objectives and clarify the vision for the future of GOSH. We propose that GOSH's long-term strategy – along with the details that sit behind it – are discussed during the Board Seminar in October 2019, with a view to finalising and publishing the document soon thereafter.

Publication of the NHS Long Term Plan

(Attachments 1&2: NHS Providers and Royal College of Paediatrics and Child Health Summaries of the NHS Long Term Plan)

The NHS long term plan has been published, following last June's announcement of a £20.5bn annual real terms uplift for the NHS by 2023/24. The Plan sets out ambitions for ensuring the NHS is fit for the future and covers a ten year window. A consultation and engagement period will now begin on the Plan, running until the summer.

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In its Long Term Plan, NHS England pledges to:

- Create a Children and Young People's Transformation Programme to oversee the delivery of commitments for 0-25 year-olds – moving towards mental and physical health service models that are person-centred, rather than an arbitrary transition to adult services based on age
- Accelerate action to achieve 50% reductions in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025
- Invest in expanding access to community-based mental health services to meet the needs of more children and young people and improve the health and wellbeing of patients with learning disabilities and autism
- Develop and implement networked care to improve outcomes for children and young people with cancer, offer all children with cancer whole genome sequencing from this year and ensure UK access to CAR-T cancer therapies and proton beam therapy.
- Improved access and consent processes for children and young people taking part in clinical trials, aiming for an increase of 50% in participation among teenagers and young adults by 2025.

We are actively engaging at various levels within NHSE and NHSI to contribute to the consultation process. Specifically, the executive team will be looking to develop a shared understanding of the potential impacts on specialised paediatric services of the proposed focus on Integrated Care Systems (ICSs) as the level of the system where commissioners and providers will make shared decisions about financial planning and prioritisation. It will also be important to develop a better understanding of how we should best contribute to national priorities including the development of the service model for 0-25 year-olds.

Brexit preparedness

(Attachments 3&4: National guidance on EU Exit Operational Readiness issued to NHS providers and commissioners of services on 21 December 2018, DHSC's Chief Pharmaceutical Officer letter to GPs, Community Pharmacists and Hospital Pharmacists, 17th January 2019)

The Chief Operating Officer (the Trust's Emergency Accountable Officer for Brexit preparedness) has established a Steering Group to convene senior accountable officers overseeing no-deal preparedness across the trust including Pharmacy, Research and Innovation (clinical trials), Human Resources, Finance, Procurement and Estates and Facilities.

The group has identified the key organisational risks to be monitored against, including – 1: financial sustainability, 2: workforce, 3: medicines, medical devices and reagents, 4: research, clinical trials and clinical networks and 5: Supply chain impacts for Estates, Facilities and Development. These areas will be assessed under the new risk on Brexit documented under the Board Assurance Framework. The group will be meeting frequently to share updates from the centre and locally, assess changing circumstances and recommend early action directly to the executive team as needed.

The trust is connected at various levels with national and local NHS networks and with local borough networks to scope and share information on the impacts of Brexit. National guidance on EU Exit Operational Readiness was issued to NHS providers and commissioners of services on 21 December 2018. It was announced on 17th January that Prof Keith Willet and Matthew Swindells have been assigned to lead NHS England and NHS Improvement's joint 'no deal' Brexit preparations.

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Workforce

GOSH employs around 400 EU staff, representing 13 per cent of the workforce. The trust ran a trust-wide engagement project to raise awareness for the Home Office's EU Settlement Pilot Scheme, which allows European NHS employees to apply for 'settled' or 'pre-settled' status. The scheme aims to help European nationals who have lived, or will go on to live, in the UK for five years to stay and work in the UK indefinitely. The trust hosted on-site drop-in sessions, signposted the Home Office communications materials, issued reminders and an offered to re-imburse the application fee, which was subsequently waved by the Government. 130 staff have applied for the scheme to date and work continues to minimise impacts on staffing and recruitment, including with subcontractors.

Medicines, medical devices and reagents

The supply of medicines (and ingredients for medicines) to the NHS is being monitored and risk-assessed nationally by the Department of Health and Social Care (DHSC). This includes supply of radioisotopes, vaccines, immunoglobulins.

The DHSC's Chief Pharmaceutical Officer (for GPs, Community Pharmacists and Hospital Pharmacists) wrote to trusts on 17th January to outline the steps taken nationally to date to protect the continuity of supply for medicines.

The GOSH chief pharmacist is engaging with DHSC's Specialty Clinical Group on Paediatrics and the all-England Chief Pharmacists Group meetings to contribute to the national process and obtain updates that may affect GOSH operationally.

The hospital pharmacy is complying with the national requirement to maintain medicine stocks at no more than 16 days' supply. The DHSC has required that suppliers of unlicensed medicines and specialised drugs arrange for a six-week supply to be in place by March 2019. The trust is increasing its stock levels for these drugs on a case-by-case basis.

The Department of Health has mandated all NHS Trusts use an online system to track medicine stocks from 1st February 2019, so that supply and demand can be monitored at a national level and stockpiling is avoided.

Research, clinical trials and clinical networks

The Research and Innovation team is putting contingency plans in place for clinical trials that are GOSH-sponsored to mitigate potential impacts on supply of drugs, devices and reagents. Contingency planning for clinical trials that are hosted at GOSH but sponsored by external parties (e.g. pharmaceutical companies) is being co-ordinated by the Department of Health. The GOSH Research & Innovation team have contacted a selection of their key sponsors to obtain information on these contingency plans and seek assurance that they are practical for GOSH.

Supply chain impacts

Other significant supply chain risks for GOSH (including both cost and availability) are subject to ongoing scoping and scenario planning. These include:

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- Reagents, which are perishable and for which the trust will require additional refrigeration capacity to increase supply.
- Hard FM items which come from mainland Europe including lifts, motors, air conditioning filters.
- Catering and soft FM supplies including cleaning products.

Learning Academy – request to delegate authority to the Finance and Investment Committee

The Board is asked to consider delegating authority for the review and approval of the business case for the Learning Academy to the Finance and Investment Committee meeting in June 2019.

EPR programme update

The Electronic Patient Record (EPR) Programme remains on plan to implement our new Epic clinical system over the Easter weekend (19th to 22nd April 2019). The design, configuration and testing phase of the Programme concludes at the end of January and preparation is well underway for training c.4500 staff. This includes initial training for 40 of our doctors who will go on to train their peers, and the scheduling of over 150 role based courses which have been tailored to the different needs of our nursing, allied health professional, medical and administrative teams. Over 3,000 new / replacement devices have been deployed across the hospital and testing of each device will begin in February. Planning for the transition is being overseen by our Directorate leadership teams, supported by our EPR Programme team and our main supplier, Epic. Our governance groups are managing existing risks and issues and progress against a specific set of 'go / no-go' criteria will be managed through Trust Board and its sub-committees, ensuring we minimise, as far as possible, the impact of this hospital-wide transformation programme on our staff and fully mitigate any potential clinical safety risks for our patients. The Programme is forecast to complete the implementation phase within the budget originally set by the Trust Board in April 2017.

Stakeholder engagement update

Since my appointment as CEO I have taken the opportunity to meet and/or speak with many of our key stakeholders, including the Director at Evelina London, the CEOs at UCLH, Barts, Imperial College, the Managing Director at UCL Partners and the CEO at Birmingham Children's. These meetings have provided some really helpful insights into our shared challenges and opportunities which will inform our ongoing interactions with these key partners as well as our longer term strategic thinking.

This kind of feedback is so valuable, so I'm delighted that our Communications Director is co-ordinating a programme to engage our key leaders and influencers in a stakeholder engagement strategy. We need to develop and use our key external relationships to benefit the patients and families we serve and deliver on our strategic aspiration to 'use our voice as a trusted partner to influence and improve care'.

I will be attending a meeting of the Children's Hospitals Alliance in March to refresh the purpose and objectives of the partnership and to obtain agreement to commission working groups tasked with amplifying our shared voices to advocate for children and young people's specialised hospital services.

Networks update

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GOSH is participating on a working group with colleagues from 15 other NHS Trusts to establish and play a leading role within the emerging North Thames Paediatric Network for Specialist Paediatric Services. The network is a time-limited partnership commissioned and accountable to NHS England's Specialised Commissioning Planning Board. The partnership will contribute to shaping future service delivery working with tertiary and secondary NHS providers and their partners in North London and beyond. Objectives include improving efficiency, effectiveness and patient experience of service provision (including by improving access and reducing delays to treatment), developing sustainable pathways, creating new models of care built around the needs of Children and Young People and addressing shared challenges such as workforce. Clinical priorities for the next two years include paediatric critical care (including long-term ventilation), paediatric surgery, Paediatric Oncology Shared Care Units (POSCUs) and palliative care, development and standardisation of patient pathways in neurology, neuro-disability, surgery and gastroenterology and transition and access to age appropriate care for 16 to 18-year-olds.

[Ends]

7 January 2019

on the day
BRIEFING

The NHS long term plan

The *NHS long term plan* has been published, following last June's announcement of a £20.5bn annual real terms uplift for the NHS by 2023/24. The *Plan* sets out ambitions for ensuring the NHS is fit for the future and covers a ten year window. A consultation and engagement period will now begin on the *Plan*, running until the summer.

This briefing summarises key content included in each chapter of the *Plan*: a new service model, action on prevention and health inequalities, progress on care quality and outcomes, the NHS workforce, digitally-enabled care, value for money and the next steps in implementing the plan. It also includes NHS Providers' view and press statement. For any questions on this briefing or our work in this area please contact Amber Jabbal, head of policy, amber.jabbal@nhsproviders.org.

Chapter 1: A new service model for the 21st century

The *Plan* includes a guarantee that over the next five years investment in primary medical and community services will grow faster than the overall NHS budget, creating a ring-fenced local fund worth at least an additional £4.5bn a year in real terms by 2023/24. It summarises a series of improvements to be delivered in the following five key areas:

1. Improving out-of-hospital care (primary and community services)
2. Reducing pressure on emergency hospital services
3. Delivering person-centred care
4. Digitally enabled primary and outpatient care (this is considered by Chapter 5)
5. A focus on population health and local partnerships through ICs

Boosting out-of-hospital care and joining up primary and community services

Additional national investment, worth £4.5bn a year in real terms by 2023/24 will be invested in primary medical and community health services (and supplemented by further funding from CCGs and ICs), to stem the pressure of high demand, expand the workforce and fund new services. Key measures include:

- **A new NHS offer of urgent community response and recovery support:** Within five years, all parts of the country will be expected to have improved the responsiveness of community health crisis response services to deliver services within two hours of referral, in line with NICE guidelines, including delivering re-ablement care within two days of referral
- **Primary care networks of local GP practices and community teams:** Funding will cover expanded community multi disciplinary teams aligned with new "primary care networks" covering 30-50,000 people. From 2019, NHS111 will start booking patients directly into GP practices, as well

as referring to pharmacies. A shared savings scheme will be offered to primary care networks so they can benefit from their improvements

- **Guaranteed NHS support for people living in care homes:** There will be an upgrade in NHS support for care home residents with care homes supported by a team of healthcare professionals, including named GP support. The new primary care networks will work with emergency services while care home staff will have access to NHSmail to allow a greater of information to NHS staff
- **Supporting people to age well:** From 2020/21 the new primary care networks will assess local population risk and reduce hospital admissions through an increased use of preventative measures such as digital health records, population health management tools and new home-based or wearable monitoring equipment

Reducing pressure on emergency hospital services

The *Plan* aims to reduce the number of hospital admissions but importantly states that that the financial assumptions underpinning the *Plan* allow for hospital capacity to follow existing trends for the next three years. Key measures include:

- **Pre-hospital urgent care:** To support patients to choose the correct 'channel' of care, a single multidisciplinary Clinical Assessment Service as part of a fully integrated NHS 111 will be embedded. The Urgent Treatment Centre model will be fully implemented by autumn 2020, so all localities have a consistent offer for out-of-hospital urgent care. The plan is vague on how ambulance services form part of pre-hospital urgent care, but capital investment will target fleet upgrades and NHS England (NHSE) will set out a new national framework to overcome fragmentation in how services are locally commissioned
- **Reforms to hospital emergency care – Same Day Emergency Care (SDEC):** Every acute hospital with a type 1 A&E department will move to a comprehensive model of SDEC by 19/20 in both medical and surgical specialties, increasing acute admissions discharged on the day of attendance from a fifth to a third
- **Cutting delays to discharge:** An average delayed transfer of care figure of 4000 or fewer delays will be achieved through enhanced primary and community services as well as the introduction of an agreed clinical care plan within 14 hours of admission including an expected date of discharge, implementation of the SAFER patient flow bundle and MDT reviews on hospital wards.

Personalised care

The NHS will support and help train staff to help patients make the right decisions for them, increase support for people to manage their own health and roll out the NHS Personalised Care model. This will include social prescribing, personalised health budgets and targeted training to NHS staff to improve care planning for those in their last year of life.

A focus on population health via ICSs

Integrated Care Systems (ICSs) are central to the delivery of the LTP, with ICSs and expected to cover the country by April 2021:

- ICSs will have a key role in working with Local Authorities at place level
- Commissioners will make shared decisions with providers on how to use resources, design services and improve population health but CCGs will continue to make some decisions independently, for example in relation to procurement and contract award. There will be a single, leaner more strategic CCG for each ICS area
- Every ICS will have:
 - A partnership board drawn from commissioners, trusts, primary care networks, local authorities, voluntary and community sector and others
 - A non-executive chair locally appointed and approved by NHSE and NHSI
 - Full engagement with primary care through a named accountable clinical director of each primary care network
- All providers with an ICS will be required to contribute to ICS performance, underpinned by:
 - potential new licence conditions supporting providers to take responsibility with system partners, for wider objectives on resource use and population health
 - longer-term NHS contracts with all providers including care requirements to collaborate to achieve system objectives
 - Changes to align clinical leadership with ICSs including ensuring Cancer Alliances and Clinical Senates align with one or more ICS
- NHSI will take a more proactive role in supporting collaborative approaches between trusts, including supporting trusts to explore formal mergers
- A new Integrated Care Provider contract will be made available for use from 2019 to be held by public statutory providers
- A new ICS accountability and performance framework will provide a consistent and comparable set of performance measures, including a new 'integration index'
- ICSs will agree system wide objectives with the relevant NHSE/I regional director and be accountable for their performance against these objectives
- NHSE/I will support CCGs and local authorities to blend health and social care budgets.

Chapter 2: More NHS action on prevention and health inequalities

To address the growing demand for healthcare created by a growing and ageing population, the *Plan* sets out an aim to target the top five causes of premature death in England.

Priority areas

- **Smoking:** while smoking rates have fallen significantly, 6.1 million people in the UK still smoke, and nearly a quarter of women smoke during pregnancy. The *Plan* makes a commitment to offering all people admitted to hospital NHS-funded tobacco treatment services by 2023/24, with an adapted model for expectant mothers and their partners. A universal smoking cessation offer will be introduced for long-term users of specialist mental health and learning disability services.
- **Obesity:** nearly two thirds of adults in England, and a third of children leaving primary school, are overweight or obese. The government has pledged to halve childhood obesity. The existing

national diabetes prevention programme, which has benefited over 100,000 people, will be doubled over the next five years, with a new digital option. All trusts will be required to deliver against the standards set out by the next version of hospital food standards, including substantial restrictions on high fat, salt and sugar food. The *Plan* sets out an ambition to work with professional bodies to improve the quality of nutrition training within medical courses.

- **Alcohol:** over five years hospitals with the highest rates of alcohol-dependence related admissions will be supported to establish Alcohol Care Teams (ACTs) using the health inequalities funding supplement from their CCGs and in collaboration with local authorities and drug and alcohol services. Hospitals which have introduced ACTs have seen a significant reduction in A&E attendances, bed days, readmissions and ambulance call outs.
- **Air pollution:** almost a third of preventable deaths are due to causes related to air pollution. In 2017 3.5% of road travel was attributable to the NHS. The *Plan* sets out plans to ensure 90% of the NHS fleet will use low emissions engines by 2028, and heating from coal and oil fuel sources in NHS buildings will be fully phased out.
- **Antimicrobial resistance:** the *Plan* identifies a need for further progress on reductions in antimicrobial prescribing in primary care, and the health service will continue to support the delivery of the government's five year action plan on antimicrobial resistance, supporting system-wide improvement, surveillance, infection prevention and control, and antimicrobial stewardship, with resources for clinical expertise and senior leadership.

Stronger action on health inequalities

The *Plan* outlines some actions to tackle such health inequalities, including:

- Targeting a higher share of funding towards areas with high levels of health inequality than would be ordinarily allocated using the core needs formulae.
- The NHS will set out specific and measurable goals for narrowing inequalities through the service improvements outlined elsewhere in the *Long term plan*. All local health systems will be expected to set out in 2019 how they will reduce health inequalities by 2023/24 and 2028/29.
- The NHS will accelerate the Learning disabilities mortality review programme and do more to keep people with learning disabilities and autism to stay well with proactive care in the community.
- An investment of £30m to meet the needs of rough sleepers, ensuring that areas most affected by rough sleeping have access to specialist homelessness mental health support.
- Identifying and supporting unpaid carers to who are twice as likely to experience poor health, including quality marks for carer-friendly GP practices.
- Rolling out specialist clinics for people with serious gambling problems.

Chapter 3: Further progress on care quality and outcomes

For all major conditions, the quality of care and the outcomes for patients are now measurably better than a decade ago. However, the *Plan* looks at both physical and mental health and outlines a range of condition specific proposals.

A strong start in life for children and young people

Services for children and young people have seen some improvement in recent years, and the *Plan* outlines a push to build on these and broaden the focus of the NHS in this area in the next five and 10 years.

Maternity and neonatal services

- The NHS will accelerate action to achieve 50% reductions in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025.
- By March 2021, most women receive continuity of the person caring for them during pregnancy, during birth and postnatally, following the launch of continuity of carer teams.
- The Saving Babies Lives Care Bundle (SBLCB) will be rolled out across every maternity unit in England, including a focus on preventing pre-term birth and the development of specialist pre-term birth clinics.
- Access to evidence-based care for women with moderate to severe perinatal
- Mental health difficulties and a personality disorder diagnosis will increase, to benefit an additional 24,000 women per year by 2023/24.

Children and young people's mental health services

- The Long term plan sets out a goal that over the coming decade 100% of children and young people who need specialist mental health care will be able to access it.
- Funding for children and young people's mental health services will grow faster than both overall NHS funding and total mental health spending.
- By 2023/24, at least an additional 345,000 children and young people aged 0-25 will be able to access support via NHS funded mental health services and school/college-based MH Support Teams.
- Current service models will be extended to create a comprehensive offer for 0-25 year olds that reaches across mental health services for children, young people and adults.

Learning disability and autism

- The NHS will tackle the causes of morbidity and preventable deaths in people with a learning disability and for autistic people.
- Uptake of the existing annual health check in primary care for people aged over 14 years with a learning disability will be improved, so that at least 75% of those eligible have a health check each year.
- The STOMP-STAMP programmes will be expanded to stop the overmedication of people with a learning disability, autism or both.
- By March 2023/24, inpatient provision will have reduced to less than half of 2015 levels.

Children and young people with cancer

- The *Plan* identifies the need to improve outcomes for children and young people with cancer, simplifying pathways and transitions between services and ensuring every patient has access to specialist expertise.
- From 2019, whole genome sequencing will be offered to all children with cancer, to enable more comprehensive and precise diagnosis, and access to more personalised treatments.
- From September 2019, all boys aged 12 and 13 to be offered vaccination against HPV-related diseases.
- Over the next five years NHSE will increase its contribution by match-funding clinical commissioning groups (CCGs) who commit to increase their investment in local children's palliative and end of life care services (this should more than double the NHS support, from £11m up to a combined total of £25m a year by 2023/24).

Redesigning other health services for children and young people

The *Plan* recognises that the needs of children are diverse and complex, and their profile should be raised at a national level.

- A children and young people's transformation programme will be created to oversee the delivery of the children and young people's commitments in the plan.
- Improvements in childhood immunisation will be prioritised.
- By 2028 the NHS will move towards service models for young people that offer person-centred and age appropriate care for mental and physical health needs, rather than an arbitrary transition to adult services based on age not need.

Better care for major health conditions

The *Plan* focuses on tackling the top five causes of early death for the people of England: heart disease and stroke, cancer, respiratory conditions, dementias, and self-harm.

Cancer

The *Plan* sets a new ambition that, by 2028, the proportion of cancers diagnosed at stages 1 and 2 will rise from around half now to three-quarters of cancer patients. The plan aims to increase awareness of symptoms, lower the threshold for referrals by GPs, improve screening, accelerate access to diagnosis and treatment, roll out personalised care plans, and expand screening of family members:

- Review the current cancer screening programmes and diagnostic capacity.
- Negotiate a capital settlement in the 2019 Spending Review, in part to invest in new equipment, including CT and MRI scanners, which can deliver faster and safer tests.
- Safer and more precise treatments including advanced radiotherapy techniques and immunotherapies will continue to support improvements in survival rates.
- Extend the use of molecular diagnostics and, over the next ten years, routinely offer genomic testing to cancer patients where clinically appropriate.

Milestones for cancer

- From 2019 we will start to roll out new Rapid Diagnostic Centres across the country.
- In 2020 a new faster diagnosis standard for cancer will begin to be introduced so that patients receive a definitive diagnosis or ruling out of cancer within 28 days.
- By 2020 HPV primary screening for cervical cancer will be in place across England.
- By 2021, where appropriate every person diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support.
- By 2022 the lung health check model will be extended.
- By 2023, stratified, follow-up pathways for people who are worried their cancer may have recurred. These will be in place for all clinically appropriate cancers.
- By 2028, the NHS will diagnose 75% of cancers at stage 1 or 2.

Cardiovascular disease

The *Plan* proposes improvement in early detection, the NHS Health Check, treatment, support of primary care multidisciplinary teams. Proposals include:

- Increase the identification of Familial Hypercholesterolaemia from 7% to 25% in the next five years through the genomics project.
- Create a national cardiovascular disease prevention audit for primary care.
- A national network of community first responders and defibrillators will help save up to 4,000 lives each year by 2028.

Milestones for cardiovascular disease

- Help prevent up to 150,000 heart attacks, strokes and dementia cases over the next 10 years.
- We will work with our partners to improve community first response and build defibrillator networks to improve survival from out of hospital cardiac arrest.
- By 2028 the proportion of patients accessing cardiac rehabilitation will be amongst the best in Europe, with up to 85% of those eligible accessing care.

Stroke care

A specific aim of the plan is to modernise the stroke workforce with a focus on cross-specialty and in some cases cross-profession accreditation of particular competencies. The plan says further implementation and development of higher intensity care models for stroke rehabilitation are expected to show significant savings. The existing national stroke audit (SSNAP) will be updated to provide a comprehensive dataset.

Milestones for stroke care

- In 2019 we will, working with the Royal Colleges, pilot a new credentialing programme for hospital consultants to be trained to offer mechanical thrombectomy.

- By 2020 we will begin improved post-hospital stroke rehabilitation models, with full roll-out over the period of the Plan
- By 2022 we will deliver a ten-fold increase in the proportion of patients who receive a thrombectomy after a stroke so that each year 1,600 more people will be independent after their stroke.
- By 2025 we will have amongst the best performance in Europe for delivering thrombolysis to all patients who could benefit.

Diabetes

The *Plan* proposes that the NHS will:

- Provide structured education and digital self-management support tools, including expanding access to HeLP Diabetes an online self-management tool for those with type 2.
- Ensure patients with type 1 diabetes benefit from life changing flash glucose monitors from April 2019.
- By 2020/21, all pregnant women with type 1 diabetes will be offered continuous glucose monitoring, helping to improve neonatal outcomes.
- Double the fund of the NHS Diabetes Prevention Programme over the next five years.

Respiratory disease

The *Plan* proposes to do more to detect and diagnose respiratory problems earlier, support the right use of medication, expand pulmonary rehabilitation and improve the response to pneumonia, particularly over winter. And from 2019, the existing NHS RightCare programme will be extended to reduce variation in the quality of spirometry testing across the country.

Adult mental health services

The long term plan builds on the *Mental health five year forward view*. The *Plan* proposes to increase the budget for mental health, in real terms, by a further £2.3 billion a year by 2023/24. Specific waiting times targets for emergency mental health services will take effect from 2020.

It sets out an expansion of talking therapies, new integrated primary care and community provision, a reduction in the average inpatient length of stay to 32 days and an upgrade of the physical environment for inpatient psychiatric care. Over the next 10 years, NHS 111 will be established as the single point of contact for those experiencing a mental health crisis. There will also be a new Mental Health Safety Improvement Programme, with a focus on suicide prevention.

Milestones for mental health services for adults

- New and integrated models of primary and community mental health care will give 370,000 adults and older adults with severe mental illnesses greater choice and control over their care and support them to live well in their communities by 2023/24.
- By 2023/24 an additional 380,000 people per year will be able to access NICE-approved IAPT services.

- By 2023/24, NHS 111 will be the single, universal point of access for people experiencing mental health crisis. We will also increase alternative forms of provision for those in crisis, including non-medical alternatives to A&E and alternatives to inpatient admission in acute mental health pathways. Families and staff who are bereaved by suicide will also have access to post crisis support.
- By 2023/24, we will introduce mental health transport vehicles, introduce mental health nurses in ambulance control rooms and build mental health competency of ambulance staff to ensure that ambulance staff are trained and equipped to respond effectively to people experiencing a mental health crisis.
- Mental health liaison services will be available in all acute hospital A&E departments and 70% will be at 'core 24' standards in 2023/24, expanding to 100% thereafter.

Short waits for planned care

Under the *Plan*, the local NHS is being allocated sufficient funds over the next five years to grow the amount of planned surgery year-on-year, to cut long waits, and reduce the waiting list. The *Plan* reinforces that patients should have a wide choice of options for quick elective care, including making use of available Independent Sector capacity.

In relation to elective care the NHS National Medical Director's Clinical Standards Review will consider the 'stop the clock' rules. But meanwhile, there will be the reintroduction of the incentive system under which hospitals and CCGs will both be fined for any patient who breaches 12 months.

Research and innovation to drive future outcomes improvement

The *Plan* sets out the important role the NHS will play in driving forwards research and innovation. It states that it will become easier to share innovation between organisations, innovation accelerated through a new Medtech funding mandate, and UK-led innovations that are proven as 'ready for spread', will be rolled out through Healthcare UK. We will also form an NHS Export Collaborative with Healthcare UK by 2021, working with selected trusts to export NHS innovations.

The *Plan* also states that the NHS will play a key role in genomics with the new NHS Genomic Medicine Service will sequence 500,000 whole genomes by 2023/24. During 2019, seriously ill children who are likely to have a rare genetic disorder, children with cancer, and adults suffering from certain rare conditions or specific cancers, will begin to be offered whole genome sequencing.

The NHS will also aim to increase the number of people registering to participate in health research to one million by 2023/24. Furthermore, to expand the NHS infrastructure for real world testing, there will be an expansion of the current NHSE 'test beds' through regional Test Bed Clusters from 2020/21.

Chapter 4: NHS staff will get the backing they need

The *Plan* does not obscure the scale of the challenges facing NHS trusts and staff with NHSE acknowledging that workforce growth "has not kept up with need" while staff have been inadequately

supported to meet the changing requirements of patients over the past decade. However while some tangible goals and new programmes have been outlined in the *Plan*, most of the requisite detail has been delayed until the publication of “the comprehensive workforce implementation plan”, due to be published later in 2019. We expect this replaces the long awaited national workforce strategy.

Workforce implementation plan 2019

- The workforce implementation plan will be overseen by NHS Improvement (NHSI), with a national workforce group established by NHSI, NHSE and Health Education England (HEE) to ensure the delivery of its actions. The aim of the plan “is to ensure a sustainable overall balance between supply and demand across all staff groups”
- The national workforce group will include the new NHS Chief People Officer, the NHS National Medical Director, the Chief Nursing Officer; and other chief professions officers. It will also be made up of representation from staff side organisations, the Social Partnership Forum, Royal Colleges, The King's Fund, Health Foundation and Nuffield Trust.
- The *Plan* does not contain a complete list of priorities for the workforce implementation plan, but specifically notes a number of areas of focus, including:
 - shaping a modern, flexible and supportive employment culture within the NHS;
 - a “new deal” for staff to tackle bullying and harassment;
 - improving staff health and wellbeing, and ability to move between NHS employers;
 - options to improve the NHS leadership pipeline, building on the Kerr and Kark reviews; and
 - domestic recruitment and training.
- The NHS national nursing supply strategy will centre on increasing the number of undergraduate training places, with a pledge to fund an additional 5,000 places from 2019/20 (a 25% increase) and reduce the nursing vacancy rate to 5% by 2028.
- A new online nursing degree will be established, “linked to guaranteed placements at NHS trusts and primary care”. The government hopes the degree will be launched in 2020 at a “substantially” lower cost than the £9,250-a-year for current students.
- The *Plan* points to an increased scrutiny on professional registration and entry standards, saying it is “paradoxical that many thousands of highly motivated and well-qualified applicants who want to join the health service are being turned away”.
- The *Plan* also promises every nurse or midwife graduating a five-year NHS job guarantee every nurse or midwife graduating within the region they qualify.
- 4,000 more mental health and learning disability nurses will be in training by 2023/24, supported by enhanced ‘earn and learn’ measures, particularly earned at mature students lacking financial support.
- The *Plan* offers very little detail on medical education and training, leaving the specifics around the recruitment and retention of doctors to be established in the implementation plan. It does however emphasise its overarching strategy to shift the balance of training away from focusing on highly specialised skills to support the development of more balanced generalist roles.

International recruitment

- The *Plan* promised a “step change” in the recruitment of international nurses to work in the NHS. NHSE acknowledges the need to rely on migrant workers in the coming years given the lead time in training new domestic workforce entrants, saying that the NHS can expect national measures will “increase nurse supplies by several thousand each year.”
- The workforce implementation plan will set out new national arrangements to support NHS organisations in recruiting overseas, recognising the difficulties faced by some trusts seeking to do this independently.
- Overall, the *Plan* gives very little new detail on how any “step change” will take place, noting that further discussions with the government will need to take place over new rules recently introduced in the immigration white paper.

Apprenticeships

- NHS trusts are asked to “take on the lead employer model” to improve the uptake of apprenticeships. The government also expects employers to offer all entry-level jobs as apprenticeships before considering other recruitment options.
- The *Plan* specifically promises a continuation of investment in nursing apprenticeships, saying that over 7,500 new nursing associates will begin employment in 2019: a 50% increase from 2018.
- The document points towards current difficulties with the apprenticeship system for NHS trusts, saying that the terms of the levy may have to change. The plan indicates that changes may not be fully considered until the government’s review of the levy in 2020.

Staff experience and diversity

- NHSI will extend its retention collaborative to all trusts, as part of efforts to improve staff retention by at least 2% by 2025. This equates to a goal of retaining an additional 12,400 nurses.
- The *Plan* notes investment in current workforce development as a key priority saying it “expects HEE to increase investment in continue professional development over the next five years”.
- Workforce diversity has been outlined as a key feature of the NHS long term plan, with the document outlining an additional £1 million to extend NHSE’s work on the Workforce Race Equality Standard until 2025.
- Furthermore, the document says that each NHS organisation will set its own target for BAME representation across its leadership team and broader workforce by 2021/22.

Other key points

- The *Plan* underlines the government’s commitment to national workforce planning in the NHS, saying it has been “disjointed at a national and local level” for too long. Annual recruitment

campaigns will be developed for roles facing the most acute shortages, in conjunction with royal colleges and trade unions.

- The government is pledging to create a “new compact with NHS leaders” to be enshrined in a new NHS leadership code setting out cultural values and leadership behaviours within the NHS.
- The document also underlines the need for greater flexibility in the workforce, and an improved use of technology: By 2021, NHSI will provide support to NHS trusts to deploy electronic rosters or e-job plans. A review of NHS workforce data will also be commissioned.
- The *Plan* re-introduces the potential for a professional registration scheme for senior NHS leaders to be introduced, while pledging to expand the NHS graduate training scheme.
- The *Plan* outlines a goal to double the number of NHS volunteers over the next three years, in part by committing an additional £2.3 million to the NHS Helpforce programme.

Chapter 5: Digitally-enabled care will go mainstream across the NHS

The *Plan* commits the NHS to be “digital first” in ten year’s time. Particular attention has been given to digitally-enabled primary and outpatient care, primarily via a digital NHS front door in the form of the NHS App.

- **Primary care:** NHSE will create a new framework for digital suppliers to offer solutions to primary care networks, with the aim of offering every patient the right to switch to a new digital GP provider. By 2023/24 every patient will have access to a ‘digital first’ primary care provider.
- **Outpatients:** There will be push towards more non face-to-face outpatient care, with the intention to reduce face to face appointments by a third. This will remove around 30 million outpatient visits a year and will be driven by the increased use of telemedicine and mobile technologies. Where appropriate, every patient will be able to opt for a ‘virtual’ outpatient appointment.

The intention is that in 10 year’s time, primary and outpatient care will be based on a model of tiered escalation depending on need. This new focus will also mean senior clinicians will be more reliant on digital technology, and less on junior staff and trainees, who will be freed up to learn and support services in other ways. This will also support the plan’s other priorities, namely: supporting people to stay well, allowing patients to manage their own health, and allowing patients to stay at home.

In terms of digital health more broadly, the *Plan* describes four ways in which ‘mainstreaming’ digitally-enabled care will improve services:

- **Improving patient experience:** a number of benefits will be realised by empowering patients and carers. To support this, the NHS App will continue to be developed so that it becomes the ‘standard online way’ for people to access the NHS. There will also be a focus on improving interoperability and increasing the uptake of mobile monitoring devices. Personal health records will become more advanced, with patients and authorised carers being able to add information themselves

- **Supporting the NHS workforce:** new digital technology will also support staff working in trusts. For example, over the next three years there is an intention for all staff working in community services to have access to mobile digital services, including patients' care records and plans. Renewed focus will also be given to digital leadership in the NHS, including a new commitment for informatics representation on the board of every NHS organisation
- **Quality clinical care:** much of this work will also require the NHS to rethink the way patients interact with services. In addition to the changes to primary and outpatient services, all providers will be expected to advance to a 'core level of digitisation' by 2024. This will include accelerating the roll out of electronic patient records, improving IT hosting, storage and networks, and building resilient cyber security. The plan states central funding will be made available to trusts to help them achieve minimum standards
- **Population health:** NHSE will deploy population management solution to ICSs during 2019. This work will also involve the increased use of de-personalised data taken from local records.

The *Plan* recognises that this will only be achieved by creating the right environment and infrastructure. This will involve, among other things, creating a digitally literate workforce, making NHS solutions available as 'open source' to developers, and requiring NHS suppliers to comply with open standards and interoperability requirements.

Milestones for digitally-enabled care

- Introducing controls to ensure new systems procured by the NHS comply with new agreed standards
- By 2020, five geographies (to be confirmed) will deliver a longitudinal health and care record linking NHS and local authority organisations. Three more areas will follow in 2021
- By 2020/21, every patient will have access to their care plan on the NHS app, as well as communications from their carer professionals
- There will be 100% compliance with mandated cyber security standards by 2021.
- In 2021/22, every local NHS organisation will have a chief clinical information officer (CCIO) or chief information officer (CIO) on their board
- By 2024 there will be universal coverage of regional local health and care records.

Chapter 6: Taxpayers' investment will be used to maximum effect

The *Plan* outlines how the NHS will continue to become more efficient over the coming decade. It restates the following five tests set out by the government in the 2018 budget, and sets out how the NHS will meet them:

1. The NHS (including providers) will return to financial balance
2. The NHS will achieve cash-releasing productivity growth of at least 1.1% a year, with all savings reinvested in frontline care
3. The NHS will reduce the growth in demand for care through better integration and prevention

4. The NHS will reduce variation across the health system, improving providers' financial and operational performance
5. The NHS will make better use of capital investment and its existing assets to drive transformation.

Returning to financial balance

The *Plan* gives a revised timetable for the NHS to return to financial balance: the aggregate provider deficit should reduce each year, and the provider sector as a whole should balance by 2020/21. This is two years later than the aspiration set out in the 2018/19 planning guidance, for the sector to be back in the black by the end of the current financial year. Meanwhile, the number of trusts and commissioners in deficit should also decrease. The number of trusts reporting a deficit in 2019/20 is expected to halve, and all NHS organisations should be in balance by 2023/24.

Previously-trailed policy changes for 2019/20 are restated, with little additional detail. These include moving away from activity based payment systems, and aligning commissioner and provider financial incentives.

NHSI will introduce an "accelerated turnaround process" for the "30 worst financially performing trusts", whose combined shortfall is equal to the overall provider sector deficit. However no detail is given on what that process will involve, or how the trusts that will be subject to it have been identified.

Separately, a new Financial Recovery Fund (FRF) will be created to enable services to become sustainable. No details are given on the size of the fund or when it will begin. It will be accessible "for trusts where deficit control totals indicate a risk to financial sustainability and continuity of services". In return, trusts must draw up a multi-year financial recovery plan with NHSE and NHSI's joint regional team, and a rate of efficiency of at least 1.6% - 0.5% above the national minimum of 1.1%. The recovery plan will set out the actions needed to make services sustainable at both trust and system level, and the agreed responsibilities within the ICS or STP. It will be expected that trusts will implement national initiatives such as Getting It Right First Time and redesigning outpatient services. The *Plan* says the FRF will mean the end of the control total and Provider Sustainability Fund (PSF) regimes for trusts which deliver on their recovery plans. It does not say what the future of the PSF and control total regimes will be for trusts which are not eligible for the FRF.

Improving efficiency and reducing waste

The plan indicates there will be a "strengthened efficiency and productivity programme". Although it does not give detail on how the programme will run, it does set out ten familiar priority areas for efficiency and productivity:

1. Improving the availability and deployment of the clinical workforce using e-rostering
2. Saving money through standardising and scaling-up procurement of consumables
3. Developing pathology and imaging networks
4. Making community, mental health and primary care services more efficient, in line with recent reviews by Lord Carter

5. Improving value from medicines spend
6. Reducing administration costs. This includes a commitment to save £700m by 2023/24, of which £400m should come from providers. The plan does not state how those figures have calculated, where the reductions in spending will come from or whether they are recurrent or cumulative savings
7. Improving the way the NHS uses land, buildings and equipment, and will dispose of surplus assets to enable reinvestment
8. Reducing the use of less effective procedures
9. Improving patient safety
10. Continuing to tackle fraud.

Capital

The *Plan* says the NHS has invested less in recent years in infrastructure than it has done in the past, and at a lower rate than other western countries. It states that meeting its future aspirations will require digital capability and diagnostic equipment will be enhanced significantly.

The capital settlement for the *Plan* period will be set out in this year's Spending Review. At the same time, a number of reforms will be set out to the regime for accessing capital. These will "remove the existing fragmentation of funding sources, short-termism of capital decision making and uncertainty for local health economies".

Next steps

With 2019/20 positioned as a transition year, the next steps for implementing the *Plan* are:

- Local health systems receiving five-year indicative financial allocations for 2019/20 to 2023/24, and being asked to produce plans for implementing the *Plan's* commitments. Those local plans will then be brought together in a national implementation programme in the autumn
- The Clinical Standards Review and the national implementation framework being published in the spring, to be implemented in October following testing and evaluation of any new and revised standards
- The NHS Assembly being established in early 2019. The Assembly – its members comprising third sector stakeholders, the NHS arm's length bodies and frontline NHS and local authority leaders – will advise the boards of NHSE and NHSI and oversee progress on the *Plan*
- The spending review (expected in the autumn) setting out allocations for NHS capital, education and training as well as public health and adult social care

In support of these steps, the *Plan* commits to automating and standardising the generation and storage of data to reduce the burden on frontline services and reduce duplication. It also undertakes to set out a single list of "essential interventions" (including effective e-rostering and e-job planning and processes for standardising and aggregating procurement demand for products and services) to maximise value. The

national bodies will also work with the Health Foundation to increase the number of ICSs building their improvement capabilities.

National operating model

NHSE and NHSI will implement a new shared operating model, with shared regional teams accountable for managing local systems and the providers within them, and ensuring systems secure the best value from their combined resources. To deliver this, the *Plan* commits to:

- A move from relying on regulation and performance management to supporting service improvement and transformation
- Strong governance and accountability mechanisms in place for systems
- A reinforcement of accountability at board, governing body and local system ICS level for adopting standards of best practice and contributing to national improvement programmes, on a comply or explain basis
- Making better use and improving the quality of frontline data and information

Approach to local systems

The *Plan* commits to “balance[ing] national direction with local autonomy to secure the best outcomes for patients”. As part of that approach, it sets out:

- An ambition for ICSs to cover England by April 2021. Local systems will be supported in producing and implementing development plans, including intensive support programme for the most challenged systems with peer support from more developed systems.
- The intention to support organisations to take on greater collaborative responsibility. As well as providing “high-quality care and financial stewardship from an institutional perspective”, organisations will be expected to take on responsibility “for wider objectives in relation to the use of NHS resources and population health”. System oversight will look at organisational and system objectives alongside organisational performance.
- Successful organisations will be asked to support their neighbours in developing capability and resilience, forming part of a ‘duty to collaborate’ for providers and CCGs.

Legislation

A “provisional list of potential legislative changes” which the national bodies would seek from government includes:

- Giving CCGs and providers **shared new duties** to promote the ‘triple aim’ of better health for everyone, better care for all patients, and local and national NHS sustainability
- Removing specific impediments to **‘place-based’ NHS commissioning**, including how CCGs can collaborate with NHSE and NHSE being able to integrate its public health functions within the Mandate
- Allowing trusts and CCGs to **exercise functions and make decisions jointly**. This would mean foundation trusts could create joint committees, and allow (with certain areas where there may be

a conflict reserved to one party) the creation of a joint commissioner/provider committee in every ICS, which could operate as a transparent and publicly accountable partnership board

- Supporting the creation of **NHS integrated care trusts**. This would better enable creation of new NHS integrated care providers (ICPs) and make organisational mergers easier to progress
- Removing the **Competition and Markets Authority's (CMA) duties** to intervene in NHS provider mergers, and its powers in relation to NHS pricing and NHS provider licence condition decisions. Monitor's 2012 Act competition roles would also be removed
- Allowing NHS commissioners to decide the circumstances in which they should use **procurement processes**, subject to a 'best value' test, and removing the wholesale NHS' inclusion in the Public Contract Regulations. Patient choice and control would be protected and strengthened
- Increasing flexibility in the **NHS pricing regime**, in order to move away from activity-based tariffs where appropriate, facilitate integration and reduce fragmentation in public health commissioning.
- Making it easier for **NHSE and NHSI** to work together, including being able to establish a joint committee and subcommittees, with corresponding streamlining of non-executive and executive functions.

NHS Providers view

A crucial next step will be the implementation of the plan which will require ruthless prioritisation of the key investment areas which will require continued engagement from trust leaders. In addition, the key interdependencies for the success of the *Plan* will be the national workforce implementation plan, along with training and education funding, capital investment, and a sustainable solution for social care funding. Some of these issues lie outside of NHSE/I's control and will be addressed in separate publications. In addition, the *Plan's* approach to addressing the wider determinants of health, will be heavily reliant on local authority support despite radical cuts to public health budgets in recent years.

Part 2 of the planning guidance is still due to be published later this week, which we expect will set out further detail on the operational and financial performance expectations for 2019/20. The trajectory to operational performance recovery against key constitutional targets is not included within the plan, however the clinical review of standards is expected to be published in spring 2019.

The importance of the local autonomy and the accountability of provider boards is mentioned within the *Plan*, although the role of the national bodies in ensuring consistency, value for money and support are equally at the forefront of the intended revised approach. The roll out of ICSs across the country by 2021, and the enhancements of the role of system working through the revised financial framework and in relation to commissioning structures, regulation and performance management are significant. We will be working closely with the national bodies, and providers, to unpack and help shape their implementation.

NHS Providers will continue to engage in the development of the detail underpinning the *Plan* and its implementation. We will also provide further analysis to members on what the *Plan* means for them and look forward to engaging members in our ongoing work in this area.

NHS Providers press statement

NHS long term plan - trusts are committed to creating world class services

Responding to the publication of the *NHS long term plan*, the chief executive of NHS Providers, Chris Hopson said:

"There will be strong support across the NHS for the vision and ambition set out in the document. Trusts and their staff are strongly committed to creating world class services and continuously improving patient outcomes. They also recognise the need to transform the way they provide care to reflect 21st century health and care needs.

"There is a huge amount to do across a wide range of areas. Successful delivery will depend on four key factors.

"First, ruthless prioritisation and effective implementation. To plan is to choose. We now need a detailed implementation plan that sets out exactly what will be delivered when. This must clearly match the priorities for each year to the available money and staff, ensuring that the trusts who have to deliver the plan are actually able to do so.

"Second, a rapid solution to current workforce shortages. This plan cannot be delivered whilst trusts still have 100,000 workforce vacancies. We need urgent action to solve what trust leaders current describe as their biggest problem. It's a major concern that we will have to wait longer to get the comprehensive plan that is needed here.

"Third, a clear path to recovering performance in areas like urgent and emergency care and routine surgery. Despite trusts working flat out, the NHS has fallen behind where it needs to be, missing all its key performance targets over the last four years. Whilst trusts are ready to look at updating these targets, we mustn't lose the enormous gains trusts made in cutting waiting lists and improving care in the early 2000s.

"Fourth, there are a range of other issues central to the success of the NHS that must be satisfactorily resolved through the spending review – social care, public health and NHS training budgets.

"The ambition and vision are welcome. But they need to be delivered.

"We welcome the commitment to an open and consultative process in developing a detailed implementation plan over the next few months. It is vital that the expertise and concerns of NHS trusts are central to those discussions. We look forward to making a full and positive contribution."

ENDS.



NHS Long Term Plan - A summary of child health proposals

[Media & External Affairs team](#)

We're pleased to see infants, children and young people placed front and centre of the NHS Long Term Plan, published in January 2019. The Plan contains a number of measures which will, if implemented, make a real difference to the health and wellbeing of children and help to achieve our vision for the NHS.

Status

[RCPCH](#)

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The RCPCH welcomed the announcement of the NHS Long Term Plan as an opportunity to place the needs of infants, children and young people at the heart of England's health services. The health of children and young people is crucial to the future wellbeing and prosperity of this country, but England's child health outcomes currently lag behind the rest of Western Europe. While there have been specific improvements and progress made in certain areas, this has not led to the kind of system wide changes that are needed to improve outcomes and ensure a healthier future for children across England.

That's why we're pleased to see infants, children and young people placed front and centre of the Plan, published in January 2019. The Plan contains a number of measures which will,

if implemented, make a real difference to the health and wellbeing of children and help to achieve our vision for the NHS, that:

- by 2028, children and young people in England will have better physical health, mental health and wellbeing
- children and young people, and their parents and carers, will experience a seamless service delivered by an integrated health and care system
- there will be a skilled workforce that listens to them, responds, and meets their needs.

The Plan was produced through consultation with health professionals, patients and the public. The RCPCH &Us Network was instrumental in ensuring that the views of children, young people and their families were influential in the Plan's development. Now that it is published, we will ensure that RCPCH &Us continue to be engaged in the new NHS Assembly, due to be established in 2019.

This briefing outlines the key proposals for child health, integrated care and workforce contained in the Plan. The RCPCH will continue to work closely with NHS England, NHS Improvement and other key stakeholders to ensure that these proposals are acted upon and implemented.

Key highlights

In its Long Term Plan, NHS England pledges to:

- create a Children and Young People's Transformation Programme which will, in conjunction with the Maternity Transformation Programme, oversee the delivery of the children and young people's commitments in this Plan
- move to a 0-25 years service and towards service models for young people that offer person-centred and age appropriate care for mental and physical health needs, rather than an arbitrary transition to adult services based on age not need
- publish a workforce implementation plan in 2019 and establish a national workforce group to ensure that such workforce actions agreed are delivered quickly
- strengthen its contribution to prevention and tackling health inequalities, basing its five-year funding allocations to local areas on more accurate assessment of health inequalities and unmet need.
- accelerate action to achieve 50% reductions in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025
- invest in expanding access to community-based mental health services to meet the needs of more children and young people
- improve its understanding of the needs of people with learning disabilities and autism and work together to improve their health and wellbeing, including piloting the introduction of a specific health check for people with autism, which if successful will be extended more widely
- increase investment in intensive, crisis and forensic community support will also enable more people to receive personalised care in the community, closer to home, and reduce preventable admissions to inpatient services.

Children and Young People's Transformation Programme

What do we want to see?

The development of a Children and Young People's Health Strategy to be delivered by a funded transformation programme led by a dedicated programme board.

What does the Plan promise?

The NHS will create a Children and Young People's Transformation Programme which will, in conjunction with the Maternity Transformation Programme, oversee the delivery of the children and young people's commitments in this Plan.

Public health

What do we want to see?

An NHS that gives children the healthiest start and continues throughout their life course.

What does the Plan promise?

Obesity

The NHS will provide a targeted support offer and access to weight management services in primary care for people with a diagnosis of type 2 diabetes or hypertension with a BMI of 30+ (adjusted appropriately for ethnicity), where the NHS can have a significant impact on improving health, reducing health inequalities and reducing costs. By 2022-23, the NHS also expects to treat up to a further 1,000 children a year for severe complications related to their obesity, such as diabetes, cardiovascular conditions, sleep apnoea and poor mental health. These services will prevent children needing more invasive treatment.

Learning disability

Over the next five years, investment to ensure that children with learning disabilities have their needs met by eyesight, hearing and dental services, are included in reviews as part of general screening services and are supported by easily accessible, ongoing care.

Immunisation

The NHS will prioritise improvements in childhood immunisation to reach at least the base level standards in the NHS public health function agreement. The programme will also work closely with other areas of government and key programmes such as the Healthy Child Programme.

Oral health

The Starting Well Core initiative is supporting 24,000 dentists across England to see more children from a young age to form good oral health habits, preventing tooth decay experienced by a quarter of England's five year olds.

Commissioning public health services

The NHS will consider whether there is a stronger role for the NHS in commissioning sexual health services, health visitors, and school nurses, and what best future commissioning arrangements might be.

Improving population health

During 2019, the NHS will deploy population health management solutions to support ICSs to understand the areas of greatest health need and match NHS services to meet them. Over the coming years these solutions will become increasingly sophisticated in identifying those groups of people who are at risk of adverse health outcomes and predict which individuals are most likely to benefit from different health and care interventions, as well as shining a light on health inequalities.

Maternity and neonatal care

What do we want to see?

An NHS that supports interventions to reduce the number of deaths in infants, and maximises women's health before, during and after pregnancy

What does the Plan promise?

Through the Long Term Plan, the NHS will accelerate action to achieve 50% reductions in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025. This will be done by the following.

Reducing infant deaths and improving safety

Rolling out of the Saving Babies Lives Care Bundle (SBLCB) across every maternity unit in England in 2019. Supporting the establishment of Maternal Medicine Networks, which will further ensure women with acute and chronic medical problems have timely access to specialist advice and care at all stages of pregnancy.

Expanding the SBLCB in 2019. This will include a focus on preventing pre-term birth, which will minimise unnecessary intervention and define a more holistic approach to risk assessment during labour, alongside further improvements to cardiotocography monitoring, and reductions in smoking during pregnancy. To care for women with heightened risk of pre-term birth, including younger mothers and those from deprived backgrounds, the NHS will encourage development of specialist pre-term birth clinics across England. The SBLCB will also encourage clinically appropriate use of magnesium sulphate – estimated to help reduce the number of pre-term babies born with cerebral palsy by up to 700 per year.

By spring 2019, every trust in England with a maternity and neonatal service will be part of the National Maternal and Neonatal Health Safety Collaborative. Every national, regional and local NHS organisation involved in providing safe maternity and neonatal care has a named Maternity Safety Champion.

Continuing to improve how it learns lessons when things go wrong and minimise the chances of them happening again. The Healthcare Safety Investigation Branch reviews all term stillbirths, early neonatal deaths and cases of severe brain injury in babies, as well as all maternal deaths. A Perinatal Mortality Review Tool is now used by all maternity providers, supporting high quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death.

Redesigning and expanding neonatal critical care services to improve the safety and effectiveness of services and experience of families. In particular, the NHS will address the shortage of neonatal capacity through the introduction of more Neonatal Intensive Care Cots where the Neonatal Critical Care Review has identified under capacity and improve triage within expert maternity and neonatal centres so that the right level of care is available to babies as close to the family home as possible.

Enhanced maternity care

Continuing to work with midwives, mothers and their families to implement continuity of carer so that, by March 2021, most women receive continuity of the person caring for them during pregnancy, during birth and postnatally.

Continuing to expand the roll-out of maternity digital care records. By 2023-24, all women will be able to access their maternity notes and information through their smart phones or other devices.

Improving access to postnatal physiotherapy to support women who need it to recover from birth.

Enhancing the experience of families during the worrying period of neonatal critical care. From 2021-22, care coordinators will work with families within each of the clinical neonatal networks across England to support families to become more involved in the care of their baby and invest in improve parental accommodation.

Perinatal mental health

Increasing access to evidence-based care for women with moderate to severe perinatal

mental health difficulties and a personality disorder diagnosis, to benefit an additional 24,000 women per year by 2023-24, in addition to the extra 30,000 women getting specialist help by 2020-21. Care provided by specialist perinatal mental health services will be available from preconception to 24 months after birth (care is currently provided from pre-conception to 12 months after birth), in line with the cross-government ambition for women and children focusing on the first 1,001 critical days of a child's life.

Expanding access to evidence-based psychological therapies within specialist perinatal mental health services so that they also include parent-infant, couple, co-parenting and family interventions; offering fathers/partners of women accessing specialist perinatal mental health services and maternity outreach clinics evidence-based assessment for their mental health and signposting to support as required; increasing access to evidence-based psychological support and therapy, including digital options, in a maternity setting. Maternity outreach clinics will integrate maternity, reproductive health and psychological therapy for women experiencing mental health difficulties directly arising from, or related to, the maternity experience.

Infant feeding

All maternity services that do not deliver an accredited, evidence-based infant feeding programme, such as the UNICEF Baby Friendly Initiative, will begin the accreditation process in 2019-20.

Workforce

Developing the expert neonatal nursing workforce. This will mean extra neonatal nurses and expanded roles for some allied health professionals to support neonatal nurses.

Children and young people's mental health services

What do we want to see?

An NHS that promotes the mental and emotional health and resilience of children and young people.

What does the Plan promise?

Funding and investment

Funding for children and young people's mental health services will grow faster than both overall NHS funding and total mental health spending. This means that children and young people's mental health services will for the first time grow as a proportion of all mental health services, which will themselves also be growing faster than the NHS overall.

Over the next five years, the NHS will continue to invest in expanding access to community-based mental health services to meet the needs of more children and young people. By 2023-24, at least an additional 345,000 children and young people aged 0-25 will be able to access support via NHS funded mental health services and school or college-based Mental Health Support Teams. Over the coming decade the goal is to ensure that 100% of children

and young people who need specialist care can access it.

Over the next five years, the NHS will also boost investment in children and young people's eating disorder services. As need continues to rise, extra investment will allow the NHS to maintain delivery of the 95% standard beyond 2020-21.

Access to support

Children and young people experiencing a mental health crisis will be able to access the support they need. Expanding timely, age-appropriate crisis services will improve the experience of children and young people and reduce pressures on accident and emergency (A&E) departments, paediatric wards and ambulance services.

Mental health support for children and young people will be embedded in schools and colleges. The Children and Young People's Mental Health Green Paper set out proposals to improve mental health support in schools and colleges. Over the next five years the NHS will fund new Mental Health Support Teams working in schools and colleges, building on the support already available, which will be rolled out to between one-fifth and a quarter of the country by the end of 2023. The NHS work with schools, parents and local councils will reveal whether more upstream preventative support, including better information sharing and the use of digital interventions, helps moderate the need for specialist child and adolescent mental health services. It will thereby test approaches that could feasibly deliver four week waiting times for access to NHS support, ahead of introducing new national waiting time standards for all children and young people who need specialist mental health services.

Complex needs

In selected areas, the NHS will also develop new services for children who have complex needs that are not currently being met, including a number of children who have been subject to sexual assault but who are not reaching the attention of Sexual Assault Referral Services.

Service models

The NHS will extend current service models to create a comprehensive offer for 0-25 year olds that reaches across mental health services for children, young people and adults. The new model will deliver an integrated approach across health, social care, education and the voluntary sector, such as the evidenced based 'iThrive' operating model which currently covers around 47% of the 0-18 population and can be expanded to 25 year olds. In addition, NHS England is working closely with Universities UK via the Mental Health in Higher Education programme to build the capability and capacity of universities to improve student welfare services and improve access to mental health services for the student population, including focusing on suicide reduction, improving access to psychological therapies and groups of students with particular vulnerabilities.

Children with long term conditions

What do we want to see?

An NHS that integrates care for children and young people with complex or multiple needs.

What does the Plan promise? - Learning disability and autism

Health promotion

Action will be taken to tackle the causes of morbidity and preventable deaths in people with a learning disability and for autistic people. This will be done by improving the uptake of the existing annual health check in primary care for people aged over 14 years with a learning disability, so that at least 75% of those eligible have a health check each year. The NHS will pilot the introduction of a specific health check for people with autism, and if successful, extend it more widely. The NHS will expand the Stopping over medication of people with a learning disability autism or both and Supporting Treatment and Appropriate Medication in Paediatrics (STOMP-STAMP) programmes to stop the overmedication of people with a learning disability, autism or both and continue to fund the Learning Disabilities Mortality Review Programme (LeDeR), the first national programme aiming to make improvements to the lives of people with learning disabilities.

Integrating systems and models of care

The whole NHS will improve its understanding of the needs of people with learning disabilities and autism, and work together to improve their health and wellbeing. NHS staff will receive information and training on supporting people with a learning disability and/ or autism. Sustainability and Transformation Partnerships (STPs) and integrated care systems (ICSs) will be expected to make sure all local healthcare providers are making reasonable adjustments to support people with a learning disability or autism. Over the next five years, national learning disability improvement standards will be implemented and will apply to all services funded by the NHS. These standards will promote greater consistency, addressing themes such as rights, the workforce, specialist care and working more effectively with people and their families. By 2023-24, a 'digital flag' in the patient record will ensure staff know a patient has a learning disability or autism. The NHS will work with the Department for Education and local authorities to improve their awareness of, and support for, children and young people with learning disabilities, autism or both and work with partners to bring hearing, sight and dental checks to children and young people with a learning disability, autism or both in special residential schools.

To move more care to the community, the NHS will support local systems to take greater control over how budgets are managed. Drawing on learning from the New Care Models in tertiary mental health services, local providers will be able to take control of budgets to reduce avoidable admissions, enable shorter lengths of stay and end out of area placements. Where possible, people with a learning disability, autism or both will be enabled to have a personal health budget (PHBs). By March 2023-24, inpatient provision will have reduced to less than half of 2015 levels (on a like for like basis and taking into account population growth) and, for everyone million adults, there will be no more than 30 people with a learning disability and/or autism cared for in an inpatient unit. For children and young people, no more than 12 to 15 children with a learning disability, autism or both per million, will be cared for in an inpatient facility.

Increased investment in intensive, crisis and forensic community support will also enable more people to receive personalised care in the community, closer to home, and reduce preventable admissions to inpatient services. Every local health system will be expected to use some of this growing community health services investment to have a seven-day specialist multidisciplinary service and crisis care. The NHS will continue to work with partners to develop specialist community teams for children and young people, such as the Ealing Model, which has evidenced that an intensive support approach prevents children being admitted into institutional care.

The NHS will focus on improving the quality of inpatient care across the NHS and independent sector. By 2023-24, all care commissioned by the NHS will need to meet the Learning Disability Improvement Standards. The NHS will work with the CQC (Care Quality Commission) to implement recommendations on restricting the use of seclusion, long-term segregation and restraint for all patients in inpatient settings, particularly for children and young people. As well as focusing on the number of people in inpatient settings, the NHS will closely monitor and – over the coming years – bring down the length of time people stay in inpatient care settings and support earlier transfers of care from inpatient settings. All areas of the country will implement and be monitored against a '12-point discharge plan' to ensure discharges are timely and effective. The NHS will review and look to strengthen the existing Care, Education and Treatment Review (CETR) and Care and Treatment Review (CTR) policies, in partnership with people with a learning disability, autism or both, families and clinicians to assess their effectiveness in preventing and supporting discharge planning.

Access and support

Over the next three years, autism diagnosis will be included alongside work with children and young people's mental health services to test and implement the most effective ways to reduce waiting times for specialist services. This will be a step towards achieving timely diagnostic assessments in line with best practice guidelines. Together with local authority children's social care and education services as well as expert charities, the NHS will jointly develop packages to support children with autism or other neurodevelopmental disorders including attention deficit hyperactivity disorder (ADHD) and their families, throughout the diagnostic process. By 2023-24 children and young people with a learning disability, autism or both with the most complex needs will have a designated keyworker.

Initially, keyworker support will be provided to children and young people who are inpatients or at risk of being admitted to hospital. Keyworker support will also be extended to the most vulnerable children with a learning disability and/or autism, including those who face multiple vulnerabilities such as looked after and adopted children, and children and young people in transition between services.

What does the Plan promise? - Children and young people with cancer

Networked care

The NHS will develop and implement networked care to improve outcomes for children and young people with cancer, simplifying pathways and transitions between services and ensuring every patient has access to specialist expertise.

Genome sequencing

From 2019, the NHS will begin to offer all children with cancer whole genome sequencing to enable more comprehensive and precise diagnosis, and access to more personalised treatments. This will reduce the use of harmful medications and interventions, support increased access to clinical trials and reduce the number of young patients who experience lifelong health problems caused by high doses of chemotherapy and radiotherapy. Children and young people in England will also be among the very first in Europe to benefit from a new generation of CAR-T cancer therapies. And children who need proton beam therapy will be able to access the most sophisticated modern precision treatment in the world here in the NHS without needing to travel abroad.

Clinical trials

The NHS will actively support children and young people to take part in clinical trials, so that participation among children remains high, and among teenagers and young adults rises to 50% by 2025. More effective consent processes for using data and tissue samples in research will contribute to improving survival outcomes. The NHS will seek the views of patients aged under 16 to ensure it continues to offer the very best services for children and young people. This will be used, alongside other cancer data, to inform service design and transformation.

HPV vaccine

From September 2019, all boys aged 12 and 13 will be offered vaccination against HPV-related diseases, such as oral, throat and anal cancer.

Palliative care

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

Redesigning other health services for children and young people

What do we want to see?

An NHS that is tailored and responsive to the needs of children and young people throughout their childhood and as they transition to adult services, such as diabetes and epilepsy services.

What does the Plan promise?

Models of care

By 2028 the NHS will move to a 0-25 years service and towards service models for young people that offer person-centred and age appropriate care for mental and physical health needs, rather than an arbitrary transition to adult services based on age not need.

Local areas will design and implement models of care that are age appropriate, closer to home and bring together physical and mental health services. These models will support health development by providing holistic care across local authority and NHS services, including primary care, community services, speech and language therapy, school nursing, oral health, acute and specialised services.

From 2019-20 clinical networks will be rolled out to ensure the NHS improves the quality of care for children with long-term conditions such as asthma, epilepsy and diabetes. This will be achieved through sharing best clinical practice, supporting the integration of paediatric skills across services and bespoke quality improvement projects.

Critical care and surgical services

Over the next five years, paediatric critical care and surgical services will evolve to meet the changing needs of patients, ensuring that children and young people are able to access high quality services as close to home as possible. Paediatric networks, which will involve hospitals, NHS staff and patients and their families, will ensure that there is a coordinated approach to critical care and surgical services, enabling children and young people to access specialised and non-specialised services in times of urgent, emergency and planned need.

Finances

Integrated Care Systems (ICSs) will become the level of the system where commissioners and providers make shared decisions about financial planning, and prioritisation. Beyond 2019-20 the NHS will introduce further financial reforms that will support ICSs to deliver integrated care. Through a process of earned financial autonomy the NHS will give local health systems greater control over resources on the basis of a track record of strong financial and performance delivery, assessed in part through the new ICS accountability and performance framework.

Workforce

What do we want to see?

An NHS that is properly staffed by motivated and dedicated child health professionals

What does the Plan promise?

Workforce Implementation Plan

The funding available for additional investment in the workforce, in the form of training, education and continuing professional development (CPD) through the Health Education England (HEE) budget has yet to be set by government. A workforce implementation plan will be published later in 2019. NHS Improvement, HEE and NHS England will establish a national workforce group to ensure that such workforce actions agreed are delivered quickly. This will include the new NHS Chief People Officer, the NHS National Medical Director, the Chief Nursing Officer and the other Chief Professions Officers. The group will show how the future challenges can be addressed for the total workforce, as well as looking at each group individually. The group will also include the Chief Midwifery Officer, along with representatives from staff side organisations, the Social Partnership Forum, Royal Colleges, The King's Fund, Health Foundation and Nuffield Trust.

Training

Depending on the HEE training budget to be agreed in the Spending Review, the number of medical school places could grow further. The national workforce group will examine further options, including:

- more part-time study options
- expanding the number of accelerated degree programmes which would allow people to train in four years rather than five years to widen access
- greater contestability in allocating the 7,500 medical training places to universities so as to drive improvements in curricula (formal and informal), and the production of medical graduates who meet the primary care and specialty needs of the NHS.

The way doctors are trained and the way they work will be a key component of the workforce implementation plan. The NHS will accelerate the shift from a dominance of highly specialised roles to a better balance with more generalist ones.

Working with the British Medical Association, the medical Royal Colleges, the General Medical Council and providers, the NHS will also address:

- how the wider NHS can support the implementation of HEE's work to improve the working lives of doctors in training, including providing adequate time for supervision, accelerating implementation of 'step out and step in' training programmes and further work to enable trainees to switch specialties without re-starting training
- how to accelerate the development of credentialing, which has been piloted by HEE, to enable doctors to broaden the scope of their practice, both during and after training
- how to reform and re-open the Associate Specialist grade as an attractive career option in line with the HEE led strategy for Specialist and Associate Specialist doctors
- the acceleration of work to ensure doctors are trained with the generalist skills needed to meet the needs of an ageing population, alongside the development of specialist

knowledge and skills

- the development of incentives to ensure that the specialty choices of trainees meet the needs of patients by matching specialty and geographical needs, especially in primary care, community care and mental health services
- the consideration of any further proposals from the work on reforming medical education which will support the delivery of the Long Term Plan.

Overseas doctors

The workforce implementation plan will set out new national arrangements to support NHS organisations in recruiting overseas. The NHS will explore the potential to expand the Medical Training Initiative so that more medical trainees from both developed and developing countries can spend time learning and working in the NHS.

The changes to the immigration rules in 2018, which exempted all doctors and nurses from the immigration cap, have facilitated more responsive routes for recruiting staff in these professional groups. The NHS will work with government to ensure the post-Brexit migration system provides the necessary certainty for health and social care employers, particularly for shortage roles.

Wellbeing

The NHS will seek to shape a modern employment culture for the NHS – promoting flexibility, wellbeing and career development, and redoubling our efforts to address discrimination, violence, bullying and harassment.

Digitally-enabled care

What do we want to see?

An NHS that uses data and technology to improve outcomes from children and young people.

What does the Plan promise?

A digital red book

A digital version of the 'red book' will help parents record and use information about their child, including immunisation records and growth.

Better use of technology

The NHS will work with the voluntary sector, developers, and individuals in creating a range of apps to support particular conditions. By 2020, the NHS aims to endorse a number of technologies that deliver digitally-enabled models of therapy for depression and anxiety disorders for use in IAPT (Improving Access to Psychological Therapies) services across the NHS. This is expected to be expanded to include therapies for children and young people and other modes of delivery, such as virtual and augmented reality, which are already demonstrating early success through the mental health GDE (Global Digital Exemplar) programme.

By 2022, technology will better support clinicians to improve the safety of and reduce the health risks faced by children and adults. An integrated child protection system will replace dozens of legacy systems to include all health care settings including general practice and the NHS will deliver a screening and vaccination solution that is worthy of the NHS' world leading services

Implementation

The Plan says that integrated care systems (ICSs) will be central to the delivery of the Long Term Plan and by April 2021 they want ICSs covering all of the country. As local systems are in different states of readiness, NHS England will support each developing system to produce and implement a clear development plan and timetable.

Systematic methods of Quality Improvement (QI) provide an evidence-based approach for improving every aspect of how the NHS operates. Through developing their improvement capabilities, including QI skills and data analytics, systems will move further and faster to adopt new innovations and service models and implement best practices that can improve quality and efficiency and reduce unwarranted variations in performance.

External links

[NHS Long Term Plan](#)



Department
of Health &
Social Care

EU Exit Operational Readiness Guidance

**Actions the health and care system in England should
take to prepare for a 'no deal' scenario.**

Published on 21 December 2018

EU Exit Operational Readiness Guidance

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EU Exit Operational Readiness Guidance

Purpose

The EU Exit Operational Readiness Guidance, developed and agreed with NHS England and Improvement, lists the actions that providers and commissioners of health and care services in England should take if the UK leaves the EU without a ratified deal – a ‘no deal’ exit. This will ensure organisations are prepared for, and can manage, the risks in such a scenario.

This guidance has been sent to all health and care providers, including adult social care providers, to ensure the health and care system as a whole is prepared. Adult social care providers are advised to use this guidance as a prompt to test their own contingency plans. A further letter has also been sent in parallel to local authorities and adult social care providers to address specific adult social care issues.

EU Exit Operational Readiness Guidance

Overview

The EU Exit Operational Readiness Guidance summarises the Government's contingency plans and covers actions that all health and adult social care organisations should take in preparation for EU Exit.

All organisations receiving this guidance are advised to undertake local EU Exit readiness planning, local risk assessments and plan for wider potential impacts. In addition, the actions in this guidance cover seven areas of activity in the health and care system that the Department of Health and Social Care is focussing on in its 'no deal' exit contingency planning:

- supply of medicines and vaccines;
- supply of medical devices and clinical consumables;
- supply of non-clinical consumables, goods and services;
- workforce;
- reciprocal healthcare;
- research and clinical trials; and
- data sharing, processing and access.

The impact of a 'no deal' exit on the health and adult social care sector is not limited to these areas, and the Department is also developing contingency plans to mitigate risks in other areas. For example, the Department is working closely with NHS Blood and Transplant to co-ordinate 'no deal' planning for blood, blood components, organs, tissues and cells (as detailed in the two technical notices on [blood](#) and [organs, tissues and cells](#) and the recent [letter](#) to the health and care system sent by the Secretary of State for Health and Social Care on 7 December 2018).

The actions in this guidance factor in the Government's revised border planning assumptions which were detailed in the Cabinet Office's [guidance](#) on 7 December 2018.

In preparation for a 'no deal' exit, the Department, with the support of NHS England and Improvement, and Public Health England, has set up a national Operational Response Centre. This will lead on responding to any disruption to the delivery of health and care services in England, that may be caused or affected by EU Exit. The Operational Response Centre will co-ordinate EU Exit-related information flows and reporting across the health and care system. The Operational Response Centre will also work with the devolved administrations to respond to UK-wide incidents.

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The Operational Response Centre has been established to support the health and care system to respond to any disruption, and will not bypass existing local and regional reporting structures.

Working closely with the Operational Response Centre, NHS England and Improvement will also establish an Operational Support Structure for EU Exit. This will operate at national, regional and local levels to enable rapid support on emerging local incidents and escalation of issues into the Operational Response Centre as required. Contact details for the regional EU Exit leads are below:

Region	Contact details for regional EU Exit lead
North East	England.euexitnortheast@nhs.net
North West	England.euexitnorthwest@nhs.net
Midlands	England.mids-euexit@nhs.net
East of England	England.eoe-euexit@nhs.net
London	England.london-euexit@nhs.net
South East	England.se-euexit@nhs.net
South West	England.sw-euexit@nhs.net

NHS providers and commissioners will be supported by local NHS teams to resolve issues caused or affected by EU Exit as close to the frontline as possible. These issues will be escalated to regional level, as required. Where issues are impacting across the health and care system at a national level, the Operational Response Centre will co-ordinate information flows and responses.

This guidance and the planning assumptions within it represent the most up to date information available. Further operational guidance will be issued and updated to support the health and care system to prepare for the UK leaving the EU prior to 29 March 2019.

EU Exit Operational Readiness Guidance

Summary

This section summarises seven areas where the government is focussing 'no deal' exit contingency planning in the health and care system, and where local action is required. Detailed actions for providers, commissioners and NHS England and Improvement regional teams are listed in Annex A (pages 15 to 33). Please read the summary and the action card that is applicable to your organisation.

Common to all of the groups of medical products listed below, it should be noted that government departments have also been working to design customs and other control arrangements at the UK border to ensure goods, including medical supplies, can continue to flow into the UK without being delayed by additional controls and checks.

However, the EU Commission has made clear that, in a 'no deal' exit, it will impose full third country controls on people and goods entering the EU from the UK. The cross-government planning assumption has therefore been revised to prepare for the potential impacts that the imposition of third country controls by member states could have. The revised assumption shows that there will be significantly reduced access across the short straits, for up to six months.

Supply of medicines and vaccines

- The Government recognises the vital importance of medicines and vaccines, and has developed a UK-wide contingency plan to ensure the flow of these products into the UK in a 'no deal' scenario.
- The plan covers medicines used by patients and service users in all four nations of the UK, as well as the UK Crown Dependencies. The Department is working very closely with the devolved administrations, the Crown Dependencies and other government departments to explore specific issues related to the various supply chains for medicines in the UK, as well as potential mitigations. The plan covers medicines used by all types of providers, including private providers.
- Earlier this year, the Department undertook an analysis using Medicines and Healthcare Products Regulatory Agency and European Medicines Agency data, on the supply chain for all medicines (including vaccines and medical radioisotopes). This identified those products that have a manufacturing touch point in the EU or wider EEA countries.
- In August 2018, the Department for Health and Social Care [wrote to pharmaceutical companies](#) that supply the UK with prescription-only and pharmacy medicines from, or via, the EU or European Economic Area (EEA) to prepare for a no deal scenario.

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Companies were asked to ensure they have a minimum of six weeks' additional supply in the UK, over and above their business as usual operational buffer stocks, by 29 March 2019. Companies were also asked to make arrangements to air freight medicines with a short shelf life, such as medical radioisotopes.

- Since then, there has been very good engagement from industry to ensure the supply of medicines is maintained in a 'no deal' exit.
- The Department will support manufacturers taking part in the contingency planning and is already providing funding for the provision of additional capacity for the storage of medicines.
- In October, the Department invited wholesalers and pre-wholesalers of pharmaceutical warehouse space to bid for government funding to secure the additional capacity needed for stockpiled medicines, and funding for selected organisations has now been agreed.
- On 7 December 2018, the Department [wrote](#) to UK manufacturers of medicines currently using the short straits crossings of Dover and Folkestone as they will want to review supply arrangements in light of the Government's updated planning assumptions.
- Whilst the six-week medicines stockpiling activity remains a critical part of the Department's UK-wide contingency plan, it is now being supplemented by additional national actions.
- The Government is working to ensure there is sufficient roll-on, roll-off freight capacity to enable medicines and medical products to continue to move freely into the UK.
- The Government has agreed that medicines and medical products will be prioritised on these alternative routes to ensure the flow of all these products will continue unimpeded after 29 March 2019. This includes all medicines, including general sales list medicines.
- In the event of delays caused by increased checks at EU ports, the Department will continue to develop the UK-wide contingency plan for medicines and vaccines with pharmaceutical companies and other government departments.
- UK health providers – including hospitals, care homes, GPs and community pharmacies – should not stockpile additional medicines beyond their business as usual stock levels. There is also no need for clinicians to write longer NHS prescriptions and the public should be discouraged from stockpiling.

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- Chief and Responsible Pharmacists are responsible for ensuring their organisation does not stockpile medicines unnecessarily. Any incidences involving the over-ordering of medicines will be investigated and followed up with the relevant Chief or Responsible Pharmacist directly.
- The Department and NHS England and Improvement are developing arrangements to allow local and regional monitoring of stock levels of medicines; arrangements are also likely to be put in place to monitor the unnecessary export of medicines.
- The Department is putting in place a “Serious Shortage Protocol”. This will involve changes to medicines legislation that will allow flexibility in primary care dispensing of medicines. Robust safeguards will be put in place to ensure this is operationalised safely, including making authoritative clinical advice available.
- Public Health England (PHE) is leading a separate UK-wide programme ensuring the continuity of supply for centrally-procured vaccines and other products that are distributed to the NHS for the UK National Immunisation Programme or used for urgent public health use. In addition to the national stockpiles that PHE has in place to ensure continued supply to the NHS, PHE continues to work alongside contracted suppliers on their contingency plans to ensure that the flow of these products will continue unimpeded in to the UK after exit day.

Supply of medical devices and clinical consumables

- On 23 October 2018, the Secretary of State for Health and Social Care [wrote](#) to all suppliers of medical devices and clinical consumables updating them on the contingency measures the Department is taking to ensure the continuity of product supply.
- One of these measures is to increase stock levels of these products at a national level in England.
- The Department is working with the devolved nations and Crown Dependencies to ensure that national contingency arrangements are aligned and able to support specific preparedness measures necessary to meet the needs of their health and care systems.
- The Department is also developing contingency plans to ensure the continued movement of medical devices and clinical consumables that are supplied from the EU directly to organisations delivering NHS services in England.

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- The Department has asked all suppliers that regularly source products from EU countries to review their supply chains and determine what measures they need to take to ensure the health and care system has access to the products it needs.
- NHS Supply Chain officials are also contacting suppliers who routinely import products from the EU to establish what measures are required to ensure they can continue to provide products in a 'no deal' scenario. Products are already being ordered.
- The Government is working to ensure there is sufficient roll-on/roll-off freight capacity to enable medicines and medical products to continue to move freely into the UK. This will help facilitate the flow of products to both NHS and private care providers.
- The Government has agreed that medicines and medical products will be prioritised on these alternative routes to ensure the flow of these products will continue unimpeded after 29 March 2019.
- There is no need for health and adult social care providers to stockpile additional medical devices and clinical consumables beyond business as usual stock levels. Officials in the Department will continually monitor the situation and, if the situation changes, will provide further guidance by the end of January 2019.
- The Department continues to engage directly with industry suppliers, trade associations, NHS providers and other government departments to develop its contingency planning approach and ensure the continued supply of medical devices and clinical consumables into the UK.

Supply of non-clinical consumables, goods and services

- The Department has identified categories of national suppliers for non-clinical consumables, goods and services that it is reviewing and managing at a national level. Examples of relevant categories include food and laundry services.
- For these categories, the Department is engaging with suppliers and industry experts to identify and plan for any supply disruption. Where necessary, there will be cross-government work to implement arrangements at the point of EU Exit to ensure continued supply.
- On food, for example, the Department is engaging with both suppliers and health experts to identify and plan for any food items that might suffer supply disruption in the event of a 'no deal'. Standard guidelines will be developed for health and adult social care providers on suitable substitution arrangements for any food items identified as being at risk.

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- The Department is also conducting supply chain reviews across the health and social care system to assess commercial risks. This includes reviews for high-risk non-clinical consumables, goods and services, and a self-assessment tool for NHS Trusts and Foundation Trusts. The results of these self-assessments were received at the end of November, and the Department is conducting analysis of the data, that will be used to provide additional guidance to Trusts and Foundation Trusts in January 2019.

Workforce

- The current expectation is that there will not be a significant degree of health and care staff leaving around exit day. Organisations can escalate concerns through existing reporting mechanisms to ensure there is regional and national oversight.

EU Settlement Scheme

- Through the EU Settlement Scheme, EU citizens will be able to register for settled status in the UK if they have been here for five years, or pre-settled status if they have been here for less than five years. This will ensure the rights of EU citizens are protected in the UK after EU Exit, and guarantee their status and right to work.
- Some EU citizens working in the health and care system would have been able to register for EU settled status under the pilot scheme that was open between the 3rd and 21st December 2018. People that did not register under the pilot scheme do not need to worry as the scheme will be fully open by March 2019 and remain open until 31 December 2020 in a 'no deal' scenario, so there will be plenty of time for EU staff to register.
- More information, including where to register, can be found on this [website](#).

Professional regulation (recognition of professional qualifications)

- Health and care professionals (including UK citizens), whose qualification has been recognised and who are registered in the UK before 23:00 on 29 March 2019, will continue to be registered after this point.
- Health and care professionals (including UK citizens), who apply to have their qualification recognised in the UK before 23:00 on 29 March 2019, will have their application concluded under current arrangements.
- Health and care professionals (including UK citizens) with an EU/EEA or Swiss qualification, who apply to have their qualification recognised in the UK from 23:00 on 29 March 2019 will be subject to future arrangements.

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Reciprocal healthcare

- These plans are without prejudice to the rights and privileges available to Irish citizens in the UK, and UK citizens in Ireland, under the Common Travel Area arrangements.
- In a 'no deal' scenario, UK nationals resident in the EU, EEA and Switzerland may experience limitations to their access to healthcare services. The Government is therefore seeking to protect current reciprocal healthcare rights through transitional bilateral agreements with other member states.
- The Government has recently introduced the [Healthcare \(International Arrangements\) Bill](#) to ensure we have the legal powers to enter into such agreements in a 'no deal' scenario. The Bill could support a broad continuance of the existing reciprocal healthcare rights under current EU regulations (such as the European Health Insurance Card).
- The Government will issue advice via www.gov.uk and www.nhs.uk to UK nationals living in the EU, to UK residents travelling to the EU and to EU nationals living in the UK. It will explain how the UK is working to maintain reciprocal healthcare arrangements, but this will depend on decisions by member states. It will set out what options people might have to access healthcare under local laws in the member state they live in if we do not have bilateral agreements in place, and what people can do to prepare. These pages will be updated as more information becomes available.
- As is currently the case, if UK nationals living in the EU face changes in how they can access healthcare, and if they return permanently to the UK and take up ordinary residence here, they will be entitled to NHS-funded healthcare on the same basis as UK nationals already living here.
- It is not possible to quantify how many people might return due to changes in reciprocal healthcare, and it is important to note that people might return to the UK for many other reasons such as changes in legal status or costs of living.

Research and clinical trials

EU research and innovation funding schemes

- The Government has guaranteed funding committed to UK organisations for certain EU funded projects in the event of a 'no deal' scenario. This includes the payment of awards where UK organisations successfully bid directly to the EU while we remain in the EU, and the payment of awards where UK organisations are able to successfully bid to participate as a third country after EU Exit, until the end of 2020.

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- This means that successful bids for EU programme funding until the end of 2020 will receive their full financial allocation for the lifetime of the project.

Clinical networks

- In a 'no deal' scenario, UK clinicians would be required to leave European Reference Networks (ERNs) on 29 March 2019. However, the UK will seek to strengthen and build new bilateral and multilateral relationships – including with the EU – to ensure clinical expertise is maintained in the UK.
- The Department and NHS England are in contact with the ERNs and no action is required at this stage. Further information will be communicated to the NHS and professional bodies in due course.

Clinical trials and clinical investigations

- The Government has issued [guidance](#) on the supply of investigational medicinal products (IMPs) for clinical trials in a 'no deal' scenario.
- The Department continues to engage with the life sciences industry regarding contract research and clinical trials of IMPs and medical devices. The Department is working closely with the NHS and is undertaking a comprehensive assessment of the potential impact of 'no deal' exit on clinical trials and investigations, to gain a greater understanding of those which might be affected by supply issues. This includes examining supply chains for IMPs, medical devices, in vitro diagnostic devices, advanced therapy medicinal products, radioisotopes and other clinical consumables, used in clinical trials and investigations, which originate from, or travel through, the EU and EEA. This assessment aims to conclude in January 2019 and, if necessary, further guidance will be issued thereafter.
- All organisations participating in and/or recruiting patients to clinical trials or clinical investigations in the UK should contact their relevant trial sponsors for confirmation of plans for supply chains for IMPs and medical devices as soon as possible.
- The Department has communicated with Sponsors of trials to emphasise their responsibility for ensuring the continuity of IMP supplies for their trials. The Government will monitor for any clinical trials or clinical investigations impacted due to disruptions to clinical trial supplies. Organisations should therefore continue to participate in and/or recruit patients to clinical trials and clinical investigations from 29 March 2019, unless they receive information to the contrary from a trial sponsor, organisation managing the trial or investigation, or from formal communications.

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Clinical Trial Regulation

- For EU-wide trials, the new EU Clinical Trial Regulation (CTR) will not be in force in the EU on 29 March 2019 and so will not be incorporated into UK law.
- However, the Government has stated the UK will align where possible with the CTR without delay when it does come into force in the EU, subject to usual parliamentary approvals. This will provide certainty for organisations conducting trials in the UK.
- Those organisations carrying out clinical trials should follow the normal process for seeking regulatory approval.

Data sharing, processing and access

- It is imperative that personal data continues to flow between the UK, EU and EEA member states, following our departure from the EU. The Department for Digital, Culture, Media and Sport and the Information Commissioner's Office (ICO) have released guidance on data protection in a 'no deal' scenario, which can be viewed on [gov.uk](https://www.gov.uk) and the ICO [website](https://ico.org.uk).
- The European Commission is unlikely to have made a data protection adequacy decision regarding the UK before EU Exit. An adequacy decision is where the European Commission is satisfied that a transfer of personal data from the EU/EEA to a country outside the EU/EEA would be adequately protected.
- Transfers of personal data from the UK to the EU/EEA should not be affected in a 'no deal' scenario. This is because it would continue to be lawful under domestic legislation for health and adult social care organisations to transfer personal data to the EU/EEA and adequate third countries in the same way we do currently.
- At the point of exit, EU/EEA organisations will consider the UK a third country. This will mean the transfer of personal data from the EU/EEA to the UK will be restricted unless appropriate safeguards are put in place.
- In order to ensure that personal data can continue to be transferred from organisations in the EU/EEA to the UK in the event there is no adequacy decision, alternative mechanisms for transfer may need to be put in place. This is the case even if organisations are currently compliant with the GDPR.
- One solution you could consider, which the ICO states that most businesses find to be a convenient safeguard, particularly when dealing with non-public organisations, is to use one of the standard contractual clauses (SCCs) approved by the EU Commission. Guidance on these SCCs can be found in the links to [gov.uk](https://www.gov.uk) and the [ICO website](https://ico.org.uk)

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above. Further information will be issued in due course. For now, health and adult social care organisations should follow the instructions detailed in Annex A to identify data flows that may be at risk in a 'no deal' exit.

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ANNEX A – Action cards

Card	Audience	Page
1	Providers: <ul style="list-style-type: none"> • NHS Trusts and Foundation Trusts (acute, mental health, community and ambulance services) • Independent providers of NHS services • GP practices • NHS dentists • Community pharmacies • Opticians • NHS 111 providers 	16
2	Commissioners: <ul style="list-style-type: none"> • Clinical Commissioning Groups • Sustainability and Transformation Partnerships/Integrated Care Systems • Specialised commissioning regional teams and hubs • Health and Justice national and regional teams • Armed Forces and their families commissioning team • Local authorities commissioning NHS services 	25
3	NHS England and Improvement regional teams	33

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Card 1 – Action card for providers

Role

All providers of NHS services – including NHS Trusts and Foundation Trusts, primary care organisations and independent sector organisations who provide NHS services – must consider and plan for the risks that may arise due to a ‘no deal’ exit.

All providers should continue with their business continuity planning, taking into account the instructions in this national guidance, incorporating local risk assessments, and escalating any points of concern on specific issues to regional NHS EU Exit or departmental mailboxes listed in this guidance. Officials monitor these mailboxes and will respond to queries. Contact details for the regional NHS EU Exit Teams are included in the overview on page 5.

Clinical Commissioning Groups and NHS England should agree the handling of communications with general practice in line with existing delegation arrangements.

Actions for providers

Local EU Exit readiness preparations

Risk assessment and business continuity planning

- Undertake an assessment of risks associated with EU Exit by the end of January 2019, covering, but not limited to:
 - The seven key areas identified nationally and detailed below.
 - Potential increases in demand associated with wider impacts of a ‘no deal’ exit.
 - Locally specific risks resulting from EU Exit.
- Continue business continuity planning in line with your legal requirements under the Health and Social Care Act 2012, taking into account this guidance and working with wider system partners to ensure plans across the health and care system are robust. These organisational and system-wide plans should be completed at the latest by the end of January 2019.
- Test existing business continuity and incident management plans against EU Exit risk assessment scenarios by the end of February to ensure these are fit for purpose.

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Communications and escalation

All providers to:

- Ensure your board is sighted on EU Exit preparation and take steps to raise awareness amongst staff.
- Ensure Local Health Resilience Partnerships, Local Resilience Forums and Local A&E Delivery Boards are sighted on EU Exit preparation in your local health economy.
- Review capacity and activity plans, as well as annual leave, on call and command and control arrangements around the 29 March 2019, but at this point there is no ask to reduce capacity or activity around this time.
- Be ready for further operational guidance from NHS England and Improvement as contingency planning work progresses.

NHS providers to:

- Confirm escalation routes for different types of issues potentially arising from or affected by EU Exit into the regional NHS EU Exit teams listed in this document.
- Note your nominated regional NHS lead for EU Exit and their contact details (included in the overview on page 5).
- Escalate any issues you have identified as having a potentially widespread impact immediately to your regional EU Exit team.
- Confirm your organisation's Senior Responsible Officer for EU Exit preparation and identify them to your regional EU Exit team as soon as possible. This role should be held by a board level member and will entail providing information returns to NHS England and Improvement, reporting emerging EU Exit-related problems, and ensuring your organisation has updated its business continuity plan to factor in all potential 'no deal' exit impacts. Organisations should also identify named staff to work in a team with the Senior Responsible Officer to support EU Exit preparation, implementation and incident response.

Reporting, assurance and information

NHS providers to:

- Be aware that if additional reporting is required, NHS England and Improvement will provide further guidance on requirements. However, existing reporting from NHS

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organisations will be used to develop a baseline assessment of the EU Exit impact on the health and care system.

- Note that regional NHS EU Exit teams will be in contact shortly to confirm your progress on these actions.
- For queries relating to specific topic areas in this guidance, please contact the relevant departmental mailboxes. Any immediate risks or concerns about provision of NHS service continuity should be escalated to the relevant regional NHS EU Exit mailbox

Supply of medicines and vaccines

All health and adult social care providers to:

- Follow the Secretary of State's [message](#) not to stockpile additional medicines beyond their business as usual stock levels. No clinician should write longer prescriptions for patients. The Department's UK-wide contingency plan for the continued supply of medicines and vaccines from the moment we leave the EU is being developed alongside pharmaceutical companies and other government departments.
- Note that there is no need to contact suppliers of medicines directly.
- Direct staff to promote messages of continuity and reassurance to people who use health and care services, including that they should not store additional medicines at home.
- Note that Chief and Responsible Pharmacists are responsible for ensuring their organisation does not stockpile medicines unnecessarily. Any incidences involving the over-ordering of medicines will be investigated and followed up with the relevant Chief or Responsible Pharmacist directly.
- Note that the Department and NHS England and Improvement are developing arrangements to allow local and regional monitoring of stock levels of medicines.
- Be aware that UK-wide contingency plans for medicines supply are kept under review, and the Department will communicate further guidance as and when necessary.
- Continue to report current shortage issues and escalate queries for medicine supply issues unrelated to current shortages through existing regional communication channels.

Regional pharmacists and emergency planning staff to:

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- Meet at a local level to discuss and agree local contingency and collaboration arrangements. The Chief Pharmaceutical Officer will hold a meeting with the chairs of regional hospital and CCG Chief Pharmacist networks (and representatives of private hospital Chief Pharmacists) in January 2019 to help inform local plans.

Supply of medical devices and clinical consumables

- Note that there is no need for health and adult social care providers to stockpile additional medical devices and clinical consumables beyond business as usual stock levels. Officials in the Department will continually monitor the situation and if the situation changes, will provide further guidance by the end of January 2019.
- Send queries about medical devices and clinical consumables provided by NHS Supply Chain to your usual contact. If you receive medical devices and clinical consumables from other suppliers, you should contact them directly with any queries as you would normally do.
- Be aware that the contingency plan is kept under review, and the Department will communicate further guidance as and when necessary.
- Send queries regarding medical devices and clinical consumables to mdcc-contingencyplanning@dhsc.gov.uk.

Supply of non-clinical consumables, goods and services

All providers to:

- Be aware that NHS Trust and Foundation Trust procurement leads have been asked to undertake internal reviews of purchased goods and services to understand any risks to operations if there is disruption in supply. This excludes goods and services that are being reviewed centrally, such as food, on which the Department has written to procurement leads previously.
- Continue commercial preparation for EU Exit as part of your usual resilience planning, addressing any risks and issues identified through your own risk assessments that need to be managed locally.
- Continue to update local business continuity plans to ensure continuity of supply in a 'no deal' scenario. Where appropriate, these plans should be developed in conjunction with your Local Health Resilience Partnership. All health organisations should be

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engaged in their relevant Local Health Resilience Partnership, which should inform Local Resilience Forum(s) of local EU Exit plans for health and care.

- Be aware that the Department is conducting supply chain reviews across the health and care system, and work is in progress to identify risk areas specific to primary care.
- Await further advice from the Department on what actions should be taken locally.

NHS Trusts and Foundation Trusts to:

- Submit the results of their self-assessment on non-clinical consumables, goods and services to contractreview@dhsc.gov.uk, if not done so already.
- Act upon further guidance to be issued by the Department in January 2019. This will be based on analysis of NHS Trusts and Foundation Trusts' self-assessments.

Workforce

- Assess whether your organisation has incurred a reduction in the number of EU nationals in your workforce before the UK leaves the EU.
- Publicise the EU Settlement Scheme to your health and care staff who are EU citizens. The scheme will open fully by March 2019 and remain open until 31 December 2020 in a 'no deal' scenario, so there will be plenty of time for EU staff to register. Further information can be viewed [here](#).
- Monitor the impact of EU Exit on your workforce regularly and develop contingency plans to mitigate a shortfall of EU nationals in your organisation, in addition to existing plans to mitigate workforce shortages. These plans should be developed with your Local Health Resilience Partnership, feed into your Local Resilience Forum(s) and be shared with your local commissioner(s). Consider the implications of further staff shortages caused by EU Exit across the health and care system, such as in adult social care, and the impact that would have on your organisation.
- Undertake local risk assessments to identify any staff groups or services that may be vulnerable or unsustainable if there is a shortfall of EU nationals.
- Ensure your board has approved business continuity plans that include EU Exit workforce planning, including the supply of staff needed to deliver services.
- Notify your local commissioner and regional NHS EU Exit Team at the earliest opportunity if there is a risk to the delivery of your contracted services.

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- Escalate concerns through existing reporting mechanisms.
- Send queries on workforce to WorkforceEUExit@dhsc.gov.uk.

Professional regulation (recognition of professional qualifications)

- Inform your staff that health and care professionals (including UK citizens), whose qualification has been recognised and who are registered in the UK before 23:00 on 29 March 2019, will continue to be registered after this point.
- Inform your staff that health and care professionals (including UK citizens), who apply to have their qualification recognised in the UK before 23:00 on 29 March 2019, will have their application concluded under current arrangements.
- Await further information from the Government on the future arrangements for health and care professionals (including UK citizens) with an EU/EEA or Swiss qualification, who apply to have their qualification recognised in the UK from 23:00 on 29 March 2019.

Reciprocal healthcare

All providers to:

- Note that, in a no deal scenario, the current arrangements for reciprocal healthcare and for overseas visitors and migrant cost recovery will continue to operate until 29 March 2019, depending on the reciprocal agreements that are concluded.
- Continue to support individuals who apply for NHS authorised treatment or maternity care in another member state (the S2 and cross-border healthcare processes).
- Note that the Department will provide updates and further information on reciprocal healthcare arrangements prior to 29 March 2019.

NHS Trusts and Foundation Trusts to:

- Maintain a strong focus on correctly charging those who should be charged directly for NHS care. Information on implementing the current charging regulations can be viewed on the webpage [here](#).
- Ensure there is capacity available for any further training that may be required if there are changes to the reciprocal healthcare arrangements. This should be undertaken by the Overseas Visitor Management team, and guidance and support materials will be made available to support this training.

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- Note that the Department will provide updates and further information in due course. This information will cover migrant cost recovery charging after 29 March 2019 to enable NHS Trusts and Foundation Trusts to amend processes and train staff if reciprocal healthcare arrangements change.

GP practices to:

- Promote completion of the supplementary questions section of the GMS1 form, and then, as appropriate, send the form to NHS Digital (NHSDigital-EHIC@nhs.net) or the Department for Work and Pensions' Overseas Healthcare Team (overseas.healthcare@dwp.gsi.gov.uk). The response on a person's non-UK EHIC/S1 helps the Department seek reimbursements from EU member states for those who are covered by the reciprocal healthcare arrangements. More information on the GMS1 form can be found [here](#). Further information for primary care staff on providing healthcare for overseas visitors from the EU/EEA can be found [here](#).

Research and clinical trials

EU research and innovation funding schemes

- Note that the Government has guaranteed funding committed to UK organisations for certain EU funded projects in the event of a 'no deal' scenario. This includes the payment of awards where UK organisations successfully bid directly to the EU while we remain in the EU, and the payment of awards where UK organisations are able to successfully bid to participate as a third country after exit, until the end of 2020.
- Provide information about your Horizon 2020 grant [here](#). This should be actioned as soon as possible. Further guidance can be found [here](#) and all queries should be sent to EUGrantsFunding@ukri.org.
- Contact officials at EU-Health-Programme@dhsc.gov.uk with information regarding your Third Health Programme grant, and any queries that you have, as soon as possible.

Clinical trials and clinical investigations

- Follow the Government's [guidance](#) on the supply of investigational medicinal products (IMPs) for clinical trials in a 'no deal' scenario, if you sponsor or lead clinical trials or clinical investigations in the UK.
- Consider your supply chains for those IMPs, medical devices, in vitro diagnostic devices, advanced therapy medicinal products, radioisotopes and other clinical

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consumables, used in clinical trials and investigations, which originate from, or travel through, the EU and EEA as soon as possible if you sponsor or lead clinical trials or investigations in the UK.

- Liaise with trial and study Sponsors to understand their arrangements to ensure that clinical trials and investigations using IMPs, medical devices, IVDs, advanced therapy medicinal products, radioisotopes and other clinical consumables which come from, or via, the EU or EEA, are guaranteed in the event of any possible border delays. If multiple sites are involved within the UK, then co-ordinate with the lead site or Chief Investigator in the UK, or organisation managing the clinical trial/investigation, e.g. Clinical Research Organisation, to ensure a single approach to the Sponsor.
- Respond to any enquires to support the Department's comprehensive assessment of the expected impact of a 'no deal' exit on clinical trials and investigations. The Department is working closely with the NHS to gain a greater understanding of who might be affected by supply issues.
- Continue participating in and/or recruiting patients to clinical trials and investigations up to and from 29 March 2019. This should occur unless you receive information to the contrary from a trial Sponsor, organisation managing the trial or clinical investigation, or from formal communications that a clinical trial or clinical investigation is being impacted due to trial supplies.
- Send queries concerning IMPs or medical devices to imp@dhsc.gov.uk

Data sharing, processing and access

- Investigate your organisation's reliance on transfers of personal data from the EU/EEA to the UK, especially those that are critical to patient care and/or would have a serious impact upon the system if they were disrupted.
- Note that many organisations tend not to disaggregate personal and non-personal data. As such, please be aware that restrictions on personal data may have knock-on effects on data more generally.
- Follow the advice from The Department for Digital, Culture, Media and Sport and the ICO on data protection in a 'no deal' scenario, which can be viewed on gov.uk and on the ICO [website](#), in particular to determine where to use and how to implement standard contractual clauses.
- Ensure that your data and digital assets are adequately protected by completing your annual [Data Security and Protection Toolkit](#) assessment. This self-audit of compliance

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with the 10 Data Security Standards is mandatory to complete by the end of March 2019, but completing it early will enable health and adult social care providers to more quickly identify and address any vulnerabilities.

- Await further guidance, which will be issued to health and care providers in due course. Assistance will also be available through webinars in early 2019.

Finance

- Record costs (both revenue and capital) incurred in complying with this guidance. Costs with a direct financial impact should be recorded separately to opportunity costs. Providers should discuss these costs with their regional NHS EU Exit support team. Feedback from providers will inform decisions on whether further guidance on cost collection is required.

Queries

For queries relating to specific topics areas, providers should contact the departmental mailboxes listed in this guidance:

- Medicine shortage queries should be raised by business as usual routes
- Medical devices and clinical consumables to mdcc-contingencyplanning@dhsc.gov.uk.
- NHS Trusts and Foundation Trusts' self-assessment on non-clinical consumables, goods and services to contractreview@dhsc.gov.uk.
- Workforce to WorkforceEUExit@dhsc.gov.uk.
- Third Health Programme grants to EU-Health-Programme@dhsc.gov.uk.
- [Horizon 2020 grants to EUGrantsFunding@ukri.org](mailto:Horizon2020grants@ukri.org)
- IMPs or clinical devices to imp@dhsc.gov.uk.

Any immediate risks or concerns relating to continuity of NHS service provision should be escalated to the relevant regional NHS EU Exit mailbox.

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Card 2 – Action card for commissioners

Role

In addition to current responsibilities, commissioners – including Clinical Commissioning Groups, Primary Care Commissioning and specialised commissioning – should ensure that their contracted health and care services are ready to manage the risks arising in a ‘no deal’ exit.

Commissioners should continue with their business continuity planning, taking into account the instructions in this national guidance, incorporating local risk assessments and escalating any points of concern on specific issues to the relevant mailboxes.

Commissioners should also liaise with providers of services that they commission, to ensure they are taking account of the actions for providers outlined in this guidance. EU Exit and its implications on health and care services should be discussed at commissioner board level on a regular basis to ensure sufficient oversight.

Actions for commissioners

Local EU Exit readiness preparations

Risk assessment and business continuity planning

- Undertake an assessment of risks associated with EU Exit by the end of January 2019, covering, but not limited to:
 - The seven key areas identified nationally and detailed below.
 - Potential increases in demand associated with the wider impacts of a ‘no deal’ exit.
 - Locally specific risks resulting from EU Exit.
- Continue business continuity planning in line with your legal requirements under the Health and Social Care Act 2012, including taking into account this guidance and working with wider system partners to ensure plans across the health and care system are robust. These organisational and system-wide plans should be completed at the latest by the end of January 2019.
- Support providers to test existing business continuity and incident management plans against EU Exit risk assessment scenarios by the end of February to ensure these are fit for purpose.

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Communications and escalation

All commissioners to:

- Ensure your board is sighted on EU Exit preparation and take steps to raise awareness amongst staff.
- Ensure Local Health Resilience Partnerships, Local Resilience Forums and Local A&E Delivery Boards are sighted on EU Exit preparation in your local health economy.
- Be ready for further operational guidance from NHS England and Improvement as contingency planning work progresses.
- Review capacity and activity plans, as well as annual leave, on call and command and control arrangements around the 29 March 2019.

NHS commissioners to:

- Confirm escalation routes for different types of issues potentially arising from or affected by EU Exit, into the regional NHS EU Exit teams listed in this document.
- Note your nominated regional NHS lead for EU Exit and their contact details (included in the overview at page 5).
- Escalate any issues you have identified as having a potentially widespread impact immediately to your regional EU Exit team.
- Confirm your organisation's Senior Responsible Officer for EU Exit preparation and identify them to your regional EU Exit team as soon as possible. This role should be held by a board level member and will entail providing information returns to NHS England and Improvement, reporting emerging EU Exit-related problems, and ensuring your organisation has updated its business continuity plan to factor in all potential 'no deal' exit impacts. Organisations should also identify named staff to work in a team with the Senior Responsible Officer to support EU Exit preparation, implementation and incident response.

Reporting, assurance and information

NHS commissioners to:

- Be aware that if additional reporting is required, NHS England and Improvement will provide further guidance on requirements. However, existing reporting from NHS

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organisations will be used to develop a baseline assessment of the EU Exit impact on the health and care system.

- Note that regional NHS EU Exit teams will be in contact shortly to confirm your progress on these actions.
- For queries relating to specific topics areas in this guidance, please contact the relevant departmental mailboxes. Any immediate risks or concerns about provision of NHS service continuity should be escalated to the relevant regional NHS EU Exit mailbox.

Supply of medicines and vaccines

- Promote the Secretary of State's [message](#): healthcare providers should not stockpile medicines beyond their business as usual stock levels, and no clinician should write longer prescriptions for patients. The Department's UK-wide contingency plan for the supply of medicines and vaccines is being developed alongside pharmaceutical companies and other government departments.
- Advise providers that there is no need to contact suppliers of medicines directly.
- Ensure providers are encouraging staff to reassure patients that they should not store additional medicines at home as the Government is working with industry to ensure a continued supply of medicines from the moment we leave the EU.
- Inform providers that Chief and Responsible Pharmacists are responsible for ensuring their organisation does not stockpile medicines unnecessarily. Any incidences involving the over-ordering of medicines will be investigated and followed up with the relevant Chief or Responsible Pharmacist directly.
- Inform providers that the Department and NHS England and Improvement are developing arrangements to allow local and regional monitoring of stock levels of medicines.
- Be aware that the UK-wide contingency plan for medicines and vaccines is kept under review, and the Department will communicate further guidance as and when necessary.
- Share letters from the Department aimed at an NHS and wider health and care provider audience (such as the third sector, private sector and home care).

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- Note that the Department has engaged directly with specialist commissioning leaders about prisons and defence. This is to address their specific needs and concerns relating to medicine supply.
- Continue to report current shortage issues and escalate queries for medicine supply issues unrelated to current shortages through existing regional communication channels.

Regional pharmacists and emergency planning staff to:

- Meet at a local level to discuss and agree local contingency and collaboration arrangements. The Chief Pharmaceutical Officer will hold a meeting with the chairs of regional hospital and CCG Chief Pharmacist networks (and representatives of private hospital Chief Pharmacists) in January 2019 to help inform local plans.

Supply of medical devices and clinical consumables

- Note that there is no need for health and adult social care providers to stockpile additional medical devices and clinical consumables beyond business as usual stock levels. Officials in the Department will continually monitor the situation and if the situation changes, we will provide further guidance by the end of January 2019.
- Send queries about medical devices and clinical consumables provided by NHS Supply Chain to your usual contact. If you receive medical devices and clinical consumables from other suppliers, you should contact them directly with any queries as you would normally do.
- Be aware that the contingency plan is kept under review, and the Department will communicate further guidance as and when necessary.
- Send queries regarding medical devices and clinical consumables to mdcc-contingencyplanning@dhsc.gov.uk.

Supply of non-clinical consumables, goods and services

- Be aware that the Department is conducting supply chain reviews across the health and care system, and work is in progress to identify risk areas specific to primary care, adult social care and public health services.

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- Continue commercial preparation for EU Exit as part of your usual resilience planning, addressing any risks and issues identified through your own risk assessments that need to be managed locally.
- Check your providers continue to update their local business continuity plans to ensure continuity of supply in a 'no deal' scenario.
- Await further advice from the Department on where actions should be taken locally by commissioners and providers of NHS-commissioned services.

Workforce

- Ensure healthcare providers that deliver your commissioned services publicise the EU Settlement Scheme to their health and care staff who are EU citizens, and support them to apply for the scheme.
- Monitor the workforce impacts of EU Exit in your primary and secondary care providers' business continuity plans and highlight risks to WorkforceEUExit@dhsc.gov.uk.
- Ensure your providers' board-approved business continuity plans include workforce planning.
- Assess whether your organisation has incurred a reduction in the number of EU nationals in your workforce before the UK leaves the EU.
- Publicise the EU Settlement Scheme to your staff who are EU nationals and actively support them to apply for the scheme when it opens in March 2019. Further information can be viewed [here](#).
- Monitor the impact of EU Exit on your own workforce regularly, and update your local business continuity plans as necessary.
- Send workforce queries to WorkforceEUExit@dhsc.gov.uk

Professional regulation (recognition of professional qualifications)

- Inform your staff and healthcare providers that health and care professionals (including UK citizens), whose qualification has been recognised and who are registered in the UK before 23:00 on 29 March 2019, will continue to be registered after this point.

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- Inform your staff and healthcare providers that health and care professionals (including UK citizens), who apply to have their qualification recognised in the UK before 23:00 on 29 March 2019, will have their application concluded under current arrangements.
- Await further information from the Government on the future arrangements for health and care professionals (including UK citizens) with an EU/EEA or Swiss qualification, who apply to have their qualification recognised in the UK from 23:00 on 29 March 2019.

Reciprocal healthcare

- Note that, in a 'no deal' scenario, the current arrangements for reciprocal healthcare and for overseas visitors and migrant cost recovery will continue to operate until 29 March 2019, depending on the reciprocal agreements that are concluded.
- Inform NHS Trusts and Foundation Trusts that they should continue to maintain a strong focus on correctly charging those who should be charged directly for NHS care.
- Note that the Department will provide updates and further information in due course. This information will cover migrant cost recovery charging after 29 March 2019 to enable NHS Trusts and Foundation Trusts to amend processes and train staff if reciprocal healthcare arrangements change.

Research and clinical trials

- Note that the Government has guaranteed funding committed to UK organisations for certain EU funded projects in the event of a 'no deal' scenario. This includes the payment of awards where UK organisations successfully bid directly to the EU while we remain in the EU, and the payment of awards where UK organisations are able to successfully bid to participate as a third country after Exit, until the end of 2020.
- Ensure your providers who receive Horizon 2020 grants input basic information about their awards into a portal, which can be accessed [here](#), as soon as possible. Further guidance can be found [here](#) and all queries should be sent to EUGrantsFunding@ukri.org.
- Ensure your providers who receive Third Health Programme grants contact officials at EU-Health-Programme@dhsc.gov.uk with information regarding their awards and any queries that they have, as soon as possible.

EU Exit Operational Readiness Guidance**Clinical trials and clinical investigations**

- Support your providers to respond to the Department's comprehensive assessment of the expected impact of a 'no deal' exit on clinical trials and investigations. The Department is working closely with the NHS to gain a greater understanding of who might be affected by supply issues.
- Support your providers who run clinical trials or investigations in the UK to consider their supply chains for those IMPs, medical devices, in vitro diagnostic devices, advanced therapy medicinal products, radioisotopes and other clinical consumables which come from, or via, the EU or EEA as soon as possible. Providers should contact relevant trial Sponsors, and if multiple sites are involved within the UK, then co-ordinate with the lead site or Chief Investigator in the UK, or organisation managing the clinical trial/investigation, e.g. Clinical Research Organisation, to ensure a single approach to the Sponsor.
- Support your providers to participate in and/or recruit to clinical trials and investigations up to and from 29 March 2019. This should occur unless providers receive information to the contrary from a trial Sponsor, organisation managing the clinical trial or investigation, or from formal communications that a clinical trial or clinical investigation is being impacted due to trial supplies.
- Send queries concerning IMPs or medical devices to imp@dhsc.gov.uk.

Data sharing, processing and access

- Investigate your organisation's reliance on transfers of personal data from the EU/EEA to the UK, especially those that are critical to patient care and/or would have a serious impact upon the system if they were disrupted.
- Note that many organisations tend not to disaggregate personal and non-personal data. As such, please be aware that restrictions on personal data may have knock-on effects on data more generally.
- Follow the advice from The Department for Digital, Culture, Media and Sport and the ICO on data protection in a 'no deal' scenario, which can be viewed on gov.uk and on the ICO [website](#), in particular to determine where to use and how to implement standard contractual clauses.
- Ensure that your data and digital assets are adequately protected, by completing your annual [Data Security and Protection Toolkit](#) assessment. This self-audit of compliance with the 10 Data Security Standards is mandatory, to be completed by end March

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2019, but early completion will enable health and adult social care organisations more time to identify and quickly address any vulnerabilities.

- Await further guidance, which will be issued to health and care providers in due course. Assistance will also be available through webinars in early 2019.

Finance

- Record costs (both revenue and capital) incurred in complying with this guidance. Costs with a direct financial impact should be recorded separately to opportunity costs. Commissioners should discuss these costs with their regional NHS EU Exit support team. Feedback from commissioners will inform decisions on whether further guidance on cost collection is required.

Queries

For queries relating to specific topics areas, commissioners should contact the departmental mailboxes listed in this guidance:

- Medicine shortage queries should be raised by business as usual routes
- Medical devices and clinical consumables to mdcc-contingencyplanning@dhsc.gov.uk.
- NHS Trusts and Foundation Trusts' self-assessment on non-clinical consumables, goods and services to contractreview@dhsc.gov.uk.
- Workforce to WorkforceEUExit@dhsc.gov.uk.
- Third Health Programme grants to EU-Health-Programme@dhsc.gov.uk.
- [Horizon 2020 grants to EUGrantsFunding@ukri.org](mailto:Horizon2020GrantsFunding@ukri.org)
- IMPs or clinical devices to imp@dhsc.gov.uk.

Any immediate risks or concerns relating to continuity of NHS service provision should be escalated to the relevant regional NHS EU Exit mailbox.

EU Exit Operational Readiness Guidance

Card 3 – Action card for NHS England and Improvement regional teams

Role

In addition to current responsibilities, NHS regional teams will be required to provide regional system oversight in a 'no deal' scenario. The forthcoming NHS EU Exit Operational Support Structure will operate at a national and regional level, and support existing regional teams. Its functions will include monitoring local preparations, responding to the escalation of issues, and co-ordinating assurance and reporting arrangements at regional level.

NHS regional teams should communicate the necessary actions to providers and commissioners, and ensure that these instructions are being followed. This assurance should be gained through reporting on resilience and business continuity plans, and through existing meetings with providers and commissioners in your area. Once the dedicated NHS EU Exit regional teams are established, they will undertake assurance of local business continuity plans in relation to EU Exit.

Regional NHS leads and mailboxes for EU Exit have been established. Further details of the structure and function of the regional operational support teams will be communicated as the functions are implemented.

EU Exit Operational Readiness Guidance

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Global and Public Health Directorate / EU and International Health / EU Exit Preparedness

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Attachment L

Trust Board 7 February 2019	
Patient Story- AB	Paper No: Attachment L
Submitted on behalf of Alison Robertson, Chief Nurse	
Aims / summary The Great Ormond Street Hospital Patient Experience Team works in partnership with ward and service managers, the Patient Advice and Liaison Service (PALS), and the Complaints and Patient Safety Teams to identify, prepare and present suitable patient stories which are selected to represent a range of experiences across a variety of wards and service areas spanning different directorates and ensuring that the experiences of families are captured. The story to be shared on 7 February 2019 will be in person. The patient (Alfie, aged 11) provided the voiceover for an animated film designed to help patients and families understand more about cleft lip palate and how it is treated. Both Alfie and his brother had bone graft treatments at GOSH and Alfie hopes that the film will help other patients feel less anxious and prepared for treatment. Alfie will share his experiences of GOSH including what was important to him and how we can improve.	
Action required from the meeting Review and comment	
Contribution to the delivery of NHS Foundation Trust strategies and plans <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	

Alfie's Story

The child first and always 



Alfie, aged 11, provided the voiceover for an animated film designed to help patients and families understand more about cleft lip palate and how it is treated.

Both Alfie and his brother had bone graft treatments at GOSH.

Alfie hopes that the film will help other patients feel less anxious and more prepared for treatment.

This story explores Alfie's experiences at GOSH.

<https://www.youtube.com/watch?v=YZanCoBSkac>



Any questions?

The child first and always



Attachment P

Trust Board 7 February 2019	
Integrated Quality Report	Paper No: Attachment P
<p>Submitted by: Dr Sanjiv Sharma, Acting Medical Director Alison Robertson, Chief Nurse</p>	
<p>Aims / summary The aim of the Integrated Quality Report is to provide an overview of quality, safety and patient experience across the Trust. This information includes:</p> <ul style="list-style-type: none"> • whether patient care has been safe in the past and safe in the present time • how the Organisation is hearing and responding to the feedback and experience of our children and young people and parents • what the Organisation is doing to ensure that we are implementing and monitoring the learning from our data sources e.g. (PALS, FFT, Complaints and external reports as appropriate) <p>Following feedback, the report has been reviewed and amended. The report now also contains</p> <ul style="list-style-type: none"> • featured clinical outcome to monitor effectiveness • learning from deaths summary • clinical audit overview • patient experience report which analyses trends across complaints, PALS and FFT <p>Executive Summary- Key Findings: The following key findings from within the report have been identified:</p> <ul style="list-style-type: none"> • there has been a statistically significant reduction in the number of cardiac arrests outside ICU • there has been a trend of information governance incidents; this report includes a new serious incident and learning from a recently closed information governance serious incident • there has been an increase in feedback about the standard of nursing care which is being addressed through a Trust wide ongoing Core Care programme to ensure basic care needs are met • the FFT response rate increased to 16.5% and Directorates have produced action plans outlining how they will meet the Trust target of 25% 	
<p>Action required from the meeting To note the style and content of the report, providing any feedback or requested changes to the Acting Medical Director and Chief Nurse to note the on-going work supporting any suggested changes to work streams.</p>	
<p>Contribution to the delivery of NHS Foundation Trust strategies and plans The work presented in this report contributes to the Trust's objectives.</p>	
<p>Financial implications No additional resource requirements identified</p>	

Attachment P

Who needs to be told about any decision? Quality and Safety team, Patient Experience team, Directorate Management teams
Who is responsible for implementing the proposals / project and anticipated timescales? Directorate Management teams with support where needed, Quality and Safety team, Patient Experience team
Who is accountable for the implementation of the proposal / project? Acting Medical Director and Chief Nurse



Integrated Quality Report

Dr Sanjiv Sharma, Acting Medical Director
Alison Robertson, Chief Nurse
January 2019
(covering November-December 2018)

Safe

Effective

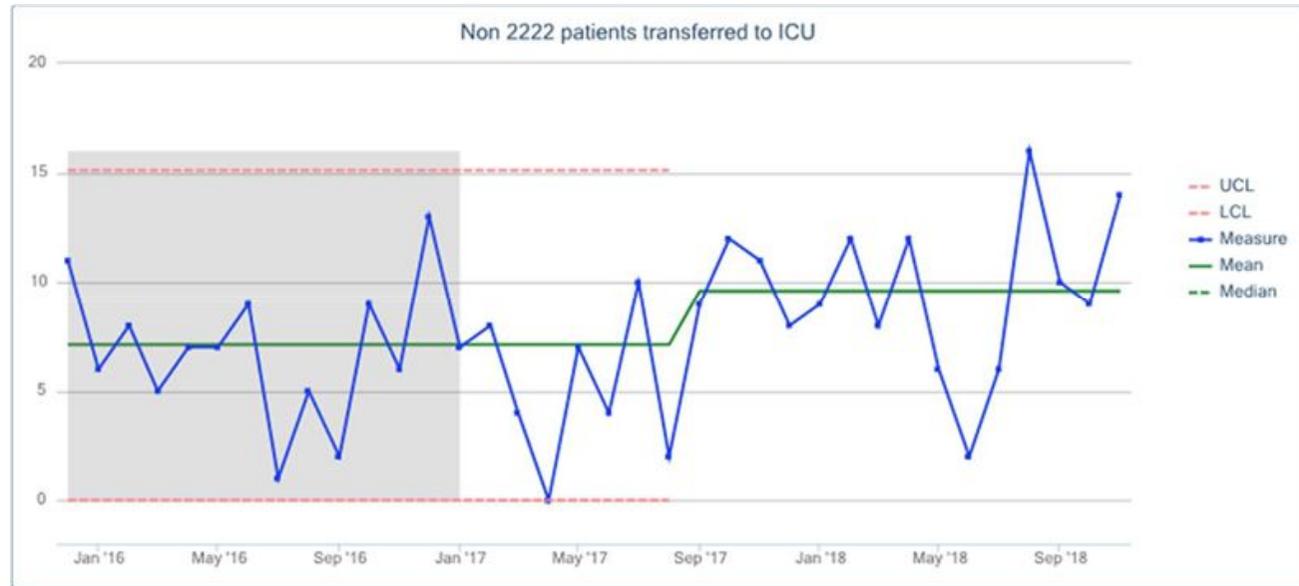
Caring

Responsive

Well- Led

Contents	Page number:
Patient Safety Measures	Page 3-10
New SIs and Never Events	Page 11
Learning from Closed SIs and Never Events	Page 12
Clinical Audit-learning from priority audit plan	Page 13
Clinical Audit- specialty led	Page 14
Learning from Deaths	Page 15
Clinical Outcomes Programme at GOSH	Page 16
Featured Clinical Outcomes- Anaesthesia	Page 17
Feature Quality Improvement Project- Early Warning Dashboard	Page 18
Patient Experience Report including Complaints, FFT and PALS	Page 19
Complaints, PALS and FFT	Page 20
PALS Q3	Page 21
Complaints Q3- formal complaints by Directorate	Page 22
Complaints Q3- top ten themes	Page 23
Complaints- red complaints	Page 24
Complaints- learning from complaints	Page 25
FFT response rate by Directorate	Page 26
FFT % Recommendation by Directorate	Page 27
FFT: Outpatient Responses	Page 28
Qualitative Comments - Parents	Page 29
Learning from feedback: core care	Page 30
Patient Experience- highlights of Q3	Page 31
Spotlight on Takeover Challenge	Page 32

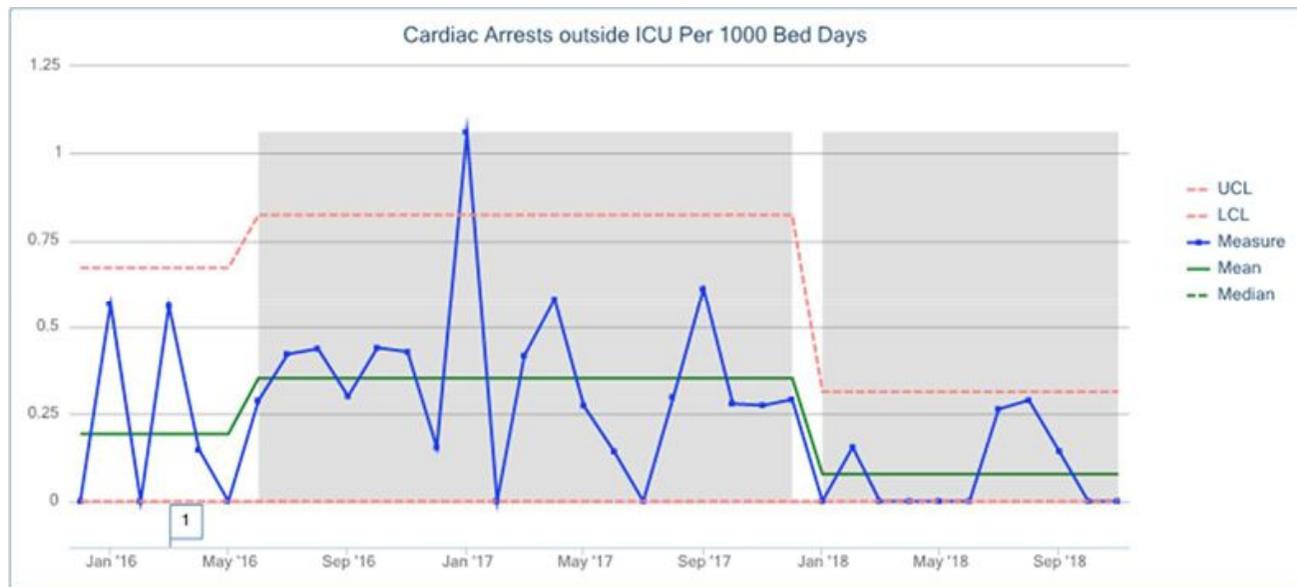
Patient Safety Measures Unplanned transfers to ICU



There is currently an average of 10 (9.60) unplanned non-2222 call patients transferred to ICU per month. This is an increase on the previous baseline, where there was an average of 7 (7.12) patients transferred each month.

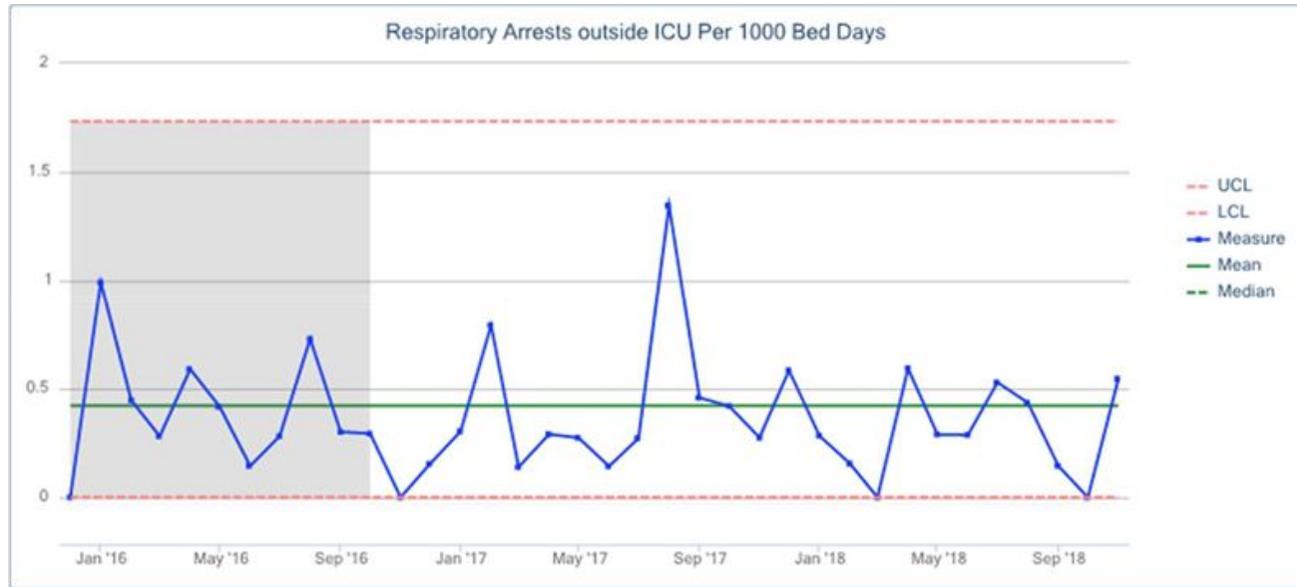
Unplanned admissions to ICU peaked in September 2018 and was reported to the Trust Patient Safety and Outcomes Committee (PSOC); on further review it was noted that a number of patients were transferred from Theatre to PICU post-operatively and were included in the number. These patients do not meet the criteria for an unplanned admission as the need for an ITU bed would have been pre-empted as a result of the potential surgery.

Patient Safety Measures Cardiac Arrests Outside ICU



There has been a recently identified statistically significant reduction in the number of cardiac arrests outside ICU per 1000 bed days per month. The current average is 0.08 cardiac arrests per 1000 bed days, a massive improvement on the previous baseline average of 0.35 per 1000 bed days. This reduction has been sustained.

Patient Safety Measures Respiratory Arrests Outside ICU



There is an average of 0.42 respiratory arrests outside ICU per 1000 bed days per month. This has remained stable since the end of 2015. Most recent months are comfortably within normal limits – no increases or decreases and nothing to hint at otherwise.

Patient Safety Measures Never Events



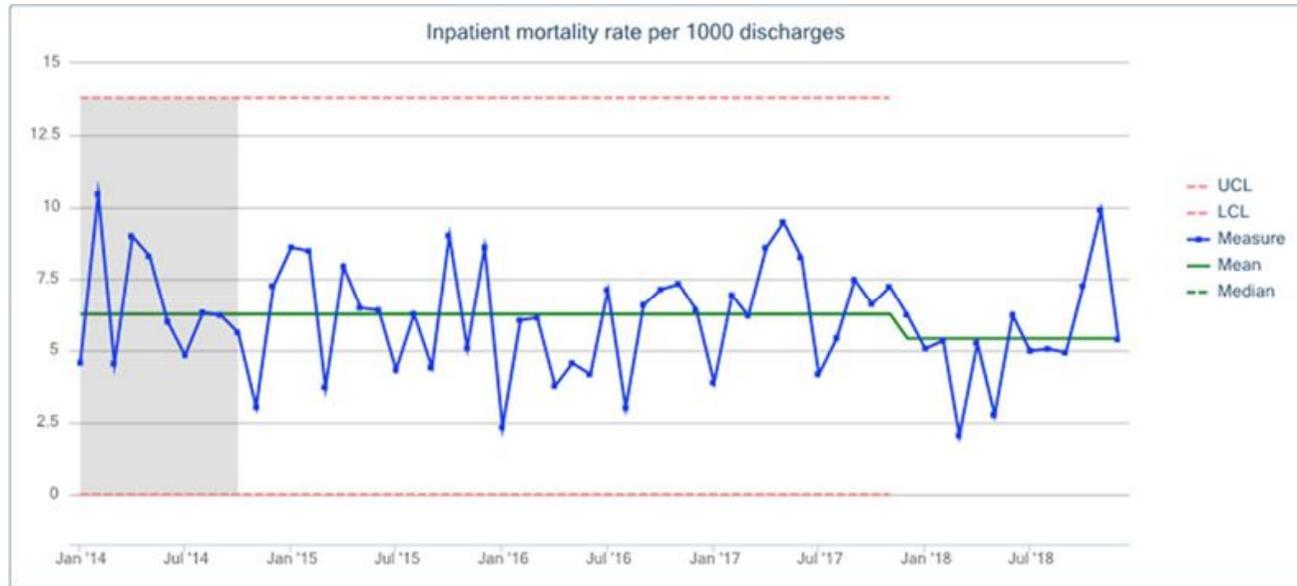
On average, there is a never event at the Trust every 220 days. The last Never Event was on 23rd March 2018, meaning there have been no never events in the previous 3 quarters. The Never Event declared in March 2018 was for a retained foreign object.

Patient Safety Measures Serious Incidents



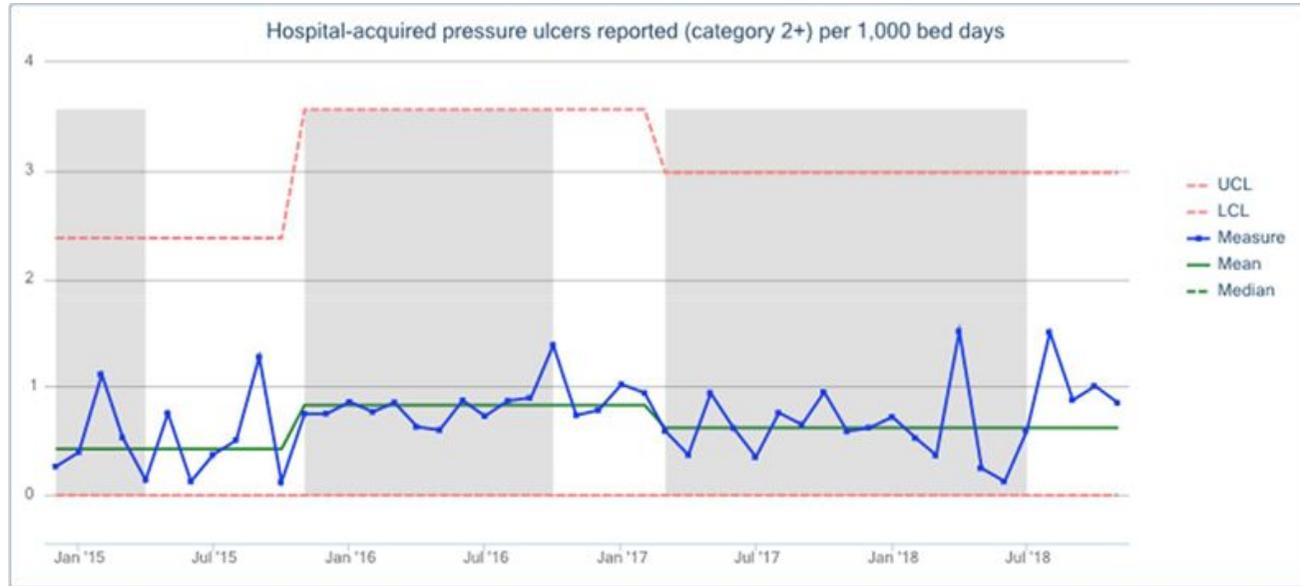
There is currently an average of 2 serious incidents per month, an increase of the previous average of 1 per month. It remains to be seen whether this increase is sustained, but it does not look likely. There has been a recent trend in information governance incidents; there were three information governance SIs declared in the Trust between September and December 2018.

Patient Safety Measures Inpatient Mortality



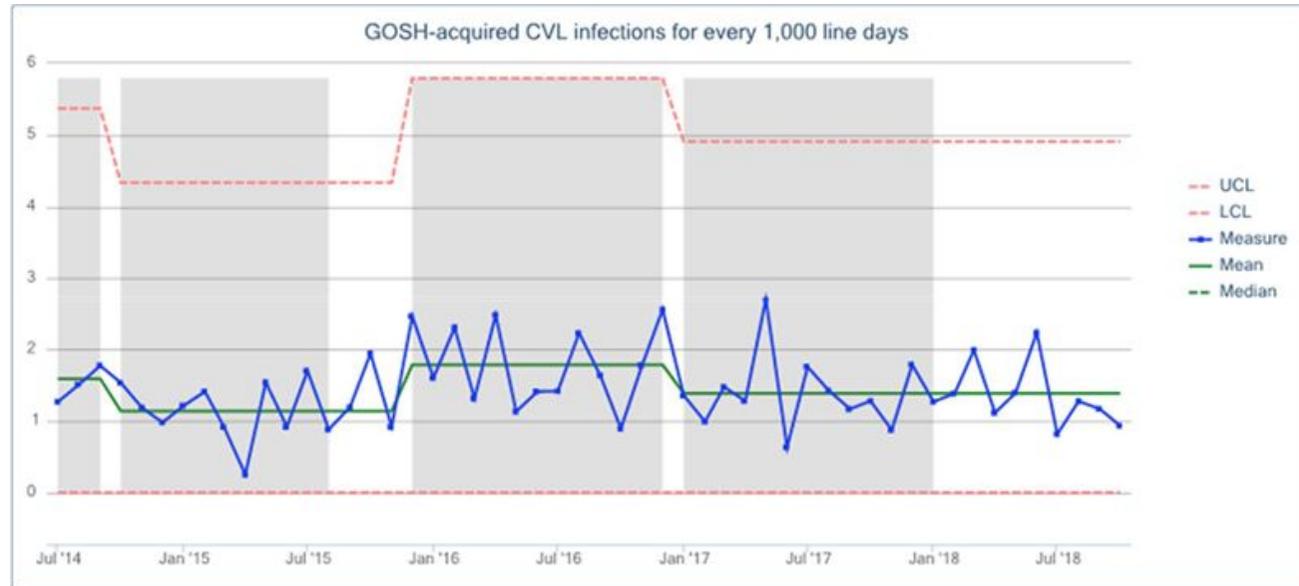
There has been a recently identified decrease in the inpatient mortality rate per 1000 discharges. The current average is 5.43, an improvement of the previous average of 6.28. The timing of this decrease aligns with safety improvement project moving from CEWS to PEWS across the Trust. We hope to be able to say that this statistically significant decrease has been sustained within the next couple of months.

Patient Safety Measures Pressure Ulcers



There is a current average of 0.62 category 2+ pressure ulcers per 1000 bed days per month, this is a decrease (improvement) on the previous average of 0.83 per 1000 bed days per month.

Patient Safety Measures CVL Infections



There is currently an average of 1.38 CVL infections per 1000 line days across the Trust. This is an improvement on the previously baselined average of 1.78 per 1000 line days.

Patient Safety New Serious Incidents and Never Events

Serious Incidents and Never Events in November- December 2018			
No of new SIs declared in November- December 2018:	1	No of new Never Events declared in November- December 2018:	0
No of closed SIs/ Never Events in November- December 2018:	3	No of de-escalated SIs/Never Events in November- December 2018:	0
The learning from the closed SIs can be found on the following slide. Further feedback is awaited from NHS England on 2 out of 3 of the SIs and those closed summaries will be included in the next report following receipt of this information.			

New SIs/Never Events declared in November-December(1)								
STEIS Ref	Incident Date	Date Report Due	Description of Incident	Directorates Involved	Patient Safety Manager	Executive Sign Off	Directorate Contact	Remedial action taken on incident identification?
2018/26315	22/10/18	30/01/19	Information Governance Breach-public area	N/A	Patient Safety Manager	Medical Director	N/A	Information retrieved within 24 hours of notification

Patient Safety learning from closed SIs and Never Events

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

Ref:	Summary:	Root Cause:	Action to Remedy Root Cause:	Trust Wide Learning:
2018/22597	<p>Information Governance breach. Subject Access Request redaction error.</p> <p>In September 2017 the Trust received a Subject Access Request for all emails which contained any personal information of an individual patient. An email search was conducted and all relevant emails were collated. As part of the process 14,818 emails as pdf documents were reviewed for any content which shouldn't be released by the Health Records team. The Health records team identified 84 separate instances of third party data. These were marked by the team for removal before release, using a tool within Adobe Pro. After approval, this data was redacted from the electronic record by accepting the marked redactions using the Redaction tool in Adobe Pro.</p> <p>The final copy of emails was released electronically in April 2018 and sent to the individual requester electronically via securesend, an encrypted portal which allows for large documents to be sent securely.</p> <p>Following receipt of their SAR, the requester responded to the Trust. Part of their letter explained that third party data was accessible in the pdf documents which had been released. This had been viewed by the requestor who had been able to remove the redactions applied by the Health Records team.</p> <p>On initial investigation it was found that while the reactions had been applied to the correct information, the data was still accessible by highlighting and copying this information. This is because staff had not ticked a box within adobe pro which removed the metadata and the redactions were not applied to a layer within the file which contained a copy of the text.</p>	<p>The root cause of the incident has been assessed as an error in the task of applying redactions by a member of staff. However, a combination of factors resulted in the inappropriate release of this data and it is clear that an increase in staff knowledge of the redaction procedure, clear guidance on the process and continuity of the software used for redaction would have prevented this from occurring. It has also been noted that this was an error that was unknown or unexpected by the team, and as such, safeguards to prevent this occurrence were minimal.</p>	<ol style="list-style-type: none"> 1. Development of specific guidance on procedure for redaction using the two software systems available, adobe pro and Nitro. 2. A specific additional quality check to be included in the redaction process by Health records prior to data release. 3. Formalised training for health records staff involved in the redaction process. 4. Consideration of the whole process of SAR with specific consideration into email searches and removal of non-relevant data. 5. Review of open and previously completed Subject Access Requests. 	<p>If redactions are to be applied to any file type, consideration should be taken to not just the information to be redacted but also the method of redaction and checks should be made to confirm this has been successful.</p>

Clinical Audit

learning from priority audit plan



A central clinical audit plan prioritises clinical audit to support learning from incidents, risk, patient complaints, and to investigate areas for improvement in quality and safety.

Examples of current and recently completed priority clinical audits

Source	Context	Progress
Learning from complaints	All dental procedures involving haemophilia patients must be communicated between the two teams to ensure appropriate cover for procedures.	Completed There is evidence that the action agreed has been implemented as agreed following the complaint. Post implementation of the recommendation (March 2018), there is evidence that the Haemophilia team and the Dental and Maxillofacial team communicated pre and post surgery in order to provide the appropriate cover of care. There is no clinical risk identified in this audit and the actions agreed have been implemented effectively
Implementation of action following SI	Re-audit of implementation of pre-operative consent clinic for elective cardiac surgery.	Audit completed in Nov 18 The agreed target for full implementation of the pre-operative consent clinic has not been achieved. There has been some improvement noted in consent forms being started at pre-admission for elective cardiac surgery, but not all surgeons are engaged in the process, and some logistical issues are in place. Has been shared with the Directorate management team to determine next steps
Incidents reporting/Red complaint	Re-audit to assess the frequency of Orthopaedic and Spinal consultant review for long term admissions on Sky Ward. In addition the audit will be extended to review the frequency of consultant attendance across a number of surgical specialities.	There has been an improvement in the number of Spinal/Orthopaedic inpatient days where there is evidence that a Spinal/Orthopaedic Consultant had reviewed the patient on Sky Ward (18% in Sep/Oct c/w 2% Mar-May). The data represents a reasonable reflection of Spinal and Orthopaedic surgeon attendance on the ward, and the results represent safe and appropriate levels of Spinal/Orthopaedic Consultant/Fellow attendance. No further action is required in relation to this audit
Implementation of patient safety alert (NG Tubes)	An audit of best practice of naso-gastric tube management was reported to PSOC in April 2018 and showed: <ul style="list-style-type: none"> positive practice of testing the position of Nasogastric tube testing, and awareness of the techniques that should be avoided. non-compliance with standards for documentation of process. Re-audit to review and support documentation of best practice with documentation of NGT.	Data collection in progress
Documentation of post-operative infection in the consent process Spinal Surgery	GOSH spinal surgery infection rates have been flagged by Public Health England for Surgical Site Infections Q42017 and Q1 2018. audit found that the documented risk of infection as part of the consent process for neuromuscular patients having spinal surgery was not in line with the infection rates noted at GOSH. In many cases a 1% risk was being documented as being discussed, when the infection rate can be between 3-8%. This will be re-audited in December 2018 to review whether a request from the Medical Director to change practice has been actioned.	Data collection in progress

"Clinical audit is a way to find out if healthcare is being provided in line with standards and lets care providers and patients know where their service is doing well, and where there could be improvements. The aim is to allow quality improvement to take place where it will be most helpful and will improve outcomes for patients."
[NHS England definition]

Clinical Audit specialty led

In addition to the priority plan of audit, support and governance is provided for clinical teams to do clinical audit that supports the quality of care at GOSH. Summary reports of new and completed clinical audits are shared on the Trust intranet, sent to the SLT membership, and reported monthly to the Patient Safety and Outcomes Committee. This helps ensure that there is appropriate oversight and that learning is shared.

Clinical Audit Prize The Clinical Audit team have developed a quarterly clinical audit prize. This will help promote, value, and incentivise sharing of clinical audit in the Trust. In addition this will support our mandatory reporting of clinical audit activity for regulatory purposes (CQC, Quality Report)

Clinical Audit prize

We want to make sure that clinical audits that our staff undertake to review quality are acknowledged and valued.

- If your team have completed a clinical audit in the last three months and wish to enter, please do by:
 - Writing down in 250 words or less how the work has or will help your team to 'achieve the best possible outcomes, through providing the safest, most effective and efficient care'.
 - Attach a brief presentation or report and email to: Audits.Prize@nhs.uk
- Headline for website: Weekly 1000 members. Winner to be announced January 2019. Contributions will be provided to all winners.
- Not in the best interest of you, they may be used in quality work, dependent on clinical



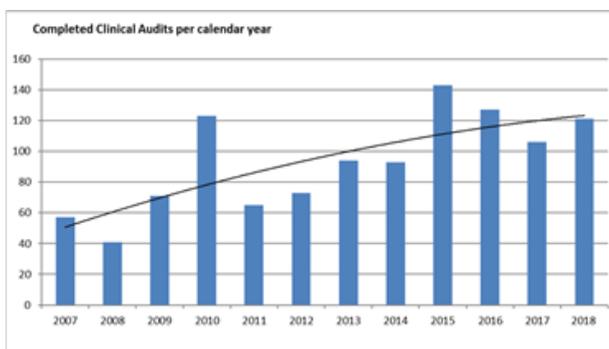
Ten high quality entries have been received and are being evaluated

Sharing audit findings

The GOSH CQC inspection report published in April 2018 highlights a culture of using clinical audit to review and improve care.

"There was a culture of reflection, assessment and audit amongst teams and services who led projects to improve patient care. For example, before relaunching a new nutrition pathway the dietetics team completed an audit of patient documentation" "The ear, nose and throat team had a significant track record of reviewing service experiences with patients and their parents. Examples such as these were evident across the hospital"

Our long term data suggests we are encouraging a culture of sharing our specialty led clinical audit activity



Some examples of clinical audits completed in Q3 that have supported the Trust aim to achieve the best possible outcomes through providing the safest, most effective and efficient care:

Ventilator prescriptions on Kangaroo and Leopard Ward

Improvement in the completion and application of ventilator prescription. Nurses have a more robust and clear way of communicating and checking what settings the child's ventilator should be on. This has led to there being no clinical incidents surrounding ventilator prescriptions with inpatients.

Use of Imaging Studies in Evaluating Patients after Bladder Augmentation

"Through this audit, we have instigated change that will save resources & costs for the trust, improve the patient pathway and importantly reduce un-necessary radiation exposure for these patients."

Evaluation of the Outcome of Bilateral Developmental dysplasia of the hip treated by a standard protocol

"made some changes to our plaster cast splinting regime, abandoned closed reduction for some high dislocations and advised that open reductions are performed by senior surgeons"

Evaluation of referral pathway for Urodynamic Requests

"This audit is a good example of a complete audit cycle. Problems were identified and quantified, changes made to address the problems and re-audit done to confirm significant positive outcomes. Audit has shown that changes to the pathway have led to significant improvements in patients going more quickly on to the waiting list."

"Just wanted to feedback that I think the clinical audit prize is a great idea. They are often thankless tasks that require a lot of work from junior members of the department with little recognition."

GOSH Senior House Officer

Learning from deaths

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.

Child Death Review Statutory Guidance published in October 2018

Additional resources and planning will need to put into place to meet the new requirements of the guidance. NHS England confirmed in writing on the 12 December that

“In the legislation, Medical Directors of NHS Trusts and Foundation Trusts are charged with ensuring that regular local multi-professional Child Death Review Meetings (CDRMs) are held to review all child deaths declared by members of their staff.

These meetings will need to be flexible and vary according to the circumstances of each child’s death and the practitioners involved. Trusts are required to have these arrangements in place by 29 September 2019”

An initial meeting at GOSH of key stakeholders took place on the 10th December to establish the next steps in meeting the requirement. A follow up meeting to clarify resources to plan the implementation is anticipated to take place in January 2019.

Learning from the Mortality Review Group : review of deaths that occurred in Q2 2018/19

Twenty children died at GOSH between 1st July and 31st September 2018. Case record reviews have been completed for 18 patients.

- One case cannot be reviewed until notes can be made available following post mortem.
- One case was not able to reviewed as the December 2018 MRG meeting was not quorate.

Of the 18 cases reviewed:

No cases had a modifiable factor in the child’s care at GOSH that may have contributed to vulnerability, ill health or death (influence score 2).

One death resulted from an unexpected complication of a procedure at GOSH. Local review found that there were no modifiable factors in the care at GOSH that could prevent future deaths, but the team is conducting a formal investigation as a Serious Incident .

The table below provides a summary of the deaths that occurred during the quarter using NHS England reporting guidance.

Total number of inpatient deaths at GOSH between 1st July and 31 st September 2018	20
Number of those deaths subject to case record review by the MRG	18
Number of those deaths investigated under the serious incident framework and declared as serious incidents	1
Number of deaths where a modifiable factor was identified at GOSH with an influence score of 2	0
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	1
Number of deaths of people with learning disabilities that have been reviewed	1
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

Page 15 of 32



Learning points for deaths occurring in Q2 2018/19

The following learning points have been identified.

Documentation

- The MCCD is an important legal document and must be completed correctly.

Clinical Care

- Early involvement of specialist teams is very helpful, particularly in ‘adult’ conditions not commonly seen in children.
- Unexpected surgical emergencies are likely, albeit infrequent, during interventional procedures. An SOP for such unexpected emergencies is useful.
- Multidisciplinary teamwork provides the best possible outcomes, particularly for complex patients with multiple problems
- Acute / unexpected collapse in an infant is commonly due to sepsis, or cardiac, metabolic, endocrine causes. A high index of suspicion must be maintained for all potential causes of deterioration in an infant who is unwell.

Support

- Family support is essential for all patients at GOSH; international patients, or those where English is not their first language may require additional guidance and support, particularly when a child dies.

A report that highlights the learning points and a summary of cases will be reported to the Patient Safety and Outcomes Committee on the 9th January

Modifiable factors to prevent future deaths

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

Clinical Outcomes Programme at GOSH

The Clinical Outcomes Programme supports clinical teams to establish their outcome measures, and collect, analyse and publish their outcomes data to the Clinical Outcomes Hub and the Trust website. Where possible, we seek to benchmark with other paediatric centres of excellence.

Clinical outcomes are broadly agreed, measurable changes in health or quality of life that result from our care.



Brain

- [Epilepsy measure development](#)



Body, Bones and Mind

- [SNAPS dashboard \(Hub\)](#)
- [Urology dashboard \(Hub\)](#)
- [Urology \(Trust website\)](#)



Operations and Images

- [Anaesthesia \(Trust website\)](#)



Sight and Sound

- [Plastic Surgery and OT \(Trust website\)](#)



Blood, Cells and Cancer

- [BMT \(Trust website\)](#)
- [Haemophilia \(Trust website\)](#)
- [HIV \(Trust website\)](#)
- [Palliative Care \(Trust website\)](#)



Heart and Lung

- Exploring publication of ICU measures to Hub
- Exploring new cardiac measures for Trust website



International and Private Patients

- Exploring options for sharing of data



Medicines, Therapies and Tests

- Exploring global AHP measure options
- Support of SLT developments
- Support of physio developments

Legend:

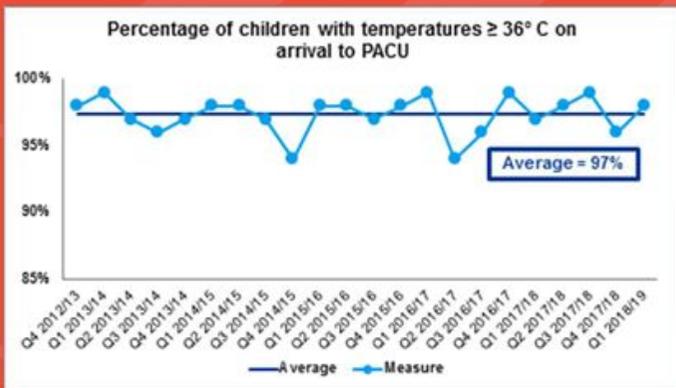
- Links to latest data on Clinical Outcomes Hub internal outcomes platform or external Trust website
- Support to establish or review measures, collect or analyse data, or other support of clinical teams

[Latest SSQD reports](#)

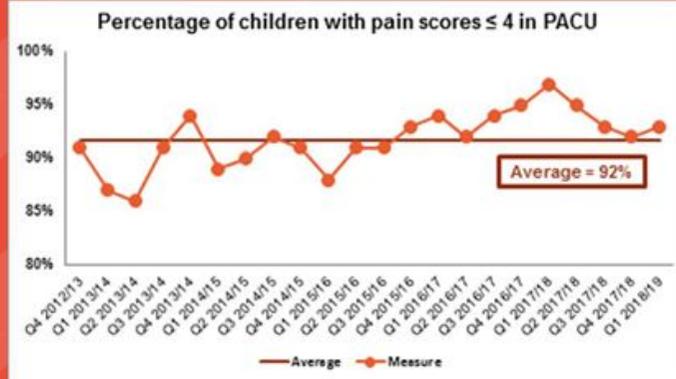
Featured clinical outcomes: Anaesthesia

Each quarter the Anaesthesia department collects data from 250 randomly chosen patients (five per cent of the caseload) while in the post-anaesthesia care unit (PACU) to help monitor our effectiveness.

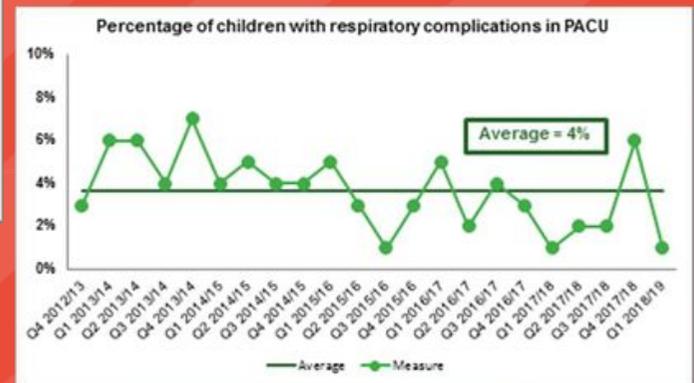
During anaesthesia and surgery a child's temperature can drop to below 36.0°C (hypothermia). Hypothermia is associated with a higher risk of complications after surgery. A range of warming devices are used during anaesthesia to prevent hypothermia (excludes heart surgery)



Pain-relieving drugs are given by the anaesthetist during surgery to ensure that children are as comfortable as possible after surgery. After surgery, the specialist nurse in the PACU will assess if the child is comfortable using a simple zero to 10 scale (no pain at zero and worst possible pain at 10). If necessary, the child will receive further pain relief to ensure s/he is comfortable before going to the ward.



Some children experience breathing problems shortly after waking up from an anaesthetic. The degree of risk will depend on the child's medical condition and the nature of surgery for which anaesthesia is being provided. Most cases of breathing problems are experienced briefly, and minimal intervention is required. Our aim is that less than 10 per cent of our patients experience respiratory complications in the PACU, a target we share with Cincinnati Children's Hospital.



*We apply the same target as Cincinnati Children's Hospital – to seek to achieve more than 90 per cent of children arriving comfortable in recovery.

QI Project- Early Warning Dashboard

What is it?

The dashboard has been designed to provide Nervecentre wards with accurate, user-friendly, patient level data to support the recognition of the deteriorating patient.

The aim is to improve the visibility of ward practices to proactively identify areas for improvement e.g. observation completeness and Sepsis recognition.

What does it show?

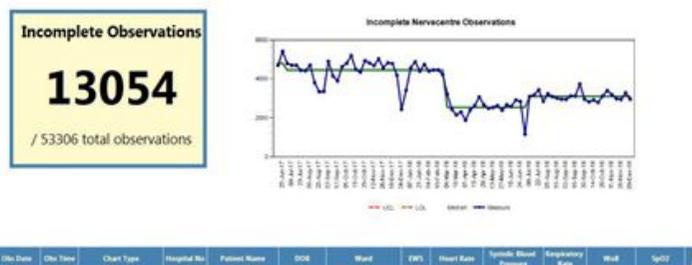
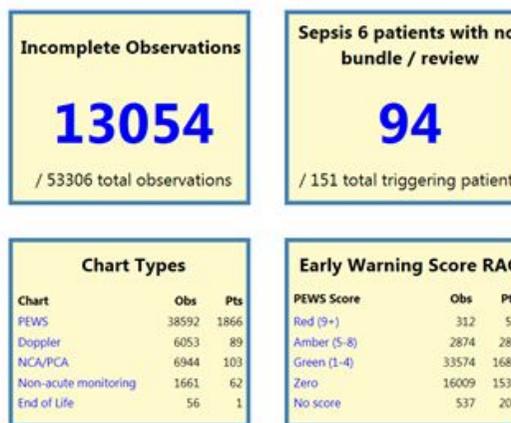
Incomplete observations – Based on the premise that ‘complete’ would be recording all 7 parameters required to generate a PEWS score

Sepsis – Sepsis 6 patients with no bundle or review completed

Chart Types – Number/ type of observations based on chart type and category

Early Warning Score RAG – PEWS scores and RAG escalation based on those scores

for nursing observations taken between 20/11/2018 and 19/12/2018, inclusive, on all wards



What should the focus be on?

Any missing observations including those recorded as ‘unable/ refused’ or ‘Unable/ Crying’, particularly when combined with an AVPU of ‘Asleep’

Inappropriate ‘Non-acute monitoring’ or ‘Doppler’ chart use

Sepsis patients with no bundle or review completed

Key Messages

This is very much a supportive tool designed to improve recognition of the deteriorating patient in a proactive manner.

The dashboard can be found within the Nursing Portal or via the below link

Link - <http://qst/m/ew>



Patient Experience Report

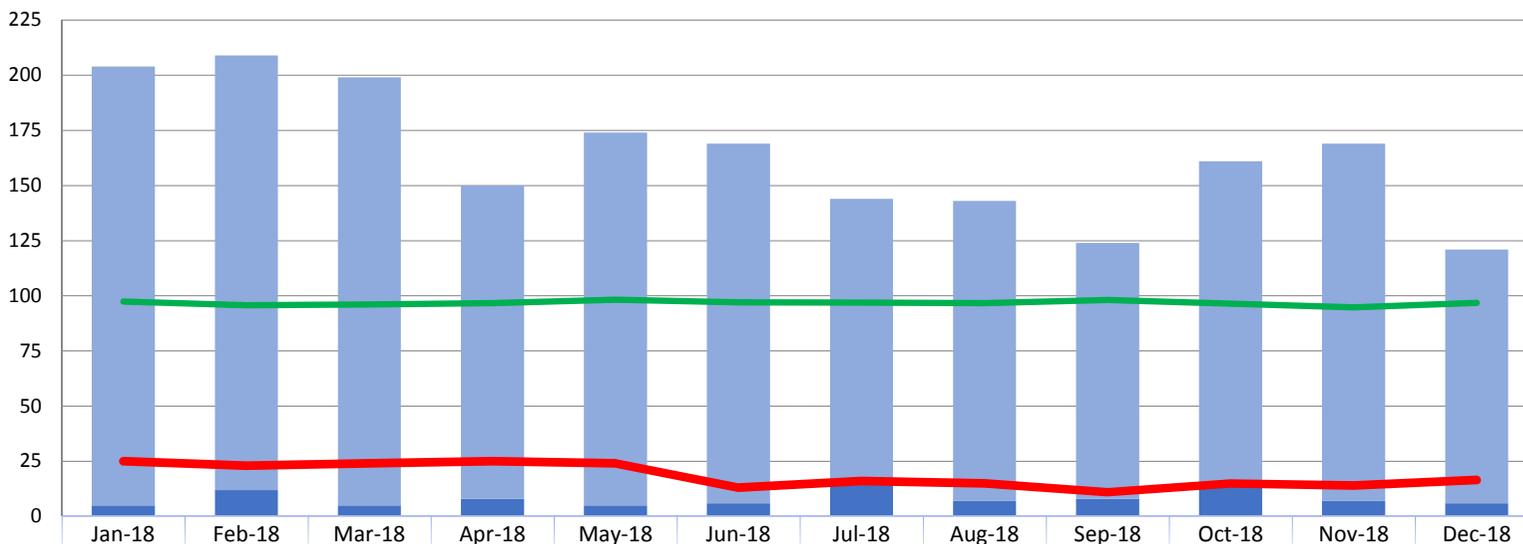
Including

- Complaints
- Friends and Family Test
- Patient Advice and Liaison Service

The new Patient Experience report outlines how the Trust listens to, and responds to feedback (including PALs queries, complaints and the Friends and Family Test) and uses this to improve the experiences of patients and their families. The report includes information about volumes of feedback received and Trust wide learning from concerns raised across PALs, Complaints and FFT about the standard of nursing care.

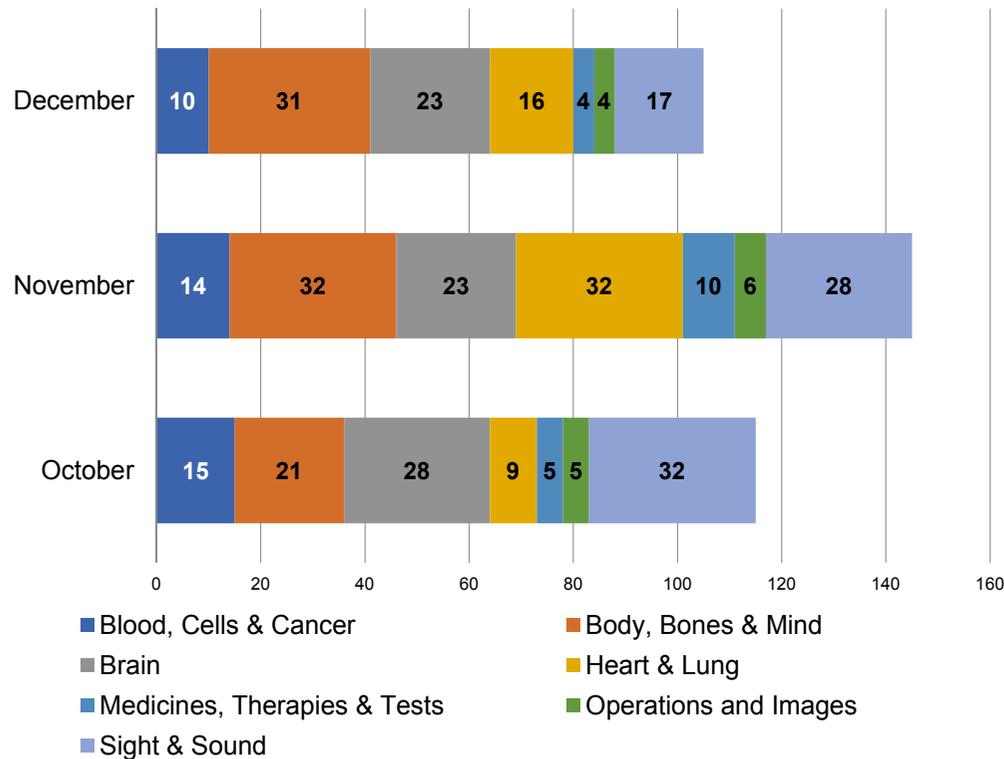
Are we responding and improving?

Patients, families and carers are able to share their experiences via numerous routes including PALS, Complaints and the Friends & Family Test (FFT).



PALS	199	197	194	142	169	163	129	136	116	146	162	115
Formal Complaints	5	12	5	8	5	6	15	7	8	15	7	6
FFT recommendation rate %	97.4	95.7	96.1	96.7	98.2	97.1	97	96.7	98.1	96.5	94.8	96.8
FFT % response rate	25	23	24	25	24	13	16	15	11	15	14	16.5

PALS data Q3

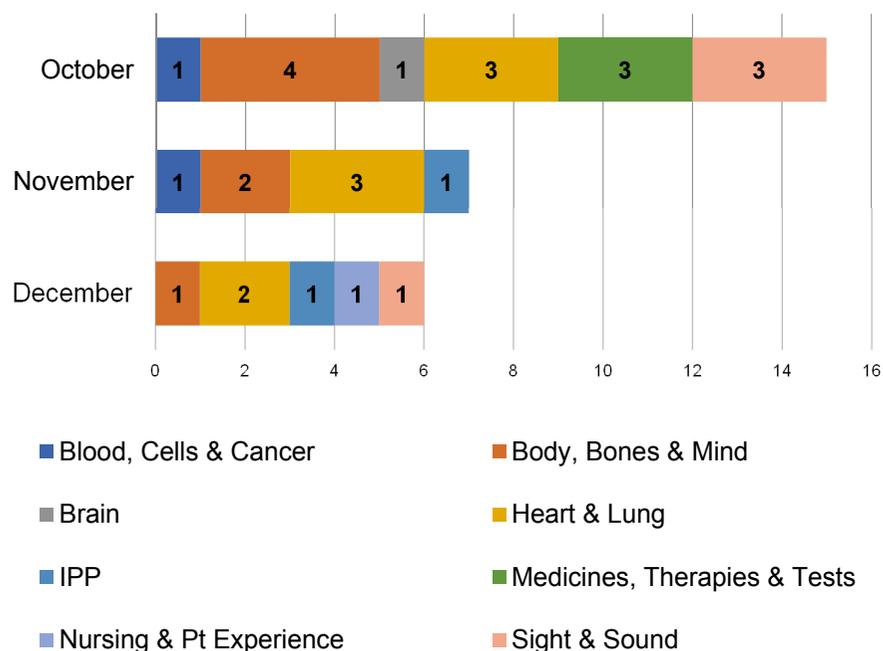


Top themes	11/18	12/18
Outpatient (Cancellation; Failure to arrange appointment; poor communication)	45	42
Lack of communication (lack of communication with family, telephone calls not returned; incorrect information sent to families, transport)	24	12
Staff attitude (Rude staff, poor communication with parents, not listening to parents)	8	13
Transport (Eligibility, delay in providing transport, failure to provide transport)	11	5
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)	24	4

Top 3 Services	PALS cases
Cardiology	57
Neurology	23
Gastroenterology	20

Complaints data Q3

Q3 Formal Complaints by directorate



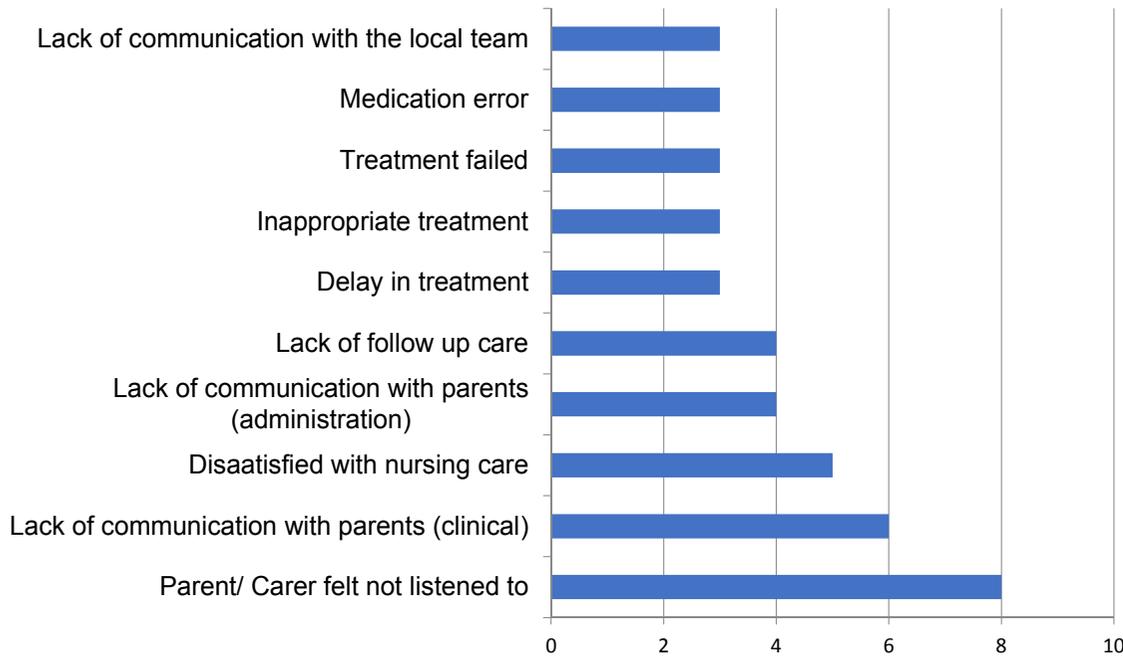
Formal complaints (n=28) fell slightly from Q2 (a reduction of 2 complaints). However, this was the busiest Q3 for complaints since 2015 and a 100% increase on the same period last year.

Complaints in October rose significantly with the main issues recorded about poor communication including concerns from families who didn't feel listened to, and who experienced difficulties getting the information they needed.

Complaints about Heart & Lung division (n=8) mainly related to Cardiology Service (n=4) with three complaints relating to concerns about access to care and treatment for Postural Orthostatic Tachycardia Syndrome (POTS). While in Body, Bones & Mind, complaints about Gastroenterology (n=2), Specialist Neonatal and Paediatric Surgery (SNAPS) (n= 2) and Urology (n=2) highlighted concerns about communication, delays and care.

Complaints themes- Q3

Top 10 themes of Formal Complaints Q3



Complaints frequently relate at least in part to communication issues and this is reflected in the formal complaints received this quarter. Some families felt that staff were unresponsive to their concerns/ requests and they experienced difficulties in getting the information and support they needed.

This quarter (n= 5) also brought an increase in complaints about nursing care (n= 2 in Q1 and n= 2 in Q2). Further detail at slide **14**.

Red (high risk) Complaints

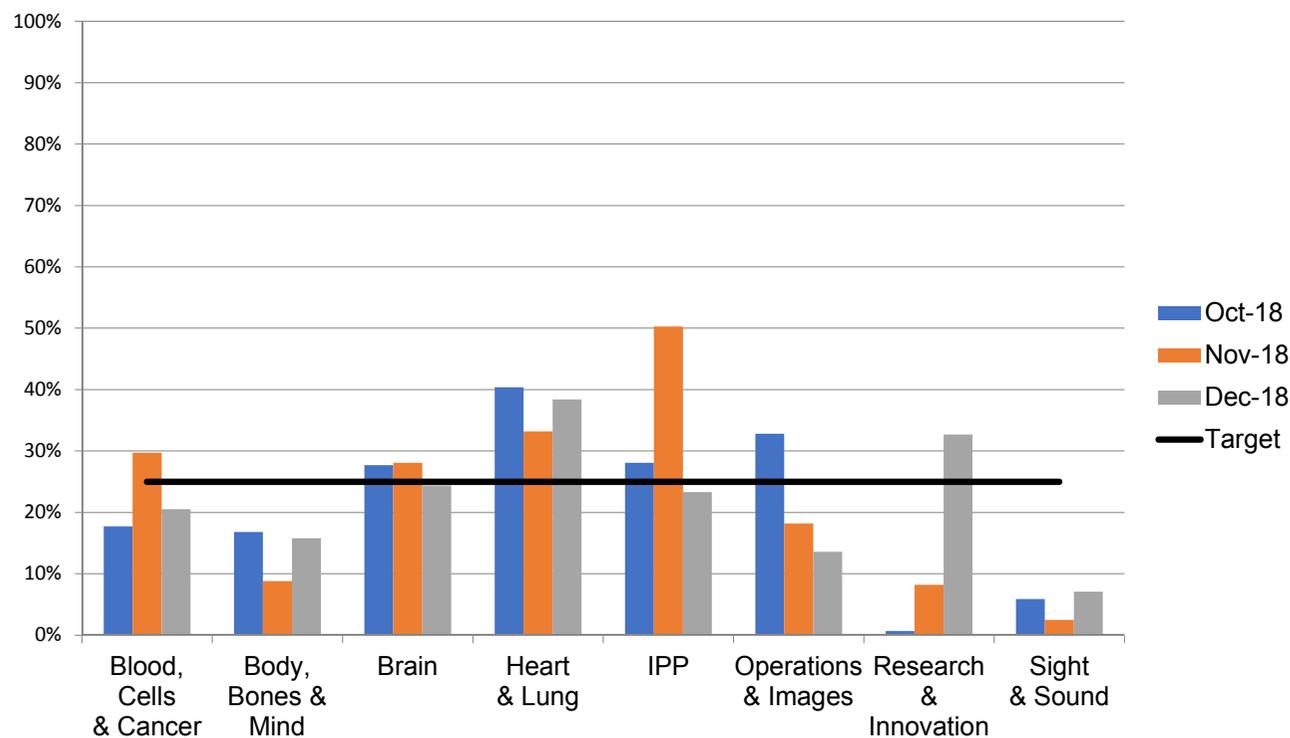
Red complaints in Q3 2018/9			
New red complaints declared in Q3:	1	Complaint about care and treatment under several teams at GOSH before patient sadly died in September 2018. This includes concerns about delays, poor coordination between departments, inadequate management of patient’s condition, staffing levels and communication between departments and with the patient’s family. Investigation being led by Heart and Lung Directorate.	
Reopened red complaints in Q3:	0	Closed red complaints in Q3:	1

Red (high risk) complaints fell from 2 in Q2 to 1 this quarter, while there were 6 amber (medium risk) complaints in contrast to 9 last quarter. There were no clear trends in the red/amber complaints this quarter but this is under close review.

Learning from complaints

Ref	Details of complaint	Action taken
18/014 red complaint	Concerns raised about communication and delays in review on a public holiday which resulted in the patient (who has complex needs) experiencing pain, dehydration and discomfort for longer than necessary.	<p>The investigation identified that inadequate coordination of care contributed to the errors in the patient's care and that there were missed opportunities to plan for possible change in his condition following surgery.</p> <p>In response to this, the Trust:</p> <ul style="list-style-type: none"> • is recruiting a new group of General Paediatric Consultants who will coordinate care of complex patients under a number of specialities, provide increased out of hours support and lead review meetings ahead of public holidays and weekends; • has improved documentation regarding consultant ward reviews; • has implemented weekly multi disciplinary Grand Ward Rounds; • reminded staff of appropriate escalation processes and available medical support; • is reviewing ways of ensuring appropriate ward cover including increased recruitment and optimising care and support provided by physician associates, senior house officers and advanced nurse practitioners.

FFT Response Rate by Directorate

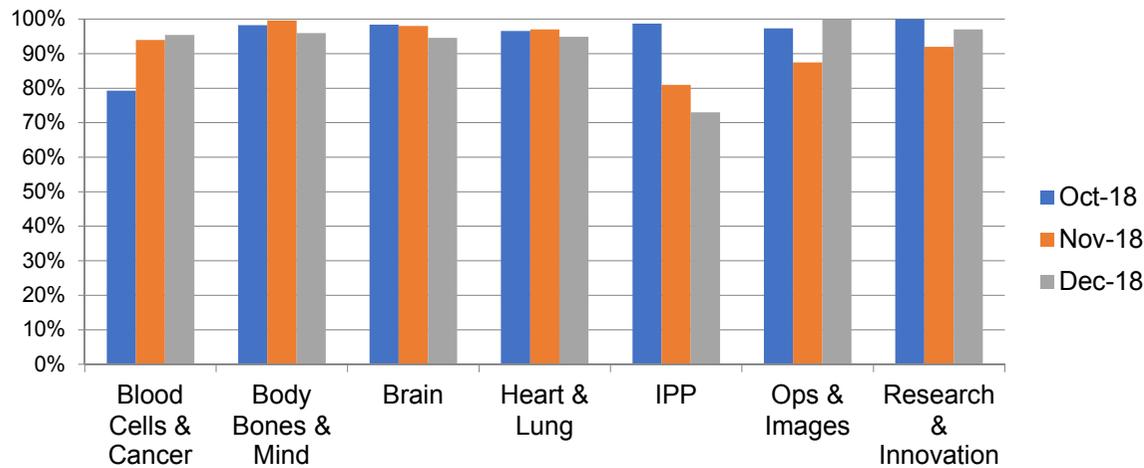


As shown on slide 4, while the overall FFT rates have increased in Q3, they did not meet the recently revised Trust target of 25%.

Benchmarking against 11 paediatric hospitals (October 18 data) FFT response rates varied between 11% and 42%. The October rate of 15% places the trust at the lowest end of the scale.

The directorates are working with the Patient Experience team to increase FFT response rates. They also presented improvement action plans at PFEEC. Directorates who are able to meet the target report doing so by discussing FFT in all team meetings, encouraging collective responsibility and ensuring that where possible FFT cards are returned before patients leave the ward/ clinic.

FFT % Recommendation by Directorate



FFT feedback at GOSH includes a high proportion of qualitative feedback indicating that families are willing to share their experiences.

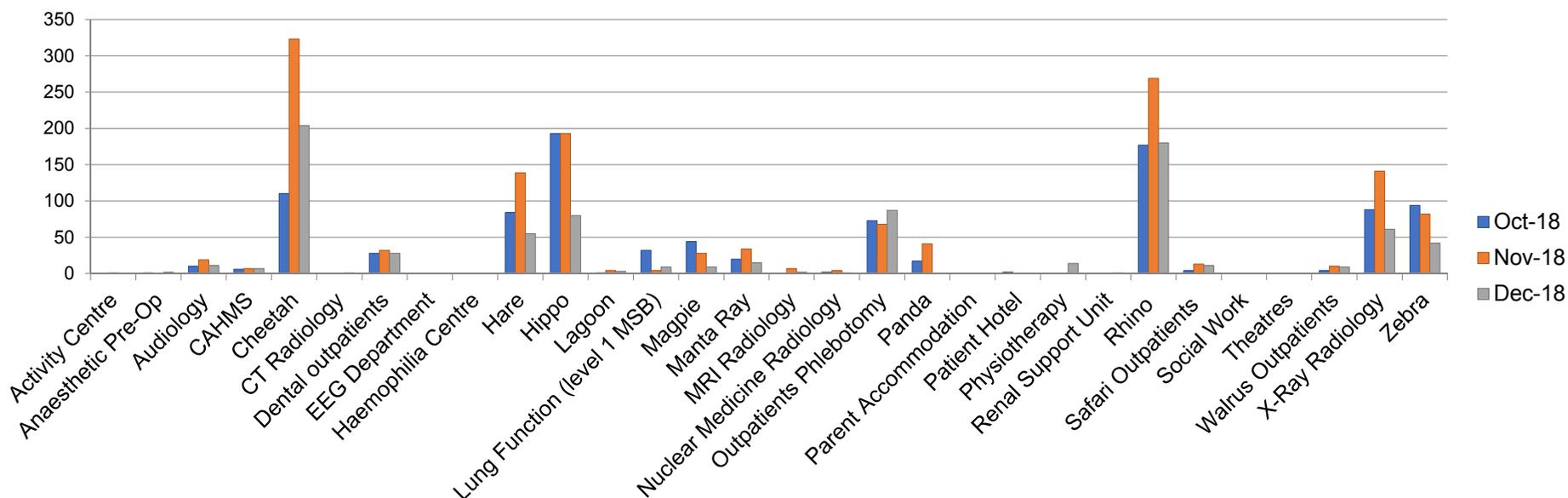
As shown in slide 4, Trust recommendation rates in October and November dropped. At 94.8% the November rate was the lowest in 2018. However, feedback remained positive with families particularly commenting on the kindness, warmth, support and caring attitude of staff.

Benchmarking against other paediatric hospitals in October 2018 (range 83% - 100%) showed the Trust at the higher end of the scale (96%).

IPP's recommendation rate fell to 73.0% with issues raised about waiting times, staffing levels and the ward environment. Work is underway to improve utilisation of rooms and reduce prescribing delays. IPP have also made changes to one ward and patient numbers to better match available staff.

	Inpatient Comments	Outpatient Comments	IPP Comments	Total Feedback	% with qualitative comments (All areas)
Oct 18	550	990	46	1586	79.3%
Nov 18	481	1419	83	1983	77.2%
Dec 18	471	832	47	1350	78.6%

FFT: Outpatient Responses



The above chart outlines the number of the FFT responses within Outpatients. There is no Trust or NHS target around outpatient feedback. There was a large increase in FFT responses in November 2018 but consistent with previous years and the reduced number of clinics in December, overall numbers dropped. All negative comments are followed up with the relevant service.

Qualitative Comments - Parents

Positive

*“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

“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 Outpatients

“Amazing nurses who cant do enough to help and make something not nice more bearable! You're all superstars!”
Panther Ward

“We are in a place of real expert care. The nurses and doctors are so friendly and welcoming to the children and they normalise the experience”
Cheetah Outpatients

“My son feels at ease when here, he is informed of what's going on in a child friendly way. All staff are friendly and caring”
Somers Clinical Research Facility

Negative

“Travelled from Nottinghamshire to be told my son's consultant is not here today. So we have travelled all this way for nothing, not to mention the expense of transport for us”.
Hare Outpatients

“This is the first appointment my daughter has had in 9 months despite starting a new drug 9 months ago. She reacted badly to that drug and I phoned, emailed on numerous occasions to ask for help but none was forthcoming! My daughter should have been reviewed 3 months after starting the new medication (NICE guidelines). She did her GCSEs this Summer and was ill throughout - again I was begging for help and advice. Todays appointment is all we got! I am utterly disgusted with GOSH!!!”
Cheetah Outpatients

All negative feedback is shared with the relevant directorate to follow up and, where possible, contact the family to respond to any concerns and agree any further action. The Sight and Sound directorate are currently looking into the comments above.

Learning from feedback: core care

This quarter there was an increase complaints about the standard of nursing care (n= 5). Families raised concerns about a lack of basic nursing care. One family reported that it was difficult to keep the patient clean because of the lack of support, assistance and practical materials received. The patient was left in soiled bedding and clothing and her basic needs were not met. Another family complained about delays in responding to and addressing the patient's pain and discomfort and delays in calls bells being responded to. In the context of these complaints, concerns were also raised about communication including that some staff did not introduce themselves before providing care.

Concerns about nursing care are also reflected in the FFT feedback received this quarter. Families reported issues with delays in responding to requests for care and information and a lack of confidence in the competence of nursing staff. PALS feedback echoed some of the concerns raised about the standard of nursing care including prolonged waiting times.

Earlier this year the Trust launched a Core Care programme to ensure that basic care needs are met. The Nurse Practice Educators completed audits on 18 wards to establish a baseline of compliance with areas of basic care including but not limited to completion of observations, risk assessments, and documentation/ record keeping. Following the audits, a four week education programme was created looking at Infection Control, Safety, Nutrition and Communication and promoting good nursing practice. A post programme audit showed improvements in the majority of areas and will shape the focus for future work on core care.

The results of this work have been shared with the Trust Nursing Board and will be presented at the Matrons' and Sisters' meetings. The Core Care Programme will run twice a year and planning is underway to identify what it will cover. Following the programme, some wards are also working on their own bespoke programmes. For example, Clinical Audit is working with the Brain Directorate to ensure that staff are able to demonstrate compassionate care through good nursing care, communication and appropriate environments.

Patient Experience- highlights of Q3

- Volunteer Services, Play, Patient Experience and the charity worked together to hold Halloween celebrations attended by 149 children. For the first time we took activities to the ward for children who couldn't attend the Lagoon
- We took delivery of mini electric cars which will be used to reduce anxiety for children heading to theatres
- We celebrated GOSHXmas!
- #feedbackFriday was launched on Twitter



Spotlight on Takeover Challenge

- In November 16 teams across the Trust and the Charity offered 27 opportunities to children and young people.
- We had two of our youngest participants (7 years old) took over as Head of Play and Head of ICT.
- Roles for children and young people including scientists, matrons, radiologists and the deputy CEO.



“I really enjoyed getting experience in the practical side of science, as this is rare when at school. It was really interesting to see how what we learn at school can be applied in real life and how this might affect treatments in the future” Rose, 15



“I liked having my own pass and phone and visiting parts of the hospital that patients never see” Miles, 7

I loved her perspective and the lightness she brought to the team. I think it’s really important in a child-centred organisation to do things like Take Over to bring experience of a child into focus on ‘behind the scenes’ decisions and thinking.” Laura, Head of Play

“I thoroughly enjoyed talking to all of the nurses and learning more about the challenges and rewards of being a paediatric nurse in a specialist hospital” Grace, 16



Attachment Q

Trust Board 7th February 2019	
Learning from Deaths. Mortality Review Group - Report of deaths in Q2 2018/2019	Paper No: Attachment Q
<p>Submitted by: Dr Sanjiv Sharma, Interim Medical Director Dr Isabeau Walker, Consultant Anaesthesia and co-chair of the MRG</p>	
<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 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 Q

Mortality Review Group: Report of deaths in Q2 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 ahead of publication of HM Government Child Death Review Statutory Guidance.

Child Death Review Statutory Guidance (published in October 2018)

It should be noted that significant resources and planning will need to be put into place to meet the requirements of the guidance. NHS England confirmed in writing on the 12 December that

“In the legislation, Medical Directors of NHS Trusts and Foundation Trusts are charged with ensuring that regular local multi-professional Child Death Review Meetings (CDRMs) are held to review all child deaths declared by members of their staff. These meetings will need to be flexible and vary according to the circumstances of each child’s death and the practitioners involved. Trusts are required to have these arrangements in place by 29 September 2019”

An initial meeting at GOSH of key stakeholders took place on the 10th December to establish the next steps in meeting the requirement. Those actions and a summary of the key changes which require implementation are attached in this report (appendix i). A follow up meeting to clarify resources to plan the implementation is anticipated to take place in January 2019.

Aim of report

The purpose of the report is to highlight modifiable factors and any learning from case record reviews at GOSH, in accordance with recommendations included in HM Government Child Death Review Statutory Guidance. Modifiable factors are defined as factors, which by means of nationally or locally achievable interventions could be modified to reduce the risk of future child deaths.

This report describes the findings from MRG reviews of GOSH inpatient deaths that occurred between 1st July and 31st September 2018.

Headlines

Twenty children died at GOSH between 1st July and 31st September 2018. Case record reviews have been completed for 18 patients.

- One case cannot be reviewed until notes can be made available following post mortem.
- One case was not able to be reviewed as the December 2018 meeting was not quorate

Of the 18 cases reviewed:

- No cases had a modifiable factor in the child’s care at GOSH that may have contributed to vulnerability, ill health or death (influence score 2¹).

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

Attachment Q

- One death resulted as an unexpected complication of a procedure at GOSH. This case is being investigated as a Serious Incident.
- One case where the review team felt that there had been a modifiable factor in the child's care *outside* of GOSH that that may have contributed to vulnerability, ill health or death (influence score two).

The table below provides a summary of the deaths that occurred during the quarter using NHS England reporting guidance

Total number of inpatient deaths at GOSH between 1st July and 31 st September 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	1
Number of deaths where a modifiable factor was identified at GOSH with an influence score of 2	0
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	1
Number of deaths of people with learning disabilities that have been reviewed	1
Number of deaths of people with learning disabilities where a modifiable factor was identified at GOSH with an influence score of 2 or more	0

Learning Disability Mortality Review notifications

The Learning Disabilities Mortality Review (LeDeR) Programme is commissioned by NHS England to review the deaths of people with learning disabilities. All NHS Trusts are required to notify LeDer of deaths of a patient with a learning disability over the age of four. The Clinical Nurse Specialist for Learning Disabilities is the lead at GOSH for notifying deaths and coordinating requests for information.

Period of deaths covered	N of notifications required by GOSH	N of notifications made	N of outstanding notifications
May 2017 to 12 th December 2018	6	6	0

Learning points for deaths occurring in Q2 2018/19

The following learning points have been identified

- The MCCD is an important legal document and must be completed correctly.
- Early involvement of specialist teams is very helpful, particularly in 'adult' conditions not commonly seen in children.
- Unexpected surgical emergencies are likely, albeit infrequent, during interventional procedures. An SOP for such unexpected emergencies is useful.
- Multidisciplinary teamwork provides the best possible outcomes, particularly for complex patients with multiple problems
- Family support is essential for all patients at GOSH; international patients, or those where English is not their first language may require additional guidance and support, particularly when a child dies.
- Acute / unexpected collapse in an infant is commonly due to sepsis, or cardiac, metabolic, endocrine causes. A high index of suspicion must be maintained for potential causes of deterioration in an infant who is unwell.

14th December 2018

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

² One case cannot be reviewed until notes can be made available following post mortem. One case was not able to reviewed as the December 2018 meeting was cancelled as the meeting would not be quorate

Attachment R

Trust Board 7th February 2019	
Integrated Performance Report: December 2018 (Reporting Month 9 2018/19)	Paper No: Attachment R
Submitted by: Andrew Taylor, Acting COO / 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	



Great Ormond Street 
Hospital for Children
NHS Foundation Trust

Integrated Performance Report

Andrew Taylor, Acting COO
February 2019
(Month 9 2018/19)

The child first and always

Executive Summary	Page 3
Integrated Performance Dashboard	Appendix I
 Caring	Page 4 – 5
 Safe	Page 6
 Responsive	Page 7 – 9
 Data Completeness	Page 10
 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

Executive Summary

February 2019 (Month 9 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 9 (December 2018) data was available, with key national submission deadlines being met and data reviewed in time for inclusion.

The child first and always





Caring

(to be reviewed alongside the Integrated Quality and Safety Report)

Friends & Family Test (FFT)

Headlines via the Performance Report for these measures are:

- Continued positive recommendation responses for those undertaking the Inpatient FFT (96.82% in December 18 compared to 94.80% in November 18)
- The rate (%) of those responding (for Inpatients) has continues to be challenging for the Trust. Following the introduction of the electronic system in June 18 the average response rate has been 13.5%, December performance has seen 16.54% a 3% increase from November, 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 26% response rate.

Response Mode of Collection	June	July	Aug	Sept	Oct	Nov	Dec
Paper	445	546	512	358	539	470	464
Online Survey	5	2	7	4	11	11	7
Total	450	548	519	362	550	481	471
GOSH Response Rate	13.01%	15.71%	15.03%	11.28%	12.54%	13.72%	16.54%
National Rate	24.8%	24.8%	24.6%	24.2%	24.5%	24.5%	NP

Please note that following discussions the Trusts internal response rate target has been reviewed and amended to 25% (previously 40%) Heart and Lung Directorate have met the internal target consistently this financial year (avg. 39%) and are sharing learning with the Directorates that are challenged.

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 Directorate Review 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.





Caring

(to be reviewed alongside the Integrated Quality and Safety Report)

Number of Complaints received in month

This indicator has been introduced to the Trust Board Dashboard from October and requested to provide additional quality measures. This indicator provides the number of complaints remaining open at the end of the reporting month.

For the month of December the Trust had 11 complaints open at 31st December 2018, these are split into the following services:-

CAHMS – 1, Urology – 1, Health Records – 1, Ophthalmology – 1, Rheumatology – 1, PICU – 2, NICU – 1, CICU -1 and IPP - 2

Each complaint is reviewed as per the Trust policy. At the end of December, two responses were overdue and of the open complaints received the oldest is from June 2018 in CAMHS, the draft response has been reviewed and being discussed January 2019.

*

Number of overdue RCA's

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



Safe

(to be reviewed alongside the Integrated Quality and Safety Report)

Number of Incident, 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 December. Year to date the Trust has reported 21 Serious Incidents and zero never events.

659 Incidents have been reported in December with a total of 1934 incidents remaining open, a reduction of 522 from the previous month. 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 zero cases of C Diff in December, with a year to date total of four. The Trust's nationally set number for 2018/19 is no more than 14 cases.

Incidents of MRSA

The Trust did not report any incidents of MRSA in December. The year to date position remains at two.

CV Line Infections

December performance was 1.00 against 1.6 per 1000 line days compared to November when the Trust reported 1.92 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 December the Trust achieved 91.15% for the data collected on PIMs. This is a decrease from November when the Trust reported 91.92%. The average this financial year is 93.70%.

The NatSSIPs project observational audits indicated the Trust continues to have excellent compliance with team brief and sign-in, time out and sign out had positive data collection but has room for improvement. The weak point is debrief and areas outside main theatre. Work is focusing on these areas.

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

The Trust reported zero patients with a grade 3 or above pressure ulcers in December. Further details are provided in Quality & Safety report.





Responsive

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

In December, the Trust continues to underachieve against the standard of 99% for patients accessing the 15 diagnostic modalities within 6 weeks of referral / request at 93.14%, this is a further deterioration from November (96.98%). The Trust has underperformed against this standard since February 2018, as previously reported this is a challenging standard for the Trust. The number of breaches for December remain significantly high compared to earlier months.

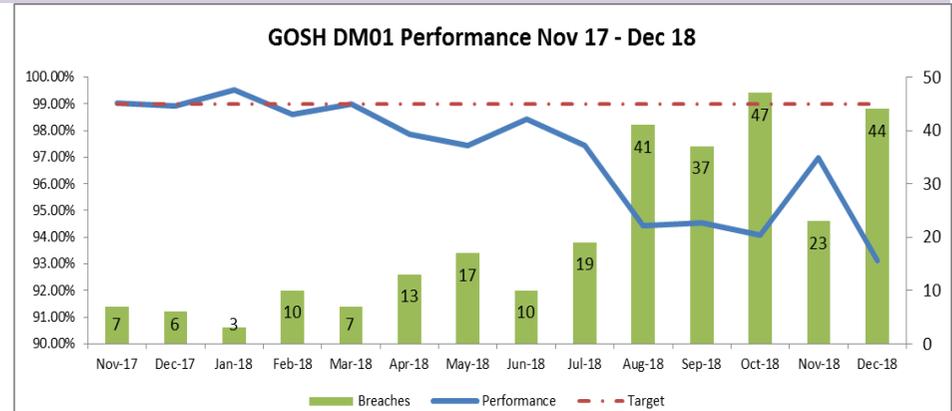
As shown in the table opposite, the overall number of breaches for December was 44 (increase of 21 from November). Breaches occurred in Audiology (1), CT (5), MRI (25), Non Obstetric Ultrasound (4), Gastroscopy (2), Urodynamic (2), Cardiac MRI (4) and Sleep Study (1).

Of the 44 breaches, 38 are attributable to modalities within Imaging. The themes for the all breaches fall into four distinct themes, 17 due to capacity issues (sedation service), 16 administrative booking processes (reasonable offers not made), 6 Trust processes (list overrun, coordination of appointments) and 5 tolerance patients (failed sedation, feed and wrap).

The continuing issues due to administrative staff not following the Trust's standard operating procedure (SOP) for offering reasonable notice to patients or processes in requesting information is disappointing. Further reiteration of the SOP to the booking teams and additional intervention by the directorate senior management teams.

The success of the sedation service has resulted in a backlog of patients awaiting their diagnostic test. To address this the service have reviewed all patients waiting and planned to utilise GA capacity within January and February to reduce the patients waiting plus explore using weekend lists.

The average percentage of patients waiting greater than 6 weeks for London Trusts in November 18 was 3%, 3 organisations reported 11% or more patients awaiting a diagnostics test.



Directorate	Breach	No Breach	Grand Total	Performance
Body, Bones & Mind	4	55	59	93.22%
Colonoscopy		7	7	100.00%
Cystoscopy		13	13	100.00%
Gastroscopy	2	18	20	90.00%
Urodynamics - pressures & flows	2	17	19	89.47%
Brain		36	36	100.00%
Neurophysiology - peripheral neurophysiology		36	36	100.00%
Heart & Lung	5	60	65	92.31%
Cardiac magnetic resonance imaging	4	14	18	77.78%
Cardiology - echocardiography		3	3	100.00%
Respiratory physiology - sleep studies	1	43	44	97.73%
Operations & Images	34	405	439	92.26%
Barium Enema		3	3	100.00%
Computed Tomography	5	45	50	90.00%
DEXA Scan		14	14	100.00%
Magnetic Resonance Imaging	25	182	207	87.92%
Non-obstetric ultrasound	4	161	165	97.58%
Sight & Sound	1	41	42	97.62%
Audiology - Audiology Assessments	1	41	42	97.62%
Grand Total	44	597	641	93.14%

Cancer Wait Times

At the time of writing the report the month of November 2018 was nationally submitted, the Trust reported two breaches against the 31 Day Subsequent Treatment – Surgery standards, this was due to incidents of the patient and consultant being unwell on the day. For all other indicators applicable to the Trust performance is at 100%. Indicative performance for December indicates compliance against all standards.



Responsive

Referral to Treatment Time (incomplete standard > 92%) – April 2018

For the month of December the Trust achieved the RTT 92% standard, submitting performance of 92.09%, this is the twelfth consecutive month since returning to reporting that the Trust has met the standard. Specialties which continue not to meet the standard are Plastic Surgery (sub-specialisation within the service), SNAPS (bed capacity), Dental and Maxillofacial Surgery (theatre capacity and consultant absence), ENT (inherited breach waits from other providers) and Urology (complex patients and capacity).

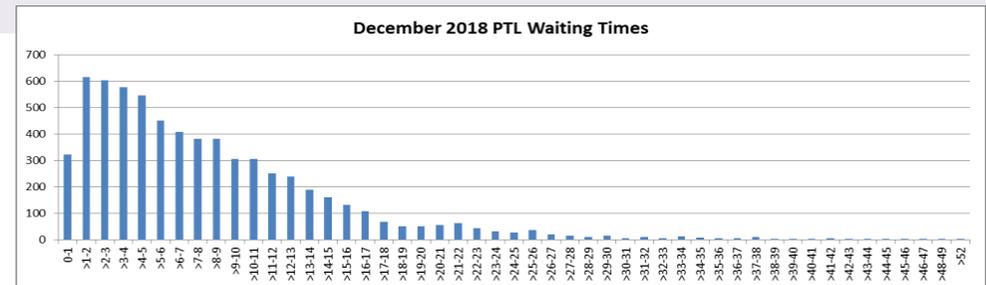
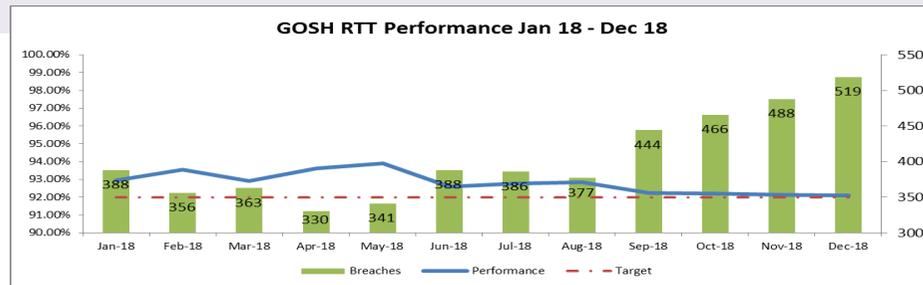
Action plans are being pulled together for Plastic Surgery, Urology and Dental/Maxillofacial Surgery due the complexity of issues within these the services. All the specialties within Operations and Images and Heart and Lung are achieving the national standard.

The number of patients waiting 40 weeks+ has increased to 24 patients in December, 17 admitted pathway and 7 non-admitted. 11 are dated in January 19. For the month of November half of the patients on the Trusts incomplete PTL were waiting less than 6 weeks, and 92 out of every 100 patients were waiting less than 18 weeks on a PTL size of 6,200 patients.

Contextually when comparing GOSH with other Children’s Trusts or other London tertiary / specialist providers, the Trust is not an outlier with differential levels of performance. Nationally out of 182 providers reporting against the standard (NHS Trusts only) 80 in November were delivering 92% or better. 21 providers reported 90-92%, 69 at 80-90% and 12 reported <80%. 4 providers did not report.

Nationally, GOSH is ranked as the 76th best performing Trust out of 182 providers. In London, GOSH is the 14th best performing Trust out of 28 Providers reporting RTT performance.

The graph below provides an overview of the distribution of the Trust’s RTT wait times (for those with known clock start pathways).



52 week waits:

The Trust reported 1 CAMHS patient waiting over 52 weeks in December. The patient was referred to GOSH at 65 weeks from Brighton and Sussex University Hospital. The patient has an outpatient consultant booked February 2019, GOSH wait to appointment is 11 weeks.

Unknown clocks starts:

The number of pathways with an unknown clock start (i.e. referred to the Trust without confirming the start date of the pathway) saw a significant decrease in December in comparison to what the Trust reported in November. Divisions have been asked to further engage with referring Trusts and escalate where necessary.

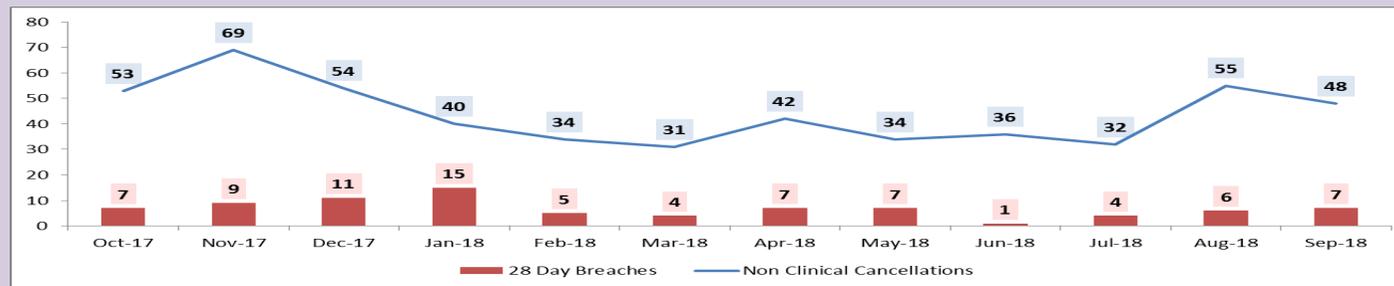




Responsive

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 December 2018, the Trust reported a improvement in performance the number of patients cancelled, however, the quarter as a whole is 20 higher than the previous quarter (155 v 135). There were 36 last minute non-clinical hospital cancelled operations in December, compared to 58 in November 2018. The areas contributing most to the quarterly position are Cardiology/Cardiac Surgery (39), Radiology (40), ENT (10), Ophthalmology (8) and Surgery (9). The main reasons recorded for quarter are List Overrun (43), Ward Bed Unavailable (46) and Emergency Case (29).



The Trust reported 21 last minute cancelled operations within 28 days of the cancellation for Quarter 3, (compared to 17 in Quarter 2). Five Cardiology/Cardiac patients, four Gastroenterology, three Surgery patient, three Dental and 6 across other specialties.

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 nine consecutive months.



The child first and always





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 99.51% of patients having valid data in December.

Mental Health: Ethnicity Completion - %

This indicator has been added the Dashboard for 2018/19 following agreement with NHSE the content of Schedule 4 of the NHS Contract.

The Trust has seen slight reduction in collating ethnicity for patients accessing mental health services, with 63.56% (-3.74%) in December having a valid ethnic code. It should be noted between April – August was 41% and September – December 63%, a 22% increase. 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 continues to improve collating our patient's NHS number.



Well-Led

Workforce Headlines

- **Contractual staff in post:** Substantive staff in post reduced from November to 4660.2 FTE (full-time equivalent) in December. However this is 347.2FTE (8.1%) higher than the same month last year.
- **Unfilled vacancy rate:** The Trust vacancy rate for December reduced to 0.4% (19FTE), well below the Trust target of 10%. Trust vacancy rates have been below target since July 2017.
- **Turnover** is reported as voluntary turnover. Voluntary turnover increased in December to 14.8% which is above target, however there is an expected seasonal spike in December, and turnover 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 1.05% of total paybill, which is below the local stretch target, and is also well below the same month last year (1.9%). 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 December the compliance across the Trust was 91%. 1 Directorate (Finance) reported 100% compliance. 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 increased to 83% but remains below the Trust target, however the Trust continues to benchmark well. Reminders of expired appraisals are being sent to managers. Targets this year remain at 90%.



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Trust KPI performance December 2018

Metric	Plan	December 2018	3m average	12m average
Voluntary Turnover	14%	14.8%	14.7% □	14.3% □
Sickness (12m)	3%	2.4%	2.4%	2.4%
Vacancy	10%	0.4%	0.7%	2.7%
Agency spend	2%	1.1%	1.1%	1.4%
PDR %	90%	83%	82%	84%
Statutory & Mandatory training	90%	91%	91%	91%

Key:

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



Well-Led

Directorate (Clinical) KPI performance December 2018

Metric	Plan	Trust	Blood, Cells & Cancer	Body, Bones & Mind	Brain	Heart & Lung	Medicine, Therapies & Tests	Operations & Images	Sight & Sound	IPP
Voluntary Turnover	14%	14.8%	17.4%	14.9%	11.1%	16.7%	10.8%	10.5%	16.3%	25.1%
Sickness (12m)	3%	2.4%	2.4%	2.0%	2.3%	2.9%	1.9%	2.3%	3.2%	4.1%
Vacancy	10%	0.4%	-12.8%	-2.6%	2.0%	3.6%	-16.3%	3.7%	-1.3%	16.2%
Agency spend	2%	1.1%	0.1%	0.3%	0.0%	0.2%	2.9%	1.0%	1.1%	0.0%
PDR %	90%	83%	85%	85%	95%	79%	86%	78%	87%	95%
Stat/Mand Training	90%	91%	89%	91%	91%	88%	92%	92%	90%	96%

Key:

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

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Directorate (Corporate) KPI performance December 2018

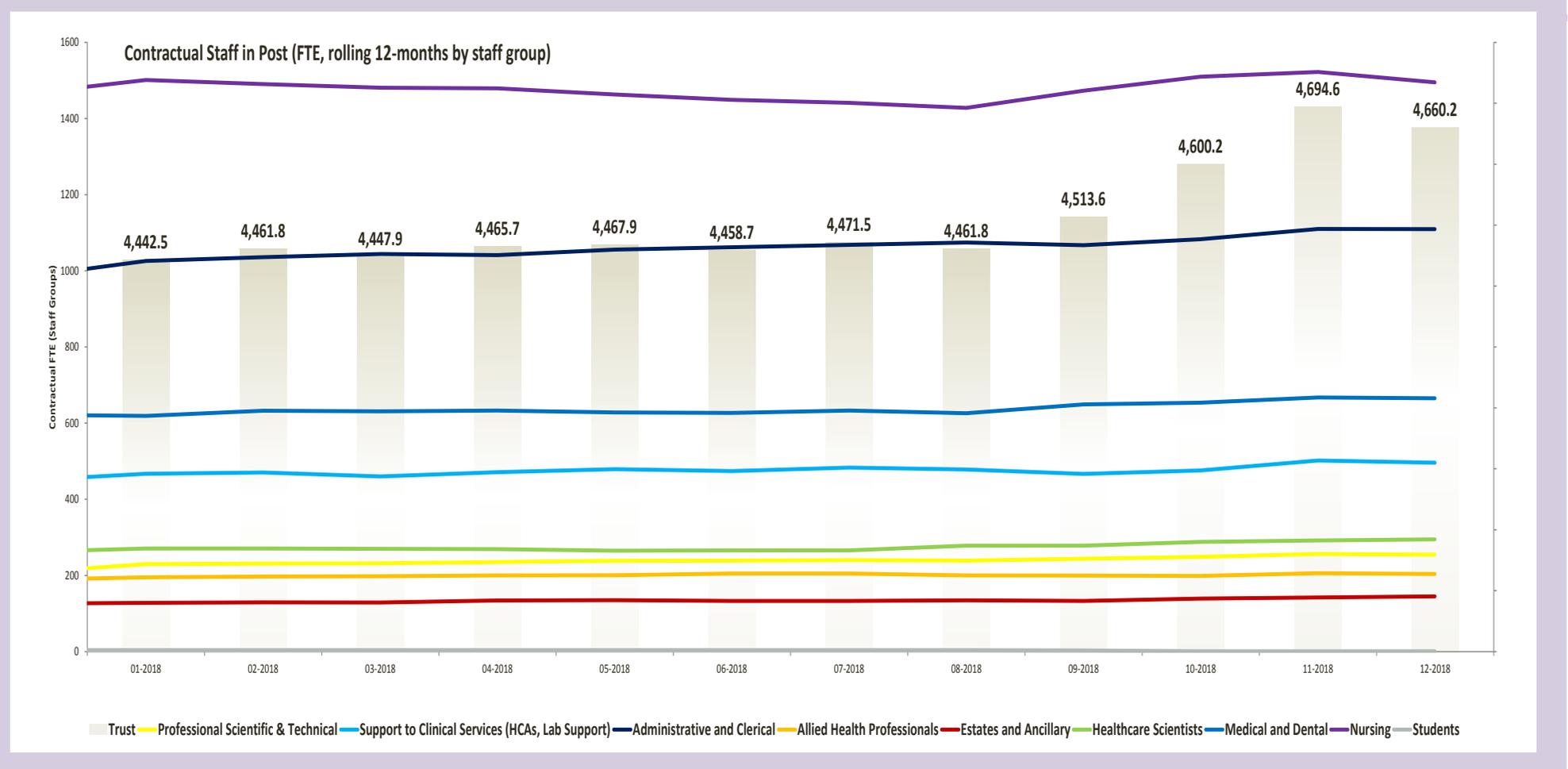
Metric	Plan	Trust	Clinical Operations	Corporate Affairs	DPS	Finance	HR&OD	Medical Director	Nursing & Patient Experience	Research & Innovation
Voluntary Turnover	14%	14.8%	16.3%	28.7%	13.9%	17.0%	22.7%	16.7%	12.8%	25.6%
Sickness (12m)	3%	2.4%	1.7%	0.0%	2.3%	1.3%	4.5%	0.9%	1.2%	1.9%
Vacancy	10%	0.4%	19.5%	13.6%	17.9%	25.6%	13.3%	2.9%	-6.4%	-72.2%
Agency spend	2%	1.1%	0.6%	-0.2%	2.4%	4.7%	8.2%	0.0%	0.7%	0.2%
PDR %	90%	83%	79%	77%	89%	70%	97%	58%	80%	72%
Stat/Mand Training	90%	91%	93%	87%	94%	100%	97%	91%	94%	91%

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 Directorates.



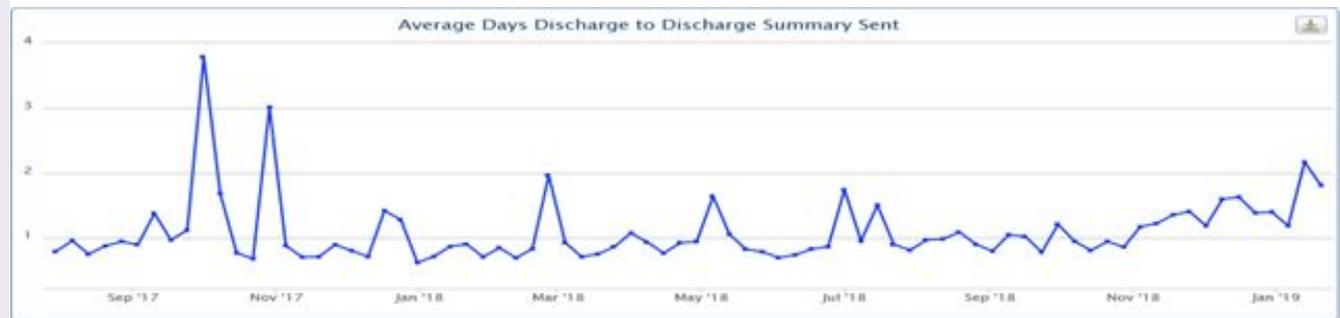
Effective

Discharge Summaries

As is evident from the SPC chart and the dashboard, performance in this area continues to fluctuate and be challenging. For December 2018, the position was 80.38% sent within 24hrs of discharge, which is an improvement from November performance (76.03%). 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 88% of patients and referrers receive a discharge summary within 48 hours of discharge, rising to 93% within 72 hours.

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 November (as this indicator is reported a month in arrears), there has been a deterioration in performance in relation to 14 day turnaround, 66.83% from 67.04% in October. For those sent within 7 working days, performance has also reduced, 36.66% from 40.06% in October. 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. It should be noted that as part of investigating the deterioration a data discrepancy has been identified, the size of the impact is yet to be fully understood.



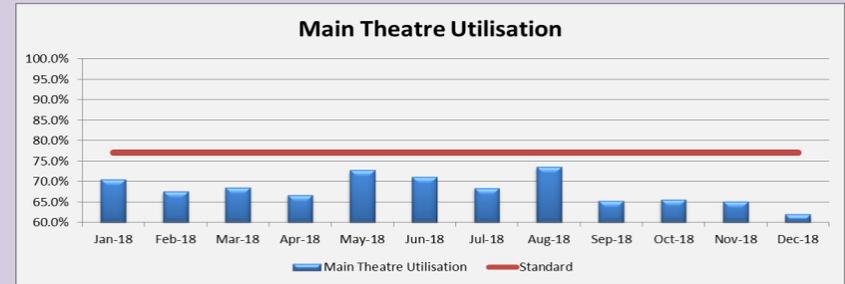
Productivity

Utilisation of main theatres has decreased further in December to 62.0% from 65.2% (November). Specialties with utilisation above 70% are Plastic Surgery (76%), Nephrology (76%), ENT (74%) and Urology (72%). Areas of concern Spinal Surgery (60%), SNAPS (69%), Orthopaedics (55%) and Neurosurgery (56%).

The main drivers for December performance are some lists were kept open by services for urgent/emergency cases over the Christmas week which were not fully utilised so would impact utilisation.

During the period a higher level of patient sickness was experienced particularly in ENT and Orthopaedics. Bed capacity was challenging on Panther and Bear particularly at the beginning of the month. Less families were accepting dates for large surgeries due to the festive period, day-cases were booked but lists remained under utilised.

Work continues on targeting fully utilising lists and addressing delays with clerking and consenting of patients.



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 December, occupancy has reduced to 78.5%. 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 an increase in the average number of beds closed in December (32) compared to 19 in November, the reasons recorded are linked to staffing and Christmas merger. This was mainly due to Sky having an average of 7 beds closed, Bumblebee 4 and Hedgehog 3 beds closed. Panther Urology, Pelican and Dragonfly all had average of 2 beds closed. PICU/NICU average of 5 beds.

Activity

Trust activity: December 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 November, the Trust reported 12 patients discharges that had amassed a combined LOS of 1,968 days of which 833 are attributable to critical care. 11 of the 12 patients discharged in December had 200 days plus LOS. The clinical coding of the admissions relate to the patients having many having complex conditions and comorbidities warranting that LOS.



Productivity

PICU Metrics

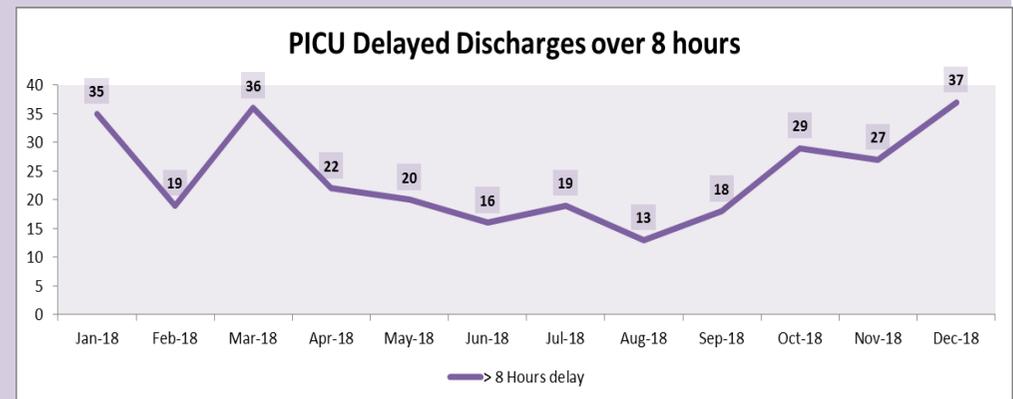
As previously reported the metrics supporting PICU shared in this month's IPR are the first iteration of KPIs. The KPIs have been agreed collaboratively with the Trusts PICU consultants and are designed to provide a triangulated picture of the service. Further analysis and intelligence will be added in future reports.

CATS PICU/NICU Refusals: The number of CATS referral refusals into PICU/NICU from other providers during December has significantly decreased to 22 from a November position of 32. Compared to the first nine months of 17/18 (146 refusals) the number of refusals in 18/19 is 133 (-13). During April – October 2018 the Trust received 275 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
Q2 18/19	45	127	35.4	8.09
Q1 18/19	27	112	24.1	6.27
Q4 17/18	No Data	No Data	No Data	No Data
Q3 17/18	99	226	43.8	19.8

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. December has seen 37 total delays over 8 hours reported compared to 27 in November. Over the last 9 months, 28% of patients have been delayed due to accessing another Provider, and 72% accessing a bed internally within the hospital.



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



Our Money



Summary

This section of the IPR includes a year to date position up to and including December 2018 (Month 9). In line with the figures presented, the Trust has a YTD Control Total Surplus of £9.3m which is £0.1m ahead of plan. The Trust is generating a YTD surplus of £0.9m which is £0.2m ahead of plan.

- Clinical Income (exc. International Private Patients and Pass through Income) is £1.5m higher than plan
- Non Clinical revenue is £2.7m higher than plan
- Private Patients income is £0.6m lower than plan
- Staff costs are £2.2m higher than plan
- Non-pay costs (excluding pass-through costs) are £1.4m 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 currently under review.

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, this currently under review

Trust Board Dashboard - December 2018

		Oct-18	Nov-18	Dec-18	Trend	Plan	NHS Standard	
Caring	Access to Healthcare for people with Learning Disability				↔			
	% Positive Response Friends & Family Test: Inpatients	97.79%	94.80%	96.82%	↑		95%	
	Response Rate Friends & Family Test: Inpatients	12.54%	13.72%	16.54%	↑		25%	
	% Positive Response Friends & Family Test: Outpatients	95.66%	92.32%	92.80%	↔		95%	
	Number of complaints open at month end (including re-opened)	18	14	11	↓			
Safe	Number of open RCAs	TBC	TBC	TBC				
	Number of Incidents	Reported: 645, Open: TBC	779, 2456	659, 1934				
	Serious Patient Safety Incidents (date reported on STEIS)	In-month: 1, YTD: 19	1, 20	1, 21	↔			
	Never Events	In-month: 0, YTD: 0	0, 0	0, 0	↔		0	
	Incidents of C. Difficile	In-month: 2, YTD: 3	1, 3	0, 4	↓			
	C. Difficile due to Lapses of Care	In-month: 0, YTD: 0	0, 0	0, 0	↔		0%	
	Incidents of MRSA	In-month: 0, YTD: 2	0, 2	0, 2	↔		0	
	CV Line Infection Rate (per 1,000 line days)	1.01	1.92	1.00	↓		1.6	
	WHO Checklist Completion	93.17%	91.92%	91.15%	↓		98%	
	Arrests Outside of ICU	Cardiac Arrests: 0, Respiratory Arrests: 0	0, 4	0, 3	↔		5	
	Total hospital acquired pressure / device related ulcer rates grade 3 & above	1	0	0	↓		0	
	Responsive	Diagnostics: Patients Waiting <6 Weeks	94.07%	96.98%	93.14%	↓		99%
		Cancer 31 Day: Referral to First Treatment	100%	-	100%	↔		85%
		Cancer 31 Day: Decision to Treat to First Treatment	100%	100%	100%	↔		96%
		Cancer 31 Day: Decision to Treat to Subsequent Treatment - Surgery	100%	67%	100%	↑		94%
Cancer 31 Day: Decision to Treat to Subsequent Treatment - Drugs		100%	100%	100%	↔		98%	
Cancer 62 day: Consultant Upgrade of Urgency of a referral to first treatment		100%	100%	100%	↔			
Last Minute Non-Clinical Hospital Cancelled Operations		61	58	36	↓			
Last Minute Non-Clinical Hospital Cancelled Operations: Breach of 28 Day Standard		6	7	8	↑		0	
Urgent Operations Cancelled for a 2nd Time		0	0	0	↔		0	
Same day / day before hospital cancelled outpatient appointments		1.54%	1.51%	1.41%	↓			
RTT: Incomplete Pathways (National Reporting)		92.19%	92.15%	92.09%	↓		92%	
RTT: Number of Incomplete Pathways <18wks (>18wks)		5501, 466	5729, 488	6040, 519	↑			
RTT: Incomplete Pathways >52 Weeks - Validated		2	3	1	↓		0	
RTT: Incomplete Pathways >40 Weeks - Validated		11	17	24	↑		0	
Number of unknown RTT clock starts		Internal Referrals: 1, External Referrals: 552	2, 391	3, 225	↔			
RTT: Total Number of Incomplete Pathways Known/Unknown	<18 weeks: 6042, >18 weeks: 488	5885, 499	6263, 524	↑				
Data Completeness	Mental Health Identifiers: Data Completeness	99.50%	99.64%	99.51%	↔		97%	
	Mental Health Ethnicity Completion - %	60.64%	67.30%	63.56%	↑		90%	
	% of Patients with a valid NHS number	Inpatients: 92.5%, Outpatients: 93.6%	92.5%, 93.8%	TBC, TBC	↔		99%	

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

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

		Oct-18	Nov-18	Dec-18	Trend	Plan	NHS Standard	
People, Management & Culture: Well-Led	Sickness Rate	2.40%	2.50%	2.40%	↔		3%	
	Turnover	Total: 17.5%, Voluntary: 14.7%	17.4%, 14.6%	17.5%, 14.8%	↔		18%, 14%	
	Appraisal Rate	Non-Consultant: 81.0%, Consultant: 83.0%	82.0%, TBC	83.0%, TBC	↔		90%	
	Mandatory Training	92.0%	91.0%	91.0%	↔		90%	
	% Staff Recommending the Trust as a Place to Work: Friends & Family Test				↔		61%	
	Vacancy Rate	Contractual: 1.8%, Nursing: 1.3%	0.3%, 0.7%	0.4%, 3.6%	↓		10%	
	Bank Spend	6.2%	6.2%	6.0%	↔			
	Agency Spend	1.07%	1.09%	1.05%	↔		2%	
	Effective	Discharge Summary Turnaround within 24hrs	85.51%	76.03%	80.38%	↔		100%
		Clinic Letter Turnaround	7 working days: 40.06%, 14 working days: 67.04%	36.66%, 66.83%	-	↓		100%
Was Not Brought (DNA) Rate NHS (exc Telephone Contacts)		8.41%	8.30%	9.10%	↓		7.73%	
Productivity		Main Theatres Theatre Utilisation	65.6%	65.2%	62.0%	↓		77%
		Outside Theatres Theatre Utilisation	56.4%	54.8%	46.8%	↓		77%
	Trust Beds Bed Occupancy	79.7%	86.9%	78.5%	↔			
	Average number of trust beds closed	Wards: 35, ICU: 5	19, 5	32, 6	↔			
	Refused Admissions	Cardiac referrals: 7, PICU / NICU referrals: 25	3, 32	0, 22	↔			
Activity (NHS & PP)	Number of PICU Delayed Discharges	Internal 8-24 hours: 3, Internal 24 hours+: 11	4, 15	7, 17	↓			
	External 8-24 hours: 0, External 24 hours+: 7	3, 5	7, 6	↔				
	Total 8-24 hours: 3, Total 24 hours+: 18	7, 20	14, 23	↓				
	PICU Emergency Readmissions < 48 hours	2	3	0	↓			
	Daycase Discharges (YOY comparison)	In-month: 2,609, YTD: 17,035	2,538, 19,570	1,991, 21,561	↓		2,094, 20,287	
	Overnight Discharges (YOY comparison)	In-month: 1,439, YTD: 9,950	1,391, 11,341	1,196, 12,537	↓		1,370, 12,914	
	Critical Care Beddays (YOY comparison)	In-month: 1,203, YTD: 7,300	916, 8,216	862, 9,078	↓		1,082, 9,664	
	Bed Days >=100 Days	No. of patients: 13, No. of beddays: 2,459	10, 2,605	12, 1,968	↔		0, 0	
	Outpatient Attendances (All) (YOY comparison)	In-month: 24,365, YTD: 156,512	24,495, 181,007	17,514, 198,521	↓		17,868, 190,669	
	Our Money	Control Total	2.3	0.5	0.6	↔		9.2, 0.1
Forecast outturn control total		12.5	12.1	12.1	↔		12.1, 0.0	
Debtor Days (PP)		213.0	217.0	207.0	↔		120.0, (87.0)	
Quick ratio (Liquidity)		1.9	2.0	1.9	↔		1.6, 0.3	
NHSI KPI Metrics		1	1	1	↔		1, 0.0	

KITE MARKING SUMMARY December 2018* - UNDER REVIEW

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	Alli 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	2	5%	24	60%

*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	N/A	
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 bacteraemia 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	Y	
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	Y	
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	
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	2	1	2	1	1	2	Y	Y	On-going through DQ Dashboard
Responsive	RTT: Number of Incomplete Pathways (Over 18 Weeks)	2	1	2	1	1	1	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 dock 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	2	2	Y	N	
Responsive	Number of unknown RTT dock 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	2	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	2	2	Y	N	
People, Management & Culture: Well-Led	Sickness Rate	2	2	1	1	3	1	Y	Y	01-Jul-18
People, Management & Culture: Well-Led	Turnover - Total	1	1	1	1	3	1	NK	NK	
People, Management & Culture: Well-Led	Turnover - Voluntary	1	1	1	1	3	1	NK	NK	
People, Management & Culture: Well-Led	Appraisal Rate	2	1	1	2	3	1	Y	Y	01-Jul-18
People, Management & Culture: Well-Led	Mandatory Training	1	1	1	1	3	1	Y	Y	
People, Management & Culture: Well-Led	% Staff Recommending the Trust as a Place to Work: Friends & Family Test	1	1	1	1	3	1	NK	NK	
People, Management & Culture: Well-Led	Vacancy Rate	2	1	1	1	3	1	Y	Y	31-Mar-18
People, Management & Culture: Well-Led	Bank Spend	2	1	1	1	3	1	Y	Y	01-Jul-18
People, Management & Culture: Well-Led	Agency Spend	2	1	1	1	3	1	Y	Y	01-Jul-18
Effective	Discharge Summary Turnaround within 24hrs	1	1	1	1	1	2	Y	Y	01-Jul-17
Effective	Clinic Letter Turnaround within # - 7 working days	2	2	2	1	2	2	Y	Y	01-Jul-17
Effective	Clinic Letter Turnaround within # - 14 working days	2	2	2	1	2	1	Y	Y	01-Jul-17
Effective	Was Not Brought (DNA) Rate NHS (exc Telephone Contacts)	1	1	1	1	1	1	Y	Y	01-Jul-17
Productivity	Excess Beddays >=100 days - number of patients	1	1	1	1	1	1	Y	N	
Productivity	Excess Beddays >=100 days - number of beddays	1	1	1	1	1	1	Y	Y	
Productivity	Critical Care Beddays	1	1	1	1	1	1	Y	Y	01-Aug-17
Productivity	Outpatient Attendances (All)	1	1	1	1	1	1	Y	Y	01-Jul-17
Productivity	Overnight Discharges	1	1	1	1	1	1	Y	Y	01-Jul-17
Productivity	Theatre Utilisation (NHS UO4) - Main theatres	2	2	2	1	2	2	Y	Y	01-Jul-17
Productivity	Average numbers of beds closed - Wards	1	1	2	1	2	2	Y	Y	01-Aug-17
Productivity	Daycase Discharges	1	1	1	1	1	1	Y	Y	01-Jul-17
Productivity	Average numbers of beds closed - ICU	1	1	2	1	2	2	Y	Y	01-Aug-17
Productivity	Theatre Utilisation (NHS UO4)	2	2	2	1	2	2	Y	Y	01-Jul-17
Productivity	Bed Occupancy	1	2	2	1	2	2	Y	Y	01-Jul-17
Productivity	Number of Beds	2	1	2	1	1	1	Y	Y	01-Aug-17
Productivity	Cardiac Refusals	1	1	2	1	1	1	Y	N	
Productivity	PICU/NICU Refusals	1	1	2	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%	This is an indicator of overall patient experience of the service received. Patients would recommend service to others if they have had a good experience.	Numerator: respondents who would be extremely likely or likely to recommend the service Denominator: total respondents	Monthly	
	Response Rate Friends & Family Test: Inpatients	>40%	This is an indicator of the percentage volume of patients responding to the Friends and Family Test Questionnaire	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%	This is an indicator of overall patient experience of the service received. Patients would recommend service to others if they have had a good experience.	Numerator: respondents who would be extremely likely or likely to recommend the service Denominator: total respondents	Monthly	
	Mental Health Identifiers: Data Completeness	>97%	Measurement of data completeness for Mental Health patients covering NHS Number, Date of Birth, Postcode, Gender, Registered GP Practice and Commissioner Code	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	The percentage of patients with a completed Discharge Letter and sent within 24hours of the patients Discharge	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%	This based on the number of NHS Patient Attendances and DNA's for all specialities covering Clinic and Ward Attenders but excludes Telephone Consultations	Numerator: number of non-attendances Denominator: total number of expected attendances	Monthly	
	Clinic Letter Turnaround within 7 Working Days	100%	The percentage of patients with a completed Clinic Letter within 7 working days of attendance	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
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

Responsive

Measure	Definition	Standard	Calculation formulae	Reporting Frequency
SAFE	C.Difficile due to Lapses of Care	0	Total number of C. Difficile infections that have been reported in the Trust.	Monthly
	Incidents of MRSA	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)	1.6	Numerator: Number of GOS acquired CVC related infections in month x 1,000 Denominator: Number of line days in month.	Monthly
	Arrests Outside of ICU	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	N/A	Monthly number of hospital acquired pressure/device related ulcers, Grade III or above.	Monthly
People, Management & Culture: Well-Led	Sickness Rate	3%	Numerator: Number of calendar days lost to sickness Denominator: Total available working calendar days.	Monthly
	Total Turnover	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	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	90%	Numerator: Number of staff members with a complete PDR Denominator: Total number of staff members eligible for a PDR.	Monthly
	Mandatory Training	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	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	10%	Numerator: Established FTE Denominator: Actual Budget FTE	Monthly
	Bank Spend	N/A	Numerator: Total amount that has been spent on Bank staff. Denominator: Total pay bill.	Monthly
	Agency Spend	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 7th February 2019	
Month 09 2018/19 Finance Report	Paper No: Attachment S
Submitted by: Helen Jameson, Chief Finance Officer	Attachment Finance Report M09
Key Points to take away	
<ol style="list-style-type: none"> 1. The Trust is required to achieve an overall control total that is agreed with NHSI annually. The Trust is in line with its control total in Month 9. In order to support the Trust's position, £3.1m has been released from contingency YTD. 2. The Trust is ahead of its income target by £3.6m (excluding pass through) at Month 9. NHS Clinical Income remains ahead of plan by £1.5m. This is offset by reduced IPP activity which was behind plan in month by £0.7m and is now £0.6m behind YTD. 3. Pay was overspent YTD by £2.2m largely due to the £2.1m 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). There continue to be 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. 4. Non pay is £1.4m overspent year to date (excluding pass through). This predominantly relates to the provision for bad debt increasing relating mainly to IPP income; additional cost associated with increased research activity and non-delivery of non pay better value schemes in month, partially offset by underspend in drug costs due to lower activity and the release of further contingency at M9 which sits in non-pay. 5. The Trust is forecasting a breakeven position at the year end to the control total. It is anticipated that activity will increase in the remaining quarter and that a number of Better Value schemes will recover some of the overspends. The Trust will need to maintain a tight grip on activity and expenditure to ensure delivery of the financial position. 	
Introduction	
<p>This paper reports the Trust's Financial Position as at the end of December 2018 (Month 9). 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.</p> <p>The Trust is currently reporting a balanced position to the control total and is forecasting to be in line with the control total at year end. In order to achieve this, a number of non-recurrent adjustments have been made YTD to support the Trust's position including the release of £3.1m of contingency.</p>	
Financial Position – Summary Points	
<p>NHS & other clinical revenue (excluding pass through) is favourable to plan by £1.5m YTD. There are some services across the Trust that are behind their activity target including SNAPs, trauma and orthopaedics and cardiac surgery. This has led to a number of lists being</p>	

cancelled over the last months. There have also been benefits for new income from the North, East and West London (NEW London) Genetic Hub and favourable to plan performance within non-elective services. The Trust agreed a block settlement with NHS England for 2018/19 specialist services which is included within the position.

Private patient income is £0.6m behind plan YTD. There continues to be significant over-delivery of income YTD in a number of areas including in PICU / NICU and CICU though this is offset by lower activity within Cancer and Respiratory. December was a particularly low month which is also attributed to some seasonal effect not seen at the same point in the prior year.

Non-clinical income is £2.7m favourable to plan YTD and £1.5m favourable in month. £2.0m of this relates to the AfC pay award funding and the YTD increase in research activity. This is however offset by better value targets held against non-clinical income which are being largely delivered through other means.

Pay is overspent by £2.2m YTD which includes the additional costs associated with the AfC pay award of £2.1m. If this is excluded, the pay budget is overspent by £0.1m. 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 adverse to plan by £1.4m YTD. This is driven largely by further increases to the impairment of receivables associated with private patient income in month. The IPP team, supported by Accounts Receivable are placing renewed efforts on bringing in a greater share of the aged debt. The adverse impact of this has been partially offset by below plan drug spend associated with lower than planned activity levels.

Financial Forecast – Summary Points

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 that will be required to hit the Trust's control total.

Statement of Financial Position – Summary Points

Indicator	Comment																						
NHSI Financial Rating	All of the five KPIs are green year to date. The forecast outturn overall is green as it is being forecast in line with plan.																						
Cash	<p>The closing cash balance was £56.3m, £10.6m 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 – higher than plan</td> <td>0.1</td> </tr> <tr> <td>Interest receivable – higher than plan</td> <td>0.2</td> </tr> <tr> <td>Inventories – higher than plan</td> <td>(0.8)</td> </tr> <tr> <td>Trade and other Receivables – higher than plan</td> <td>3.3</td> </tr> <tr> <td>Trade and Other Payables - higher than plan</td> <td>8.3</td> </tr> <tr> <td>Provisions – higher than plan</td> <td>0.2</td> </tr> <tr> <td>Other liabilities – lower than plan</td> <td>(1.2)</td> </tr> <tr> <td>Capital expenditure – lower than plan</td> <td>6.0</td> </tr> <tr> <td>PDC received – higher than plan</td> <td>1.0</td> </tr> <tr> <td>Cash variance to plan</td> <td>10.6</td> </tr> </tbody> </table>	Variance/movement	Cash variance vs plan YTD (£m)	EBITDA – higher than plan	0.1	Interest receivable – higher than plan	0.2	Inventories – higher than plan	(0.8)	Trade and other Receivables – higher than plan	3.3	Trade and Other Payables - higher than plan	8.3	Provisions – higher than plan	0.2	Other liabilities – lower than plan	(1.2)	Capital expenditure – lower than plan	6.0	PDC received – higher than plan	1.0	Cash variance to plan	10.6
Variance/movement	Cash variance vs plan YTD (£m)																						
EBITDA – higher than plan	0.1																						
Interest receivable – higher than plan	0.2																						
Inventories – higher than plan	(0.8)																						
Trade and other Receivables – higher than plan	3.3																						
Trade and Other Payables - higher than plan	8.3																						
Provisions – higher than plan	0.2																						
Other liabilities – lower than plan	(1.2)																						
Capital expenditure – lower than plan	6.0																						
PDC received – higher than plan	1.0																						
Cash variance to plan	10.6																						
NHS Debtor Days	NHS Debtor days in month was 8 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 fell from 217 to 207 days due to higher receipts in month from embassies.
Creditor Days	Creditor days increased in month from 25 to 26 days but is still in line with plan.
Inventory Days	Drug inventory days decreased in month from 6 to 10 days. Non-Drug inventory days increased in month from 79 to 88 days. Both of these increases are as a result of holding higher stock over Christmas and the associated reduced activity in this period.
Action required from the meeting	
<ul style="list-style-type: none"> To note the Month 9 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, Q2 and Q3 leading to the receipt of £4.9m 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. £2.7m of PSF funding remains to be delivered in the final quarter of the financial year 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 9 2018/19

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Trust Performance Summary for the 9 months ending 31 Dec 2018

KEY PERFORMANCE DASHBOARD

FINANCIAL PERFORMANCE

	In month			Year to date			Full Year Forecast	
	Plan	Actual	RAG	Plan	Actual	RAG	Fcst	RAG
INCOME <i>incl. passthrough</i>	£37.4m	£37.9m	●	£352.1m	£355.1m	●	£478.1m	●
PAY	£22.5m	£22.7m	●	£196.3m	£198.5m	●	£266.5m	●
NON-PAY <i>incl. passthrough</i>	£14.8m	£13.2m	●	£134.2m	£135.0m	●	£182.8m	●
CONTROL TOTAL	-£1.3m	£0.6m	●	£9.2m	£9.3m	●	£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 9, the Trust position is £0.1m favourable to the planned control total; this includes the release of £3.1m of contingency. The Trust has entered into a block agreement with NHSE for 2018/19 and the YTD position reflects this settlement as well as the CCG income which remains above plan. YTD Pay costs are £2.2m adverse to plan due to the £2.1m AIC pay award and research costs driven by greater activity within R&I. Non-pay is £0.7m adverse to plan an improved in month due to a reduction in the impairment of receivables, although these costs remain high in the YTD position.

INCOME BREAKDOWN RELATED TO ACTIVITY

Income breakdown Year to Date	Plan (£m)	Actual (£m)	Var (£m)	RAG
NHS & Other Clinical Revenue	£210.6m	£212.1m	£1.5m	●
Pass Through	£47.7m	£47.0m	(£0.7m)	
Private Patient Revenue	£47.4m	£46.8m	(£0.6m)	●
Non-Clinical Revenue	£46.5m	£49.2m	£2.7m	●
Total Operating Revenue	£352.1m	£355.1m	£2.9m	●

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

AREAS OF NOTE:

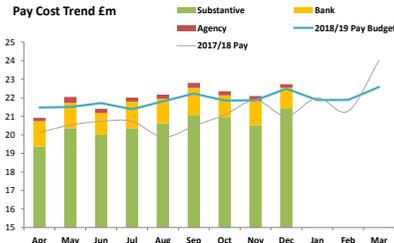
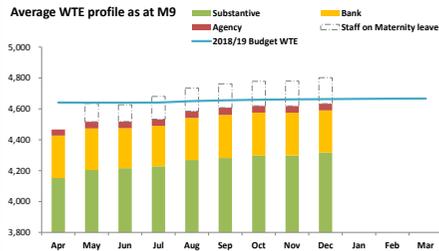
Operating revenue remains favourable to plan YTD (£2.9m). The Trust has entered into a block contract with NHSE for 2018/19, this is represented in the YTD NHS Clinical Income and Non-clinical income. YTD non-clinical income is £2.7m ahead of plan which is driven by the £2.0m AIC pay review income and over performance of research income YTD of £2.8m. These are offset by the Better Value target that is being partially achieved through NHS income. IPP income is £0.7m below plan in month which is at a lower level than the preceding 8 months. This has resulted in a YTD position of £0.6m adverse to plan.

PEOPLE

	M9 Plan Av. WTE	M9 Actual Av. WTE	Variance
PERMANENT	4,634.9	4,317.9	317.0
BANK	20.3	272.3	(251.9)
AGENCY	8.1	43.5	(35.4)
TOTAL	4,663.3	4,633.6	29.7

AREAS OF NOTE:

The pay costs have risen throughout the year due to the increased AIC award and incremental progression of staff combined with increased service provision linked to the Cardiac business case. The Cardiac business case has also driven up the average WTE within the trust. Vacancies in the permanent workforce are being covered by a combination of bank and agency staff. The calculation excludes 168.5 contractual WTE's on maternity leave within the Trust.



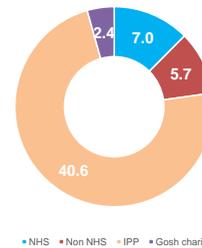
CASH, CAPITAL AND OTHER KPIS

Key metrics	Plan	Actual
Cash	£45.7m	£56.3m
IPP Debtor days	120	207
Creditor days	30	26
NHS Debtor days	30	8

Capital Programme	YTD Plan M9	YTD Actual M9	Full Year Fcst
Total Trust-funded	£18.0m	£10.4m	£19.4m
Total Donated	£37.4m	£26.0m	£35.7m
Grand Total	£55.5m	£36.4m	£55.0m

NHSI metrics	Plan M9	Actual M9
CAPITAL SERVICE COVER	1	1
LIQUIDITY	1	1
I&E MARGIN	1	1
VAR. FROM CONTROL TOTAL		1
AGENCY		1
TOTAL		1

Net receivables breakdown (£m)



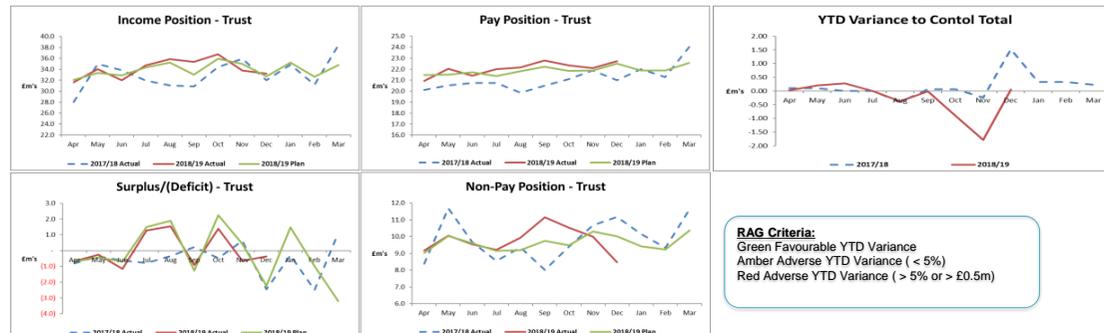
AREAS OF NOTE:

- Cash held by the Trust is higher than plan by £10.6m.
- The capital programme is £19.1m behind plan (£7.6m Trust funded and £11.4m donated) due to slippage on a number of IT and Estates projects.
- The forecast capital expenditure outturn has been reviewed and updated on a scheme by scheme basis. The revised forecast outturn for trust-funded capital expenditure is £8.6m lower than plan. The two most significant projects contributing to this are the Medical Equipment Decontamination Unit (MEDU) and EPR. Charity-funded expenditure outturn is forecast at £9.3m lower than plan. The two most significant projects contributing to this are the Sight and Sound Hospital and Southwood Courtyard developments.
- IPP debtor days have fallen in month to 207 from 217. IPP are holding meetings with embassies in order to reduce debt further.
- NHSI metrics are on plan.

Trust Income and Expenditure Performance Summary for the 9 months ending 31 Dec 2018

Annual Budget	Income & Expenditure	2018/19								Rating	Notes	2017/18		CY vs PY	
		Month 9				Year to Date						YTD Actual	Variance		
		Budget	Actual	Variance	%	Budget	Actual	Variance	%				(£m)	(£m)	%
(£m)	(£m)	(£m)	%	(£m)	(£m)	(£m)	%	YTD Variance	(£m)	(£m)	%				
280.59	NHS & Other Clinical Revenue	22.54	22.22	(0.32)	(1.42%)	210.59	212.06	1.47	0.70%	G	1	207.00	5.06	2.44%	
63.49	Pass Through	4.77	4.70	(0.07)	(1.47%)	47.68	47.01	(0.67)	(1.41%)	R	2	49.30	(2.29)	(4.65%)	
63.55	Private Patient Revenue	5.14	4.45	(0.69)	(13.42%)	47.36	46.79	(0.57)	(1.20%)	R	3	43.80	2.99	6.83%	
62.93	Non-Clinical Revenue	4.99	6.51	1.52	30.46%	46.48	49.19	2.71	5.83%	G	4	42.30	6.89	16.29%	
470.56	Total Operating Revenue	37.44	37.88	0.44	1.18%	352.11	355.05	2.94	0.83%	G		342.40	12.65	3.69%	
(260.28)	Permanent Staff	(22.29)	(21.41)	0.88	3.95%	(194.54)	(184.67)	9.87	5.07%			(170.30)	(14.37)	(8.44%)	
(0.50)	Agency Staff	(0.04)	(0.18)	(0.14)	(350.00%)	(0.38)	(2.09)	(1.71)	(450.00%)			(3.50)	1.41	40.29%	
(1.87)	Bank Staff	(0.16)	(1.14)	(0.98)	(612.50%)	(1.40)	(11.78)	(10.38)	(741.43%)			(12.50)		0%	
(262.65)	Total Employee Expenses	(22.49)	(22.73)	(0.24)	(1.07%)	(196.32)	(198.54)	(2.22)	(1.13%)	R		(186.30)	(12.24)	(6.57%)	
(13.48)	Drugs and Blood	(1.04)	(0.31)	0.73	70.19%	(10.09)	(8.52)	1.57	15.56%	G		(9.70)	1.18	12.16%	
(41.45)	Other Clinical Supplies	(3.23)	(3.49)	(0.26)	(8.05%)	(31.56)	(31.80)	(0.24)	(0.76%)	A		(32.60)	0.80	2.45%	
(60.62)	Other Expenses	(5.75)	(4.67)	1.08	18.78%	(44.89)	(47.63)	(2.74)	(6.10%)	R		(45.20)	(2.43)	(5.38%)	
(63.49)	Pass Through	(4.77)	(4.70)	0.07	1.47%	(47.68)	(47.01)	0.67	1.41%			(48.70)	1.69	3.47%	
(179.04)	Total Non-Pay Expenses	(14.79)	(13.17)	1.62	10.95%	(134.22)	(134.96)	(0.74)	(0.55%)	R		(136.20)	1.24	0.91%	
(441.69)	Total Expenses	(37.28)	(35.90)	1.38	3.70%	(330.54)	(333.50)	(2.96)	(0.90%)	R		(322.50)	(11.00)	(3.41%)	
28.87	EBITDA (exc Capital Donations)	0.16	1.98	1.82	1,137.50%	21.57	21.55	(0.02)	(0.09%)	G		19.90	1.65	8.29%	
(16.79)	Owned depreciation, Interest and PDC	(1.42)	(1.41)	0.01	0.64%	(12.40)	(12.30)	0.11	0.85%			(13.60)	1.31	9.60%	
12.08	Control total	(1.26)	0.57	1.83	145.74%	9.17	9.26	0.09	0.94%	G		6.30	2.95	46.90%	
(11.60)	Donated depreciation	(0.99)	(0.96)	0.02	2.13%	(8.49)	(8.41)	0.1	0.99%			(4.40)	(4.01)	(91.02%)	
0.48	Net (Deficit)/Surplus (exc Cap. Don. & Impairments)	(2.24)	(0.39)	1.85	82.59%	0.68	0.85	0.17	25.00%			1.90	(1.05)	(55.26%)	
(2.52)	Impairments	0.00	0.00	0.00	0.00%	0.00	0.00	0.00	0.00%			0.00	0.00	0%	
44.97	Capital Donations	3.09	3.14	0.05	1.62%	37.44	26.00	(11.44)	(30.56%)			18.10	7.90	43.65%	
42.93	Adjusted Net Result	0.85	2.75	1.90	223.53%	38.12	26.85	(11.27)	(29.56%)			20.00	6.85	34.25%	

Plan Annual	Directorates	2018/19								Rating
		Month				Year to Date				
		Budget	Actual	Var	Var %	Budget	Actual	Var	Var %	
(£m)	(£m)	(£m)	(£m)	(£m)	(£m)	(£m)	(£m)	(£m)	(£m)	
15.04	Blood Cells & Cancer	1.03	0.67	(0.36)	(34.95%)	11.36	11.48	0.12	1.06%	G
22.41	Body Bones & Mind	1.64	1.04	(0.60)	(36.59%)	16.78	13.02	(3.76)	(22.41%)	R
19.86	Brain	1.47	1.54	0.07	4.76%	14.97	16.48	1.51	10.09%	G
54.38	Heart & Lung	4.33	3.44	(0.89)	(20.55%)	40.99	38.81	(2.18)	(5.32%)	R
(18.71)	Medicines Therapies & Tests	(1.59)	(0.83)	0.76	47.80%	(14.04)	(13.78)	0.26	1.85%	G
(30.12)	Operations & Images	(2.49)	(2.48)	0.01	0.40%	(22.63)	(22.45)	0.18	0.80%	G
10.23	Sight & Sound	0.73	0.95	0.22	30.14%	7.70	8.50	0.80	10.39%	G
24.88	International Private Patients	1.91	1.47	(0.44)	(23.04%)	18.70	15.78	(2.92)	(15.61%)	R
1.87	Research And Innovation	0.06	0.19	0.13	216.67%	1.26	2.27	1.01	80.16%	G
(87.76)	Corporate/Other	(8.35)	(5.42)	2.93	35.09%	(65.92)	(60.86)	5.06	7.68%	G
12.08	Control total	(1.26)	0.57	1.83	145.24%	9.17	9.25	0.08	0.87%	



LAG 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 a favourable position to the control total (£0.1m). Private patient income is at its lowest level in 2018/19 and now has a YTD underperformance (£0.6m). YTD income is partially offsetting under delivery within the Better Value Program. The position includes the release of £3.1m of contingency YTD.

Notes

- NHS & other clinical revenue (excluding pass through) is favourable to plan by £1.5m YTD. This is driven by the NHSE block which includes funding for additional service provision and the overperformance on CCG activity.
- Private Patient income has fallen in month; it is now £0.7m below the M9 plan and is at its lowest level this year. Closure of beds in December and the increased complexity of cases requiring ICU beds has led to the reduced activity levels.
- Non-clinical income is £2.7m favourable YTD which includes £2.0m of income for the AfC pay award and additional income for genetics testing.
- YTD pay is adverse to plan by £2.2m due to the additional cost of the AfC pay award of £2.1m. 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 £0.7m adverse to plan YTD largely due to increased impairments of receivables for IPP income.
- Income from capital donations is £11.4m 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 has been delayed to coincide with the replacement of MRI number 4.

Trust Income and Expenditure Forecast Outturn Summary for the 9 months ending 31 Dec 2018

Full Year Actual 2017/18 (£m)	31 Dec 2018 Income & Expenditure	Internal Forecast				Rating Forecast Variance to plan
		Annual Budget	Full-Yr	Variance to Plan		
		(£m)	(£m)	(£m)	%	
280.64	NHS & Other Clinical Revenue	280.59	284.82	4.23	1.49%	G
64.33	Pass Through	63.49	62.60	(0.89)	(1.42%)	
57.26	Private Patient Revenue	63.55	63.24	(0.31)	(0.49%)	A
59.65	Non-Clinical Revenue	62.93	67.41	4.48	6.65%	G
461.88	Total Operating Revenue	470.56	478.07	7.51	1.57%	
(231.99)	Permanent Staff	(260.28)	(247.92)	12.36	(4.99%)	
(4.38)	Agency Staff	(0.50)	(2.87)	(2.37)	82.58%	
(17.34)	Bank Staff	(1.87)	(15.67)	(13.80)	88.07%	
(253.71)	Total Employee Expenses	(262.65)	(266.46)	(3.81)	1.43%	R
(12.37)	Drugs and Blood	(13.48)	(12.75)	0.73	(5.73%)	G
(43.66)	Other Clinical Supplies	(41.45)	(43.24)	(1.79)	4.14%	R
(61.97)	Other Expenses	(60.62)	(64.18)	(3.56)	5.55%	R
(64.33)	Pass Through	(63.49)	(62.60)	0.89	(1.42%)	
(182.33)	Total Non-Pay Expenses	(179.04)	(182.77)	(3.73)	2.04%	R
(436.04)	Total Expenses	(441.69)	(449.23)	(7.54)	1.68%	R
25.84	EBITDA (exc Capital Donations)	28.87	28.84	(0.03)	(0.10%)	G
(15.93)	Owned Depreciation, Interest and PDC	(16.79)	(16.76)	0.03	(0.18%)	
9.91	Control total	12.08	12.08	0.00	0.00%	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	35.65	(9.32)	(26.14%)	
22.45	Adjusted Net Result	42.93	33.61	(9.32)	(27.73%)	

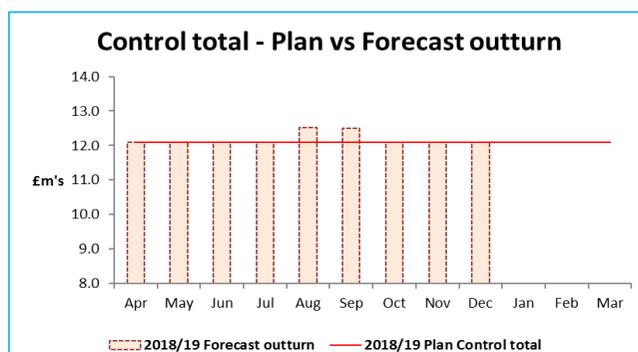
Notes

Summary

- The Trust is forecasting a year end position that breaks even with the Trust control total of a £12.1m surplus.
- A block contract has been agreed with NHSE for 2018/19 and is included in the NHS Clinical income and non clinical income numbers of the forecast.

Notes

- NHS Clinical income is forecast to be £3.3m favourable to plan which is driven by the additional service provision on top of the original contract and overperformance on CCG activity.
- Private patient income is forecast to be £0.3m adverse to the plan which is in line with the M8 forecast. Work to ensure Private Patients can access services in line with plans is essential in the final quarter of the year as delivery of the private patient forecast is key to delivering the control total.
- Pay is forecast to be £3.8m adverse to plan by the year end. 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 and additional research income.
- Non-pay is forecast to be £4.6m adverse at the year end excluding pass through. The higher than planned spend reflects increases in the level of impairments for IPP debt and increased costs associated with increased research. A key focus for the Trust will be to ensure the aged debt is paid and thus reduce the provision, reducing non pay costs for the remainder of the year.
- 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, Q2 and Q3 and is planning to breakeven at the year end. In order to deliver the control total and achieve the PSF it is important that the Private patient forecast is achieved. If this does not occur then the control total will be missed and PSF will not be achieved further deteriorating the position.



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

2018/19 NHS Income & Activity for the 9 months ending 31 Dec 2018

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	16,079	14,028	(2,051)	£18,944	£19,681	£737	G	£1,178	£1,403	19.1%	£3,156	(£2,419)
Elective	10,555	10,116	(439)	£48,905	£46,301	(£2,604)	R	£4,633	£4,577	(1.2%)	(£566)	(£2,038)
Hdu Bed Days	2,610	2,468	(142)	£1,923	£2,493	£570	G	£737	£1,010	37.0%	£674	(£104)
Highly Specialised Services	14,037	13,050	(987)	£22,867	£22,157	(£710)	R	£1,629	£1,698	4.2%	£900	(£1,610)
Inpatient excess bed days	6,441	4,892	(1,549)	£3,696	£2,787	(£909)	R	£574	£570	(0.7%)	(£20)	(£889)
ITU Bed Days	8,591	7,560	(1,031)	£24,972	£23,769	(£1,203)	R	£2,907	£3,144	8.2%	£1,792	(£2,995)
Non Nhs Clinical Income	1,266	1,814	548	£3,302	£3,363	£61	G	£2,608	£1,854	(28.9%)	(£1,368)	£1,429
Non-Elective	1,231	1,344	113	£13,573	£15,422	£1,849	G	£11,026	£11,475	4.1%	£603	£1,246
Other Nhs Clinical	47,786	50,014	2,228	£38,001	£40,855	£2,854	G	£795	£817	2.8%	£1,100	£1,754
Outpatients	121,559	123,057	1,498	£30,566	£31,287	£721	G	£251	£254	1.2%	£369	£352
Total	230,155	228,343	(1,812)	£206,749	£208,115	£1,366	G				£6,640	(£5,274)

Summary

Income is favourable against plan due to changes in respect of the national genomics contract and the overperformance on CCG commissioned income. The adverse activity variance is partially due reduced elective attendances within the organisation partially driven by beds and increased complexity.

The key activity year to date variances are summarised below:-

Elective is 439 adverse to plan excluding excess bed days and this is due to the under-performance within paediatric surgery, urology and paediatric trauma & orthopaedics 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) has an adverse variance of 1,031. This is due to reduced levels for PICU & CICU as some beds remain unoccupied across the Trust.

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

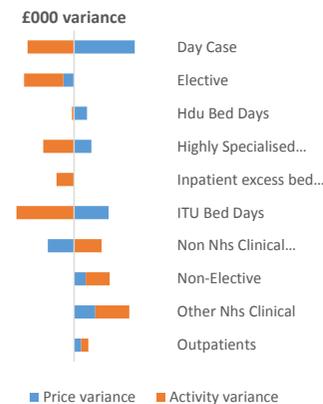
Non-elective activity is due to increases in paediatric surgery, nephrology, neurology and neurosurgery.

Other NHS clinical income Includes:-

- Flex to freeze estimated movement £450k
- Additional funding for delivery cystic fibrosis second line screening £59k
- Prior year benefit of £184k between year end and final activity values

Outpatients activity is favourable driven by increased radiology attendance from July.

Price and activity variance



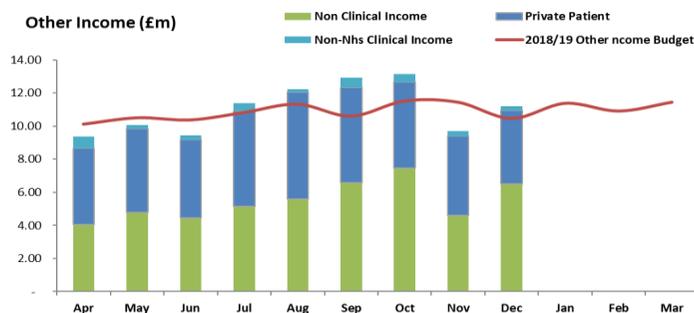
RAG Criteria:
Green Favourable Variance to plan
Amber Adverse Variance to plan (< 5%)
Red Adverse Variance to plan (> 5% or > £0.5m)

2018/19 Other Income for the 9 months ending 31 Dec 2018

Great Ormond Street 
Hospital for Children
NHS Foundation Trust

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	£5,136	£4,452	(£684)	£47,359	£46,786	(£573)	R	
Non NHS Clinical Income	£4,396	£340	£228	(£112)	£3,302	£3,430	£128	G	
Non-NHS Clinical Income	£67,941	£5,476	£4,680	(£796)	£50,661	£50,216	(£445)	A	
Education & Training	£8,676	£723	£765	£42	£6,507	£6,084	(£423)	A	
Research & Development	£22,530	£1,692	£1,728	£36	£16,920	£19,698	£2,778	G	
Non-Patient Services	£771	£58	£35	(£23)	£579	£521	(£58)	A	
Commercial	£1,603	£121	£114	(£7)	£1,204	£1,131	(£73)	A	
Charitable Contributions	£6,248	£469	£906	£437	£4,692	£5,513	£821	G	
Other Non-Clinical	£23,097	£1,923	£2,957	£1,034	£16,580	£16,240	(£340)	A	
Non Clinical Income	£62,925	£4,986	£6,505	£1,519	£46,482	£49,187	£2,705	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 adverse to plan in month (£0.7m), and £0.6m adverse YTD. Revenue within Cardiac Surgery, Neurology, ENT and PICU is above plan; although this is being offset by lower activity within Gastro, Cancer, Cardiac and Respiratory. PICU has seen an uplift in activity due to the increasingly complex referrals that have been received that need access to ICU beds.
- Research income is £2.8m above plan YTD due to increased grants and recognition of the income associated with the achievement of milestones within current grants. A number of grants have also finished and the final costs and associated income have been recognised in the accounts.
- Other Non-Clinical income is £1.0m favourable in month due to the income received to fund the AfC pay award for which £2.0m has been received YTD; this is not budgeted for (in line with NHSI guidance). This has been offset by the Trust wide income better value targets being included here within the Trust annual plan.

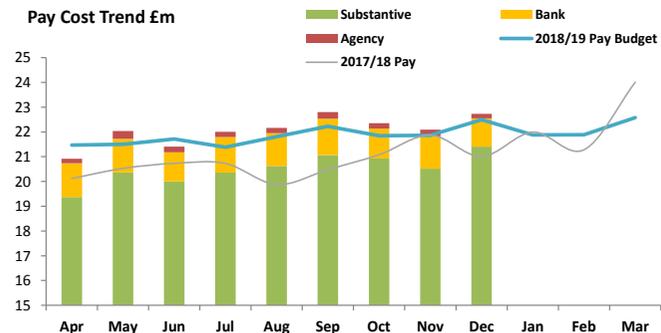
Workforce Summary for the 9 months ending 31 Dec 2018

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

Em including Perm, Bank and Agency Staff Group	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)	
Admin (inc Director & Senior Managers)	36.9	1,136.1	43.3	34.7	1,076.7	43.0	2.2	59.4	1.9	0.2	G
Consultants	39.2	355.7	146.9	38.0	337.7	150.0	1.2	18.0	2.0	(0.8)	G
Estates & Ancillary Staff	3.0	130.4	30.8	3.0	125.6	31.8	0.0	4.8	0.1	(0.1)	G
Healthcare Assist & Supp	7.3	315.2	30.7	6.6	283.9	31.1	0.6	31.4	0.7	(0.1)	G
Junior Doctors	19.1	355.2	71.7	19.7	331.4	79.1	(0.6)	23.8	1.3	(1.9)	R
Nursing Staff	59.4	1,620.6	48.9	58.3	1,551.4	50.1	1.1	69.2	2.5	(1.4)	G
Other Staff	0.4	8.7	54.0	0.2	5.0	59.6	0.1	3.7	0.2	(0.0)	G
Scientific Therap Tech	36.1	918.3	52.4	35.1	878.7	53.3	1.0	39.5	1.6	(0.6)	G
Total substantive and bank staff costs	201.3	4,840.2	55.5	195.7	4,590.4	56.8	5.6	249.8	10.4	(4.8)	G
Agency	0.4	8.1	61.7	2.1	43.3	64.2	(1.7)	(35.2)	(1.5)	(0.2)	R
Total substantive, bank and agency cost	201.7	4,848.3	55.5	197.8	4,633.7	56.9	3.9	214.5	8.9	(5.0)	G
Reserve*	(5.3)	(184.0)	0.0	0.8	0.0	0.0	(6.1)	(184.0)	(7.6)	1.5	R
Total pay cost	196.3	4,664.2	56.1	198.5	4,633.7	57.1	(2.2)	30.5	1.3	(3.5)	R
Remove Maternity leave cost				(2.3)			2.3			2.3	G
Total excluding Maternity Costs	196.3	4,664.2	56.1	196.2	4,633.7	56.5	0.1	30.5	1.3	(1.1)	G

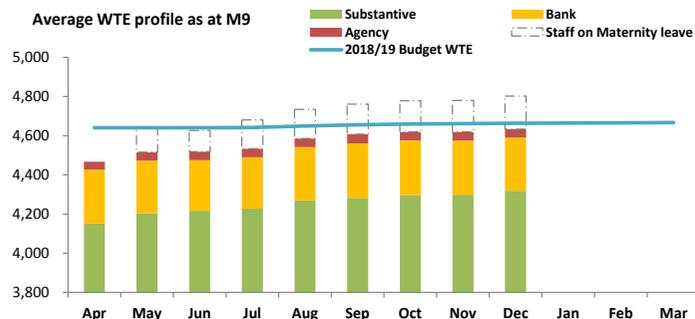
*Plan reserve includes WTEs relating to the better value programme

Pay Cost Trend £m



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

Average WTE profile as at M9



Summary

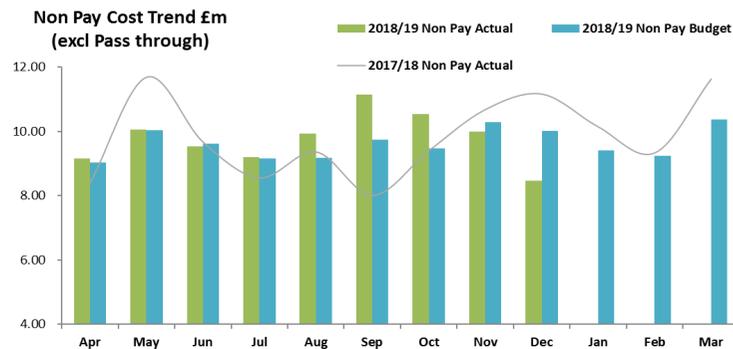
- YTD actual pay spend is £198.5 m which is £2.2m adverse to plan. A key contributor to this overspend is the additional pay in relation to the AfC Pay Award (£2.0m); funding of £1.9m has been provided for but is captured within Non-Clinical Revenue. The value of funding to GOSH has been reduced following an increase in the clawback value by the DoH for staff working on Private Patients (£0.3m).
- The table above does not include 168.5 contractual WTE for staff on maternity leave which cost £2.3m YTD. If this cost is excluded then the average cost per WTE is higher than plan by £0.4k per WTE.
- Substantive and bank staff YTD costs are £5.6m below plan, due to vacancies which can be seen by the £10.4m volume variance. These vacancies are being partially offset by the increased cost of staff (partially offset by AfC funding) and the £2.1m agency spend predominantly within PICU & Pharmacy.
- The reserve line contains the unallocated pay better value target which is offsetting the underspend within pay.
- A number of the 118 newly qualified nurses that started on the 24th September are working as supernumerary as they undergo their induction training within the Trust.
- We are not expecting to breach the agency ceiling set by NHSI and the Trust is currently below the YTD agency ceiling.

Non-Pay Summary for the 9 months ending 31 Dec 2018

Non-Pay Costs (excl Pass through) YTD				
	Budget (£m)	Actual (£m)	Variance	RAG YTD Actual variance
Drugs Costs	8.52	7.02	1.50	G
Blood Costs	1.56	1.50	0.06	G
Business Rates	2.97	2.89	0.08	G
Clinical Negligence	5.31	5.31	0.00	G
Supplies & Services - Clinical	31.56	31.80	(0.24)	A
Supplies & Services - General	2.81	3.96	(1.14)	R
Premises Costs	24.78	24.05	0.73	G
Other Non Pay	9.02	11.42	(2.41)	R
Total Non-Pay costs	86.54	87.95	(1.41)	R
Depreciation	15.32	15.16	0.16	G
PDC Dividend Payable	5.63	5.83	(0.20)	A
Total	107.49	108.94	(1.45)	R

Top 5 YTD Clinical* Non Pay overspends by Speciality (£m)				
	YTD 2018/19 Budget (£k)	YTD 2018/19 Actual (£k)	Variance (£k)	Trend
Genetics	2,250	2,833	(582)	↑
Nephrology	2,127	2,691	(564)	↑
Cardiac Critical Care	1,308	1,842	(534)	↑
Bone Marrow Transplant	1,973	2,252	(279)	↑
Wards (Exc. Haem/Onc)	779	964	(185)	↑

Top 5 YTD Clinical* Non Pay underspends by Speciality (£m)				
	YTD 2018/19 Budget (£k)	YTD 2018/19 Actual (£k)	Variance (£k)	Trend
Neuromuscular	735	30	706	↑
Cardiac Serv	3,760	3,429	331	↑
Clinical Immunology	1,517	1,265	252	↑
Snaps	636	391	245	↑
Critical Care Barrie	2,749	2,535	215	↑



*Clinical non-pay excludes passthrough

Summary

- YTD non-pay excluding pass through is adverse to plan by £1.5m. A key driver is the YTD increase in the impairment of receivables of £3.2m. This is driven by the delayed payment of private patient income, this drives the Other Non Pay variance.
- The M9 increase in the impairment of receivables was partially offset by the continued underspend in premises associated with reductions in software maintenance contracts and below plan drugs costs linked to activity. Supplies & Services General continues to be overspent due to increased catering costs.

Top 5 clinical over/under spends

The key areas with Non-pay overspends are:

- Genetics** - higher than plan Next Generation Sequencing and lab consumables linked to the Genetics reconfiguration
- Nephrology** - The majority of the overspend relates to Drugs costs and Blood costs which correlates to the over performance in NHS Clinical Income.
- Cardiac Critical care** - This overspend is driven by ECMO related expenditure for high value patient activity
- Bone Marrow Transplant** - Mainly driven by spend on blood and in line with over-performance on activity versus plan.
- Wards (Exc. Haem/Onc)** - Mainly driven by spend on Ward drugs in line with activity.

The key areas of Non-pay underspends are:

- Neuromuscular** - continues to underspend on splints, braces and drugs.
- Cardiac Service** - underspent by £0.3m due to delays in opening of Alligator Ward.
- Clinical Immunology** - underspend mainly due to a positive variance against drug costs, in line with an under-performance on activity.
- SNAPS** - consumables underspend due to lower activity.
- Critical Care (PICU/NICU)** - underspends due to NHS activity volume shortfall against plan driven by low referrals.

RAG Criteria:

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

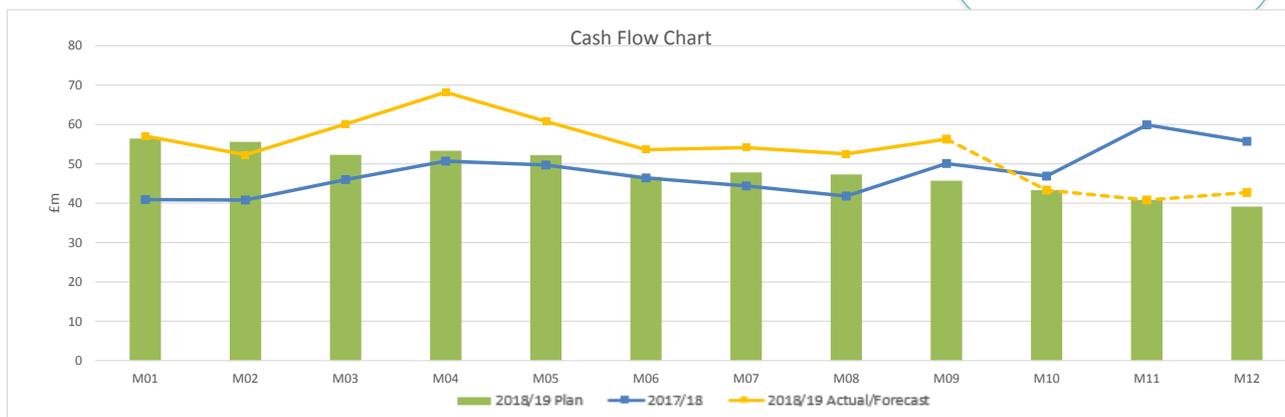
Cash, Capital and Statement of Financial Position Summary for the 9 months ending 31 Dec 2018

31 Mar 2018 Audited Accounts £m	Statement of Financial Position	YTD Plan 31 Dec 2018 £m	YTD Actual 31 Dec 2018 £m	YTD Variance £m	Forecast Outturn 31 Mar 2019 £m	YTD Actual 30 Nov 2018 £m	In month Movement £m
463.29	Non-Current Assets	503.09	484.19	(18.90)	492.85	480.78	3.41
85.92	Current Assets (exc Cash)	94.58	98.62	4.04	82.18	96.58	2.04
55.69	Cash & Cash Equivalents	45.71	56.28	10.57	55.79	52.50	3.78
(69.95)	Current Liabilities	(70.78)	(76.68)	(5.90)	(63.88)	(70.16)	(6.52)
(5.51)	Non-Current Liabilities	(5.03)	(5.12)	(0.09)	(4.87)	(5.17)	0.05
529.44	Total Assets Employed	567.57	557.29	(10.28)	562.07	554.53	2.76

31 Mar 2018 Audited Accounts £m	Capital Expenditure	YTD Plan 31 Dec 2018 £m	YTD Actual 31 Dec 2018 £m	YTD Variance £m	Forecast Outturn 31 Mar 2019 £m	RAG	YTD variance
5.81	Redevelopment - Donated	17.35	7.81	9.54	11.10	R	
9.06	Medical Equipment - Donated	4.09	4.42	(0.33)	8.54	G	
9.78	ICT - Donated	16.00	13.77	2.23	16.01	A	
24.65	Total Donated	37.44	26.00	11.44	35.65	A	
6.99	Redevelopment & equipment - Trust Funded	7.26	3.52	3.74	5.03	R	
1.61	Estates & Facilities - Trust Funded	2.33	0.66	1.67	2.02	R	
4.73	ICT - Trust Funded	8.45	6.24	2.21	12.30	A	
13.33	Total Trust Funded	18.04	10.42	7.62	19.35	R	
37.98	Total Expenditure	55.48	36.42	19.06	55.00	A	

31-Mar-18	Working Capital	30-Nov-18	30-Nov-18	RAG	KPI
19.00	NHS Debtor Days (YTD)	7.0	8.0	G	< 30.0
189.00	IPP Debtor Days	217.0	207.0	R	< 120.0
27.70	IPP Overdue Debt (£m)	30.9	31.4	R	0.0
5.00	Inventory Days - Drugs	6.0	10.0	G	7.0
70.00	Inventory Days - Non Drugs	79.0	88.0	R	30.0
35.00	Creditor Days	25.0	26.0	G	< 30.0
70.3%	BPPC - NHS (YTD) (number)	43.2%	43.5%	R	> 95.0%
43.3%	BPPC - NHS (YTD) (£)	80.9%	81.1%	R	> 95.0%
89.3%	BPPC - Non-NHS (YTD) (number)	84.4%	84.8%	R	> 95.0%
85.0%	BPPC - Non-NHS (YTD) (£)	90.3%	90.6%	G	> 95.0%

RAG Criteria:
 NHS Debtor and Creditor Days: Green (under 30); Amber (30-40); Red (over 40)
 BPPC Number and £: Green (over 95%); Amber (95-90%); Red (under 90%)
 IPP debtor days: Green (under 120 days); Amber (120-150 days); Red (over 150 days)
 Inventory days: Green (under 21 days); Amber (22-30 days); Red (over 30 days)



Comments:

- The capital programme is £18.7m behind plan (£7.2m Trust funded and £11.5m donated). The following Trust funded programmes have slipped against plan; Network/Wi-Fi hardware (£0.5m); various estates projects (£1.8m); Phase 4 (£0.9m) and MEDU (£1.1m).
- Cash held by the Trust is higher than plan by £10.6m. The variance was largely as a result of lower than planned expenditure on Trust funded capital projects (£7.6m).
- Total Assets employed at M09 was £10.3m lower than plan as a result of the following:
 - Non current assets totalled £480.8m (£18.9m less than plan largely as a result of the slippage on Estates and IT projects);
 - Current assets excluding cash less Current liabilities totalled £21.9m (£1.9m lower than plan).
 - Cash held by the Trust totalled £56.3m (£10.6m higher than plan)
 - Non current liabilities totalled £5.1m (£0.1m higher than plan)
- Overdue IPP debt increased in month to £31.4m (£30.9 in M8). This increase largely relates to debt from Embassies which fall outside terms.
- IPP debtor days decreased from 217 days to 207 days.
- The cumulative BPPC for NHS invoices (by number and value) improved slightly in month since M07
- The cumulative BPPC for Non NHS invoices (by number and value) also improved slightly since M07
- Creditor days increased in month to 26 days but this remains within target of 30 days.

Trust Board 7 February 2019	
CQC Readiness Update	Paper No: Attachment T
Submitted by: Dr Sanjiv Sharma, Acting Medical Director	
Aims / summary The aim of this report is to provide the Board with an update on the Trust's progress with CQC readiness in preparation for future inspections. The report provides an overview of the work streams being undertaken to ensure the ongoing management of compliance with the Trust. An overview of the plan of work is incorporated which includes an overview of the mock inspection framework (CQC Quality Rounds) that is being produced.	
Action required from the meeting To note the Trust's plan for CQC readiness and support the on-going work streams detailed within, providing any feedback to the Acting Medical Director.	
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	
Who needs to be told about any decision? Dr Sanjiv Sharma, Acting Medical Director Salina Parkyn, Head of Quality and Safety	
Who is responsible for implementing the proposals / project and anticipated timescales? Quality and Safety team, Directorate Management teams with support where needed	
Who is accountable for the implementation of the proposal / project? Dr Sanjiv Sharma, Acting Medical Director	

CQC Readiness Update January 2019

Dr Sanjiv Sharma, Acting Medical Director

Report contents

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CQC quality rounds- short term implementation	Page 9

CQC Inspection

- The Trust received the routine provider information request (RPIR) from the CQC on 02/01/2019 indicating that that the CQC were due to inspect the Trust within the next **6 months** and will inspect Well-Led and *at least* one core service.
- The Trust has since agreed with the CQC that any potential inspection and RPIR be delayed until the second half of the calendar year due to the significant resource required for the upcoming EPIC roll out. This will remain an unannounced inspection which will inspect Well-Led and *at least* one core service.

CQC Readiness

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

The initial work being undertaken will include:

- Weekly Steering Groups with Deputy Chiefs of Service
- Mock inspection framework (CQC Quality Rounds) being drafted and implemented
- Service line meetings with Directorates and Medical Director established and on-going
- Communication plan being drafted
- CQC action plan routinely monitored and scrutinised
- Gap analysis of information for RPIR being undertaken for future request
- Work to review potential areas/sources of learning being undertaken e.g. review of themes from other CQC reports, evaluation of insight reports

Driver Diagram

Ongoing management of Trust compliance

CQC Readiness

Trust compliance

RPIR submitted

Quality Rounds established

Learning from CQC completed

Compliance register up to date

Identification of Information & Executive leads

Progress Tracker

Submission Received

Steering group review of submission & finalisation

Quality Round framework agreed

Quality Round teams identified & agreed

List of wards/areas for review confirmed

Scheduling of review dates with QR teams & wards/areas

Quality Round progress tracker

Guidance & comms for areas receiving a Quality Round

Evaluation of CQC insight reports

Evaluation of CQC inspection reports from acute centres/paediatrics

Review and action of local action plans

Review and action of previous negative comments

Updated contacts (Responsible Leads & Exec Leads)

Updated status of current items in the Register

Identification and status of new items to be added

Finalisation of working document

Trust compliance plan - overview

18/19 Q4	19/20 Q1	19/20 Q2	19/20 Q3	19/20 Q4	20/21 Q1	20/21 Q2	20/21 Q3
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RPIR submitted
(delayed until later in 2019)

Quality Rounds– ‘Well-Led’ to be integrated into all				Quality Rounds– Peer review across Directorates
SAFE rounds	EFFECTIVE rounds	CARING rounds	RESPONSIVE rounds	

Learning from CQC

Compliance register maintenance

Quality Round Framework

Current work:

- Project plan in place for Quality Round Framework (QRF)
- Executive team have provisionally agreed to the project plan and suggested that Directorates are paired to undertake the QRs as peer reviews
- CQC inspection framework reviewed and amended to be the foundation of the Quality Round (QR) reviews
- Agreed that in year one, the QRs will focus on one CQC KLOE(key lines of enquiry) per quarter with Well-Led in continual review
- First focus area agreed as SAFE; followed by Response, Caring and then Effective
- SAFE QR form drafted and currently being digitized to enable the QR teams to complete the form on Ipad. Form has been designed to be user friendly and to minimise administration requirements where possible
- Quality Round information leaflets for staff and for QR teams being drafted; this will brief staff on the expectation of the QRs and also of their responsibilities

Next steps:

- Pilot SAFE QR form (pilot to be undertaken by Q&S staff) and then share with Executive team for approval
- Information leaflets and comms plan to be finalised and implemented
- Timetable for Quality Rounds to be agreed and finalised
- Intranet site to be updated to include information on Quality Rounds (in the future plan there will be scope to include data analysis from the QRs once these have been established and a full cycle undertaken)
- Framework documentation to be drafted in parallel with on-going work

CQC Quality Rounds– long term implementation

18/19 Q4	19/20 Q1	19/20 Q2	19/20 Q3	19/20 Q4	20/21 Q1	20/21 Q2	20/21 Q3
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Establish round teams

Finalise QR framework

Prioritise areas for review

Quality Rounds– ‘Well-Led’ to be integrated into all

SAFE rounds

EFFECTIVE rounds

CARING rounds

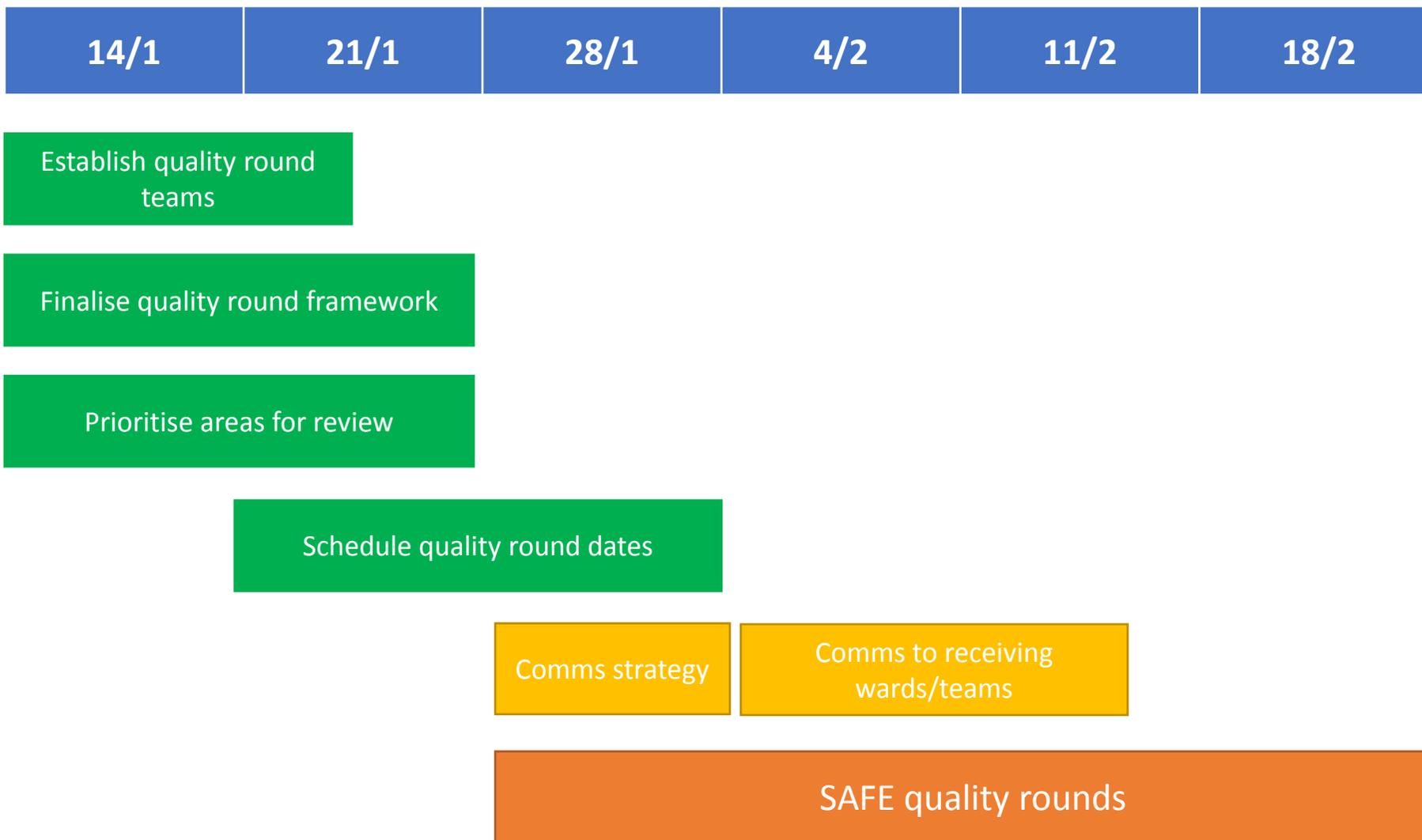
RESPONSIVE rounds

Identify and implement digital solution

Prioritise areas for review

Quality Rounds– Peer review across Directorates

CQC Quality Rounds– short term implementation



Trust Board 7 February 2019	
GOSH Well Led CQC Assessment Update	Paper No: Attachment
Submitted by: Matthew Shaw, Chief Executive	
Co-presented by Matthew Shaw, CEO and Anna Ferrant, Company Secretary	
Aims / summary To provide the Board with an update on progress with preparation for the CQC Well Led assessment in autumn 2019.	
Action required from the meeting To note progress with the preparations for the well led assessment including: <ul style="list-style-type: none"> • Progress with closure of actions against the independent Well Led Governance Review conducted in October 2016. • Progress with closure of actions against the negative commentary presented in the April 2018 CQC Well Led Report. • The action plan to close gaps around the eight CQC Well Led Key Lines of Enquiry (KLOEs). 	
Contribution to the delivery of NHS Foundation Trust strategies and plans Good governance	
Financial implications None	
Who needs to be told about any decision? Progress with the preparation for the review will be shared with the Council of Governors. The KLOE action plan will be shared with the Senior Management Team.	
Who is responsible for implementing the proposals / project and anticipated timescales? Executives	
Who is accountable for the implementation of the proposal / project? Chief Executive	

GOSH Well Led Assessment CQC Assessment Update

The Trust has been advised that the next CQC scheduled Well Led Assessment will be conducted in autumn 2019. In preparation for this assessment, the executive team have conducted a review of evidence against the 8 Key Lines of Enquiry under the Well Led Governance Framework.

As part of preparation for the assessment, the executive team have reviewed progress with responses to the following:

- closure of actions against the recommendations in the independent Well Led Governance Review conducted by Deloitte in October 2016.
- closure of actions against the negative commentary presented in the April 2017 CQC Well Led Report.

Any outstanding actions from these two reports have been included in an overarching actions plan in preparation for the Well Led assessment later this year. Further details are outlined below.

Progress against recommendations in the independent Well Led Governance Review conducted in October 2016

Under guidance from NHS Improvement, providers are encouraged to carry out externally facilitated, developmental reviews of their leadership and governance using the well-led framework every three years. The last independent GOSH Well Led Governance Review was conducted between June – October 2016. Following an open competition, Deloitte LLP was selected as the preferred bidder to conduct the review.

By January 2018, 23 out of 36 recommendations had been actioned. **Appendix 1** (in a separate pack for information only) provides a list of the 13 outstanding actions to deliver the recommendations. The actions against those recommendations that require further work have been carried over into the Well Led Assessment Action Plan 2019 (see below).

Progress with actions against the negative commentary presented in the April 2017 CQC Well Led Report.

Whilst the CQC made no formal recommendations to the Trust in relation to the findings in its Well Led Assessment published in April 2018, the Trust took it upon itself to review any negative commentary in the report and ensure that relevant actions were taken to mitigate the issues raised.

Appendix 2 (in a separate pack for information only) provides a list of outstanding actions to mitigate the negative comments raised. The actions against those comments that require further work have been carried over into the Well Led Assessment Action Plan 2019 (see below).

Assessment against the 8 Key Lines of Enquiry under the Well Led Governance Framework.

The executive team have reviewed evidence against the KLOEs and developed a draft action plan in preparation for the Well Led assessment conducted by the CQC later in the year (see **Appendix 3** in a separate pack for information). This incorporates any outstanding actions from the Deloitte externally-facilitated review and the previous CQC Well Led report, as

noted above. The action plan will continue to be updated as other work is identified. Progress with the plan will be monitored by the Executive Management Team.

The executive team has also started to collate evidence against each of the 8 KLOEs along with a narrative explaining the evidence, examples and gaps. Copies of this will be made available to the Board once refined.

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

- Ensuring that strategies and associated plans are developed, consulted on, communicated across the Trust, monitored and implemented.
- Ensuring that governance frameworks, procedures and policies are in place and up to date.
- Ensuring staff (all groups) and director appraisals and mandatory training targets are met.
- Reviewing how strategy, decisions, changes to practice, learning from risks are communicated across the Trust to all staff groups.
- Ensuring that directors and senior managers are visible to staff.
- Being deliberate about documenting:
 - Progress with strategic and local partnerships.
 - Responding to external benchmarked data such as the staff survey results etc.
 - Progress with actions against internal and external reviews of GOSH services.

Anna Ferrant, Company Secretary and Louisa Desborough, Strategic Partnerships Adviser to the CEO.

Rec. No.	Recommendation	Progress/ Comments
		<ul style="list-style-type: none"> • Nursing Involvement in Service Development • Nursing staff Support • Nursing Careers • Nursing Knowledge <p>Staff were able to give their feedback anonymously to encourage them to be either positive and/or negative in their feedback. 351 comments were received over 7 sessions. A report was submitted to the Trust Board in December 2018 with follow up at QSAC in January 2019.</p> <p>Following the staff consultation on the clinical operations restructure and appointment of the new roles across the directorates, an event was held off site to support the new teams getting to know one another and working together.</p> <p>The annual staff survey is now sent to all staff and not a random selection of staff.</p> <p>A proposal has been presented at EMT making recommendations for staff engagement with senior leaders, including senior team involvement in CEO communications. These proposals are for Trust-wide communications, to augment existing staff engagement by leaders.</p> <p>Following comments arising from the 2018 CQC report, the Communications Team is working with an external provider to develop a stakeholder relations strategy, mapping our stakeholder relations strategy, mapping our stakeholders and developing a plan for engagement. (ADDED TO WELL LED ACTION PLAN)</p>
10	<p>Commission an ongoing Board development programme. This programme should include informal time for BMs to meet together and opportunities to reflect on the Board's effectiveness and contribution towards enabling GOSH to become the leading children's hospital in the world.</p>	<p>The Kings Fund (KF) has been appointed to provide support and run a development programme for the executive team. In addition, the KF will also provide topic based support (masterclasses) for the Board - presenting on key issues that are relevant to the role of the Board within the current NHS which will support all Board members to remain updated on key external matters affecting the Trust or influencing decisions that affect the Trust. The Advisory Board will provide similar masterclasses (the Trust is a member). The opportunities provided by the KF and the Advisory Board will be considered as part of a Board development programme, led by the new Director of HR and OD. (ADDED TO WELL LED ACTION PLAN)</p>
11	<p>A follow-up review by Deloitte in the Summer of 2017 to independently verify the progress that has been made in implementing the recommendations of this report.</p>	<p>The Board is considering when the next external independent review of the Trust governance framework will be conducted. Q1 2019/20 has been proposed, noting the timing of the forthcoming CQC Well Led Inspection in Autumn 2019. (ADDED TO WELL LED ACTION PLAN)</p>
13	<p>Introduce 360 degree feedback for EDs and NEDs from Board colleagues and from Councillors to improve the quality of appraisal discussions.</p>	<p>The Trust is road-testing a new tool for 360 degree appraisal of executive directors. This will be piloted in March 2019. (ADDED TO WELL LED ACTION PLAN)</p>

Rec. No.	Recommendation	Progress/ Comments
15	As part of the Board development programme, ensure that sufficient time is allocated to considering why GOSH is successful, the risks to that continued success and the role of the Board in sustaining and furthering that success.	This recommendation is now rolled in to recommendation 10A (see above). The executive team have conducted a review of the work underway across the team and mapped out delivery dates and reporting timelines to the Board. The executive team plan to discuss with the NEDs the vision for the Trust. A meeting has been set for May 2019 for an initial discussion followed by a full presentation on options for the October Strategy Board Day. (ADDED TO WELL LED ACTION PLAN)
16	Align the Board Code of Conduct to the Trust's 'Always' values and ensure that BM objectives include reference to the importance of role modelling these values and behaviours.	Council code updated, approved and rolled out to Governors Board code updated and subject to approval at the February Board (ADDED TO WELL LED ACTION PLAN)
20	Comprehensively explore the culture of the organisation to identify whether any changes need to be made.	The new Head of OD will lead on this. The approach will need to be congruent and consistent with the Board and wider leadership development needs analysis - both of which are now underway. A risk has been included on the Board Assurance Framework around culture at GOSH and will be actively monitored by the Board:
21	Introduce a tool, such as a 'culture barometer', to measure and monitor aspects of GOSH's culture to provide greater Board oversight of this important area.	<p>The risk that GOSH fails to develop its culture in alignment with its strategy and values, impacting on:</p> <ul style="list-style-type: none"> • The effective implementation of plans and policies across the Trust and the associated impact on safety and quality of services and the patient and family experience. • The ability of the Trust to attract competent staff and promote the Trust as a place to work and feel engaged. • Missed market opportunities arising from a failure to remain agile and connected and adapt to the ever-changing NHS landscape. • The Trust's reputation with partners, commissioners, regulators, the NHS and the public. <p>It includes focus on the development of an organisational development strategy/plan and statement about the Trust's intended culture.</p> <p>Work is underway to develop an action plan to respond to the results from the 2018 staff survey. (ADDED TO WELL LED ACTION PLAN)</p> <p>A workforce strategy is also under development. A leadership strategy is part way developed and will be considered at EMT over the next few months. (ADDED TO WELL LED ACTION PLAN)</p>
26	Introduce improvements to the Board and Committee administration to ensure smooth-running support.	<p>Boardpad has been replaced with Diligent (an digital system for accessing board papers)</p> <p>A new Deputy Company Secretary appointed with focus on work between Board and Council.</p> <p>Work underway to conduct a corporate governance review of all committees</p> <p>All Board assurance committees have conducted an effectiveness review in 2018 and actions have been implemented</p>

Appendix 2 - Progress with actions against the remaining open negative commentary presented in the April 2017 CQC Well Led Report.

ID	Issue Highlighted in CQC 2018 Report	Update/ action
4	Some staff we spoke to were unable to describe learning implemented in relation to serious incidents. There was limited evidence of shared understanding of key learning issues throughout the trust.	<p>The assurance and escalation framework is under review. The risk escalation process has been revised, documented and shared at OPDG (now OB) and EMT and Board.</p> <p>Learning from events have been re-established.</p> <p>SI reports are shared at the Patient and Safety Outcomes Committee (PSOC) and information is to be cascaded to teams from PSOC representatives. SI reports are under review.</p> <p>The risk management strategy is under review. (ADDED TO WELL LED ACTION PLAN)</p>
5 6 41	<p>The trust missed opportunities for engagement with some of the local stakeholders. The trust does not demonstrate open and positive relationships with key stakeholders. It was not sharing information promptly and was often defensive when challenged on performance and safety.</p> <p>The trust did not proactively engage and lead on paediatric care and treatment locally.</p> <p>.....The trust was located within the footprint for North Central London sustainability and transformation partnerships (STP). Although the trust was fully supportive of a joined up local planning process to deliver transformational change, they felt the STP model did not directly correlate with the trust's tertiary services model which extended both across London but also throughout England.</p> <p>.....The trust did not take a proactive role in using their considerable expertise and resources to show leadership in working together with other regional and local providers of children and young people's care.</p>	<p>Great Ormond Street Hospital sits geographically with the North Central London (NCL) Sustainability & Transformation Plan (STP). GOSH has only 2.3% of patients funded via the NCL CCG network, with the majority of income commissioned via NHSE (85.7%) and other NHS organisations (i.e. non NCL CCGs) (12.0%). The Trust is engaged on the relevant paediatric child health agendas within the NCL STP. GOSH Directors attend professional meetings i.e. the STP CEO, STP Medical Director, STP Human Resources Director and STP Directors of Finance Meetings.</p> <p>Reporting from the STP professional groups to be built in as standing agenda item on EMT.</p> <p>Various examples of partnership working are documented.</p> <p>Stakeholder relations strategy under development. (ADDED TO WELL LED ACTION PLAN)</p>
7	Pharmacy services did not report any key performance indicators directly to the board meaning there was a limited accountability or oversight of this service.	<p>Hospital Pharmacy Transformation Programme underway and reviewed as business as usual to relevant committees. (ADDED TO WELL LED ACTION PLAN)</p> <p>Medicines management annual report to be reviewed. (ADDED TO WELL LED ACTION PLAN)</p>
8	The trust did not provide assurances that all incidents were being properly recorded in a central database of patient safety incident reports and shared with external partners. The trust did not resolve an issue with uploading information into the central system which was brought to their attention as early as August 2017.	The Trust has had a central database to record incidents since 2003, the web based application was rolled out in 2013. The Trust discovered an issue with the uploading of incidents to the NRLS in July 2017 and raised the concern with the NRLS and Datix. Work to resolve the issue commenced immediately with the root cause of the problem not been easily identifiable. However, Datix, the NRLS team and the patient safety team worked together to resolve the technical issue that was identified between Datix and the NRLS.

ID	Issue Highlighted in CQC 2018 Report	Update/ action
9	<p>Staff felt learning from high profile cases had not always been implemented or sufficiently considered by the trust leaders. High profile cases often impacted on day to day service oversight and the trust’s leaders did not always fully plan for additional operational pressures nor implement prevention mechanisms to minimise this impact.</p>	<p>The Trust has conducted a review following the high profile media case in 2017. The review looked at how the Trust managed the case and supported staff with the following objectives:</p> <ul style="list-style-type: none"> -To provide emotional support to staff -To listen and respond to staff affected by the event -To learn from went well and what needed improving so that we have a framework that can be employed for any future similar events -To share learning -To gather, reflect upon and implement any appropriate recommendations <p>Actions are in the process of being implemented but include:</p> <ul style="list-style-type: none"> -Roll out of a revised and approved Acceptable Behaviour Policy (the Trust’ Conflict Resolution Policy has been refreshed and renamed as the Acceptable Behaviour Policy – plans are being put in place to roll this out. The aim of the policy is to identify inappropriate or unsafe behaviours that impact on the safe provision of care to patients; support staff and patients or careers to better understand what behaviours impact negatively on the safe provision of care to patients; end or reduce harm to staff and patients resulting from inappropriate or unsafe behaviours. The Policy embodies the Trust Always Values by drawing on the Always Welcoming commitment to provide a safe environment and the Always One Team commitment to working collaboratively to prove the best quantity care for children and young people.) (Progress with this ADDED TO WELL LED ACTION PLAN) - Provision of support for staff from external provides including psychologists - a Trust wide Schwartz round and facilitate a sharing experience event for those directly affected. - A technical Q and A sessions for staff to ask questions about how the case was handled and to learn for the future <p>Work with other providers dealing with similar cases including Alder Hey (sharing experiences and supporting staff)</p>
10	<p>The trust was in a process of addressing findings from an independent review of their governance framework which took place in 2016. They were still to complete work required to facilitate improvements in relationships between trust’s board and members’ council, as well as ensure inclusivity and address potential concerns of the members council. Evidence from the well-led inspection indicated that there had not been a dynamic pace of change in the past and additional support from the board is required to achieve this.</p> <p>The trust’s ‘member’s council’, established to hold the board’s non-executive directors to account, did not feel that the trust actively engaged them in governance. Those we were in contact with also felt the trust was not always transparent with them. Similarly, staff we spoke with did not always feel the trust assured their voices were heard and acted on.</p> <p>In 2016, the trust commissioned an independent review of their governance framework. The governance review report was prepared in October 2016 and noted some</p>	<p>A number of actions completed:</p> <ul style="list-style-type: none"> -New Council appointed and inducted. -Governors involved in review and approval of revised Trust Constitution outlining key ways governors will be kept involved -Governors worked to produce a development plan for their group development - Chair leads private meeting with Governors prior to every Council meeting -All governors allocated a NED buddy - Governors provided with access to GOSH email and GOSH GOLD Learning Site - Governors appraised of press cuttings on regular basis -Working with governors to agree implementation of new constituency boundaries and election timetable (CWG) -Governors and young people involved in the CEO recruitment stakeholder panels -Governors appointed from a shortlist the external auditors for the Trust - approved at December Council meeting -Governors invited to various events including Staff Forums when the Chair/ NEDs are in attendance; CEO leaving party etc. <p>BAF Risk 18 (culture) documents the controls in place to mitigate risks around the culture and the actions to be taken</p>

ID	Issue Highlighted in CQC 2018 Report	Update/ action
	<p>areas of strength including its comprehensive approach to risk management.However, they were still to facilitate improvement of relationship between trust's governing bodies (the board and members council), comprehensively explore the culture of the organisation and address some other issues raised in the report.</p>	<p>Actions to be undertaken:</p> <p>Work underway to develop a Governor portal - due for launch early February 2019 at Council meeting</p> <p>Development of an organisational development strategy/plan and statement about the Trust's intended culture (ADDED TO WELL LED ACTION PLAN)</p> <p>Risk Management Strategy requires updating(ADDED TO WELL LED ACTION PLAN)</p> <p>Action plan to respond to staff survey results 2018(ADDED TO WELL LED ACTION PLAN)</p> <p>Development of a workforce strategy(ADDED TO WELL LED ACTION PLAN)</p> <p>Development of a final Education and Training Strategy (ADDED TO WELL LED ACTION PLAN)</p> <p>Staff engagement strategy under development (ADDED TO WELL LED ACTION PLAN)</p> <p>Stakeholder engagement strategy under development (ADDED TO WELL LED ACTION PLAN)</p>
33	<p>Although nurses had access to leadership programmes they said the trust did not have an overall leadership training programme which would be beneficial to all. The approach taken by the trust was to provide separate training to different staff groups.</p>	<p>Band 7 leadership programme in place at the time of the CQC assessment. Leadership framework to support directorate teams approved and being rolled out.</p> <p>Director of Education in place to co-ordinate education across all staff groups.</p> <p>Trust Board has approved the concept of Learning Academy which is in development</p>
34	<p>The chief pharmacist reported into the medical director who had board level responsibility for medicines management. Multiple changes at board level over the last few years meant information exchange both up and down the organisation was not a smooth process. Although within the pharmacy department there was a clear leadership structure in place however this was not aligned to divisional structure set up within the trust.</p>	<p>Hospital Pharmacy Transformation Programme underway.</p> <p>Medicines management annual report to be reviewed</p> <p>Medicines Management Risk added to Board Assurance Framework (ADDED TO WELL LED ACTION PLAN)</p>
36	<p>The trust's policy stated that enhanced DBS checks should be repeated every three years, however, three of the fifteen files we reviewed contained DBS certificates that were more than three years old. The trust told us for remaining staff they had a log of the DBS reference numbers and all staff had relevant DBS checks in place.</p>	<p>The Recruitment and Selection Policy states:</p> <ul style="list-style-type: none"> - The Trust will assess an applicant's suitability for positions which are included in the Rehabilitation of Offenders Act (1974) (Exceptions) Order 1975 as amended) using criminal record checks processed through the Disclosure and Barring Service (DBS). Where a DBS certificate at either standard or enhanced level can legally be requested (where the position is one that is included in the Rehabilitation of Offenders Act (1974) (Exceptions) Order (1975) as amended) and where appropriate Police Act Regulations (as amended), the Trust can only ask an individual about convictions and cautions that are not protected. - In circumstances where a disclosure is positive, at interview, or in a separate discussion, the recruitment team shall ensure that an open and

ID	Issue Highlighted in CQC 2018 Report	Update/ action
		<p>measured discussion takes place on the subject of any offences or other matter that might be relevant to the position. Failure to reveal information that is directly relevant to the position sought could lead to withdrawal of an offer of employment. The Resourcing Service Manager will undertake to discuss any matter revealed on a DBS certificate with the individual seeking the position before withdrawing a conditional offer. The Trust will accept certificates registered under the DBS update service as long as the original certificate satisfies the required level of check for the role.</p> <p>DBS checks are conducted every 3 years from date of appointment. An audit will be conducted in April 2019. (ADDED TO WELL LED ACTION PLAN)</p> <p>The DBS process is subject to review and a paper will be brought to the EMT in February 2019 (ADDED TO WELL LED ACTION PLAN)</p> <p>Audit of compliance with DBS process to be conducted in April 2019 (ADDED TO WELL LED ACTION PLAN)</p>
38	<p>We found that copies of the director's application form, CV, job description and offer letter were kept on record by the trust. However, the trust's HR director told us that all paperwork related to the interview and assessment process were destroyed after 12 months. This meant we were unable to assess if the trust followed good practice in relation to recruitment and selection of their directors for the sample of files we viewed. Following the inspection the trust told us that paperwork was only destroyed for unsuccessful candidates. However, during the inspection we requested to see and were not provided with this information for the sample of director's files we reviewed.</p>	<p>The necessary paperwork is filed in HR for employed directors. An audit of the paperwork will be conducted in April 2019.</p>
40	<p>There was no separate medicines optimisation strategy.</p>	<p>Hospital Pharmacy Transformation Programme underway.</p> <p>Medicines Management Risk added to Board Assurance Framework</p> <p>Medicines management annual report to be reviewed</p> <p>(ADDED TO WELL LED ACTION PLAN)</p>
42	<p>The trust did not have a designated recruitment or workforce strategy that set out their approach to future workforce decisions and addressed the long-term risks associated with workforce planning.Nurses were unaware of workforce strategy and felt that there were no plans to retain experienced and skilled workforce but instead the trust was disproportionately focused on nurses' recruitment with little emphasis on retention.</p>	<p>Workforce plan is submitted to NHSI annually</p> <p>Workforce Strategy and Organisational Development Strategy to be developed once the Director of HR and OD is appointed (mid-March 2019) (ADDED TO WELL LED ACTION PLAN)</p>
43	<p>Nurses told us that they did not feel their contributions were always appreciated by the trust and they lacked nursing leadership at board level to ensure the nursing voice was heard within the organisation. They did not feel processes were equally applied to all staff groups and that they did not have an equal say when participating in multidisciplinary meetings.</p>	<p>New directorate structure strengthens nursing leadership. Restructure has created the Head of Nursing and Patient Experience role as part of the directorate leadership team</p> <p>Terms of reference revised for Nursing Board, Matrons meeting and Operational Sisters meeting.</p> <p>Following concerns raised by nursing staff and other professions about the changes to bank rate pay, the FTSU service met with nurses and healthcare assistants to hear feedback on the following four areas:</p> <ul style="list-style-type: none"> • Nursing Involvement in Service Development

ID	Issue Highlighted in CQC 2018 Report	Update/ action
		<ul style="list-style-type: none"> • Nursing staff Support • Nursing Careers • Nursing Knowledge <p>Staff were able to give their feedback anonymously to encourage them to be either positive and/or negative in their feedback. 351 comments were received over 7 sessions. A report was submitted to the Trust Board in December 2018 with follow up at QSAC in January 2019.</p> <p>Following the staff consultation on the clinical operations restructure and appointment of the new roles across the directorates, an event was held off site to support the new teams getting to know one another and working together.</p> <p>The Trust is implementing the Cognitive Institute Safety and Reliability Programme across the Trust from Board to Ward. This includes establishment of a safety champions' programme. The Programme addresses the influence and impact of organisational climate, leadership commitment, and high performance work practices on quality and safety in healthcare. The programme will provide a framework for the development of leadership competencies, a safety culture and will emphasise the importance of professional accountability. (ADDED TO WELL LED ACTION PLAN)</p>
45	The trust did not fully comply with recommendations set out by the freedom to speak up guidance and the National Guardian's Office.	The Trust has a Freedom to Speak Up Guardian and Ambassadors in place. The Guardian reports quarterly to the Quality and Safety Assurance committee (a Board committee) and annually to the Board. The Intranet site has rolling banners promoting the service and newsletters have been circulated to all staff. This has prompted staff to contact the service.
46	Board members told us they felt performance issues were escalated to the relevant committees and the structures established to resolve and manage them appropriately. However, we found some key issues or potential high risks were not always brought to board members attention at early stage. This included an anomaly in reporting to the national reporting and learning system (NRLS).	<p>The NRLS system issues were reported to executive Board members and mentioned verbally at a Board meeting at the time.</p> <p>A review has taken place of the GOSH Assurance and Escalation Framework - presented at the December 2018 Board meeting. This is in the process of being updated.</p> <p>The escalation risk route for risks has also been reviewed and updated - documented in one place and circulated to all senior managers.</p>
48	There was also a corporate risk register which was reviewed regularly and presented to the audit committee and the board. We found that the register was reflective of organisational risks and the score system used to assess risk allowed trust to set out mitigation actions accordingly. However, the senior leaders of the organisation did not always know of its existence and could not verbalise who had an oversight of the corporate risk register and what was the process for including risks on it.	<p>The Operational Board (OB) is now responsible for reviewing all trust wide risks and high rated risks.</p> <p>A revised risk escalation process highlights responsibilities</p> <p>Regular updates on the Board Assurance Framework to be presented at the Operational Board - awaiting the updated OB ToR</p>

ID	Issue Highlighted in CQC 2018 Report	Update/ action
49	<p>The trust had a system for the management of patients' safety alerts. However, they had a number of overdue Central Alerting System (CAS) alerts dating to September 2016, which were still incomplete. CAS alert system is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care. This is an area which had been raised for action by the interim medical director and monitored by service commissioners.</p>	<p>The Trust has a central monitoring system for the CAS alerts that are received. There are a number of alerts that remain open as the Trust does not have full assurance that the actions taken will mitigate the risk described in the alert. The CAS alerts are monitored at PSOC and at the CQRG (with the commissioners). The Trust's process is to keep the alert open until assurance is obtained that the action plan is complete and the change is sustainable. In June 2018, following our CQC report, NHS England wrote to all NHS Trusts reminding them of the need to complete the actions within the alert and for them not to be closed on the basis on an action plan.</p>
51	<p>Policy documents we reviewed were not unified for ease of reading and understanding by the targeted audience, document control sheets were not routinely used in every policy document reviewed by us, there was no standardised structure and layout.</p> <p>Some of the documents we reviewed were not adequately version controlled. For example, review date or version numbers were not recorded in the policy dated March 2015 referring to the Fit and Proper Persons Requirement. Where document control sheets were attached to a policy document they did not always contain required information. For example, Child Death Overview Information Sharing Policy did not note what amendments were introduced in December 2017 when the policy was reviewed and if the document was assessed against best-practice information governance policies and standards. Another policy despite noting on the cover sheet that it was in its final version had a document watermark placed on it saying it was a draft version. The policy also did not note when it was developed or when it was due to be reviewed (Safety Standards for Invasive Procedures Policy).</p>	<p>Policy owners use a standard template which has been refreshed.</p> <p>Guidance provided to all policy owners on drafting and updating of policies including document control papers, tracked changes showing updates made. Policy owners attend the PAG to present the changes at the meeting. The minutes of the PAG provide further assurance of the management of policies.</p> <p>Deputy Company Secretary provides regular updates on progress with policies to the PAG and SMT</p>
53	<p>We noted that information provided for the public on the trust website was not always easy to find, up to date or in a user-friendly form. The director of communication was aware of the issue and said the website was being updated and patients have been involved in setting out key priorities and consulted on the layout of the future website.</p>	<p>We have completed a review of the website architecture.</p>
54	<p>In August 2017, analysis by CQC indicated that there was a potential anomaly with GOSH NRLS data for one week in July 2017; the trust had reported 689 no harm incidents for one day. The trust responded that the 'blip' was because they had reorganised their divisional structures in 2016. As a result of this reorganisation (and moving of specialities within divisions), the trusts data team had remapped the reporting codes on the recording system to ensure that the trust could continue to review incidents accurately. Also, they had observed an anomaly within the upload system, as a result of remapping of codes, rather than a problem with GOSH reporting and governance processes. The trust expressed that they were confident that the issues they previously identified were now resolved.</p> <p>However, CQC noted that their data upload in September 2017 also contained an anomaly which indicated the issues was not resolved.</p>	<p>This technical anomaly is now resolved. No issues have been identified by the Patient Safety team, NRLS, Datix or the CQC.</p>

ID	Issue Highlighted in CQC 2018 Report	Update/ action
56	<p>We reviewed eight serious incident reports.</p> <p>.....there was limited evidence of shared understanding of key learning issues throughout the trust.</p> <p>.....some reports stated only the title of the approver rather than their full name, and some reports did not have the electronic incident reporting system reference number on (although all included the Strategic Executive Information System [STEIS] reference number). We also observed that the executive summaries did not summarise learning and recommendations from the investigation. There was no section in the SI report template to record any relevant safeguarding information.</p> <p>....we noted that one action plan did not address all recommendations made in the SI report, and two action plans had no completion date or assigned accountable person for the actions listed. Action achievement status had not always been updated.</p> <p>.....NHS England told us that the timeliness of completion of investigations remained an area of scrutiny and whilst it was clear that the trust completed any immediate actions, the delay in completing a report and sharing it with the family was an area for improvement.</p>	<p>The SI process is being reviewed with the input of the Deputy Chiefs of Service and the Heads of Nursing. (ADDED TO WELL LED ACTION PLAN)</p> <p>All of the SI reports, the one page fliers and the Trust wide learning is shared at PSOC and feed the 'learning from.....' Lunch time events. A 'Learning at GOSH' subgroup is being created so that all Trust wide learning is shared and disseminated.</p> <p>The SI reports have a consistent approach so that the author, approver and STEIS reference number are all clear by their titles and not individual names.</p> <p>All of the actions from the SI reports are listed onto Datix and are monitored electronically. These actions are audited by the Clinical Audit Manager. The hard copy reports will not be updated as once they are signed off as approved, the actions are monitored on Datix.</p>
57	<p>The trust told us that patients and families were informed of the notifiable safety incident in line with the requirements of the Duty of Candour (DoC) regulations. However, there was no mention of DoC in the SI reports, such as whether the incident met the criteria for DoC or if the DoC process had been implemented.</p> <p>We found variable standards of engagement with parents with regards to the duty of candour.</p>	<p>The Trust has a Duty of Candour Policy in place outlining how staff are open and transparent when responding to incidents. This policy requires updating including a process for staff to manage moderate harm cases in relation to Duty of Candour. (ADDED TO WELL LED ACTION PLAN)</p>
58	<p>Nurses told us that they did not always feel supported by the trust when they were dealing with grief; they provided examples where senior managers were slow to acknowledge difficulties and emotional strain faced by staff carrying for a child at their end of life.</p>	<p>Liaising with the bereavement co-ordinator on the support that is given</p>

Appendix 3

GOSH Well Led Assessment – January 2019 GAP ASSESSMENT AND ACTION PLAN

W1 KEY LINE OF ENQUIRY Is there the leadership capacity and capability to deliver high-quality, sustainable care?					
PROMPTS					
<ul style="list-style-type: none"> • Do leaders have the skills, knowledge, experience and integrity that they need – both when they are appointed and on an ongoing basis? • Do leaders understand the challenges to quality and sustainability, and can they identify the actions needed to address them? • Are leaders visible and approachable? • Are there clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership, and is there a leadership strategy or development programme, which includes succession planning? 					
Ref.	Source	Lead	Action	Deadlines	Status/ Comments
Board skills, knowledge and experience					
W1.A1	Gap assess	CoSec	Declaration of Interest Policy review	15 Mar 2019	Pending redraft of current policy and implementation of purchased IT system to record declarations
W1.A2	CQC report	CoSec	Mandatory training up to date for executives and NEDs Updates to go to EMT and board	EMT review Jan Board update Feb/March 2019	Acting Dir HROD has emailed an update on execs to Dep Co Sec. Report to Board members. Company Secretary to develop a dashboard including well led KPIs
W1.A3	Gap assess	CoSec	Appraisal process for newer NEDs to be completed	6 February Council meeting Board Apr 2019	Paper on Council of Governors' agenda in February 2019
W1.A4	Gap assess	EA (CEO)	Appraisals up to date for all exec team members	End Feb 2019	CF to look up on GOSH GOLD and book in any outstanding PDR meetings
W1.A5	Gap assess	HROD	Update to Nom Com on the process for exec succession planning and talent management	Nom Comm 3 rd Apr	Exec teams to nominate current staff that are important to develop for succession. Anna to circulate a template to populate. HROD does an annual assessment but will consider a wider ongoing process within the OD strategy.

					Executive organogram updated by Co Sec and circulated to Board in February 2019
W1.A6	CQC report	HROD	Review of performance against policy for board and SMT members: Fit and Proper Person Test (exec & NEDs) and DBS (all staff & board)	End Feb 2019	
W1.A7	Deloitte	HROD	Implement 360 degree appraisal into exec development and NED appraisal process	22 March 2019	360s for executive team to be conducted via 360 Strengthscope in advance of EMT away day 22 March. (Pilot for exec PDRs and NED 360s.) Board discussion needed about format for NED appraisal, noting governors' feedback on merits of a formal process
W1.A8	Exec work prog	CEO, SPA* (CEO)	Confirm programme for executive team development (King's Fund)	February 2019 (CEO update to Feb board)	King's Fund preparing a programme of quarterly team sessions and individual interventions based around recommendations from Deloitte, Well Led etc. (including externally facilitated strategy sessions.)
W1.A9	Exec work prog	CEO, SPA (CEO)	Confirm programme for chair and NED development (King's Fund plus other partners)	March 2019	CEO's office working in partnership with the King's Fund to create a content-led, educational programme e.g. masterclasses. Team will obtain feedback from the NHSI's Well Led programme for board development in March – currently a phase 1 pilot for a small number of trusts. Next step is to programme an external board effectiveness review.
W1.A10	Deloitte	CoSec	Update Board Code of Conduct	February 2019	On February 2019 Board agenda
W1.A11	CQC report	SPA (CEO), EA (CEO)	Add an update on engagement with external stakeholders into CEO's board report and schedule topic-specific updates. Ensure updates on work with partners is reported at EMT	February 2019	(NB this is a process to develop the board's knowledge base – stakeholder input to the strategy is covered in W.2)

*SPA = Strategic Partnerships Adviser to the CEO *HoS&P = Head of Strategy and Planning *EA = Exec Assistant DPP = Dir Performance and Planning DProg = Director of programmes

W1.A12	CQC report re risk	COO	Board oversight of Brexit risk	Update to board: February 2019	BAF risk being updated by small short-life steering group w/c 21 Jan. Fortnightly meetings of a working group meeting to be established.
Leaders understand the challenge to quality and safety					
W1.A13	Exec work prog	CoSec & HROD	Establishment of a Workforce and Education Assurance Committee (permanent or task and finish – TBC at February 2019 Board)	Board paper Feb	(If approved at Board in February 2019) proposal for assurance committee to commence in March 2019
W1.A14	CQC report	COO/ EA (CEO)	Establish an engagement event with the GOSH referrer community	March 2019	Trust internal engagement/events lead drafting a proposal to come to EMT under 'stakeholder engagement' standing item EA (CEO) to agree with executives the standing item topics for EMT and relevant executive owners for regular reporting
W1.A15		HROD	Add staff to Friends and Family Test paper– process map and paper to board	April 2019	To be built into the Board calendar
Quality issues at GOSH					
W1.A16	Exec work prog	EA (CEO) & CoSec	Refresh board work plan in light of executive work plan, reporting requirements and assurance against the strategy	April 2019	EA (CEO) to update the exec team priorities GANT chart ahead of each fifth EMT and circulate with papers so that the priorities/timescales are kept 'live'. Mat and Claire will refer to the exec projects GANT chart when planning EMT agendas. CoSec to update the board work plan including statutory reporting.
W1.A17	CQC report – escalation	EA (CEO)	Add Clinical Quality Review Group report to EMT agenda as a standing item and pull through minutes of CQRG	Feb 2019	EA (CEO) to agree with executives the standing item topics for EMT and relevant executive owners for regular reporting

W1.A18		EA (CEO)	Exec team to submit headline messages to EMT administrator from key committees (via committee chairs). These will be collated as an EMT paper so that everyone is clear on issues and risks being discussed and escalated from these committees.	Ongoing	EA (CEO) to collate as a paper for each fifth EMT meeting
W1.A19		CEO/ SPA (CEO)	Produce a rolling report for board collating the findings of internal and external reviews commissioned by GOSH to provide exec and board level assurance on case-specific concerns about quality, safety, standards etc. (Corporate as well as operational.)	End April	Exec team to send any significant reviews or reports to SPA (CEO). CEO's team to create a report template, allocate owners and socialise. Provide to MS for sign off. Co Sec to advise on board reporting schedule.
W1.A20		All execs	Develop a process for horizon-scanning on key national reviews that are relevant to GOSH – to identify risks in the system, applicable learnings and recommendations.	EMT agenda Feb	To discuss at EMT. Quality issues stay with MD. Other execs should own theirs for now. Further consideration required at EMT.
Board visibility					
W1.A21	Exec work prog	Dir of Comms & EA (CEO)	Create a schedule of walk-arounds for execs and NEDS. Include evenings for NEDs. Discuss the coming 6 months with the NEDs – using 'Perfect Ward' as a template.	Early Feb 2019	Already established NED walkrounds prior to board meetings. EA to CEO is documenting existing walkrounds and it is agreed execs will walk round clinical and corporate areas once a month at least with NEDs invited to join.
W1.A22	CQC report - visibility	Dir of Comms & EA (CEO)	Create a schedule of board engagement activities with staff and stakeholders.	April 2019	A schedule of meetings with the CEO and chairman with key external stakeholders will be part of the stakeholder engagement strategy. Chair dinners with different staff scheduled to Feb – these need to be extended across the year.
Priority for ensuring sustainable, compassionate, inclusive and effective leadership					
W1.A23	Exec work prog	CN	Establish a plan to develop a leadership strategy	22 nd May Board	Paper to come to EMT by end April 2019

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W1.A24	Exec work prog	HROD & COO	Update EMT on implementation of the SMT coaching and mentoring programme across the new directorate leadership teams	May EMT	Programme approved at January EMT and being rolled out
W1.A25	Exec work prog	HROD & COO	Progress update to EMT & board on the LGBT, BAME, gender and disability groups: exec ownership, actions, communications. See W3.A14	3 rd April board	Board will receive WRES plan in Q1 2019 LGBT exec lead is CEO BAME and Gender exec lead: HROD Disability: Dir Development Chairs to be appointed, set up their groups and update the board on progress and examples.
W1.A26		HROD	Schedule an unconscious bias session with the board – content-led, information-based session e.g. best practice.	By April 2019?	Factor into the board development programme

W2	KEY LINE OF ENQUIRY: Is there a clear vision and credible strategy to deliver high-quality sustainable care to people, and robust plans to deliver?				
PROMPTS					
<ul style="list-style-type: none"> Is there a clear vision and a set of values, with quality and sustainability as the top priorities? Have the vision, values and strategy been developed using a structured planning process in collaboration with staff, people who use services, and external partners? Do staff know and understand what the vision, values and strategy are, and their role in achieving them? Is the strategy aligned to local plans in the wider health and social care economy, and how have services been planned to meet the needs of the relevant population? Is progress against delivery of the strategy and local plans monitored and reviewed, and is there evidence to show this? 					
Ref.	Source	Lead	Action	Deadlines	Status/ Comments
Clear vision and values					
W2.A1	Exec work prog	HoS&P*	Create a summary report on the staff and stakeholder consultation (process, audiences consulted, outcomes) used to inform the development of the operational strategy (the House).	Feb 2019	The strategy was consulted on and shared widely with staff, council, CQRG and NHSE. HoS&P to confirm that appropriate updates on Open House 2019 went to Ops Board and SLT.
W2.A2	Exec work prog	(CEO) & execs	Create clear delivery and reporting plans/processes for the 'House' – the operational strategy. (This document should come to EMT for approval and progress updates.)	Updates to March EMT and April board	The 'House' implementation plan will be linked to the EMT work plan and monitored by the Better Value Programme Board, which will extend its remit to oversee a 3-5 year transformation process.
W2.A3	Exec work prog	Dir of Comms	Create an internal comms strategy. Refresh intranet content and identify other internal comms channels/fora to ensure that staff are aware of the strategy refresh and how we used their feedback.	April board	Proposals to come to EMT
W2.A4	Exec work prog	Dir of Comms, SPA (CEO)	Stakeholder audit & mapping: list and prioritise partners & networks we engage with, define relationship leads at EMT and/or GK Strategy objectives 'kick-off' session.	Board updates Feb & April 2019	GK Strategy interviews and workshops ongoing through Feb/March. SPA (CEO) to draw together info on GOSH staff/consultants on national committees.
W2.A5	Exec work prog	CEO SPA (CEO)	Identify and align other strategic initiatives, such as the Joint Research Strategy and Hospital Funding Priorities Steering Group (project managed by GOSHCC). Identify an EMT and board reporting	TBC	Research Strategy board is chaired by NED James Hatchley and attended by CEO & CFO. CEO and CFO attend the Hospital Funding Priorities Steering Group.

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			process.		Quarterly updates to EMT and board. (For further consideration and discussion, including comms alignment.)
W2.A6	Exec work prog	Dir of Comms, CEO, SPA (CEO)	Develop a stakeholder engagement strategy. Nominate exec/board leads for key stakeholders. Add stakeholder engagement as a standing item to EMT agenda.	Strategy workshop 4 th Feb 2019. Board update 7 th Feb 2019. Messaging workshop by early March. Board approval April 2019.	Stakeholder engagement strategy to be delivered by GK Strategy in a two-stage process of audit and message/strategy development. Role of board to be considered. Strategy to be reviewed following development of GOSH Long Term strategy.
W2.A7	Exec work prog	CEO, SPA (CEO), COMMS	Create a list of key unresolved strategic issues. Develop a series of board-approved position statements on each (e.g. digital transformation, 10-year plan, cardiac services, paediatric services across North London, personalised medicine, commercial strategy.)	April 2019	List to be prepared for exec strategy session 11 th Feb 2019 Message development session for stakeholder engagement strategy (facilitated by GK Strategy) to be held on 4 th March 2019.
W2.A8	Exec work prog	CEO, SPA (CEO)	Design a six-month consultation process on long-term strategy – engaging with GOSH opinion formers, sounding out trusted external colleagues, presenting transformational scenarios to stimulate discussion with staff, Council, commissioners etc.	Programme design - April 2019 (Delivery plan over six months - to board on 30 th October 2019)	Output: Articulate the GOSH 5-10 year vision. Co-design GOSH-specific key principles to guide exec team and board decision-making and prioritising for big strategic decisions. Apply these criteria to long term strategy design process and broader board decision-making.
W2.A9	Exec work prog	CEO	Develop a commercial strategy that builds on GOSH long-term strategy.	TBC	For further consideration and discussion as part of the long term strategy engagement phase. Dir Comms to explore charity partnerships' suitability for pro-bono scoping work on opportunities.
W2.A10	CQC report	HROD	Review and report on the organisational impact of the GOSH values	Update in July 2019	Staff FFT indicates staff are aware of the GOSH values but staff survey results indicate the reverse. Incoming HROD to consider within OD/Leadership strategy – developing compassionate leadership.

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W2.A11	Exec work prog	MD	QI Strategy – endorsing which QI process to use and the QI priorities	March 2019	Quality priorities are being updated by Head of Quality and Safety. Will need to be presented in the annual Quality Report presented at QSAC.
W2.A12	CQC report		Develop an education and training strategy	April 2019	

W3	KEY LINE OF ENQUIRY: Is there a culture of high-quality, sustainable care?				
	PROMPTS <ul style="list-style-type: none"> Do staff feel supported, respected and valued? Is the culture centred on the needs and experience of people who use services? Do staff feel positive and proud to work in the organisation? Is action taken to address behaviour and performance that is inconsistent with the vision and values, regardless of seniority? Does the culture encourage openness and honesty at all levels within the organisation, including with people who use services, in response to incidents? Do leaders and staff understand the importance of staff being able to raise concerns without fear of retribution, and is appropriate learning and action taken as a result of concerns raised? Are there mechanisms for providing all staff at every level with the development they need, including high-quality appraisal and career development conversations? Is there a strong emphasis on the safety and wellbeing of staff? Are equality and diversity promoted within and beyond the organisation? Do all staff, including those with particular protected characteristics under the Equality Act, feel they are treated equitably? Are there cooperative, supportive and appreciative relationships among staff? Do staff and teams work collaboratively, share responsibility and resolve conflict quickly and constructively? 				
Ref	Source	Lead	Action	Deadlines	Status/ Comments
<u>Values and culture</u>					
W3.A1	CQC report	HROD & CEO	Review staff survey results on support for staff and respect for staff including actions.	February 2019	To be brought to Feb 2019 EMT in readiness for reporting to April Board
W3.A2	Exec work prog	HROD & MD	HROD & MD to create a spreadsheet and confidential board update on recent cases of unacceptable behaviour in clinical teams.	March 2019	Going forward, the spreadsheet will be updated quarterly and reported to EMT and board to monitor progress
W3.A3 (Also W1.A13)	Exec work prog	CoSec & HROD	Possible establishment of the Workforce and Education Board assurance committee	Board paper February 2019	(If approved) proposal for assurance committee to commence in March 2019
W3.A4	Exec work prog	CEO & CoSec	Consider the appointment of an associate NED on the Board with HR/OD expertise	Board paper February 2019	Individual will be an employee (not appointee and so not appointed by Council)

Action taken to address behaviour issues					
W3.A5	Exec work prog	MD	Update to Board on progress with implementation of Cognitive	March 2019 (April 3 rd board)	(Also note W.3.A3)
Openness and honesty in response to incidents					
W3.A6	CQC report	MD	Update the Being Open and Duty of Candour Policy. Document how the Trust manages moderate harm cases consistently.	March 2019	Needs drafting, consultation and approval via PAG
W3.A7	CQC report	MD	Review of the Serious Incident Policy taking account of negative commentary in the CQC report.	March 2019	The SI process is being reviewed with the input of the Deputy Chiefs of Service and the Heads of Nursing.
Induction, appraisal and career development					
W3.A8	CQC report	HROD, MD, COMMS	Review data and ensure appraisals and mandatory training are in place across all directorates including our own staff and honorary staff. Roll-out staff comms to raise awareness of the importance of mandatory training.	March 2019	HROD to bring updates to EMT, OB and other forums with granular detail on which staff groups are (and are not) complying.
W3.A9	CQC report	HROD, MD, CN	Create and socialise a list of leadership programmes for clinical and non-clinical staff	May 2019	Exec team to review list and assess whether there is coherence and programmes are optimised, promote uptake as considered necessary.
W3.A10	CQC report	MD	Implementation update on revalidation action plan	May 2019?	Update is annually to Board – in July. Require an update prior to this to EMT to assure actions closed
W3.A11	CQC report	HROD	Co-design and deliver a Workforce Transformation Strategy to address cultural transformation	August 2019 for 18 th Sept board	This work will be led by the incoming HR & OD
W3.A12	Exec work prog	CN	Update on Learning Academy	June FIC Board 18 th July	Ask Feb board to delegate authority to approve the business plan to FIC.
Supporting patients and staff – equality					

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W3.A13	Exec work prog	CEO	Launch staff forums on LGBT, BAME, gender and disability	March 2019	Board will receive WRES plan in Q1 2019
W3.A14	Exec work prog	HROD	Update on BAME and LGBT staff fora: what changes have been proposed/ implemented? See W1.A25	3 rd April board	Board will receive WRES plan in Q1 2019
Supporting our staff – well-being					
W3.A15	CQC report	HROD	Update on progress with implementation of Trust Recovery Programme to Trust Board	3 April 2019 Board	Present at EMT beforehand
W3.A16	CQC report	HROD	Provide an update on Carefirst – effectiveness, awareness, number of staff accessing?	Update to Operational Board May 2019	Health and Wellbeing plan to be put on intranet. CareFirst contract up for review. EAPs alone not enough – we need an internal solution – high profile case learnings. Coming to EMT. Needs to go to Operational Board. Consider how to draw together with the other staff benefits.
W3.A17	CQC report	HROD	Commission an impact report or similar to update on progress of the multi-disciplinary health and wellbeing group and other staff wellbeing projects. Look into mental health first aiders.	Staff benefits review to Operational Board in March 2019	Discussed at H and S committee
W3.A18	Exec work prog	HROD	Refresh the executive review process for GEMS	Feb EMT	
W3.A19	Exec work prog	CFO	Patient/family and staff accommodation review	18 th Sept Board	Charity to be asked to lead the review on the basis of funding impact. Report to be considered by EMT in advance of board update.
Supporting staff – safety					
W3.A20		COMMS	Comms to issue a note on the standard operating procedure for response and escalation when a staff member or visitor becomes ill on site.	Feb 2019	Response to recent staff incident
Cooperative, supportive and appreciative relationships among staff					
W3.A21	Exec work prog	CN	Provide update on an action plan for the roll-out of Acceptable Behaviour Policy	March 2019?	EMT update?

W4 KEY LINE OF ENQUIRY: Are there clear responsibilities, roles and systems of accountability to support good governance and management?					
PROMPTS					
<ul style="list-style-type: none"> Are there effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services? Are these regularly reviewed and improved? Do all levels of governance and management function effectively and interact with each other appropriately? Are staff at all levels clear about their roles and do they understand what they are accountable for, and to whom? Are arrangements with partners and third-party providers governed and managed effectively to encourage appropriate interaction and promote coordinated, person-centred care? 					
Ref.	Source	Lead	Action	Deadlines	Status/ comments
Board and committee structure					
W4.A1	Exec work prog	CoSec	Schedule of matters reserved for the Board requires updating	3 April 2019 Board	Present at EMT beforehand
W4.A2	Exec work prog	CoSec	Conduct external board effectiveness review	TBC at February 2019 Board	Request for approval of timing of next external review. Possibly Q1 2020/21
Delivery of sustainable services					
W4.A3	Exec work prog	Dir of Redev	Sustainability Management Plan to be reviewed	To Board for 3 rd April	Present at EMT beforehand
W4.A4	Exec work prog	MD	Update on progress with job planning	March 2019	Update to be presented at EMT
W4.A5	Exec work prog	CEO	Redesign the Better Value Programme Board to incorporate both the existing oversight on Better Value and a 'Future Hospital' programme to oversee a 3-5 year transformation programme.	TBC	Exec team to work with director of programmes to develop a transformation programme based on trust strategy implementation plan and re-frame the programme board.
Escalation and accountability					
W4.A6	CQC report	CoSec	Review and update the Assurance and Escalation Framework	March 2019	Deputy CoSec tasked with delivery

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W4.A7	Exec work prog	CoSec	Corporate Governance review of committees at GOSH	April 2019	Deputy CoSec tasked with delivery
W4.A8	Exec work prog	MD	Compliance Register being updated	March 2019	Head of Quality and Safety tasked with delivery
W4.A9	CQC report	MD	Risk Management Strategy under review	Early March 2019	Head of Quality and Safety tasked with delivery – requires drafting, consultation and approval at RACG and then to Board
Internal audit					
W4.A10	Exec work prog	CoSec	Confirm format of internal audit monitoring at RACG		DepCo Sec to prepare for presentation at RACG
Engagement with third parties and partners					
W4.A11	Exec work prog	Dir of Comms & SPA CEO	Development of Stakeholder Engagement Strategy – review stakeholder engagement via standing EMT item	April 2019	See W2 actions
W4.A12	Exec work prog	CFO	PLICS review for directorates and assessment of income from partnership models (including Genomics Laboratory Hub)	September 2019	TBC
W4.A13	Exec work prog	CEO	Develop a commercial strategy as a result of feedback during the GOSH Future Strategy consultation, income review (above) and work commissioned via the Better Value/Future Hospital Transformation Board. (See W4.A5)	Early 2020	

W5					
KEY LINE OF ENQUIRY: Are there clear and effective processes for managing risks, issues and performance?					
PROMPTS <ul style="list-style-type: none"> • Are there comprehensive assurance systems, and are performance issues escalated appropriately through clear structures and processes? Are these regularly reviewed and improved? • Are there processes to manage current and future performance? Are these regularly reviewed and improved? • Is there a systematic programme of clinical and internal audit to monitor quality, operational and financial processes, and systems to identify where action should be taken? • Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions? Is there alignment between the recorded risks and what staff say is 'on their worry list'? • Are potential risks taken into account when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities? • When considering developments to services or efficiency changes, how is the impact on quality and sustainability assessed and monitored? Are there examples of where financial pressures have compromised care? 					
Ref	Source	Lead	Action	Deadlines	Status/ Comments
Assurance and Escalation Framework					
W5.A1	CQC Report	CoSec	Review and update the Assurance and Escalation Framework	March 2019	Dep CoSec – see W4.A8
Performance Monitoring					
W5.A2	Exec work prog	MD	Compliance with child death overview process – Action plan to be created	April 2019	
W5.A3	CQC Report	MD	Pharmacy – KPI reporting and medicines optimisation strategy/ medicine management annual report	May – September 2019	Medicines Management risk added to BAF. Outlines timelines for a broad work programme to mitigate risk
W5.A4	Exec work plan	COO	Design a rolling internal review process (Including corporate) to ensure things are regularly picked up	February 2019	Paper to EMT Andrew has developed a template for directorates
Reporting and assessment of risk					
W5.A5	CQC report	MD	Risk Management Strategy under review	Early March 2019	Head of Quality and Safety tasked with delivery – requires drafting, consultation and approval at RACG and then to Board
W5.A6	CQC report	COO	Business planning and business case templates under review. Mechanism for reporting into board.	March 2019	Peter Hyland/ James Scott reviewing this and ensuring fit for purpose and

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					adequately prompts users to document all risks (finance, activity and quality) Discussions ongoing with CFO & COO
W5.A7	Exec work prog	CoSec	Develop a standard operating procedure for undertaking internal and external reviews of GOSH services	April 2019	Present at EMT and discuss with Board/QSAC
Examples of risk management at Board Level					
W5.A8	CQC report	COO	Review of how high profile cases are managed in the future following learning from previous cases	May 2019	Consideration of use of business continuity planning for these cases. Report to be presented at EMT

W6 KEY LINE OF ENQUIRY: Is appropriate and accurate information being effectively processed, challenged and acted on?					
PROMPTS <ul style="list-style-type: none"> • Is there a holistic understanding of performance, which sufficiently covers and integrates people's views with information on quality, operations and finances? Is information used to measure for improvement, not just assurance? • Do quality and sustainability both receive sufficient coverage in relevant meetings at all levels? Do all staff have sufficient access to information, and do they challenge it appropriately? • Are there clear and robust service performance measures, which are reported and monitored? • Are there effective arrangements to ensure that the information used to monitor, manage and report on quality and performance is accurate, valid, reliable, timely and relevant? What action is taken when issues are identified? • Are information technology systems used effectively to monitor and improve the quality of care? • Are there effective arrangements to ensure that data or notifications are submitted to external bodies as required? • Are there robust arrangements (including appropriate internal and external validation) to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards? Are lessons learned when there are data security breaches? 					
Ref	Source	Lead	Action	Deadlines	Status
Performance monitoring					
W6.A1	Exec work prog	HROD	OD plan to incorporate data interpretation skills assessment, particularly for clinical leaders	Oct 2019	For discussion at Operational Board
W6.A2	Exec work prog	CEO	Board development project to incorporate an assessment of the type of information required by the board and consider their needs in terms of information/education on data	April 2019	Not started
W6.A3	Exec work prog	CEO, COMMS	GOSH Long Term Strategy Consultation and Stakeholder Engagement review to collate information on GOSH stakeholders, which will be added to the GOSH stakeholder lists. CRM software to be purchased in late 2019 to ensure contact information is up to date and live updates on queries/feedback can be logged and shared with engagement leads.	Dec 2019	Stakeholder list to be developed as part of the first phase of the stakeholder engagement strategy
W6.A4	Exec work prog	MD	QI dashboards to be updated to match new directorates	April 2019	

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Data quality					
W6.A5	Exec work prog	Dir P&I (COO)	Performance and planning team to provide integrated updates to EMT (including on the alignment of data quality function with major programmes such as EPR)	TBC	An action on the BAF
W6.A6	Exec work prog	DProg (COO)	Programme management software to be considered to provide live reports and oversight on key programmes and enable collaboration between teams	Oct 2019	HoS&P, DProg & SPA (CEO) are scoping options with a view to creating a brief
W6.A7	Exec work prog	CEO/ EA (CEO)	EMT to review information submitted for decision-making as part of the EMT work planning process	Ongoing with a deliberate focus at every fifth EMT meeting	
W6.A8	Exec work prog	CEO	Appoint a Chief Clinical Information Officer to the board to advise on the organisation's progress with implementing new technologies – including live projects - EPR and clinical research information	Ongoing – following board appointment	Board asked to consider adding a non-voting exec post holder at February 2019 Board
W6.A9	Exec work prog	COMMS	Ongoing reviews of GOSH Web and the internet	Summer 2019	

W7					
KEY LINE OF ENQUIRY: Are the people who use services, the public, staff and external partners engaged and involved to support high-quality sustainable services?					
PROMPTS					
<ul style="list-style-type: none"> Are people's views and experiences gathered and acted on to shape and improve the services and culture? Does this include people in a range of equality groups? Are people who use services, those close to them and their representatives actively engaged and involved in decision-making to shape services and culture? Does this include people in a range of equality groups? Are staff actively engaged so that their views are reflected in the planning and delivery of services and in shaping the culture? Does this include those with a protected equality characteristic? Are there positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs? Is there transparency and openness with all stakeholders about performance? 					
Ref	Source	Lead	Action	Deadlines	Status
W7.A1	CQC report	CN	Children and Young People's CQC Survey		Underway
W7.A2	Exec work plan	HROD	YPF involvement in executive & NED recruitment during 2019	May 2019	HROD to devise a plan
W7.A3	Exec work plan	CN	Patient involvement and experience strategy	April 2019	
W7.A4	CQC report	COO	Establish an engagement event with the GOSH referrer community	March 2019 – see W1.A14	Trust internal engagement/events lead drafting a proposal to come to EMT under 'stakeholder engagement' standing item EA (CEO) to agree with executives the standing item topics for EMT and relevant executive owners for regular reporting
W7.A5	Exec work plan	CoSec	Team to revise the confidential agenda threshold to ensure that as many items as possible are discussed at the public board	Ongoing	
W7.A6	CQC report	COMMS & SPA (CEO)	Stakeholder engagement strategy in development, stakeholder engagement update to be added to all EMT agendas and CEO board reports	April 2019	

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W7.A7	Exec work plan	CEO	Consultation on GOSH Long Term strategy will involve all key stakeholder groups	October 2019	
W7.A8	Deloitte	COMMS	Internal comms strategy to be developed	April 2019	
W7.A9	Exec work prog	CEO	Staff forums on gender and disability to be launched	March 2019 See W1.A25	Board will receive WRES plan in Q1 2019 Board will receive WRES plan in Q1 2019 LGBT exec lead is CEO BAME and Gender exec lead: HROD Disability: Dir Development Chairs to be appointed and set up their groups and update the board on progress and examples.

W8					
KEY LINE OF ENQUIRY: Are there robust systems and processes for learning, continuous improvement and innovation?					
PROMPTS					
<ul style="list-style-type: none"> • In what ways do leaders and staff strive for continuous learning, improvement and innovation? Does this include participating in appropriate research projects and recognised accreditation schemes? • Are there standardised improvement tools and methods, and do staff have the skills to use them? • How effective is participation in and learning from internal and external reviews, including those related to mortality or the death of a person using the servicer? Is learning shared effectively and used to make improvements? • Do all staff regularly take time out to work together to resolve problems and to review individual and team objectives, processes and performance? Does this lead to improvements and innovation? • Are there systems to support improvement and innovation work, including objectives and rewards for staff, data systems, and processes for evaluating and sharing the results of improvement work? 					
Ref	Source	Lead	Action	Deadlines	Status
W8.A1	Exec work plan	MD	Safety and Reliability programme being piloted and subject to roll out	Ongoing	
W8.A2	Exec work plan	MD	Flow project under review (better value programme)	18 th September 2019 board	Discussion to be held on whether the board needs an interim update
W8.A3	Exec work plan	MD	QI Strategy – endorsing which QI process to use and the QI priorities	March 2019	
W8.A4	Exec work plan	CEO	Digital strategy board under consideration – will oversee ICT, EPR and DRIVE	March 2019	
W8.A5	Exec work plan	COO	Design a rolling internal review process (Including corporate) to ensure things are regularly picked up	February 2019	Paper to EMT Andrew has developed a template for directorates
W8.A6	CQC report	CEO/ SPA (CEO)	Produce a rolling report for board collating the findings of internal and external reviews commissioned by GOSH to provide exec and board level assurance on case-specific concerns about quality, safety, standards etc. (Corporate as well as operational.)	End April 2019	Exec team to send any significant reviews or reports to SPA (CEO). CEO's team to create a report template, allocate owners and socialise. Provide to MS for sign off. Co Sec to advise on board reporting schedule.

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W8.A7	CQC report	All execs	Develop a process for horizon-scanning on key national reviews that are relevant to GOSH – to identify risks in the system, applicable learnings and recommendations.	EMT agenda February 2019	To discuss at EMT. Quality issues stay with MD. Other execs should own theirs for now. Further consideration required at EMT.
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Trust Board 7 February 2019	
Safe Nurse Staffing Report for November and December 2018	Paper No: Attachment U
Submitted by: Alison Robertson, Chief Nurse.	
Aims / summary	
<p>This report provides the Board with an overview of the Nursing workforce during the month of November and December 2018 and is set out in line with the National Quality Board (NQB) Standards and Expectations for Safe Staffing published in 2016.</p> <p>It provides assurance that arrangements are in place to safely staff the inpatient wards with the right number of nurses with the right skills and at the right time.</p>	
Action required from the meeting	
<p>To note the information in this report on safe staffing including:</p> <ol style="list-style-type: none"> 1. The assurance of the safe staffing levels on the inpatient wards for November and December. 2. The increase in patient acuity in both November and December. 3. Overall the nursing vacancy rate is 2.2% well below the Trust target of 10%, however IPP has a vacancy rate of 30%. 4. Turnover rates in December were at the second highest level over the last year at 17.2%. IPP and Heart and Lung directorates had the highest rates in both November and December. 5. The Trust is now in cohort 4 of the NHSI retention support programme and a detailed retention plan is in development. 	
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	



Great Ormond Street
Hospital for Children
NHS Foundation Trust

Safer Staffing Report November/December 2018

The child first and always

Always

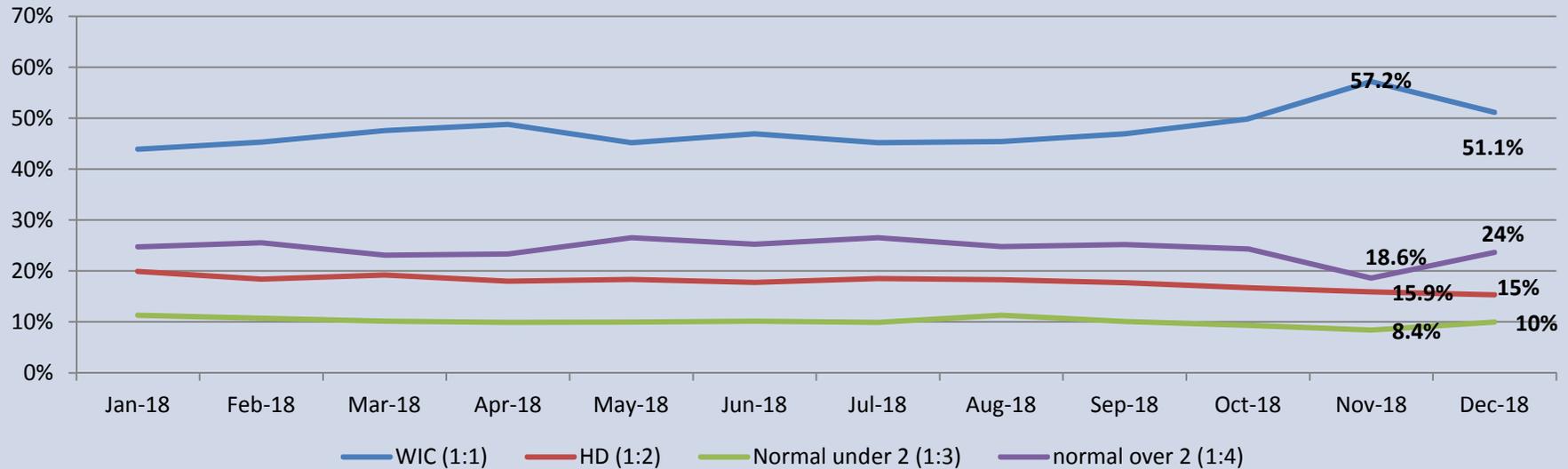


Nursing & HCA Safe Staffing- November/December 2018

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>	<h3 style="text-align: center;">Unify Actual vs Planned Hours</h3> <table border="1"> <caption>Unify Actual vs Planned Hours Data</caption> <thead> <tr> <th>Month</th> <th>Percentage</th> </tr> </thead> <tbody> <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%</td></tr> <tr><td>Oct-18</td><td>100%</td></tr> <tr><td>Nov-18</td><td>92.5%</td></tr> <tr><td>Dec-18</td><td>93.6%</td></tr> </tbody> </table>	Month	Percentage	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%	Oct-18	100%	Nov-18	92.5%	Dec-18	93.6%	<p>Actual vs Planned: The Trust overall average fell within the recommended parameters though there has been a downward trend in the actual nursing hours available since August. However, in November, 6 wards recorded having lower actual hours than the recommended 90% parameter. In all these wards the actual CHPPD was good with over 11.3 hrs/patient. This indicates there was either a lower than planned level of activity and/or a higher level of patient acuity. The acuity data (page 3) shows there was an increase in patient acuity across the Trust and therefore activity had to be reduced to maintain safe staffing levels.</p> <p>In December, 10 wards recorded having less than the recommended parameter but again all these wards had over 12.6 CHPPD. This again indicates that activity levels were lower than planned and still with a higher acuity of patients. Activity was low as a result of it being the Christmas period.</p> <p>No unsafe shifts were reported for either of these months.</p>																										
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<p>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.</p>	<h3 style="text-align: center;">Care Hours Per Patient Day</h3> <p style="text-align: center;">(excluding ICU's)</p> <table border="1"> <caption>Care Hours Per Patient Day Data</caption> <thead> <tr> <th>Month</th> <th>Total CHPPD</th> <th>HCA</th> <th>Nursing</th> </tr> </thead> <tbody> <tr><td>Jan-18</td><td>~13.5</td><td>~2.0</td><td>~11.5</td></tr> <tr><td>Feb-18</td><td>~13.0</td><td>~2.0</td><td>~11.0</td></tr> <tr><td>Mar-18</td><td>~13.0</td><td>~2.0</td><td>~11.0</td></tr> <tr><td>Apr-18</td><td>~13.0</td><td>~2.0</td><td>~11.0</td></tr> <tr><td>May-18</td><td>~13.0</td><td>~2.0</td><td>~11.0</td></tr> <tr><td>Jun-18</td><td>~13.0</td><td>~2.0</td><td>~11.0</td></tr> <tr><td>Jul-18</td><td>~13.0</td><td>~2.0</td><td>~11.0</td></tr> <tr><td>Aug-18</td><td>~14.0</td><td>~2.0</td><td>~12.0</td></tr> <tr><td>Sep-18</td><td>~12.0</td><td>~2.0</td><td>~10.0</td></tr> <tr><td>Oct-18</td><td>~12.0</td><td>~2.0</td><td>~10.0</td></tr> <tr><td>Nov-18</td><td>9.1</td><td>1.9</td><td>7.2</td></tr> <tr><td>Dec-18</td><td>9.0</td><td>1.7</td><td>7.3</td></tr> </tbody> </table>	Month	Total CHPPD	HCA	Nursing	Jan-18	~13.5	~2.0	~11.5	Feb-18	~13.0	~2.0	~11.0	Mar-18	~13.0	~2.0	~11.0	Apr-18	~13.0	~2.0	~11.0	May-18	~13.0	~2.0	~11.0	Jun-18	~13.0	~2.0	~11.0	Jul-18	~13.0	~2.0	~11.0	Aug-18	~14.0	~2.0	~12.0	Sep-18	~12.0	~2.0	~10.0	Oct-18	~12.0	~2.0	~10.0	Nov-18	9.1	1.9	7.2	Dec-18	9.0	1.7	7.3	<p>The Trust average of CHPPD for December was 10.7, slightly lower than the November data of 11. 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 December indicate that patients received, on average just less than 1:2 nursing.</p> <p>This measure provides more granular detail of actual nursing time available for the actual number of patients. However it does not account for the actual patient acuity and therefore can not be looked at in isolation.</p>
Month	Total CHPPD	HCA	Nursing																																																			
Jan-18	~13.5	~2.0	~11.5																																																			
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Nursing & HCA Safe Staffing- November/December 2018

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:

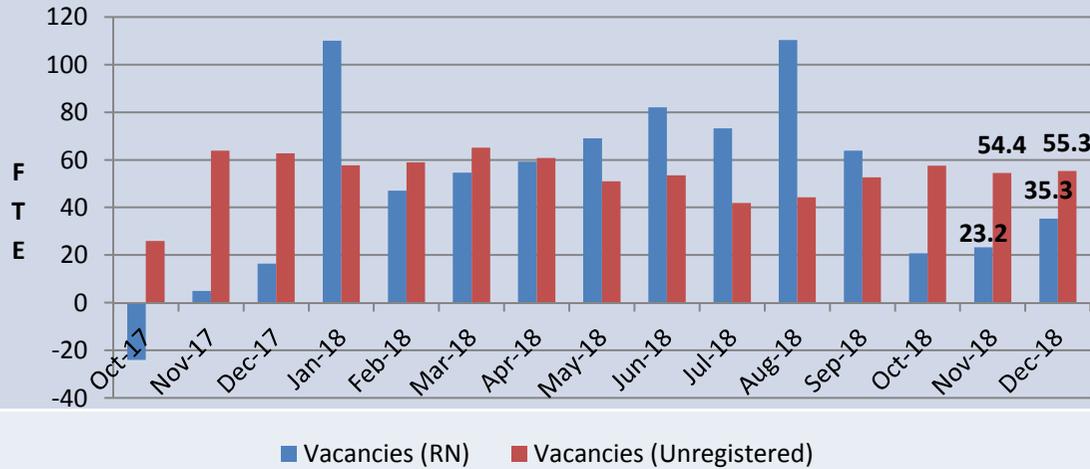
- Normal dependency Under 2 Years - 1 Nurse: 3 Patients
- Normal dependency Over 2 Years - 1 Nurse: 4 Patients
- Ward High Dependency (HD) - 1 Nurse: 2 Patients
- Ward Intensive Care (WIC) - 1 Nurse: 1 Patient

The trend in patient acuity requiring a nurse to patient ratio of 1:1 or 1:2 level of care increased in November and though it decreased slightly in December it was still above the yearly average. Patients with normal dependency of 1:3 and 1:4 were only 27% of the total reported in November. Acuity and activity trends are discussed at the 6 monthly establishment reviews with the Ward Manager, Matron and Head of Nursing to ensure all wards have the correct nursing establishment to account for any sustained changes in activity or acuity.

Nursing & HCA Safe Staffing- November/December 2018

Recruitment & Retention	Comments
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Vacancies & Pipeline

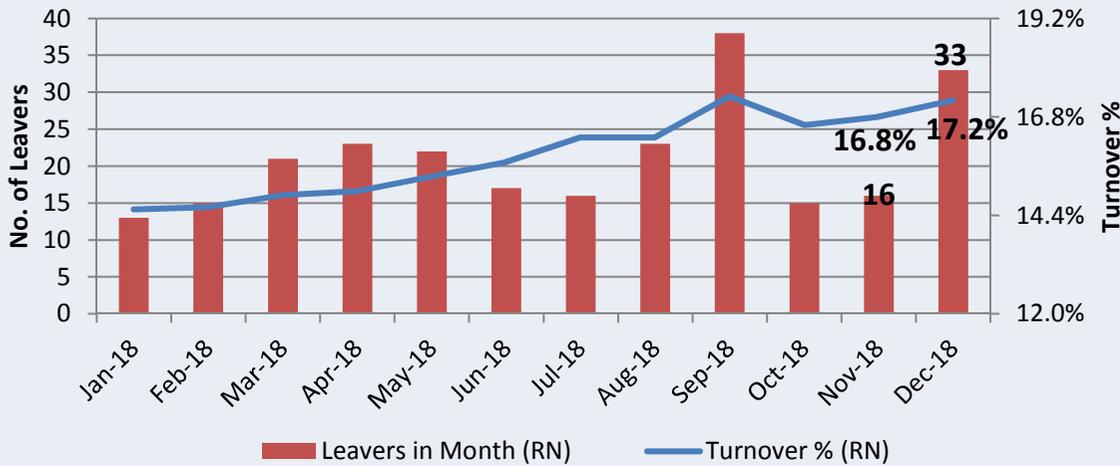


The RN Vacancy rate for December was 2.2% (35.3 WTE), which was an increase from the previous month (1.5%: 23.2 WTE), but is well below the set Trust target of 10%.

Unregistered Vacancies in December were 17.5% (55.3 WTE) which is an increase on November (17.3%: 54.4 WTE)

While the Trust rate is low, Band 6 Vacancies are 8.9% with Band 5 vacancies 3.5%. Vacancy hotspots remain IPP & Sky Ward.

Voluntary Turnover & Leavers



Turnover increased in December to 17.2%, with leavers in month increasing to 33. November was slightly lower at 16.8%, but remains above target of 14%.

From exit interviews/surveys leavers in the last twelve months have identified the main reasons for leaving included: - relocation (39%) and work life balance (24%). The Trust has begun participating in the NHSI retention support programme. As part of this programme a data pack has been shared with the Trust to help us understand our trends in; turnover, reasons for leaving and age profile of our staff compared to peers.

Nursing & HCA Safe Staffing- November/December 2018

Nursing Workforce Metrics by Division: November							
Division	Actual vs Planned %	CHPPD (exc ICUs)	RN Vacancies (FTE)	RN Vacancies (%)	Turnover %	Sickness %	Maternity %
Blood, Cells & Cancer	93.9%	12.1	-4.5	-2.2%	18.6%	3.6%	2.9%
Body, Bones & Mind	95%	10.0	-2.9	-1.3%	13.5%	2.3%	3.5%
Brain	83.4%	10.6	-3.2	-2.6%	11.5%	2.4%	5.7%
Heart & Lung	101%	12.2	-0.3	-0.1%	19.5%	4.7%	3.4%
International & PP	94.2%	10.6	28.9	26.2%	24.6%	5.8%	4.9%
Operations & Images	-	-	2.8	1.5%	10.0%	4.5%	2.3%
Sight & Sound	84.6%	11.3	-19.9	-64.4%	15.0%	5.5%	4.5%
Trust	92.5%	11.0	23.2	1.4%	16.8%	3.6%	3.8%

Nursing & HCA Safe Staffing- November/December 2018

Nursing Workforce Metrics by Division: December							
Division	Actual vs Planned %	CHPPD (exc ICUs)	RN Vacancies (FTE)	RN Vacancies (%)	Turnover %	Sickness %	Maternity %
Blood, Cells & Cancer	98.2%	12.5	-4.4	-2.1%	19.0%	6.8%	2.9%
Body, Bones & Mind	96.4%	9.9	-0.8	-0.3%	13.8%	2.5%	3.8%
Brain	81.7%	10.5	-2.2	-1.8%	12.3%	3.0%	4.5%
Heart & Lung	96.8%	11.8	8.9	1.9%	20.1%	4.8%	3.9%
International & PP	78.2%	9.1	30.9	28.0%	26.1%	6.8%	4.9%
Operations & Images	-	-	6.0	3.2%	12.0%	4.4%	2.9%
Sight & Sound	84.5%	11.3	-21.9	-70.8%	15.1%	5.4%	4.4%
Trust	100%	12.2	35.3	2.2%	17.2%	3.7%	4.0%

Highlights: - November/December

Successes

- Continuing success with recruitment of B2 HCSW Clinical Apprenticeships with 10 candidates starting in March.
- Band6 Market-Place event held in December in collaboration with the Nursing Advisory Board which was well reviewed.
- Capital Nurse CYP External Rotation pilot finished in December 2018 ,
 - The Trust is awaiting feedback from the 5 members of staff who undertook a placement in 5 other organisations to help inform future plans.
 - This programme has expanded and now includes; Lewisham & Greenwich, Moorfields, Homerton and Southend NHS Trusts.
- Organising bespoke recruitment roadshow campaigns both for NQNs and experience staff nurses in Scotland and North East England to start in the New Year.
- Continuing project with PMO regarding Pick'n'Mix hours concept to attract experienced nurses requiring flexible working hours.
- Invitation from NHSI to join Cohort 4 Retention initiative. A project team has been established and an introductory conference call was held in January, a site visit is scheduled for the 14th Feb. An action plan is in development to address some of the key issues and will be shared with HONs, Matrons and Ward Sisters over February,. The final plan will be submitted to NHSI in March.
- Invitation to participate in the Trustwide Accommodation Improvement project for all staff.

Challenges

- Turnover and recruitment in IPP. Changes have been made to the ward leadership on Bumblebee to help identify and address some of the staffing issues. The Head of Nursing has also arranged regular drop in sessions for ward staff to try and gain a better understanding of the challenges.
- Recruitment of experienced staff for Sky ward and ITUs. Plans have been developed by the Directorate HONs to address these areas specific challenges
- Budgeted establishments are not correctly aligned to wards. Further work is urgently required to ensure all budgeted nursing posts are allocated to the correct wards

The child first and always



DRAFT Quality, Safety and Experience Assurance Committee Workplan

Report	Frequency (committee meets January, April, July and October)	Responsible Executive Officer/ Senior Officer
Quality and Safety		
Integrated Quality and Safety Update (outcome and patient focused, based on benchmarked data and external assurance where available) including: <ul style="list-style-type: none"> the work of the Patient Safety and Outcomes Committee including updates on key programmes of work the work of the Patient and Family Experience and Engagement Committee, including updates on key programmes of work such as transition and provision of services for patients with learning disabilities 	Quarterly Quarterly	Medical Director Chief Nurse
Update on issues arising from patient stories at Board	April and October	Chief Nurse
Update on clinical outcomes by directorate	Annual – October	Medical Director
Emerging clinical and risk issues	Quarterly and also deep dives at quality development half days with the Board (1-2 times a year)	All executives
Review of the Trust’s Quality Report (note – updates on progress with implementing the report will now be at Trust Board via the integrated quality report)	April	Medical Director
Safeguarding Update	Quarterly	Chief Nurse
Deep dives in to specific areas as directed by the Board and agreed by the committee for the next meeting	Quarterly	Relevant executive
Internal control and risk management		
Board Assurance Framework update including focus on quality related strategic risks including: <ul style="list-style-type: none"> Assurance of management of quality related high level and trust wide risks (compliance with the risk management framework) 	Quarterly April	Company Secretary and Relevant executives Medical Director

Attachment V

Report	Frequency (committee meets January, April, July and October)	Responsible Executive Officer/ Senior Officer
Research Governance Update	Annual - January	Director of Research and Innovation
Health and Safety Update	Quarterly	Director of HR and OD
Compliance Update <ul style="list-style-type: none"> • CQC standards • Other regulators/ professional bodies • Accreditations 	Quarterly	Medical Director
Learning from quality focused internal reviews	Quarterly update on progress with any actions	Medical Director/ Chief Nurse
Learning from quality focused external reviews (national reviews and local reviews of other organisations)	Quarterly update on progress with any actions	Medical Director/ Chief Nurse
Update on quality related whistle blowing cases and	Quarterly	Director of HR and OD
Update on Freedom to Speak Up cases	Quarterly	Freedom to Speak Up Guardian/ Medical Director
Update on quality impact of Better Value Schemes	Quarterly	Acting Chief Operating Officer
Audit and assurance		
Internal audit annual operational workplan	April	Internal auditor
Internal audit and external audit quality related reports	Quarterly and as available	Internal auditor
Update on implementation of internal audit and external audit recommendations	Quarterly	Chief Finance Officer
Clinical audit update (including update on management of confidential enquiries and NICE guidance)	Quarterly	Medical Director
Clinical audit annual workplan	April	Medical Director
Progress with actions against CQC surveys	January and July	Chief Nurse
Governance		
Committee self-assessment and Terms of reference revision	October	Company Secretary
Summary report from the Audit Committee	Quarterly	Company Secretary
Update from the Ethics Committee	April and October	Clinical Ethics Chair
Freedom of Information Act Update	July	Medical Director

Great Ormond Street Hospital for Children NHS Foundation Trust: Board Assurance Framework (January 2019)

No.	Short Title	Risk type and description	Gross Risk		Net Risk		Risk Appetite	Mitigation time horizon	Executive Lead	Reviewed By	Last Updated by Risk Owner	Assurance Committee	Last Reviewed by Assurance Committee
			L x C	T	L x C	T							
1	Financial Sustainability	Strategic & Operational Failure to continue to be financially sustainable due to: <ul style="list-style-type: none">• Reductions in tariffs and impact of new 2019/20 tariff and potential reduction in MFF• Impact of inflationary costs and potential impact of Brexit of cost of drugs, supplies and staffing• Challenges in completing contracts with NHS Commissioners• Lack of capacity to deliver growth in activity /income targets for NHS and non NHS activities (including IPP);• Challenges is obtaining appropriate growth funding in Contract;• Inadequate local pricing in NHS contract;• Delivery of financial efficiency targets;• Failure to collect IPP debt;• Lack of capital funding in the NHS potentially limiting major capital projects to those that can be supported by the Charity• Changes to accounting standards could impact delivery of the control total and prevent the trust from securing the SPF funding• Robust financial management across all operational and corporate teams• Risk to charity funding supporting both patient welfare and capital programmes in the current economic climate.	4 x 5	20	4 x 5	20	Low (1-6)	1-2 years	Chief Finance Officer	Helen Jameson, Chief Finance Officer	18/12/2018	Audit Committee	April 2017 January 2018 October 2018
2	Better Value	Operational The risk that the organisation will not deliver productivity and efficiency targets and that targets indirectly impact on patient care	4 x 4	16	4 x 2	8	Low (1-6)	1-2 years	Acting Chief Operating Officer	Jon Schick, Programme Director, PMO	28/12/2018	Audit Committee	April 2017 Jan 2018 October 2018
3	IPP Contribution	Strategic & Operational The risk that the organisation will not deliver IPP contribution targets	4 x 5	20	4 x 3	12	Med (8-10)	1-2 years	Acting Chief Operating Officer	Chris Rockenbach, General Manager, IPP	09/01/2019	Audit Committee	May-16 April 2017 Jan 2018 Sept 2018 (TB)
4	Recruitment and Retention	Operational The risk that the organisation will be unable to recruit and retain sufficient highly skilled staff	4 x 5	20	3 x 5	15	Med (8-10)	1-2 years	Director of HR and OD	Alison Hall, Acting Director of HR and OD	10/01/2019	Quality & Safety Assurance Committee (To Workforce and Education Assurance Committee TBC)	July 2016 April 2017 Oct 2017 May 2018

No.	Short Title	Risk type and description		Gross Risk		Net Risk		Risk Appetite	Mitigation time horizon	Executive Lead	Reviewed By	Last Updated by Risk Owner	Assurance Committee	Last Reviewed by Assurance Committee
				L x C	T	L x C	T							
5	Operational Performance	Operational	The trust is unable to demonstrate compliance with Performance Management Framework/ Monitor's licence	5 x 4	20	2 x 4	8	Low (1-6)	1 year	Acting Chief Operating Officer	Peter Hyland, Director, Planning & Information/ Anna Ferrant, Company Secretary	08/01/2019	Audit Committee/ Quality & Safety Assurance Committee	Oct-16 Oct 2017 (AC) May 2018 Jan 2019
6	GOSH Strategic Position	Strategic	Lack of priority given to specialist paediatrics in the NHS wide strategies leading to lack of progress in developing appropriate system wide services and support for GOSH's role	3 x 3	9	3 x 3	9	Med (8-10)	5-10 years	Acting Chief Operating Officer	Peter Hyland, Director, Planning & Information	08/01/2019	Audit Committee	Jan 2017 Jan 2018 October 2018
7	Unreliable Data	Operational	Failure to monitor data quality impacting on accurate, consistent and appropriate data reporting across the Trust and to external parties (commissioners etc.)	4 x 4	16	3 x 3	9	Low (1-6)	1-2 years	Acting Chief Operating Officer	Pippa Mullan, Head of Information, & Peter Hyland, Director, Planning & Information	08/01/2019	Audit Committee	Oct-16 May 2017 April 2018 January 2019
8	Research Income	Strategic	The Trust may not be able to provide the required level of research infrastructure or leverage additional research income as core research funding streams are reduced	3 x 3	9	2 x 3	6	Med (8-10)	1-2 years	Director, Research & Innovation	Jenny Rivers, Dep Dir, R&I	03/01//2019	Audit Committee	July 2017 April 2018 Jan 2019
9	Research Hospital Status	Strategic	The Trust may not deliver its full Research Hospital vision if key research alliances are not fostered	3 x 3	9	2 x 3	6	Med (8-10)	3-5 years	Director, Research & Innovation	Jenny Rivers, Dep Dir, R&I	03/01//2019	Quality & Safety Assurance Committee	Oct-16 July 2017 April 2018 February 2019 (TB)
10	Electronic Patient Records	Operational	<p><u>Short – Term – Project Implementation and Go-Live-2 years)</u> The risk that the EPR programme will not be delivered on time or within budget. Key risks being monitored by programme board:</p> <ul style="list-style-type: none"> Programme budget Procurement risks Capability/ resource risks Clinician, Executive and other staff engagement Risks associated with multiple clinical systems The risk that at go live the system is not available for a period of time, data migration issues or operation of system causes data quality issues post go live impacting on reporting. Change management is effective to ensure adoption of best practice. <p><u>Long – Term – Optimisation and Benefits Realisation</u> The risk that the 18 month period following EPR system implementation is not maximised to ensure optimisation of the system and the benefits are not maximised for the organisation as outlined in the Business Case.</p>	4 x 4	16	4 x 4	16	Low (1-6)	1-2 years	Chief Executive	Mat Shaw, Chief Executive/ Richard Collins/ EPR Programme Director	03/01/2019	Audit Committee	Oct-16 Oct 2017 May 2018 Jan 2019
11	Business Continuity	Operational	The trust is unable to deliver normal services and critical functions during periods of significant disruption.	3 x 4	12	3 x 3	9	Low (1-6)	1 year	Acting Chief Operating Officer	Camilla McBrearty, Emergency Planning Officer/ Andrew Taylor, Acting COO	07/01/2019	Audit Committee	May-16 May 2017 April 2018 (TB)

No.	Short Title	Risk type and description	Gross Risk		Net Risk		Risk Appetite	Mitigation time horizon	Executive Lead	Reviewed By	Last Updated by Risk Owner	Assurance Committee	Last Reviewed by Assurance Committee	
			L x C	T	L x C	T								
12	Redevelopment	Operational	Inadequate planning or management of infrastructure redevelopment may result in poor VFM or failure to deliver expected business benefit.	3 x 4	12	3 x 3	9	Med (8-10)	1-5 years	Dir, Development & Property Services	Stephanie Williamson, Dep Dir of Development & Property Services	27/12/2018	Audit Committee	May-17 Jan 2017 Oct 2017 April 2018 Dec 2018 TB
NEW RISK (13)	Information Governance	Operational	Personal and sensitive personal data is not effectively collected, stored, appropriately shared or made accessible in line with statutory and regulatory requirements.	4 x 5	20	4 x 5	20	Low (1-6)	1 year	Acting Chief Operating Officer	Peter Hyland/ Anna Ferrant	17/01/2019	Audit Committee	
NEW RISK (14)	Medicines Management	Operational	Medicines are not managed in line with statutory and regulatory guidance (procuring, storing, prescribing, manufacturing and giving of medicines (including self-administration)) and that processes are not appropriately documented or monitored.	4 x 5	20	4 x 5	20	Low (1-6)	1-2 years	Acting Chief Operating Officer	Steve Tomlin, Chief Pharmacist/ Andrew Taylor, Acting Chief Operating Officer	28/01/2019	Quality & Safety Assurance Committee	
NEW RISK (15)	Consistent delivery of quality services	Operational	All services are not appropriately managed or governed or are of the appropriate standing to deliver quality services within a complex, specialist health environment.	4 x 4	16	2 x 4	8	Low (1-6)	1-2 years	Medical Director	Sanjiv Sharma, Acting Medical Director	23/01/2019	Quality & Safety Assurance Committee	
NEW RISK (16)	Brexit	Strategic	Brexit will have an adverse impact on the ability of Trust to ensure continuity of effective patient care including but not limited to financial sustainability, availability of workforce, access to medicines and medical devices and participation in collaborative research and access to research funding, clinical trials and clinical networks.	4 x 5	20	4 x 5	20	Med (8-10)	1-5 years	Acting Chief Operating Officer	Anna Ferrant, Company Secretary/ Andrew Taylor, Acting Chief Operating Officer	31/01/2019	Trust Board	
NEW RISK (17)	Service Innovation	Operational	Failure to embrace service transformation and deliver innovative, patient centred and efficient services including: <ul style="list-style-type: none"> failing to identify where transformation is needed and continuing to operate inefficient and ineffective services failing to work in partnership with staff and others (commissioners, referrers other stakeholders including the third sector) to identify, plan and design service transformation failing to ensure appropriate resources (finances and workforce) are made available to lead and implement transformation of services failing to support staff in making change happen. 	4 x 4	16	3 x 4	12	Med (8-10)	1-5 years	Acting Chief Operating Officer	Jon Schick, Programme Director/ Andrew Taylor, Acting Chief Operating Officer	29/01/2019	Quality & Safety Assurance Committee (Workforce and Education Assurance Committee - TBC?)	
NEW RISK (18)	Culture	Strategic	The risk that GOSH fails to develop its culture in alignment with its strategy and values, impacting on: <ul style="list-style-type: none"> The effective implementation of plans and policies across the Trust and the associated impact on safety and quality of services and the patient and family experience. The ability of the Trust to attract competent staff and promote the Trust as a place to work and feel 	4 x 4	16	3 x 4	12	Low (1-6)	1-5 years	Chief Executive	Alison Hall, Acting Director of HR and OD	23/01/2019	Trust Board (Workforce and Education Assurance Committee - TBC?)	

No.	Short Title	Risk type and description	Gross Risk		Net Risk		Risk Appetite	Mitigation time horizon	Executive Lead	Reviewed By	Last Updated by Risk Owner	Assurance Committee	Last Reviewed by Assurance Committee
			L x C	T	L x C	T							
		<p>engaged.</p> <ul style="list-style-type: none"> • Missed market opportunities arising from a failure to remain agile and connected and adapt to the ever-changing NHS landscape. • The Trust's reputation with partners, commissioners, regulators, the NHS and the public. 											

GOSH BAF Risks – Gross Scores January 2019

Likelihood	Consequences				
	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
5 Almost Certain				5. Operational Performance	
4 Likely				7. Unreliable data 2. Better Value 10. EPR 15. Consistent delivery of services 18. Culture 17. Service Innovation	3. IPP Contribution 14. Medicines Management 4. Recruitment & Retention 1. Financial Sustainability 13. Information Governance
3. Possible			9. Research Hospital 8. Research Income 6. GOSH Strategic Position	11. Business Continuity 12. Redevelopment	
2. Unlikely					
1. Rare					

GOSH BAF Risks – Net Scores January 2019

Likelihood	Consequences				
	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
5 Almost Certain					
4 Likely		2. Better Value	3. IPP Contribution	10. EPR	1. Financial Sustainability 14. Medicines Management 13. Information Governance
3. Possible			6. GOSH Strategic Position 7. Unreliable data 12. Redevelopment 11. Business Continuity	18. Culture 17. Service Innovation	4. Recruitment & Retention
2. Unlikely			9. Research Hospital 8. Research Income	5. Operational Performance 15. Consistent delivery of services	
1. Rare					



Developmental reviews of leadership and governance using the well-led framework: guidance for NHS trusts and NHS foundation trusts

June 2017

support collaborate challenge improve inspire

Delivering better healthcare by
inspiring and supporting everyone we
work with, and challenging ourselves
and others to help improve outcomes
for all.

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1. Introduction

The boards of NHS foundation trusts and NHS trusts (referred to from here on as providers) are responsible for all aspects of the leadership of their organisations. They have a duty to conduct their affairs effectively and demonstrate measurable outcomes that build patient, public and stakeholder confidence that their organisations are providing high quality, sustainable care.

Providers are operating in challenging environments characterised by the increasingly complex needs of an ageing population, growing emphasis on working with local system partners to create innovative solutions to long-standing sustainability problems, workforce shortages and the slowing growth in the NHS budget.

As set out in *Developing people – improving care*, these challenges require changes in how leaders equip and encourage people at all levels in the NHS to deliver continuous improvement in local health and care systems and gain pride and joy from their work. Robust governance processes should give the leaders of organisations, those who work in them, and those who regulate them, confidence about their capability to maintain and continuously improve services.

In-depth, regular and externally facilitated **developmental reviews of leadership and governance** are good practice across all industries. Rather than assessing current performance, these reviews should identify the areas of leadership and governance of organisations that would benefit from further targeted development work to secure and sustain future performance.

The external input is vital to safeguard against the optimism bias and group think to which even the best organisations may be susceptible. We therefore strongly encourage all providers to carry out externally facilitated, developmental reviews of their leadership and governance using the well-led framework every three to five years, according to their circumstances.

2. About this guidance

This guidance on our updated well-led framework for leadership and governance developmental reviews sets out the process and content of these developmental reviews. It supports providers to maintain and develop the effectiveness of their leadership and governance arrangements. It replaces *Well-led framework for governance reviews: guidance for NHS foundation trusts* (April 2015), and applies to both NHS trusts and foundation trusts

The guidance retains a strong focus on **integrated quality, operational and financial governance** and includes a new framework of key lines of enquiry (KLOEs) and the characteristics of good organisations. It provides strengthened content on leadership, culture, system-working and quality improvement.

In a change from previous frameworks, and in support of our commitment to working more closely with our regulatory partners, the structure of our framework (KLOEs and the characteristics) is **wholly** shared with the Care Quality Commission (CQC), and underpins CQC's regular regulatory assessments of the well-led question. This means that information prepared for regulation can also be used for development, and vice versa.

The main elements of this framework are also reflected in NHS England's improvement and assessment framework for clinical commissioning groups (CCGs).

However, while CQC's regulatory assessments are primarily for assurance, developmental reviews are primarily for providers themselves to facilitate continuous improvement. Drawing on the latest research and evidence, we also describe updated good practice to help providers identify their own areas for development and key barriers to overcome.

This good practice is not a checklist: a mechanical 'ticking off' of each item is unlikely to lead to better performance. The attitude of organisational leaders to the review process, the connections they draw between the framework's different areas, and their judgements about what needs to be done to continually improve, are much more important.

We therefore strongly encourage providers to engage with the review processes openly and honestly, selecting an external facilitator to provide tailored support and prioritise actions arising from reviews.

We also encourage providers to make more use of peer review, to utilise and enhance skills within the NHS, draw on learning from others and share learning back with the system. This is how providers individually and together will gain the greatest benefit from these reviews.

A note on system working

We know the increasing focus on working with partners across health and social care, for example in sustainability and transformation partnerships (STPs), creates a tension for providers as they continue to work on organisational performance as part of wider system performance.

We maintain our focus on organisations because this is the statutory basis for service provision, but we have increased the emphasis in this guidance on working proactively with partners. Many of the principles of good governance at organisational level are applicable at system level and we encourage local system partners to use this framework for development if it is appropriate.

How to use this guidance: comply or explain

This guidance is issued on a '**comply or explain**' basis. This means we strongly encourage providers to carry out developmental reviews or equivalent activities approximately every three years to ensure they identify potential risks before these turn into issues. Better performing providers are probably already doing this, and, for example, using internal audit functions to work on particular areas of concern.

In keeping with the [Single Oversight Framework](#) we use to identify the level of support providers need, we are providing extra flexibility based on individual circumstances. This means we can agree longer timeframes for review (up to a maximum of five years) where risks seem lower and shorten the timeframe where risks seem higher, or where particular circumstances suggest a review may be necessary (eg significant turnover of board members, organisational transactions, or significant deterioration in some aspect of performance).

On that basis:

- **Comply** means we strongly encourage all providers to carry out developmental reviews every three years or within the agreed timeframe agreed with NHS Improvement using this guidance.
- **Explain** means a provider needs to give a considered explanation if it uses alternative means to assure itself regarding its leadership and governance or chooses to omit material components of the framework (eg one or more of the eight KLOEs). Departing from the guidance may be justified where a provider can demonstrate it is meeting the actions expected under the guidance in a similar manner, for example partial reviews over consecutive years. We will always consider the circumstances of an individual case.

3. Managing reviews

This section describes the common steps of a developmental review. Providers are free to tailor their approach to suit their organisational circumstances, provided they incorporate the principal areas of enquiry set out in the framework. Annexes A to D provide further detail as noted below.

Stage	Notes
<p>Initial investigation to determine scope of review (see Annex A)</p>	<p>The board should reflect on its performance with an initial investigation that involves self-review against the framework. This should identify any areas in the framework or extra areas outside the framework (eg arising from internal and external audit review findings, annual or corporate governance statements) that require particular focus as part of the review.</p> <p>Clarifying the scope of the review will enable the board to engage external facilitators with appropriate skills.</p> <p>The board should be as honest as possible in this assessment as the congruence between the provider's self-review and the external facilitator's perception can indicate the provider's level of insight.</p>
<p>Commissioning an external reviewer (see Annex B)</p>	<p>External facilitation is a key part of developmental reviews: it provides objectivity and challenge that may not be available within the provider.</p> <p>Choosing an external facilitator is the provider's responsibility. As well as the skills and experience needed to address specific areas of focus arising from self-review, the provider must ensure their supplier can take a holistic view of the organisation, connecting findings from different parts of the review and supporting action-planning, including suggesting appropriate interventions.</p> <p>Providers should also ensure reviewers are suitably independent of the board. This includes avoiding using reviewers who have done audit or governance-related work for the provider in the previous three years, unless there are suitable safeguards against conflict of interest</p>

	<p>(ie information barriers).</p> <p>We also encourage providers to consider involving peer reviewers as part of their external facilitation team, where appropriate, to make use of and enhance leadership and governance capability in the NHS.</p>
<p>Detailed review (see Annex C)</p>	<p>Following review and discussion of the initial investigation, the external facilitator should carry out detailed review against relevant aspects of the framework using a variety of methods that offer insight into the provider’s leadership and governance processes.</p> <p>Each of the eight KLOEs should be reviewed at a basic level and rated using a scheme that allows the prioritisation of findings and guides action-planning and the escalation of any immediate concerns.</p> <p>External facilitators should engage with peer reviewers, where commissioned, for specialist input (for example on clinical governance, leadership, culture, improvement).</p>
<p>Board report and action planning</p>	<p>The external facilitator should work with the provider board to prioritise the review findings, and agree recommendations and developmental actions in response. These should be detailed in a report for the board. We encourage providers to agree the format of the report with their facilitator at the start of the process.</p>
<p>Letter to NHS Improvement</p>	<p>Once the action-planning is done, providers should send NHS Improvement a letter confirming they have completed the review, any material issues that have been found and/or any areas of good practice that could be shared with others, for example through a case study.</p>
<p>Implementing the action plan (see Annex D)</p>	<p>By far the most important part of a review is what the provider does as a result, and how this is given priority among other organisational activities.</p> <p>We encourage providers to draw on the support offers and resources available from agencies across the NHS and more widely (see our Improvement Hub).</p>

4. The well-led framework and descriptions of good practice

The well-led framework is structured around eight key lines of enquiry (KLOEs):

<p>1</p> <p>Is there the leadership capacity and capability to deliver high quality, sustainable care?</p>	<p>2</p> <p>Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?</p>	<p>3</p> <p>Is there a culture of high quality, sustainable care?</p>
<p>4</p> <p>Are there clear responsibilities, roles and systems of accountability to support good governance and management?</p>	<p>Are services well led?</p>	<p>5</p> <p>Are there clear and effective processes for managing risks, issues and performance?</p>
<p>6</p> <p>Is appropriate and accurate information being effectively processed, challenged and acted on?</p>	<p>7</p> <p>Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?</p>	<p>8</p> <p>Are there robust systems and processes for learning, continuous improvement and innovation?</p>

In the pages that follow, each of the framework’s KLOEs is supplemented by **characteristics of good organisations**, and **detailed descriptions of good practice**.

For read-across with CQC’s assessment process, we have also included the prompts that CQC inspection teams use to assess each KLOE.

Each section follows the format shown on the next page.

<p>Joint CQC & NHS Improvement KLOE eg KLOE 1 Is there the leadership capacity and capability to deliver high quality, sustainable care?</p>
<p>Characteristic of 'good' organisations (shared with CQC) eg Leaders at all levels are visible and approachable.</p>
<p>Detailed description of good practice eg Leaders across the organisation are described by staff members as visible, approachable and welcoming challenge. They are accessible through different channels (such as surveys, focus groups, workshops, patient safety walkabouts and approaches such as the 15 steps challenge).</p> <p>Senior leaders can evidence how their approach enables them to understand the issues staff face, and identify and address blocks to improvement.</p>
<p><i>CQC inspection teams will consider the following prompts as part of their assessments in relation to this KLOE:</i></p> <p style="text-align: center;"><i>W1.3 Are leaders visible and approachable?</i></p>

Key terms used in the descriptions of good practice

- **The board:** we use this term when we mean the board as a formal body.
- **Senior leaders:** we use this term when we mean the organisation’s most senior internal leaders, ie formal board executive and non-executive directors and their direct reports.
- **Leaders across the organisation:** we use this term when we mean people at all levels in the organisation (including senior leaders as defined above) who have formal responsibility for the management of others, service delivery, or particular pieces of work.
- **Staff members:** we use this term to mean everyone in the organisation.
- **Protected characteristics:** this refers to the characteristics defined in the Equalities Act 2010.

KLOE 1. Is there the leadership capacity and capability to deliver high quality, sustainable care?

Leaders have the experience, capacity, capability and integrity to ensure that the strategy can be delivered and risks to performance addressed.

Senior leaders can evidence how the organisation has the relevant capability, experience, expertise and capacity across its leadership to manage quality, operations and finance effectively at all levels across the organisation to ensure:

- development and delivery of the corporate strategy and any associated strategies and plans
- continuous organisational development and improvement.

Senior leaders across the organisation, and especially executive and non-executive board members:

- are clear about their roles
- demonstrate personal values and styles aligned with the interests of patients, carers and frontline staff, and the seven principles of public life
- are self-aware and seek personal development and learning
- prioritise safeguarding and quality.

The board is stable, diverse and members function effectively as a team with:

- clear role definition, communication and constructive challenge
- appreciation of diversity of thought, experience and background
- awareness of how their own behaviour affects the rest of the organisation
- awareness of the organisation's impact on the local health economy and environment
- regular time out together to identify, reflect and act on success and failures.

The board regularly reviews its effectiveness (performance, governance, working relationships, skills) and impact on the organisation, and acts on the findings, sharing them openly with staff, patients and the public.

All board subcommittees (such as the audit committee) and subgroups carry out and act on annual self-assessments of their effectiveness.

The leadership is knowledgeable about issues and priorities for the quality and sustainability of services, understands what the challenges are and takes action to address them.

Senior leaders, especially board members, are able to describe:

- the quality, operational and financial issues and challenges the organisation faces, and the priorities within these
- the underlying reasons for these challenges, with reference to wider system factors and benchmarking
- what the organisation is doing to address these challenges and monitor progress in the short, medium and long term.

Senior leaders can evidence that they engage and are encouraged to engage in rigorous and constructive challenge of each other on governance processes, including but not limited to the teams and executives responsible for them.

The chair and non-executive directors participate fully in this challenge and review process, both through the board and by taking part in relevant board subcommittees (such as the audit committee) and subgroups.

Compassionate, inclusive and effective leadership is sustained through a leadership strategy and development programme and effective selection, development, deployment and support processes and succession-planning.

Senior leaders can evidence that the organisation takes a strategic approach to developing leadership and managing talent to ensure there are enough appropriately skilled, diverse and system-focused leaders to deliver high quality, effective, continuously improving, compassionate care.

Senior leaders can evidence that a leadership strategy and succession plan are in place and regularly reviewed, based on quantitative and qualitative data. They should cover clinical and managerial leadership positions at board level and key roles below board level (such as clinical, operational, finance leads).

Senior leaders can evidence that leadership development, coaching and mentoring programmes are accessible to leaders and potential leaders at all levels and support the development of high quality, sustainable care cultures by:

- bringing together clinical and managerial staff
- supporting team-working and system-working

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- ensuring leaders gain a broader systems perspective (for example through the use of secondments or stretch assignments)
- ensuring there is a balance of experiential learning alongside coaching and classroom-based learning
- focusing on knowledge, skills, attitudes and behaviours
- ensuring that those with protected characteristics are represented in the take up of development opportunities

Leaders at every level are visible and approachable.

Leaders across the organisation are described by staff members as visible, approachable and welcoming challenge. They are accessible through different channels (such as surveys, focus groups, workshops, patient safety walkabouts and approaches such as the [15 steps challenge](#)).

Senior leaders can evidence how their approach enables them to understand the issues staff face, and identify and address blocks to improvement.

CQC inspection teams will consider the following prompts as part of their assessments in relation to this KLOE:

- W1.1 Do leaders have the skills, knowledge, experience and integrity that they need – both when they are appointed and on an ongoing basis?*
- W1.2 Do leaders understand the challenges to quality and sustainability and can they identify the actions needed to address them?*
- W1.3 Are leaders visible and approachable?*
- W1.4 Are there clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership, and is there a leadership strategy or development programme, which includes succession planning?*

KLOE 2: Is there a clear vision and a credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?

There is a clear statement of vision and values, driven by quality and sustainability. It has been translated into a robust and realistic strategy and well-defined objectives that are achievable and relevant.

Senior leaders can evidence that there is a clear, well-thought out, comprehensive picture of how the organisation's services will look in the future, centred on the people who use services and their carers, and they have mapped a route to achieving this. This is supported by a vision and values that present a clear and compelling picture of patient and service user centred care in the context of the wider local health and care system.

Senior leaders can evidence a clear focus on continuous improvement, staff and user engagement and ambitions to be a learning organisation in a wider learning system.

Senior leaders can evidence how the organisation's key quality, operational and financial priorities have informed the development of the strategy, which has a small number of clear quality, operational and financial objectives that steer the organisation sustainably towards its vision. The strategy covers:

- safety, clinical outcomes, patient experience,
- workforce capacity and capability
- productivity and efficiency, affordability, financial performance
- the organisation's part in delivering the priorities of the local health and care economy
- sustainable development in relation to the environment
- staff health and wellbeing.

The strategy is aligned to local plans in the wider health and social care economy and services are planned to meet the needs of the relevant population.

Senior leaders can evidence that the organisation’s strategy clearly articulates the shared purpose and principles for working with other organisations, and the system’s goals in the wider local and national context:

- the organisation’s strategy should be aligned to plans for sustainability and transformation across the wider local health and care economy
- there should be an explicit link to the multiyear plans to maintain or achieve clinical and financial sustainability across the wider local health and care economy
- there is a narrative on how the organisation plans to respond to key NHS initiatives on quality, operational productivity and sustainability
- there is a narrative on how the organisation will meet the needs of and work to improve wider population health.

Staff in all areas know, understand and support the vision, values and strategic goals and how their role helps in achieving them.

Senior leaders can evidence how the strategy, vision, values and goals across quality, operations and finance have been shared and promoted across all parts of the organisation, supported by an appropriate communication plan.

Staff members can explain the organisation’s goals and initiatives to others when asked, and their own part in delivering the aspects relevant to them.

External partners, including commissioners, key patient groups and service delivery partners, can describe the goals and initiatives relevant to them, and how they support delivery of local health and care economy and/or national priorities.

The vision, values and strategy have been developed through a structured planning process in collaboration with people who use the service, staff and external partners.

Senior leaders can evidence that a structured approach has been taken to strategy development, integrating quality, operations (including workforce capacity) and finance. This includes evidence of how the organisation has understood:

- its current operating environment, its current weaknesses, and the future for which it needs to plan, both in a local health and care context, and in response to national priorities
- the goals and objectives that arise from this
- the determinants of its quality, operational and financial performance
- the options for change and how these are prioritised over the short, medium and long term (for example one year, two to five years and over five years), so that short-term responsiveness contributes to longer term aims.

This also includes evidence of how it has planned to implement the proposed solutions and review the approach/adapt to a changing environment.

Senior leaders can evidence how they have identified stakeholders and involved them in developing the strategy. This will include at least:

- people who use the services and their representatives
- staff
- external partners (such as health and local authority commissioners, other health and care providers, local Healthwatch, local politicians and MPs).

These stakeholders are able to describe how their involvement has influenced the outcomes of the strategy development process.

Progress against delivery of the strategy and local plans is monitored and reviewed, and there is evidence of this. Quantifiable and measurable outcomes support strategic objectives, which are cascaded throughout the organisation. The challenges to achieving the strategy, including relevant local health economy factors, are understood and an action plan is in place.

Senior leaders can evidence how the organisation's strategic goals and objectives, reflecting those of the local health and system, are cascaded through the organisation by informing the objectives and performance targets for business units, teams and staff members.

Senior leaders can evidence that there are detailed delivery plans; progress against them is monitored and aggregated in a structured way, and the board and local health and care economy leaders regularly discuss and respond to them as appropriate, focusing on delivering the strategic goals and objectives.

Senior leaders can explain and evidence how the strategy is regularly reviewed and refreshed, if needed, to ensure that it remains achievable and relevant.

CQC inspection teams will consider the following prompts as part of their assessments in relation to this KLOE:

- W2.1 Is there a clear vision and a set of values, with quality and sustainability as the top priorities?*
- W2.2 Is there a robust realistic strategy for achieving the priorities and delivering good quality, sustainable care?*
- W2.3 Have the vision, values and strategy been developed using a structured planning process in collaboration with staff, people who use services, and external partners?*
- W2.4 Do staff know and understand what the vision, values and strategy are, and their role in achieving them?*
- W2.5 Is the strategy aligned to local plans in the wider health and social care economy, and how have services been planned to meet the needs of the relevant population?*
- W2.6 Is progress against delivery of the strategy and local plans monitored and reviewed and is there evidence to show this?*

KLOE 3 Is there a culture of high quality, sustainable care?

Leaders at every level live the vision and embody shared values, prioritise high quality, sustainable and compassionate care, and promote equality and diversity. They encourage pride and positivity in the organisation and focus attention on the needs and experiences of people who use services. Behaviour and performance inconsistent with the vision and values are acted on regardless of seniority.

Senior leaders can evidence that there is a compelling vision and a clear set of values across the organisation, with staff members demonstrating their commitment to high quality, effective, continually improving, compassionate and sustainable care.

Senior leaders can evidence that staff recruitment, promotion and appraisal processes are aligned with the organisation's vision and values and behaviours and reinforce a culture of inclusive, diverse leadership.

Leaders across the organisation develop positivity, pride and identity across the organisation through, for example:

- celebrating the successes of teams and individuals, including rewarding staff who consistently deliver care or perform beyond expectation
- emphasising how the work makes a difference to patients and the community
- building a sense of positivity about the future.

Staff survey results demonstrate high levels of positivity and pride.

Leaders across the organisation celebrate behaviour consistent with the organisation's vision and values, and address behaviour which is contrary to them, wherever and at whatever level this behaviour occurs.

Senior leaders can evidence that there is a comprehensive induction programme for all staff groups (including junior doctor and agency staff) derived from the vision, values and strategy.

Senior leaders can evidence that the provider has a culture of integrity and probity, including fraud awareness and prevention and appropriate standards of business conduct.

Candour, openness, honesty, transparency and challenges to poor practice are the norm. The leadership actively promotes staff empowerment to drive improvement, and raising concerns is encouraged and valued. Staff actively raise concerns and those who do (including external whistleblowers) are supported. Concerns are investigated sensitively and confidentially, and lessons are shared and acted on. When something goes wrong, people receive a sincere and timely apology and are told about any actions being taken to prevent the same happening again.

Senior leaders can evidence that they look for and take appropriate and timely action to address issues arising from:

- reported incidents and concerns
- complaints and feedback from patients, service users and carers
- input from governors, patient groups, local Healthwatch networks
- internal and external reviews of its culture.

Senior leaders can evidence that the reporting of errors and speaking up is normalised. Staff members are encouraged to raise concerns and report incidents, and to regard complaints and feedback from patients as means of learning for continuous improvement and innovation. They are supported to regard complaints positively.

Senior leaders can evidence that there are appropriate and effective mechanisms, which staff members are aware of and have confidence in, for raising concerns and reporting errors and incidents. The national whistleblower policy has been adopted, and there is an accessible Freedom to Speak Up Guardian who provides regular updates to the board.

Senior leaders can evidence that there are appropriate and effective mechanisms for turning concerns/incidents into improvement actions based on inquiry about the root causes of what has happened, where constructive challenge is welcome at all levels of the organisation, including the board.

There are processes for providing all staff at every level with the development they need, including high-quality appraisal and career development conversations.

Senior leaders can evidence that they promote and demonstrate their commitment to continued learning and development for all staff members, so they have appropriate levels of quality, operational and financial skills, qualifications and understanding. Senior leaders can evidence they act on issues such as low training and appraisal rates.

Senior leaders can evidence that there are processes to ensure that all staff members, including senior leaders, are able to:

- do any necessary mandatory training, including updating professional registration/revalidation
- understand functions across the range of activities in the organisation, not just their own (such as finance for non-finance managers)
- develop through leading or taking part in challenging projects or other appropriate learning opportunities, with rapidly increasing equality of access to these opportunities, especially for those with protected characteristics
- take part in high quality appraisal and career development conversations, aiming to help individuals achieve their potential.

Senior leaders can evidence that staff have the freedom to work autonomously, where appropriate and safe, and there is appropriate devolution of decision-making and permission to experiment with new ways of working appropriate to their skills and grounded in a strong safety culture.

Leaders model and encourage compassionate, inclusive and supportive relationships among staff so that they feel respected, valued and supported. There are processes to support staff and promote their positive wellbeing.

All staff members demonstrate commitment to acting compassionately towards their colleagues through:

- using a variety of approaches to listen to staff views
- understanding where they need to improve support, engagement, wellbeing and staff feeling valued
- empathising and taking intelligent action in response to what they find.

Senior leaders can evidence ownership of an organisational development strategy, co-developed with staff across the organisation and regularly updated, that articulates what the organisation is doing to improve.

Senior leaders can evidence that there are systems to monitor, manage and support staff pressure.

Equality and diversity are actively promoted and the causes of any workforce inequality are identified and action taken to address these. Staff, including those with protected characteristics under the Equality Act, feel they are treated equitably.

Senior leaders can evidence that members of staff with protected characteristics are treated equitably, and can safely share concerns and be listened to in a meaningful and sustained way.

They can evidence the organisation's commitment to inclusion and equality through:

- proactive engagement with staff, staff networks, trades unions and other staff organisations on the inclusion and equality agenda
- comparing metrics on staff engagement, bullying, harassment, recruitment and promotion among those with protected characteristics and the wider workforce
- ownership and regular monitoring of an effective equality and diversity strategy and plan, shared with all staff and other local interests as needed
- participating in developmental initiatives relating to building an inclusive workforce and wider healthcare services
- action on areas identified for development through any of these means.

There is a culture of collective responsibility between teams and services. There are positive relationships between staff and teams, where conflicts are resolved quickly and constructively and responsibility is shared.

Senior leaders can evidence that there are appropriate and effective mechanisms to enable effective team working at all levels in the organisation, including the board, and within and across teams (for example between finance and operations). In practice, this means:

- collaboration and co-operation within and across teams, role modelled by the leaders of those teams and senior leaders
- individuals and teams provide practical support to others, particularly in difficult circumstances
- conflicts are resolved quickly
- responsibility is shared to deliver high quality care
- shared leadership so that everyone contributes their experience and ideas
- clear objectives in collaborative work with different members or teams understanding each other's needs and responsibilities
- performance at team level is measured and understood by team members (or by individuals involved in any cross-team collaborations).

CQC inspection teams will consider the following prompts as part of their assessments in relation to this KLOE:

- W3.1 Do staff feel supported, respected and valued?*
- W3.2 Is the culture centred on the needs and experience of people who use services?*
- W3.3 Do staff feel positive and proud to work in the organisation?*
- W3.4 Is action taken to address behaviour and performance that is inconsistent with the vision and values, regardless of seniority?*
- W3.5 Does the culture encourage, openness and honesty at all levels within the organisation, including with people who use services, in response to incidents? Do leaders and staff understand the importance of staff being able to raise concerns without fear of retribution, and is appropriate learning and action taken as a result of concerns raised?*
- W3.6 Are there mechanisms for providing all staff at every level with the development they need, including high quality appraisal and career development conversations?*
- W3.7 Is there a strong emphasis on safety and well-being of staff?*
- W3.8 Are equality and diversity promoted within and beyond the organisation? Do all staff, including those with particular protected characteristics under the Equality Act, feel they are treated equitably?*
- W3.9 Are there co-operative, supportive and appreciative relationships among staff? Do staff and teams work collaboratively, share responsibility and resolve conflict quickly and constructively?*

KLOE 4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?

Structures, processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services, are clearly set out, understood and effective.

Board members can evidence that they understand their personal accountability for the quality, operational and financial performance of the organisation.

Senior leaders can evidence that they are clear about who is responsible and accountable for the provision, quality and performance of services, including decision-making, delivery, and management of risks and issues in relation to quality, operations and finance. This is demonstrated in:

- clear and consistently applied levels of delegations and processes for recording decisions and escalation, which are monitored for compliance
- a clear organisational structure that cascades responsibility for delivering quality, operational and financial performance from 'board to front line to board'
- clear policies in place to ensure that conflicts of interest are identified and managed.
- a clear management structure that defines accountabilities for use of resources (including workforce, financial budgets, IT, estates, etc)
- effective systems and processes that enable close working between quality, operational and finance functions
- clear processes for planning and budgeting for all income and expenditure
- the robust and timely implementing of controls in response to issues/concerns raised by internal or external audit, or encounters with serious fraud.
- regular reviews of governance processes across quality, operations and finance

Senior leaders can evidence that there is a robust system of internal control, overseen by board subcommittees, to safeguard patient safety, service quality, investment, financial reporting and the organisation's assets.

Working with partners

Senior leaders can demonstrate that there are arrangements to ensure appropriate interaction with processes and governance systems that involve groups of partners and/or stakeholders from other local health and care organisations.

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Senior leaders can evidence that all interested parties are clear about roles, responsibilities, structures and processes for planning, budgeting and reporting on any partnerships, joint ventures, shared services and sources of non-NHS income and understand, for example, protocols for:

- governing the use of any pooled budgets, with appropriate management structures to support and enforce the agreed practice
- the escalation and resolution of issues between parties
- dealing with overspends and underspends that are reviewed regularly.
- sharing data
- the termination of any arrangements.

The board and other levels of governance in the organisation function effectively and interact with each other appropriately.

The board operates as an effective unitary board demonstrating:

- clarity around its function, including the powers it reserves for itself and those it delegates to subcommittees and others
- stable and regularly attending membership (including non-executive directors) of a size appropriate to the requirements of the organisation
- appropriate balance between challenge and support, for example between executive and non-executive directors, and between governors and non-executive directors (where applicable)
- appropriate information flows supporting decision-making and the timely resolution of risks and issues
- that it operates within its terms of reference, and regularly reviews achievement against them.

The board’s agenda is appropriately balanced and focused between:

- strategy and current performance (short term and long term)
- quality, operations and finance
- making decisions and noting/receiving information
- internal matters and external considerations
- business conducted at public board meetings and that done in confidential sessions.

Staff are clear on their roles and accountabilities.

Staff members understand the organisation's key quality, operational and finance priorities, and how their own goals and objectives contribute to the organisation's performance as a whole and how this is measured.

Staff members understand they are accountable for delivering high quality, sustainable care, and optimising use of the organisation's resources. They are supported to identify and tackle obstacles in relation to these aims, escalating risks effectively.

CQC inspection teams will consider the following prompts as part of their assessments in relation to this KLOE:

- W4.1 Are there effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services? Are these regularly reviewed and improved?*
- W4.2 Do all levels of governance and management function effectively and interact with each other appropriately?*
- W4.3 Are staff at all levels clear about their roles and do they understand what they are accountable for and to whom?*
- W4.4 Are arrangements with partners and third-party providers governed and managed effectively to encourage appropriate interaction and promote coordinated, person-centred care?*

KLOE 5. Are there clear and effective processes for managing risks, issues and performance?

There is an effective and comprehensive process to identify, understand, monitor and address current and future risks.

Leaders across the organisation are able to describe the current and future quality, operational and financial risks that relate to their areas of work, and the plans to mitigate them.

Senior leaders can evidence that the organisation has effective, timely, horizon-scanning, scenario-planning and reporting processes so that it is sufficiently aware of changes in the internal and external environment (including risks from the wider local health and care economy) that may affect delivery of strategy and/or affect quality and financial sustainability.

Senior leaders can evidence that a board assurance framework and dynamic risk registers are in place and assessed by the board at least quarterly and demonstrate:

- attention to both internal and external risks, and their impact on planning
- a robust process for collating, evaluating, quantifying and reporting key risks
- a clear understanding of the board's risk appetite and tolerance, which is reviewed regularly (at least annually) and appropriately communicated to staff
- a commitment to learning lessons from inquiries (for example, safeguarding lessons from the [2015 Savile review](#)), internal and external reviews of their own organisation, and of other organisations, and sharing this learning with staff, patients and the public.

Senior leaders can evidence that there is a clear risk management process understood by staff members, including the board, its subcommittees and subgroups, so that they identify, assess, understand, assign responsibility for and act on risks relevant to their area of responsibility. This includes internal escalation and external escalation if the risks affect other organisations.

Senior leaders can evidence that emergency preparedness/crisis management planning has been carried out and there is a robust business continuity plan.

Financial pressures are managed so that they do not compromise the quality of care. Service developments and efficiency changes are developed and assessed with input from clinicians so that their impact on the quality of care is understood.

Senior leaders can evidence that service development or efficiency initiatives:

- are developed with relevant stakeholders (especially service users, their carers, clinical and operational staff), with due regard to the [public sector equality duty](#).
- make use of relevant published research, evidence, benchmarking data and operational experience
- identify measures and early warning indicators to be monitored during and after implementation, with an associated risk management plan
- are assessed consistently according to their impact on quality and sustainability, including the cumulative and aggregate impact of smaller schemes on patient pathways or professional groups
- are monitored during implementation and afterwards, with mitigating actions taken if necessary.

The organisation has the processes to manage current and future performance.

Senior leaders can evidence that there is a performance management system for quality, operations and finance across all departments, which comprises:

- appropriate performance measures relating to relevant goals and targets
- reporting lines within which these will be managed, including how this will happen across teams (for example finance and operations)
- policies for managing/responding to deteriorating performance across all activities, at individual, team, service-line and organisational levels, with clear processes for re-forecasting performance trajectories
- a programme or portfolio management approach that allows the co-ordination of initiatives across the organisation, and with external partners as required
- a clear process for identifying lessons from performance issues and sharing these across the organisation on a regular, timely basis
- clear processes for reviewing and updating policies regularly to take account of organisational learning, and changes in the operating environment and national policy.

Performance issues are escalated to the appropriate committees and the board through clear structures and processes.

Senior leaders can evidence that there are clear processes for:

- escalating quality, operational and financial performance issues through the organisation to the relevant committees as part of and outside the regular meeting cycle as required, linked to the organisation’s risk matrix and consistent with the organisation’s risk appetite.
- creating robust action plans, with clear ownership, timeframes and dependencies, all of which are monitored and followed up at subsequent meetings until they are resolved.

Senior leaders can further evidence that:

- these processes are effective
- the appropriate individuals/management levels are aware of the issues and are managing them through to resolution
- themes arising from the most frequent risks and issues are analysed to identify barriers that need to be removed to drive improvement.

Clinical and internal audit processes function well and have a positive impact on quality governance, with clear evidence of action to resolve concerns.

Senior leaders can evidence that there is a clear, co-ordinated, continuous programme of clinical audit, peer review and internal audit, overseen and challenged by the board, which:

- aligns with priorities identified from risk intelligence and/or gaps in other assurance.
- competent individuals or teams (as appropriate) carry out to meet the needs identified
- is oriented to action, to address gaps from the audits in a timely manner and monitor them to ensure they are driving improvement
- ensures learning from the audits is shared across the organisation to facilitate wider improvement.

CQC inspection teams will consider the following prompts as part of their assessments in relation to this KLOE:

- W5.1 Are there comprehensive assurance systems, and are performance issues escalated appropriately through clear structures and processes? Are these regularly reviewed and improved?*
- W5.2 Are there processes to manage current and future performance? Are these regularly reviewed and improved?*
- W5.3 Is there a systematic programme of clinical and internal audit to monitor quality, operational, and financial processes, and systems to identify where action should be taken?*
- W5.4 Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions? Is there alignment between the recorded risks and what staff say is 'on their worry list'?*
- W5.5 Are potential risks taken into account when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities?*
- W5.6 When considering developments to services or efficiency changes, how is the impact on quality and sustainability assessed and monitored? Are there examples of where financial pressures have compromised care?*

KLOE 6. Is appropriate and accurate information being effectively processed, challenged and acted on?

Quality and sustainability both receive sufficient coverage in relevant meetings at all levels.

Staff receive helpful data on a daily basis, which supports them to adjust and improve performance as necessary.

Senior leaders can evidence that the board, its committees and subgroups as a core part of their meetings:

- receive and discuss information covering quality, operations and finance, and their inter-relationships; each committee's particular focus arising from its terms of reference
- appropriately challenge and interrogate the information and assumptions presented to inform decision-making, making use of benchmarking and other external sources as appropriate

Senior leaders can evidence that core financial information is presented and robustly challenged throughout the organisation. This information is presented in the context of non-financial information, risks and mitigations, and there is a balance between actuals and projections, detail of cost and income categories, granularity of divisional/ locality/ business unit information, and links with operational drivers.

Senior leaders can evidence that service line reporting approaches (ideally at patient level) are used for financial reporting and patient level costing has been or is being implemented.

Integrated reporting supports effective decision-making. There is a holistic understanding of performance, which sufficiently covers and integrates the views of people, with quality, operational and financial information.

Senior leaders can evidence that the reporting approach integrates quality, operations and finance, appropriate to the size and complexity of the organisation. The board, its committees and sub-committees, use it to:

- ensure that the impact of all service development and efficiency programmes is understood on the quality and sustainability of all relevant areas of the organisation before decisions are made
- understand areas of good and under-performance
- support evidence-based decision-making, using sensitivity analysis where appropriate

Senior leaders can evidence that there are monthly dashboards covering the most important indicators for the scrutinising committee. These dashboards are used effectively and:

- present the most recent (or recent enough to be relevant) data available
- where appropriate give preference to absolute data over relative data
- present both information for improvement and for assurance:
 - **measurement for improvement** means that data is presented using appropriate statistical methods to enable tracking of processes, balancing measures and outcomes over time, paying attention to variation rather than simply comparing against targets and thresholds at particular times
 - **measurement for assurance** means information is compared with target levels of performance (along with a red-amber-green rating), historic own performance and external benchmarks (where available and helpful).
- are frequently reviewed and updated to maximise effectiveness of decisions; and where useful metrics are lacking, the board commits time and resources to developing new metrics
- form a pyramid of reports, with increasing granularity that can be used to understand individual, business unit, service line, divisional and organisational performance as required.

Performance information is used to hold management and staff to account.

Senior leaders can evidence that there are quality, operational and financial reporting procedures, which provide robust information on organisational performance and enable key strategic and operational risks to be identified and managed. This information can be accessed by any staff members who require it for their work.

Senior leaders can evidence that the board, its committees and subcommittees regularly use information to understand and support the improvement of all areas of the organisation, including qualitative/ narrative text to explain outlying performance alongside the agreed metrics. This includes performance information relating to:

- divisions, localities, service lines and clinical units
- across patient pathways, internal and external
- the organisation's strategy and any associated plans.

Senior leaders can evidence that they make use of relevant indicators in relation to the people or the human resources (HR) strategy, for example:

- safe staffing
- workforce capacity and capability to deliver the future strategy
- intelligence on values, behaviours and attitudes
- HR health indicators, including information on equality and diversity
- performance appraisal, training and development; and leadership.

The information used in reporting, performance management and delivering quality care is usually accurate, valid, reliable, timely and relevant, with plans to address any weaknesses.

Senior leaders can evidence that the information the board, its subcommittees and subgroups receive comes from reliable and suitable sources and covers an appropriate mix of qualitative and quantitative intelligence.

Senior leaders can evidence that there are robust and reliable processes, systems and controls for producing the information covering data collection, checking, processing and reporting, which are captured in clear standard operating procedures.

Senior leaders can evidence that arrangements for supporting how performance indicators are prepared and reported are reviewed regularly.

Information technology systems are used effectively to monitor and improve the quality of care.

Senior leaders can evidence that, through dedicated chief information officer and chief clinical information officer leadership, the organisation is delivering higher quality, more effective and lower cost care through effective use of information technology (IT), data and analytics.

Senior leaders can evidence that the organisation is constantly looking to learn from others – both nationally and internationally – on how best to identify and exploit the opportunities that IT, data and analytics provide to monitor and improve the quality of care.

Senior leaders can evidence a mature understanding of the role of digital technology as a change management and improvement mechanism to transform operating procedures and care delivery models.

Senior leaders can evidence that IT adheres to the latest standards of cyber security to minimise risk to patient care and organisational reputation.

Senior leaders can evidence that the organisation’s IT adopts all of the relevant data and information standards, enabling accurate timely and comprehensive use of data across the enterprise and effective sharing with trusted partners across the local health and care system.

Staff members understand the benefits of working ‘paper-free’ and have sufficient understanding of the role of IT, data and analytics to improve patient outcomes, organisational and system sustainability.

Staff members demonstrate confidence in the use of IT, data and analytics relevant to their roles to support patient care.

Data or notifications are consistently submitted to external organisations as required.

Senior leaders can evidence that the relevant departments understand the routine and exceptional data requirements of external bodies.

Senior leaders can evidence that there are appropriate and effective mechanisms for the collection, preparation and sign-off of the necessary information on routine and exceptional bases to support timely delivery to external organisations.

There are robust arrangements for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Senior leaders can evidence that there are an information governance (IG) framework and documented processes and procedures to support the co-ordinated and integrated care through appropriate and lawful information-sharing and the effective management of records.

Senior leaders can evidence that the organisation is able to maintain the confidentiality and security of the personal confidential data it processes and all reasonable care is taken to prevent inappropriate access, modification or manipulation of that data. This includes ensuring there are arrangements to:

- secure against unauthorised access to data
- safeguard against unauthorised modification of data
- make readily accessible the required data to authorised users only.

CQC inspection teams will consider the following prompts as part of their assessments in relation to this KLOE:

W6.1 Is there a holistic understanding of performance, which sufficiently covers and integrates people's views with information on quality, operations and finances? Is information used to measure for improvement, not just assurance?

W6.2 Do quality and sustainability both receive sufficient coverage in relevant meetings at all levels? Do all staff have sufficient access to information, and challenge it appropriately?

W6.3 Are there clear and robust service performance measures, which are reported and monitored?

W6.4 Are there effective arrangements to ensure that the information used to monitor, manage and report on quality and performance is accurate, valid, reliable, timely and relevant? What action is taken when issues are identified?

W6.5 Are information technology systems used effectively to monitor and improve the quality of care?

W6.6 Are there effective arrangements to ensure that data or notifications are submitted to external bodies as required?

W6.7 Are there robust arrangements (including appropriate internal and external validation), to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards? Are lessons learned when there are data security breaches?

KLOE 7 Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?

A full and diverse range of people’s views and concerns is encouraged, heard and acted on to shape services and culture.

Staff members are committed to actively seeking the views of patients, service users, carers and the public, both directly and via other groups (such as local Healthwatch organisations, patient representative groups, members and governors (where appropriate)) through a variety of channels and with due regard to the public sector equality duty.

Senior leaders can evidence that these views, including those received as concerns and complaints, are regarded as a way to understand and improve performance, and routinely used to inform service development.

The board receives and reviews quantitatively and qualitatively analysed data at least quarterly, triangulated with other risk intelligence, and addresses any risks or development areas identified.

Senior leaders can evidence that the organisation communicates to the public fully, regularly, and in accessible ways:

- the decisions taken by the Board and the rationale for them
- performance measures and outcomes that include objective coverage of both good and bad performance.

For foundation trusts, senior leaders can evidence how governors are enabled to hold the non-executive directors individually and collectively to account for the performance of the board of directors and to represent the interests of NHS foundation trust members and of the public.

The service proactively engages and involves all staff (including those with protected equality characteristics) and ensures that the voices of all staff are heard and acted on to shape services and culture.

Senior leaders can evidence that staff at all levels are actively involved in planning and delivery of significant service developments in a variety of ways and with due regard for the public sector equality duty. Senior leaders can evidence how staff input has influenced plans.

Continues...

Staff members can describe how they are encouraged to feed back, through a variety of channels, on an ongoing basis as well as through specific mechanisms. This will include but is not limited to an annual staff survey.

The Board reviews quantitatively and qualitatively analysed data, triangulated with other risk intelligence (such as complaints, incidents), and addresses any development areas identified. Senior leaders can evidence how stakeholder input has influenced plans.

The service is transparent, collaborative and open with all relevant stakeholders about performance, to build a shared understanding of challenges to the system and the needs of the population and to design improvements to meet them.

External stakeholders describe working relationships with the organisation as positive, underpinned by trust, respect and co-operation.

Senior leaders can evidence that there are appropriate and effective mechanisms to enable the organisation to work proactively with local health and care system partners to:

- build a shared understanding of population health, patient needs and system challenges
- design improvements to create long term sustainability.

Senior leaders can evidence their commitment to developing positive and effective working relationships with local health and care system partners by:

- dedicating appropriate face-to-face time to working with counterparts in other organisations to build trusting relationships
- regularly attending systems meetings from staff with appropriate capacity, experience and seniority
- engaging external stakeholders in formal internal governance committees where appropriate
- proactively seeking and acting on feedback on the quality of these relationships (for example through 360° stakeholder surveys)
- co-operating constructively with third parties with specific roles in relation to the organisation (such as commissioners and other providers).

Senior leaders can evidence that the organisation responds with flexibility and agility to changes in the local health economy, and takes part in pooled activities which may include:

Continues...

- common quality improvement (QI) approach
- pooled transformation and improvement resources
- trust-building efforts for finance, clinicians, etc
- delegated decision-making
- local area talent management planning and leadership development
- local health economy plans delivery groups

Senior leaders can evidence that the organisation proactively engages and shares data openly on relevant quality, operational and financial performance with all major external stakeholders (including health and local authority commissioners, Health and Wellbeing Boards, Healthwatch, patient groups and MPs).

Senior leaders can evidence that the organisation's decision-making is transparent, and the processes in place enable stakeholders, including commissioners, to find out easily how and why the board has made key decisions in addition to responding to freedom of information requests.

Staff members proactively engage with relevant delivery partners (general practitioners, local authorities, third sector providers, other community, mental health, acute and specialist providers) to identify improvement opportunities, performance or resourcing issues and to ensure overall quality along pathways.

CQC inspection teams will consider the following prompts as part of their assessments in relation to this KLOE:

W7.1 Are people's views and experiences gathered and acted on to shape and improve the services and culture? Does this include people in a range of equality groups?

W7.2 Are people who use services, those close to them and their representatives actively engaged and involved in decision-making to shape services and culture? Does this include people in a range of equality groups?

W7.3 Are staff actively engaged so that their views are reflected in the planning and delivery of services and in shaping the culture? Does this include those with a protected equality characteristic?

W7.4 Are there positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs?

W7.5 Is there transparency and openness with all stakeholders about performance?

KLOE 8: Are there robust systems and processes for learning, continuous improvement and innovation?

There is a strong focus on continuous learning and improvement at all levels of the organisation, including through appropriate use of external accreditation and participation in research.

Leaders across the organisation can articulate and demonstrate their commitment to the organisation's improvement approach, across quality, operations and finance functions by:

- taking a proactive approach to innovation and improvement, including active engagement in the delivery of initiatives (some initiatives could be led personally by individual board members)
- setting realistic but stretching performance objectives for the organisation
- encouraging learning from sector, national and international best practice, the creation of best practice where it doesn't exist and sharing back learning widely.

Senior leaders can evidence how they create a safe and hospitable environment for experimentation and learning, by:

- seeing failure not as a negative but as learning that can be embedded in future practice to deliver performance improvement
- taking time out to identify and act on the board's own successes and failures
- demonstrating how reviewing quality, operational and financial information has resulted in actions that have successfully improved performance.

There is knowledge of improvement methods and the skills to use them at all levels of the organisation.

Senior leaders can evidence that they actively encourage the use of a standardised improvement methodology embedded across the organisation to improve the quality, efficiency and productivity of services. This can be any method chosen by the organisation.

Board members demonstrate at least a basic awareness of the key improvement concepts (such as variation and system thinking) and can show how they have used these in improvement initiatives (such as understanding performance in terms of variation).

Continues...

Senior leaders can evidence that quality/continuous improvement training is offered to staff at all levels, and staff with appropriate leadership and analytical skills are available to lead and support improvement and innovation.

Staff members demonstrate their confidence and competence by improving their services involving patients and carers, and by sharing their skills with others through coaching and training.

The service makes effective use of internal and external reviews, and learning is shared effectively and used to make improvements.

Senior leaders can evidence how the organisation has learned from internal and external reviews and the effectiveness of its response to recommendations from external auditors and assessors.

Senior leaders can evidence how, where appropriate, external support networks and expertise are used to support ideas for development and improvement (for example use of benchmarking, working with patient groups, participating in peer learning networks on a range of topics, linking with healthcare providers and other improvement interventions and tools).

Staff are encouraged to use information and regularly take time out to review individual and team objectives, processes and performance. This is used to make improvements.

Senior leaders can evidence that:

- staff are clear about their personal priorities and objectives
- managers give timely and balanced feedback about progress towards objectives
- staff and teams are able to review these objectives against information and data
- there are appropriate and effective mechanisms for teams to work together to resolve problems, review team objectives, processes and performance on a regular basis.

There are organisational systems to support improvement and innovation work, including staff objectives, rewards, data systems and ways of sharing improvement work.

Senior leaders can evidence that there is an improvement strategy that promotes the adoption of the chosen improvement methodology and ensures it is reflected in the organisation's systems and processes. This means that:

- improvement is seen as the way to address performance in teams, between teams, or along pathways as appropriate
- staff objectives and appraisal processes include innovation and improvement
- improvement and innovation successes are celebrated throughout the organisation and learning is shared widely in the organisation, with other organisations in the health and care system, and more widely through contributions to conferences and journals.

Senior leaders can evidence that all staff members are supported to carry out improvement work with:

- appropriate resources (time and money) to deliver the projects they identify
- timely access to the data they need (such as service line data), the tools they need to analyse it (such as templates or software to generate statistical process control/run charts, etc) and analytical expertise to support them if required.

CQC inspection teams will consider the following prompts as part of their assessments in relation to this KLOE:

W8.1 In what ways do leaders and staff strive for continuous learning, improvement and innovation? Does this include participating in appropriate research projects and recognised accreditation schemes?

W8.2 Are there standardised improvement tools and methods, and do staff have the skills to use them?

W8.3 How effective is participation in and learning from internal and external reviews, including those related to mortality or the death of a person using the service? Is learning shared effectively and used to make improvements?

W8.4 Do all staff regularly take time out to work together to resolve problems and to review individual and team objectives, processes and performance? Does this lead to improvements and innovation?

W8.5 Are there systems in place to support improvement and innovation work including objectives and rewards for staff, data systems, and processes for evaluating and sharing the results of improvement work?

Annex A: Scoping your developmental review

This annex summarises some points you should consider in preparing for a review. It is not exhaustive, but should help to start the process.

Scope of the review

The scope of developmental reviews should cover the eight KLOEs in this guidance at an appropriate level. There may also be development areas the provider is aware of outside the framework arising from, for instance, internal and/or external audit review findings, or information from the annual governance statement and the corporate governance statement. The board should tailor the scope, or place emphasis within the review accordingly.

Self-review

Purpose of regular self-review

The purpose of regular self-review is to promote self-knowledge, reflection and vigilance, and the development and improvement of leadership and governance. It helps providers identify their strengths and development areas to deliver continuous improvement. High performing providers are likely to carry out some form of self-review of their leadership and governance regularly and frequently.

As with the scope of the developmental review, boards are responsible for setting the scope of regular self-reviews, but we suggest they should cover the full scope of the well-led framework at an appropriate level. Ideally, self-reviews will be carried out annually but providers should determine this for themselves.

Completing self-reviews

A nominated provider lead or team may co-ordinate the self-review but it should be completed and signed-off by the full board. In practice, this could mean that a nominated board member works with the board secretary and

their staff to gather the information and the evidence against each question and present their findings and initial conclusions to the board for discussion and challenge. The whole board is responsible for arriving at an overall conclusion.

The output of the self-review will include the self-review questionnaire (or equivalent), ratings and rationale for the ratings. This information may help inform the CQC well-led provider information request as part of the regular regulatory assessment process, but supplying the full self-review is not mandatory.

Preparation for development reviews

Self-review is an important first step in preparing for externally facilitated developmental reviews. Providers should assess themselves to provide insight for themselves and the external facilitator into how they gauge their own leadership and governance performance and identify any particular areas of interest or concern either within or outside the eight questions.

A good self-review should help identify where the provider needs to focus and therefore inform the choice of external reviewer.

During a developmental review, the self-review should be presented to the external facilitator for comments and further discussion. The reviewer will then agree areas for further scrutiny with the board.

Rating the self-review

Each of the KLOEs should be rated using a scheme that allows prioritisation of findings and escalation of concerns, informed by the good practice examples in the framework. Each judgement should be backed up by evidence where appropriate.

Rating will aid prioritisation and ensure that issues are brought to the attention of the board. Boards should ensure that their approach facilitates continuous improvement rather than a compliance mindset. The reviews should not be about 'meeting a bar', but rather about prioritising improvement actions.

Key line of enquiry	Priority rating	Explanation of self-rating assessment	How is the board assured? Evidence for assessment	What are the principal actions/areas for discussion with your external review team
1. Is there the leadership capacity and capability to deliver high quality, sustainable care?				
2. Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?				
3. Is there a culture of high quality, sustainable care?				
4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?				
5. Are there clear and effective processes for managing risks, issues and performance?				
6. Is appropriate and accurate information being effectively processed, challenged and acted on?				
7. Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?				
8. Are there robust systems and processes for learning, continuous improvement and innovation?				

Annex B: Commissioning an external facilitator

This annex sets out what to consider when choosing an external team to facilitate developmental reviews against this framework.

Boards need to assure themselves that the appointed external facilitator is independent and able to provide a robust and reliable judgement of a provider's leadership and governance.

As part of the commissioning process, facilitators should also demonstrate:

- a clear and concise understanding of the purpose and objective of the review; knowledge of how to carry out a rigorous leadership and governance review, covering the specific areas detailed in the well-led framework; and the ability to use an appropriate range of tools and approaches
- relevant skills and experience, including:
 - credibility and experience in carrying out leadership and governance reviews at healthcare providers; ideally, the selected team will be multidisciplinary with a broad range of skills relevant to all aspects of board leadership and governance, such as strategic planning, quality governance, cultural assessment, organisational development and management information and analysis
 - experience in supporting healthcare providers to develop their leadership and governance with an understanding of continuous quality improvement and methodologies
 - knowledge of the healthcare sector, and the internal and external challenges faced by providers
 - knowledge of the regulatory framework the provider operates in
 - an ability to manage the review process: reviewers should provide a credible and detailed plan of the proposed project governance regime including the approach to the quality assurance of the work, risk

management, reporting and escalation lines, and evidence of clear leadership for the work with a named individual.

- named personnel (and CVs in the response), and clarity about their role and what they will do during the review.

Peer review input

Our ambition is that, over time, making use of and participating in developmental reviews will become an integral part of the role of senior leaders across the NHS. This is one of the main ways in which we can share the valuable learning, experience and ideas within the NHS leadership community and make it accessible to everyone, across our organisations.

This ambition will take some time to realise, but as a first step, we encourage providers where possible to involve, or to select suppliers who offer to involve, appropriately skilled peer reviewers as part of the external facilitation team. We will be providing further support and guidance about this in due course.

We will also be compiling a list of peer reviewers and this list will be available on request. We will include details about this on our website later this year.

<https://improvement.nhs.uk/resources/well-led-framework/>

Annex C: Carrying out a developmental review

This annex sets out:

- potential methods of carrying out a review
- the process of prioritising and rating your findings
- action-planning.

There is no 'one size fits all approach' to developmental reviews: we encourage providers to think about how to shape the methodology to support their needs. Providers are responsible for commissioning these reviews and so should assure themselves that the review tools and methods are suitable for their circumstances.

Because of this, the guidance below provides examples of tools and is not prescriptive. Experienced reviewers can use their own tools and methods.

Prioritising and rating findings

The findings from the review will usually be presented in a report for the board, covering methodology, scope, findings, and areas of good practice or weakness against which to plan developmental actions. It is important that issues or concerns are prioritised but plans for maintaining good practice should also be considered.

We encourage providers to agree the format in which they would like the findings to be presented at the start of the review process.

Action-planning

The board is ultimately accountable for delivering improvements, and so action-planning should involve the whole board. The board should consider how to track actions and the timeframe for resolution. Developmental reviews are most useful where issues are resolved in a timely manner.

NHS Improvement has a range of support offers (see Annex D) that boards may draw on when addressing issues.

Examples of tools

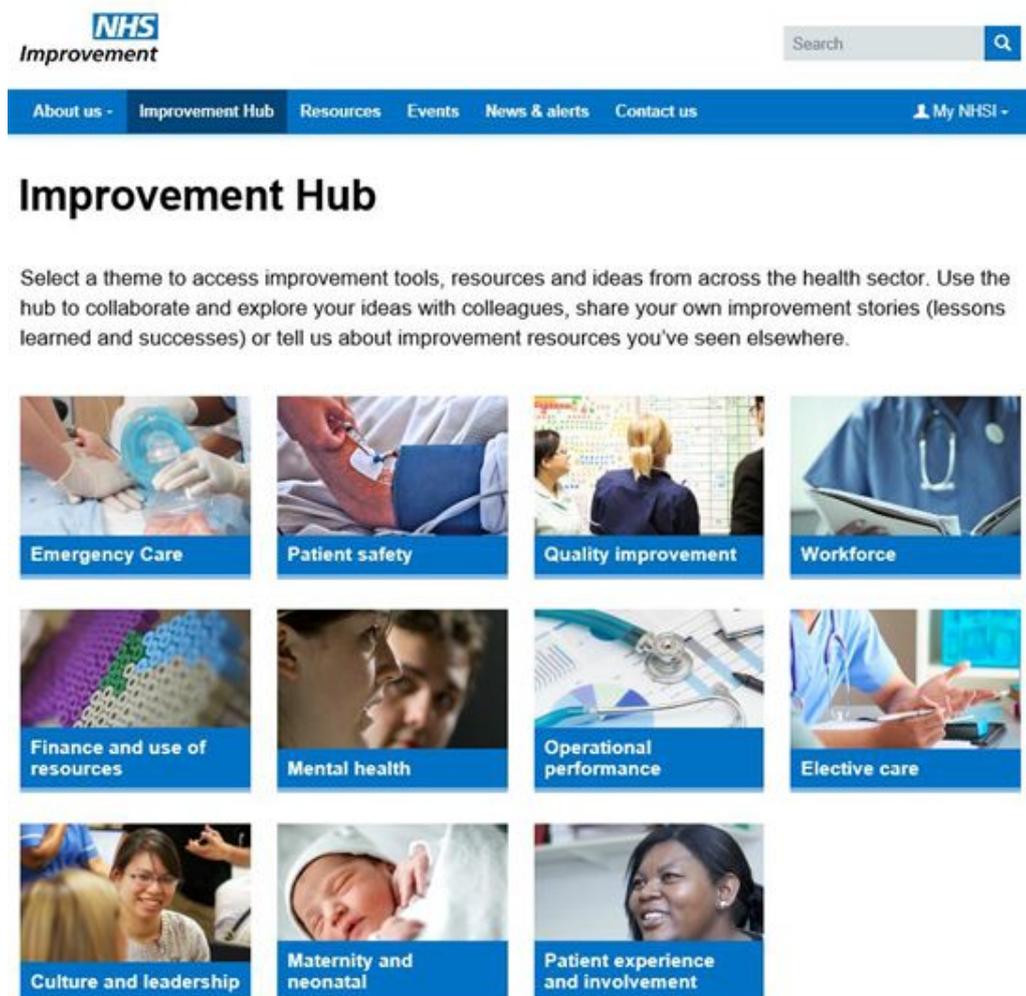
Tool	Suggested components	Purpose
Desktop document review	Board and key subcommittee agendas, minutes and papers; board assurance framework; audit reports; strategic documents, eg the provider's strategy and business plan, quality strategy, quality improvement plan and people strategy; and internal/ external audit reports, annual governance and corporate governance statements, alongside any other relevant reviews.	To provide a view of: <ul style="list-style-type: none"> • how ongoing issues and risks in the provider are communicated and managed • the quality of information produced to support decision-making • how the board prioritises issues at the provider and divides its attention.
One-to-one interviews	All board members, the trust secretary, lead governor, head of quality governance, head of workforce, clinical directors and heads of business units, and local stakeholders (including clinical commissioning groups and patient representatives).	To gain individuals' views of the provider's governance and to provide a 'safe' environment in which to explore issues and discuss sensitive information, as appropriate.
Stakeholder surveys	Staff and patient groups, commissioners and providers	To get internal and external parties' views of the provider's governance to cross-reference with the board's own views and test the board's awareness.
Focus groups with internal and external stakeholders	Staff, patient groups, commissioners, contracted or outsourced suppliers	To get internal and external parties' views of the provider's governance to cross-reference with the board's own views and test the board's awareness.

Tool	Suggested components	Purpose
Board and subcommittee observations	Observations of at least one board meeting and relevant subcommittees, including audit and quality.	To identify the dynamics of the board, including agenda management, depth and breadth of information used to make decisions and progress priorities, and the way they challenge and hold each other to account for the leadership of the provider.
Board skills inventory	Matching skills to the requirements of the board's work and identifying any gaps.	To ensure the board has the skills and experience needed.
Board self-assessment	Board members to rate how effective they believe the board is.	To provide a view of how effective the board believes itself to be.
Peer practices	On areas of governance in the sector, in similar organisations or providers.	To assess how the provider compares against any known examples of particularly effective and robust governance practices.

Annex D: Accessing support and further reading

New support offers are available all the time. The easiest way to find out about them is to visit the Improvement Hub: <https://improvement.nhs.uk/improvement-hub/>

This includes resources from across the NHS, as well as discussion forums and case studies.



Further reading

Good governance practice

British Quality Foundation (2013) [EFQM Excellence Model](#)

Committee on Standards in Public Life (1995) [The 7 principles of public life](#)

Department of Health (2011) [Board Governance Assurance Framework for Aspirant Foundation Trusts](#)

Department of Health (ongoing) [Information Governance](#)

NHS Providers and DAC Beachcroft (2015) [Foundations of Good Governance: A Compendium of Best Practice \(3rd edition\)](#)

NHS Leadership Academy (2013) [The Healthy NHS Board 2013: Principles for Good Governance](#)

NHS England (2017) [Managing Conflicts of interest in the NHS](#)

Reviews and investigations

Department of Health (2016), [Operational productivity and performance in English NHS acute hospitals: Unwarranted variations](#) (Lord Carter)

Department of Health (2014), [Examining new options and opportunities for providers of NHS care: The Dalton Review](#)

Department of Health (2014) [Better leadership for tomorrow: NHS Leadership Review](#). (Lord Rose)

Francis, R. (2013) [Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry](#).

Lampard K., Marsden E. (2015) [Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile](#)

National Advisory Group on the Safety of Patients in England (2013), [A promise to learn – a commitment to act: Improving the safety of patients in England](#)

National Improvement and Leadership Development Board (2016) [Developing People – Improving Care: A national framework for action on improvement and leadership development in NHS-funded services](#)

Smith, E. (2015), [Review of centrally funded improvement and leadership development functions](#), Final report of review on behalf of NHS England, Monitor, NHS Trust Development Authority, Health Education England, Public Health England and the Care Quality Commission.

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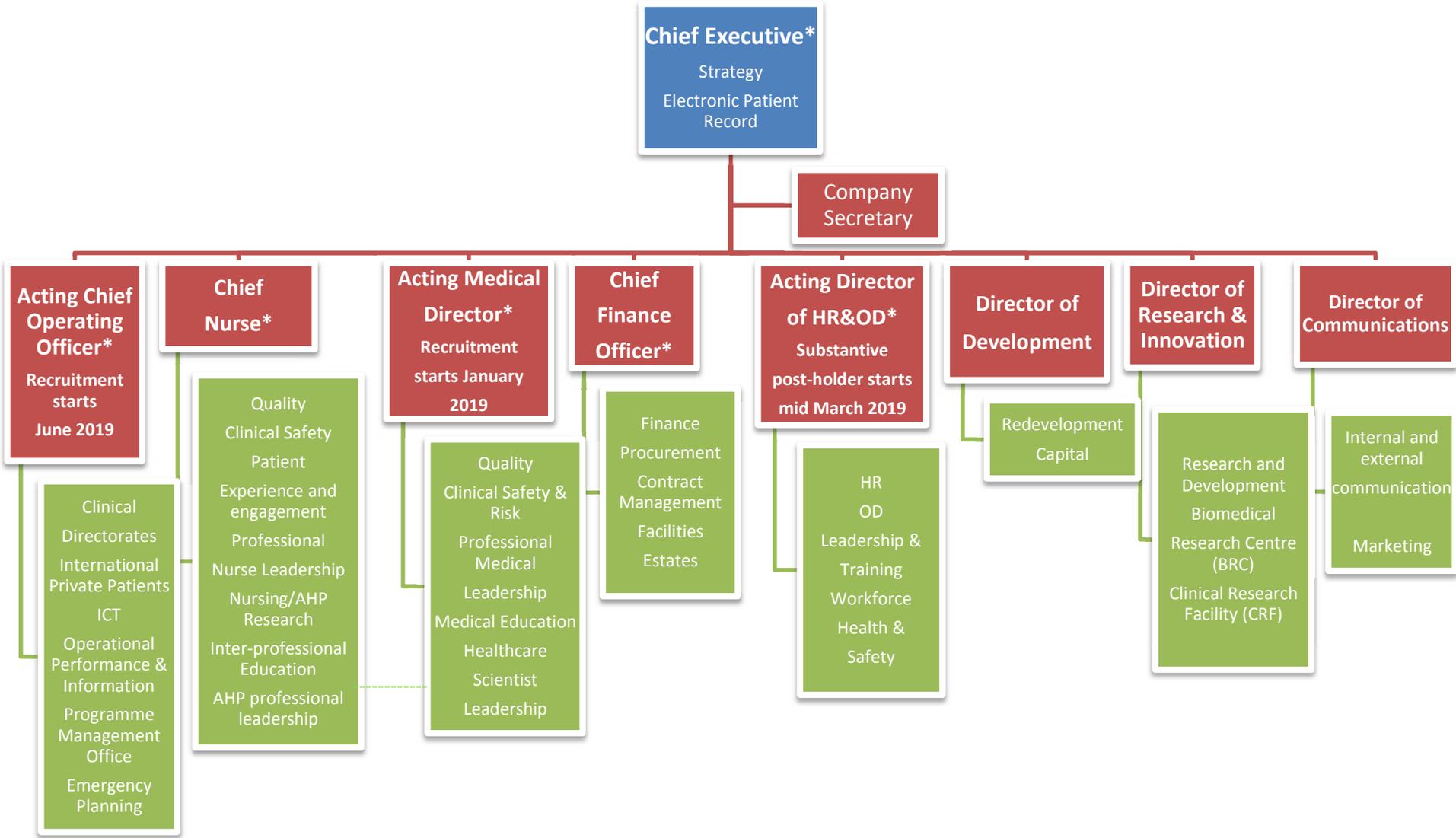


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GOSH Executive Director Structure (January 2019)



* Voting Board member

Trust Board 7 February 2019	
Corporate Governance Update	Paper No: Attachment V
Submitted by: Anna Ferrant, Company Secretary	
Aims / summary To provide an update on the following matters to Board members: <ul style="list-style-type: none"> • Review of the Quality and Safety Assurance Committee's terms of reference and work-plan and proposal for a change of name of the committee (for approval). • Discussion on proposal to establish a Workforce and Education Assurance Committee. • Discussion on proposal to appoint a Chief Information Officer/ Chief Clinical Information Officer (CCIO)/ or Chief Research Information Officer (CRIO) to the Board as a non-voting director. • Discussion on proposal to appoint an Associate NED on the Board • Update on executive portfolios. • Discussion on timings of an external developmental review against the well led framework at GOSH. • Final Board Assurance Framework risk statements 2019-20 (for approval) • Corporate Governance Review of Trust committees underway. 	
Action required from the meeting To note the update, discuss the proposals and approve the following recommendations: <ul style="list-style-type: none"> • To approve the Quality and Safety Assurance Committee's terms of reference and work-plan. • To approve the revised Board Assurance Framework risk statements. 	
Contribution to the delivery of NHS Foundation Trust strategies and plans Good governance	
Financial implications Yes – the appointment of the CIO will incur an additional cost – data is being sought	
Who needs to be told about any decision? An update will be provided to the Council on any approvals made. The post of CIO will be advertised internally under the normal Trust process.	
Who is responsible for implementing the proposals / project and anticipated timescales? Company Secretary	
Who is accountable for the implementation of the proposal / project? Chief Executive	

Attachment V

For approval: Review of the Quality and Safety Assurance Committee (QSAC)

The Quality and Safety Assurance Committee (QSAC) has delegated authority to ensure that the correct structures, systems and processes are in place within the Trust to appropriately manage quality and safety related matters and strategic and operational quality related risks.

Following the annual review of the effectiveness of QSAC it was proposed that the scope of the committee is considered with reference to how it can more effectively be supported to receive assurance on key and relevant clinical and quality risks and issues in a timely way.

A meeting of the Chair of the QSAC (Amanda Ellingworth), the Medical Director (Mat Shaw), the Chief Nurse (Alison Robertson) and the Company Secretary (Anna Ferrant) was held on 11 December 2018 to discuss the findings and consider any changes and implications for the QSAC terms of reference and work-plan.

The meeting recommended the following:

- The key matters for consideration at QSAC should be based on a reflection of quality and safety matters at GOSH via benchmarked data and external facing reviews/ audits and surveys. This would include a focus on benchmarked quality metrics, external quality reporting results (audits, reviews, learning from reports at other trusts, GOSH inspection reports), patient and staff survey results etc.
- Across the year, 1-2 half day meetings of all Board members (with a particular requirement for QSAC members to attend) will be held to conduct deep dives into specific quality strategic matters such as the robustness of and delivery against plans for the Trust’s clinical strategy (to be drafted in 2019); assurance against the CQC requirements; assurance of the management of current key strategic quality matters etc.
- QSAC has considered a draft revised terms of reference and work-plan. The committee agreed with the change in focus to its reports and made minor amendments to the documents (inviting the Head of Patient Experience to the meetings and proposing that reports on clinical outcomes were presented by directorate and that clinical teams were invite to attend the committee to discuss the outcome data). The committee agreed that the work-plan would remain under review, in particular, the frequency of reporting on specific topics throughout the year. A copy of the revised Terms of Reference and work-plan is attached **at Appendices 1 and 2**.
- The committee agreed that a proposal is put to the Board to rename the committee the Quality, Safety and Experience Assurance Committee. The committee agreed that inclusion of ‘experience’ in the title would highlight its commitment to seeking assurance of the impact of service delivery on patients and families’ experiences.

The Board is asked to:

- **approve the revised QSAC terms of reference and work-plan.**
- **consider the proposal to change the name of the QSAC to the Quality, Safety and Experience Assurance Committee (QSEAC).**
- **consider establishing 1-2 half day meetings for all Board members to conduct deep dives into specific quality strategic matters.**

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For discussion: Establishment of a Committee/ Task and Finish Group to seek assurance of the controls and assurance in place to mitigate risks around culture, service innovation, workforce and education

At the meeting on 11 December, attendees discussed the establishment of a Workforce and Education Assurance Committee or similar. Justification for establishment of such a committee was made as follows:

- The revised Board Assurance Framework includes risks on culture, service innovation and workforce. It was agreed that the Board requires a dedicated focus on the controls and assurances in place to mitigate these risks as well as to provide a focus on development of the education and training agenda across all professions. It was agreed that the QSAC work-plan was already too busy to adequately review assurance and challenge these plans. It was agreed that the risks facing the Trust required an in-depth focus from Board members in a separate assurance committee meeting.
- The appointment of the new Director of HR and OD will bring with it an opportunity to develop a Trust-wide workforce modernisation plan. It is proposed that the committee will seek assurance of delivery of this plan on behalf of the Board.
- At its meeting on 17 January 2019, the QSAC discussed the proposal to establish a dedicated committee to review culture, service innovation, workforce and education. A concern was raised about disaggregating discussions on culture, workforce and education from quality and safety. However, committee members also agreed that there was currently insufficient time to seek assurance on all of these matters via the QSAC, which constantly struggles with tightly-packed agendas. Some committee members supported an alternative proposal to establish a task and finish group for a period of 6 months to a year. The group would review the risks around culture, innovation, workforce and education facing the Trust with the aim of subsuming the work of the group into QSAC once mitigations were understood and assurance reporting established by the group. QSAC would continue to receive assurance across all quality related matters.
- The internal auditor informed the QSAC that it was becoming increasingly common for Trusts to establish a separate workforce assurance committee.

Should a new committee or group be established, it is proposed that it will:

- Be chaired by a NED and have 2-3 other NED members (in the same way as the QSAC and Audit Committee). Executive Directors and other managers will be in attendance.
- Meet 4 times a year in February, June, September and December to avoid those months when other assurance committee are already timetabled and to help manage NED and executive diaries.
- Be administered by the HR and OD department including the Director of HR and OD working with the Chair of the committee/ group to draft the agenda and the HR department calling for papers, uploading papers to Diligent, drafting minutes, chasing actions and conducting an annual effectiveness review.
- Receive reports on the following:

Attachment V

- Development of and progress with delivery against a new Workforce Transformation Strategy including assurance of the development of a workforce plan and other plans/ strategies on leadership, resourcing and attraction, OD and culture and talent management.
- Assurance of development and delivery of workforce plans across the Trust, in particular for large scale developments such as the Children's Cancer service
- Assurance of how the Trust embraces service transformation and delivers innovative, patient centred and efficient services, working in partnership with staff and others (commissioners, referrers other stakeholders including the third sector)
- Establishment of the Learning Academy at GOSH and assurance of the associated plans for education, training and apprenticeships
- Assurance of delivery of the Trust Strategy 'Fulfilling Our Potential' via monitoring of metrics on culture at GOSH including survey results (for example staff survey results including a focus on bullying and harassment at GOSH), audits, internal performance metrics (appraisals, turnover rates etc.).

The Board is asked to consider options for establishment of a new Board assurance committee or task and finish group to seek assurance of the controls and assurance in place to mitigate risks around culture, service innovation, workforce and education.

For approval: Final Board Assurance Framework Risk Statements for 2019-20

The Risk Assurance and Compliance Group (RACG) (chaired by the CEO and attended by executives and senior operational managers) met on 28 November 2018 and reviewed the BAF in relation to:

- The accuracy and appropriateness of the current BAF risks.
- Gaps in strategic risks facing the Trust and proposals for new risks to be considered by the Board for inclusion in the BAF.
- Review of the current Trust risk appetites and application of these to the existing and new recommended risks.

At the December 2018 Board meeting, Board members were asked to note the results of the review and approve the following:

- Changes to the existing BAF risks and maintenance of the remaining BAF risks.
- Recommendations for new BAF risks.
- The revised Risk Appetite statements.

The Board agreed that the Audit Committee Chair review the proposed risks and that a final version of the risk statements be submitted to the February 2019 Board meeting. The statements were considered by the Audit Committee Chair including the associated assurance committees responsible for reviewing the risks. A summary of the final BAF risks are attached at **Appendix 3** for final Board approval. The Risk Assurance and Compliance Group reviewed the proposed new BAF risk scores at its meeting on 30 January. The assurance committees will request deep-dives on the revised risks going forward. One of the risks (Brexit) will be reported directly to the Trust Board.

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The Board is asked to approve the final revised BAF risk statements for 2019-10.

For discussion: Appointment of a Chief Information Officer/ Chief Clinical Information Officer (CCIO)/ or Chief Research Information Officer (CRIO) to the Board (non-voting)

Rt Hon Matthew Hancock, Health Secretary has recently stressed the importance of trusts making the best use of their data and that one way to do this was to having a CIO “*probably on their board, certainly reporting directly to the chief executive..*”.

The Chief Executive has discussed the above statement with the executive team and has concluded that leadership at the Board on digital and information transformation across our organisation is essential and a key enabler to delivery of the Trust’s strategy (Fulfilling Our Potential).

The GOSH Trust Board is currently made up of the following directors:

Executive directors	Non –executive directors
Mat Shaw, Chief Executive	Mike Rake, Chair
Helen Jameson, Chief Finance Officer	Akhter Mateen, NED and Deputy Chair
Alison Robertson, Chief Nurse	James Hatchley, NED and SID
Sanjiv Sharma, Acting Medical Director	Rosalind Smyth, NED (appointed and Director of the UCLGOSH ICH)
Alison Hall, Acting Director of HR and OD	Amanda Ellingworth, NED
Andrew Taylor, Acting Chief Operating Officer	Chris Kennedy, NED
	Kathryn Ludlow, NED

The Code of Governance requires that “*At least half the board of directors, excluding the chairperson, should comprise non-executive directors determined by the board to be independent.*” The Board currently meets this requirement.

The GOSH Constitution states:

- 22.2 *The Trust Board is to comprise:*
 - 22.2.1 *a non-executive Chair*
 - 22.2.2 *6 other non-executive directors; and*
 - 22.2.3 *6 executive directors.*

The Board currently meets the requirements under the Constitution and Code of Governance.

On this basis, the Board is asked to consider the appointment of a Chief Clinical Information Officer (CCIO) or Chief Research Information Officer (CRIO) as a non-voting director, reporting directly to the CEO. The director would have the same authority to attend all Board meetings and relevant assurance committee meetings and will be held to account in the same way as the other key non-voting directors (Director of Research and Innovation, Director of Development and Director of Communications).

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The Board is asked to consider the appointment of a Chief Information Officer/ Chief Clinical Information Officer (CCIO)/ or Chief Research Information Officer (CRIO) as a non-voting director position on the Trust Board.

For discussion: Consideration of appointment of an Associate Non-Executive Director on the Board

Board Members are asked to consider the current skill mix of the Board in relation to people management and cultural change. This is a key matter for the Trust going forward. Whilst a new Director of HR and OD has recently been appointed and other Board members have some skills and experience in this area, it is proposed that consideration be given to the appointment of an Associate Non-Executive Director with this background. The individual could also be invited to attend the Audit Committee and Quality and Safety Assurance Committee as an 'independent' member on these committees (this member was in place previously on these assurance committees) to provide challenge around cultural change.

For information: The role of Associate NED has been used successfully in the NHS (particularly non FTs) and is viewed from a governance perspective as a 'consultant'. The role of Associate Non-executive Director role is not a statutory position and the Trust does not have the power under its Constitution to create any other role or office in the membership of the Board. The role is not appointed to or approved by the Council of Governors. An Associate NED therefore, may not be a member of the Board, even in a non-voting capacity, or be viewed in any way as a NED. They do not count towards the quorum, do not vote and would be recorded as 'in attendance' at a meeting. The Board can decide on the length of tenure of the position (it is not restricted by a specific term).

The Board is asked to consider the appointment of an Associate Non-Executive Director with a background in people management and cultural change.

For discussion: External Well Led Effectiveness Review at GOSH

In June 2017, NHS Improvement updated its guidance on *Developmental reviews of leadership and governance using the well-led framework*. The framework encourages all providers to carry out externally facilitated, developmental reviews of their leadership and governance using the well-led framework every three years (although this can be longer – up to 5 years - where risks seem lower or there has been a turnover of Board members etc.). These reviews are in addition to the CQC regulatory assessments of well led.

The structure of the framework underpins the CQC's regular regulatory assessments. Information prepared for a CQC assessment can also be used for external development reviews and vice-versa.

The external development reviews are designed for providers to facilitate continuous improvement. **Appendix 4** provides information about the reviews, including the Key Lines of Enquiry (same as for CQC) and a template timetable for appointing an external facilitator and undertaking the review.

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The Trust last conducted an external review against the well led framework in 2016. Noting the possible timing of a CQC regulatory scheduled assessment at GOSH in the autumn 2019 (TBC), the Board is asked to consider a proposal to conduct an external developmental review in Q1 2020/21. This will provide substantive Board members time to develop an understanding of the Trust and the remit of their role (the Medical Director position will go out to advert in Q4 2019/20 and the Chief Operating Officer position in Q3 2019/20). The CQC inspection will have reported by end of December 2019/ January 2020 and findings from this assessment will inform focus of the developmental review. Plan for how the review will be conducted will be considered later in 2019 at the Board.

The Board is asked to consider a proposal to conduct an external developmental review in Q1 2020/21.

For information: Changes to other executive director portfolios

The incoming Chief Executive Matthew Shaw has made the following changes to the existing executive director portfolios:

- Strategy will now be the responsibility of the Chief Executive (previously under the Deputy Chief Executive). The Trust Board work-plan will be shared with the Board in April 2019 and will document how the Board will be updated on progress with the strategy throughout the year.
- Professor Andrew Taylor has been appointed as Acting Chief Operating Officer. This replaces the role of Deputy CEO on an interim basis for the next 6 months (noting strategy has now moved from this post to the CEO). A new COO role will be advertised at the end of this period. Andrew will cover this new role whilst continuing to operate as Clinical Director of Operations.
- Dr Sanjiv Sharma has been announced as the Acting Medical Director at GOSH. The recruitment process for the substantive post has started with the aim of making an appointment by end April 2019.
- Responsibility for estates and facilities has now moved to the Chief Finance Officer (previously the Director of Development).
- The substantive Director of HR and OD, Caroline Anderson will start work at the Trust in mid-March 2019.

A revised executive portfolio organogram is attached at **Appendix 5** for information. This will be published on the Trust website.

For information: Corporate Governance Review of Committees underway

The Board is asked to note that a review of the Trust's committees, sub-committees and groups has started aiming to be completed by the end of January– mid February 2019.

The purpose of the review is to:

- Develop a clear map of all Committees, Sub-Committees and Groups at GOSH.
- Review the terms of reference (and where available, the work-plan) for every Committee, Sub-Committee and Group at GOSH to ensure:

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- There is clarity of purpose for every Committee, Sub-Committee and Group;
- There are appropriate reporting lines to other Committees covered by the terms of reference;
- Reference is made to the appropriate policies for which the Committee, Sub-Committee or Group is responsible for consulting on and recommending to the Policy Approval Group (PAG);
- Appropriate membership and attendance;
- That any decision making is made in accordance with the terms of reference and complies with the Trust's financial governance framework.

The output of this review is to:

- Improve reporting and information flows at GOSH;
- Improve decision making across the governance structure;
- Support chairing / administrating of the Committees, Sub-Committees or Groups, and
- Clarify the expectations of members and attendees at the Committee, Sub-Committee or Group.

Dr Anna Ferrant
Company Secretary

Quality, Safety and Experience Assurance Committee Draft Terms of Reference

1.0 Authority & Scope

- 1.1 The **Quality, Safety and Experience Assurance Committee** is a sub-committee of the Trust Board and is chaired by a Non Executive Director.
- 1.2 It has delegated authority from Trust Board to seek assurance of the quality of care and treatment in all services provided by the Trust.
- 1.3 The definition of 'Quality' includes clinical effectiveness and outcomes, safety (patient, public and staff). **The committee will also receive reports** on patient and carer experience, equality and inclusion.

2.0 Purpose

The purpose of the Committee is:

- 2.1 To review the establishment and maintenance of an effective system of governance, risk management and internal control in relation to clinical services, research and development, education and training and workforce, in order to ensure to ensure the delivery of safe, high quality, patient-centred care.
- 2.2 To provide assurance to the Board and that the necessary structures and processes are in place to deliver safe, high quality, patient-centred care and an excellent patient experience.
- 2.3 To review and seek assurance on any issues identified by the Trust Board (as requiring more detailed review that fall within the remit of the committee) including on any quality, safety or patient experience matters or shortcomings arising from the Trust's operational and quality and safety performance.
- 2.4 To be assured 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.
- 2.5 To assure the Trust Board that the controls to mitigate risk within the areas of responsibility of the committee are in place and working within a regulatory and legislative framework.
- 2.6 To assure the Board 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.
- 2.7 **To seek assurance on behalf of the Board that services provide safe, high quality, patient-centred care when benchmarked against other appropriate organisations as well as the assessment of patients, families and staff experiences of those services.**
- 2.8 To assure the Trust Board that the annual internal audit and annual clinical audit plans are aligned and focused on the appropriate quality focused risks
- 2.9 To be responsible for reviewing, on behalf of the Trust Board, progress with quality improvement priorities set in the Quality Strategy and Quality Report.
- 2.10 To work in partnership with the Audit Committee and ensure that implications for clinical care of non-clinical risks and incidents are identified and adequately controlled. This will include seeking assurance of health and safety across the Trust.

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3.0 Duties

Governance, internal control and risk management

- 3.1 To receive and review at each meeting those entries on the Trust's Board Assurance Framework (BAF) which are to be overseen by the Committee.
- 3.2 To receive annual assurance reports in relation to both research and development and education and training governance issues.

Audit

- 3.3 To review the Internal Audit operational plan and more detailed work programme and make recommendations, on the clinical, research and development, and education and training aspects of the Internal Audit annual workplan.
- 3.4 To receive and review the findings of Internal and External Audit reports covering patient safety, quality and experience, research and development, and education and training, and to assure itself that the management of the Trust is implementing the agreed recommendations in a timely and effective way.
- 3.5 To review the annual Clinical Audit programme and receive and review findings of clinical audit reports. This will include (by exception) details of national clinical audits where the Trust is identified as an outlier or a potential outlier.

Quality, safety and experience

- 3.6 To receive regular reporting on compliance with the Care Quality Commission's Standards, including any areas of current concern or focus.
- 3.7 To receive all reports on the Trust produced by the Care Quality Commission and to seek assurance on the actions being taken to address recommendations and other issues identified.
- 3.8 To ensure that the Trust learns from national and local reviews and inspections (**on both the systems at GOSH and other organisations**) and **on the basis of the findings** implements all necessary recommendations to improve the safety and quality of care
- 3.9 To receive reports on significant concerns or adverse findings highlighted by external bodies (**on both the systems at GOSH and other organisations**) in relation to clinical quality and safety and patient experience and seek assurance of the actions being taken by management to address these.
- 3.10 To review the Trust's Quality Report and make recommendations.
- 3.11 To receive regular exception reports covering quality outcomes, safety (including health and safety matters) and patient experience issues and themes escalated from the Patient Safety and Outcomes Committee and the Patient Family Experience and Engagement Committee. **The use of benchmarked metrics and reporting from external bodies and patient/ service users and staff will provide the necessary assurance of the robustness of the systems and processes in place.**
- 3.12 To receive notice of any 'whistleblowing' concerns **and freedom to speak up** concerns raised on quality or safety matters.
- 3.13 To request 'deep dive' reports on any matters arising from within its terms of reference **and receive these presentations at both meetings of the QSAC and separate quality focused development sessions 1-2 times a year (as arranged).**
- 3.14 To require internal audit:
 - to initiate special projects or investigations on any matter arising from within its terms of reference;
 - to monitor the implementation of audit recommendations by management and report progress at every meeting;
 - to consider any other relevant matters, as determined by the Committee.

Attachment V

4.0 Reporting

- 4.1 The Committee will receive reports as outlined in the committee work-plan.
- 4.2 The Quality Assurance and Safety Committee Chairman will present a summary report to the Trust Board following every meeting.
- 4.3 A summary of the **Quality, Safety and Experience Assurance Committee** will be shared with the Audit Committee (and vice versa).
- 4.4 The Committee will provide an annual report to the Trust Board on the effectiveness of its work and its findings, including its review of relevant Board Assurance Framework entries and audit reports covering areas within its terms of reference. This will be presented in the Trust's Annual Report.

4.0 Membership

- 4.1 Three Non-Executive Directors, one of whom shall chair the meeting.
- 4.2 The Board may appoint an independent member in addition to the non-executive director members to bring further experience and expertise. The same independent member would sit on both the Audit Committee and **Quality, Safety and Experience Assurance Committee**.
- 4.3 For a quorum, there must be at least two Non-Executive Directors.
- 4.4 The following shall be expected to attend meetings:
 - Chief Executive
 - Deputy Chief Executive
 - Medical Director
 - Chief Nurse
 - Director of Human Resources and Organisational Development
 - Internal Auditor
 - Head of Quality and Safety
 - Head of Patient Experience
 - Company Secretary
- 4.5 Additional members may be added or invited to attend as appropriate. In particular, where appropriate, the Committee will invite clinical teams to attend its meetings to provide assurance on key governance and risk issues.
- 4.6 The Company Secretary will ensure that the Executive Office provides appropriate administrative support to the committee, Chair and committee members.

5.0 Frequency of meetings

- 5.1 The Committee will meet 4 times a year and committee dates will be sent out at the beginning of the year.
- 5.2 Members are expected to attend a minimum of 3 meetings per year.
- 5.3 Papers for the meeting will be sent out one week before the meeting.

6.0 Monitoring

- 6.1 The Committee shall review its terms of reference on an annual basis, including attendance at meetings, coverage of the terms of reference and workplan requirements

Attachment V

during the year. The views of members of the committee, staff attending the meeting and receiving requests for reports will be sought as part of the review. Recommendations will be brought to the committee for consideration and approval.

6.2 The Chair of the committee shall draw to the attention of the Board any issue that requires disclosure to the full Board or requires executive action.

6.3 The Chair will give an account of the committee's work in the Trust's annual report.

6.4 The Committee shall undertake an annual review of its effectiveness which will be reported to the Trust Board.

Attachment G

Council of Governors

6th February 2019

**Quality, Safety and Experience Assurance Committee Summary Report
January 2019**

Summary & reason for item: To provide an update on the January meeting of the Quality and Safety Assurance Committee. The agenda for this meeting is also attached.

Councillor action required: The Council is asked to NOTE the update.

Report prepared by: Victoria Goddard, Trust Board Administrator.

Item presented by: Amanda Ellingworth, Chairman of the Quality and Safety Assurance Committee

Attachment G

**Summary of the meeting of the Quality and Safety Assurance Committee
Held on 17th January 2019**

Matters arising

Following the update that had been given at the October 2018 Committee meeting about GOSH's non-compliance with Medicines and Healthcare products Regulatory Agency (MHRA) standards around irradiating blood due to the delayed deployment of the single available software solution, it was confirmed that no feedback had been received from the MHRA regarding the non compliance, and no incidents had occurred around the irradiation of blood.

Update on review of remit of QSAC and annual workplan

Discussion took place around potentially establishing a Workforce and Education Assurance Committee of the Board which would provide detailed focus on culture, workforce and education and service innovation.. The Committee agreed that the key aim of any new arrangement was to increase the time available for oversight of these matters, which to date had been insufficient for the depth of discussion required. Some concern was raised about the potential risk of disaggregating discussion about culture and workforce from quality and safety. Further discussion would take place at Trust Board. The Committee approved revised Terms of Reference and workplan and agreed that it would propose to the Board that the Committee be renamed the Quality, Safety and Experience Committee in recognition of the increased focus that would be placed on family and patient experience.

Emerging clinical/quality issues

A paper had been discussed at the Executive Management Team meeting about the leadership development programme for the new operational structure. It was noted that in general, performance had reduced since the new structure had been implemented. An Acting Chief Operating Officer role had been developed which will have focused responsibility for performance, and strategy will move into the CEO remit.

An analysis of the impact of the reduction in the specialist bank rate on quality of services was reviewed. It was emphasised that overall the Trust had increased the number of bank shifts being filled over the last four months and were operating at the highest use of bank staff ever. The committee welcomed the plan to review the overall reward arrangements for bank staff, using the principles of equity amongst staff and parity with neighbouring trusts' rates where possible.

Integrated Quality and Safety Report

A statutory child death review process had been introduced and the Trust was required to be compliant by September 2019 which would be challenging for GOSH due to the complexity and wide geographical origins of GOSH patients and the requirement to receive correspondence from external parties. Work continues towards compliance.

Quarterly Safeguarding Report (October 2018 – December 2018)

An interim solution to provide 24/7 safeguarding coverage would be implemented on 1st March 2019 and it was agreed that any issues with gaps after this date would be reported by exception to the committee. Work was taking place to complete the actions arising from the internal audit report into safeguarding. Social work had developed a system which would ensure that all referrals were electronic once Epic was in place.

Attachment G

Risk Assurance and Compliance Group Update on the Board Assurance Framework

The Committee agreed to revise the way that deep dives were undertaken to be in line with the process adopted by the Audit Committee.

- Risk 5: The trust is unable to demonstrate compliance with Performance Management Framework/ Monitor's licence

There remained challenges around the delivery of diagnostics targets and focus was being placed on this as well as the CQC and Well Led Action Plans. The Electronic Patient Record (EPR) implementation was also a key risk. A CQC inspection of GOSH would be taking place in the second half of 2019. It was noted that the compliance register which listed the Trust's regulatory requirements outside of the Monitor licence would be discussed at the next meeting.

Research Governance Update

It was likely that the MHRA (Medicines and Healthcare products Regulatory Agency) would undertake an inspection in 2019. One 'major finding' had been made at the last inspection around medical oversight of trials and further progress was required in this area. The Committee noted that alongside research governance at GOSH, considerable collaboration takes place both nationally and internationally and suggested it would be helpful to set out these frameworks in the context of Brexit.

Compliance Framework Update

Work was taking place to complete the CQC's routine provider information request which had a return deadline of 23rd January 2019.

Health and Safety Update

Work was continuing to take place to implement safer sharps and a review of products that could easily be replaced was underway. Interim arrangements were in place to ensure the Trust was safe as there was a gap in the Fire Officer role.

Whistle blowing update - Quality related whistle blowing cases

A previous case had been successfully resolved and a new case reported which was currently being investigated.

Freedom to Speak Up Update

Discussion took place around the complex interaction of staff emotional and mental wellbeing and stress on the cases that were raised. It was noted that there were a number of cases where tackling performance issues had brought to the fore a number of other issues. The committee requested that the issue of stress and emotional and mental wellbeing of staff fell into the remit of the proposed new workforce and education assurance committee.

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

A three to five year transformation plan was being developed for outpatients and discussion about this would be taking place with the Senior Leadership Team in February 2019.

Internal Audit Progress Report (October 2018 – December 2018)

The Committee received two final reports: risk management which had provided a rating of significant assurance with minor improvement opportunities, and infection control which had also provided a rating of significant assurance with minor improvement opportunities.

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Internal and external audit recommendations update

Good progress continued to be made in reducing the number of outstanding recommendations. It was noted that it was unlikely that the GOSH strategic workforce plan would be completed by the deadline because it was important for the newly appointed Director of HR and OD to influence this once she started in post.

Clinical Audit update October 2018 – December 2018

Discussion took place around the implementation of pre-operative consent clinics in cardiac which had not been achieved. The Chief Executive said that he had written to the team being clear that the consent clinic process must be in use for all patients with the exception of those who were urgent and last minute.

Matters to be raised at Trust Board

The paper to the Trust Board about the proposed workforce and education assurance committee to be clear about the way in which the QSAC would continue to receive assurance on the general overview and how matters would be selected for deep dives.

Any other business

- Safeguarding

Discussion took place around compliance with safeguarding training for honorary contract holders. Work was taking place to ensure that the honorary contracts listed were still in place and the committee suggested that honorary contracts should be limited to those individuals who required an appraisal to be undertaken at GOSH.

Attachment G

QUALITY AND SAFETY ASSURANCE COMMITTEE
Thursday 17 January 2019 2:00pm – 5:00pm in the Charles West
Room, Great Ormond Street Hospital for Children NHS Foundation
Trust

AGENDA

	Agenda Item	Presented by	Attachment	Time
1.	Apologies for absence	Chair	Verbal	2:00pm
2.	Minutes of the meeting held on 11 th October 2018	Chair	A	
3.	Matters arising/ Action point checklist	Chair	B	
4.	Update on review of remit of QSAC and annual workplan	Company Secretary	D	2:10pm
5.	Emerging clinical/quality issues - Analysis of impact of the reduction in the specialist bank rate on quality of services	Chair Chief Nurse	Verbal E	2:30pm
<u>QUALITY AND SAFETY</u>				
6.	Integrated Quality and Safety Report	Acting Medical Director/ Chief Nurse	F	2:45pm
7.	Quarterly Safeguarding Report (October 2018 – December 2018)	Chief Nurse	G	3:00pm
<u>RISK AND GOVERNANCE</u>				
8.	Risk Assurance and Compliance Group Update on the Board Assurance Framework Deep dives into BAF risks: Risk 5: The trust is unable to demonstrate compliance with Performance Management Framework/ Monitor's licence	Company Secretary Acting Chief Operating Officer	H I	3:10pm
9.	Research Governance Update	Deputy Director of Research and Innovation	J	3:20pm
10.	Compliance Framework Update	Head of Quality and Safety	K	3:35pm
11.	Health and Safety Update	Director of HR & OD	L	3:45pm
12.	Whistle blowing update - Quality related whistle blowing cases	Acting Director of HR and OD	M	3:55pm

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13.	Freedom to Speak Up Update	Acting Medical Director	N	4:05pm
AUDIT AND ASSURANCE				
14.	Update on quality and safety impact of Fit for the Future programme (linked to BAF risk 2: Productivity)	Acting Chief Operating Officer	O	4:10pm
15.	Internal Audit Progress Report (October 2018 – December 2018)	KPMG	P	4:20pm
16.	Internal and external audit recommendations update	KPMG	Q	
17.	Clinical Audit update October 2018 – December 2018	Clinical Audit Manager	R	4:35pm
18.	Matters to be raised at Trust Board	Chair of the Quality and Safety Assurance Committee	Verbal	4:50pm
19.	Any Other Business	Chair	Verbal	
20.	Next meeting	Thursday 4th April 2018 2:00pm – 5:00pm		
21.	Current Terms of Reference and Acronyms	1		

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**Summary of the meeting of the Audit Committee
Held on 24th January 2019**

The Committee noted the minutes of the October 2018 Quality and Safety and Assurance Committee and Finance and Investment Committee.

Board Assurance Framework Update: Risk Assurance and Compliance Group review of the BAF

Six new risks had been added to the BAF and the Committee emphasised the importance of ensuring that the assurance committees had sufficient capacity to review these risks. It was noted that the Audit Committee was providing oversight to only one additional risk.

The Committee reviewed the following high level risks:

- Risk 8: The Trust may not be able to provide the required level of research infrastructure or leverage additional research income if core research funding streams are reduced

The Committee requested assurance on the short and mid/long term risk given the risk score was the lowest on the BAF. There was confidence around the ability to sustain the level of research income and a steady number of publications were being produced, many of which were high impact. Discussion was taking place about how job plans could be changed to include research time as this was the limiting factor for many clinicians.

- Risk 10: The risk that the EPR programme will not be delivered on time or within budget

The most recent independent review had given an amber assurance rating with one critical recommendation and weekly operational readiness forums were taking place. Discussion took place about staff awareness and it was confirmed that some directorates had over 85% of staff booked onto EPR training and large majority of staff were aware of the project. An issue had arisen with the installation of a dedicated connection to the Epic data centre and the Trust had challenged Epic's escalation process. Assurance had been provided that this was now in hand. The NEDs agreed that they would use their walkrounds as an opportunity to ask staff about their knowledge of and views on the implementation of the EPR.

Data Quality and GDPR Update

Discussion took place around the number of subject access requests including requests for email searches and it was noted that GOSH received a large number of requests compared to its size.

Focus was being placed on data readiness for Epic. A kitemarking review was underway, and a programme of weekly audits had begun for RTT random samples.

Cyber security breach and systems down time update

Discussion took place around the toll fraud which had taken place and noted that learning had been around the engagement with the supplier and the requirement for engineers to be on site rather than sending changes from offsite. The Committee requested data around the number of breaches and attempted breaches in future reports.

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Preparedness: Update on emergency planning; LSMS; fire and business continuity (tests, incidents and plans)

The NHS England assurance process had been conducted and the Trust had received a rating of substantial assurance with some recommendations made. Approximately 70% of business continuity plans had been submitted. Discussion took place about undertaking a large scale table top exercise.

IPP debt provisioning

A large payment had been received in January 2019 which covered a small amount of aged debt. Discussions were taking place with one territory to increase the monthly payments which were being received in order to reduce the aged debt. The Committee requested benchmarking information about GOSH's approach to provisioning from the auditors.

IFRS 9 and 15

The Committee confirmed that it was comfortable with the approach being taken towards IFRS 9 and 15.

Sector Developments

Guidance on the Quality Report had been issued and it was confirmed that the indicators which would be audited were 62 week cancer waits and RTT. Discussion took place around the methodology for reviewing RTT.

Internal Audit Progress Report (November 2018 – January 2019) and Technical Update including annual IA plan process

Three reports were received on: safeguarding, risk management and theatres. All had received a rating of significant assurance with minor improvement opportunities. The Committee emphasised the importance of ensuring the risks on the Trust Wide Risk Register had been reviewed within the target timescales. Discussion took place about the way in which the remaining days in the audit programme could be used most effectively.

Internal and external audit recommendations – update on progress

It was noted that the Trust continued to reduce the number of outstanding recommendations which now stood at five, however other Trusts had reduced them further and more work was to be done.

Counterfraud Update

Information around cybercrime would be circulated to the Trust as a whole in the week beginning 28th January and a training survey would be sent to relevant groups.

Planning for 2018/19 year-end including review of Accounting Policies

Discussion took place around the valuation of land and buildings and it was noted that the valuer would be undertaking their work in January 2019.

Raising Concerns in the Workplace Update

Discussion took place around one open case which had previously been raised to the Trust Board.

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Write offs

Discussion took place around losses in pharmacy and the likelihood that this was due to one expensive drug rather than a large number of items. Improvement was required in stock rotation.

Update on Procurement Waivers

There had been an increase in waivers due to the progress being made with the Zayed Centre for Research and it was noted efficiencies were being made in procurement by the Trust's new procurement partners.

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Summary of the Finance and Investment Committee held on 10 December 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 Wednesday 5 December 2018.

The FIC held formal meetings on 10 December 2018 and 1 February 2019. Highlights from the 10 December 2018 meeting are covered below. The Chair will provide a verbal update of key issues from the 1 February meeting.

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 seven of the 2018/19 financial year £0.9m behind its control total.
- Cash was higher than plan by £6.3m.
- The Trust achieved RTT Incomplete Pathway national standard for the 9th consecutive month
- The Trust needs to disseminate the message that significant savings needed to be delivered this year.
- Discussed the EPR programme noting that the project remained on track.

Performance and finance standing updates

Finance report 2018/19 Month seven finance report

The Trust was behind its control total by £0.9m in Month seven. This was a further decline from Month six.

The Trust would not receive its quarterly Provider Sustainability Fund (PSF) if it did not reach its quarterly control total. Should the Trust make it back over the course of the financial year, the Trust would receive it.

Cash was higher than plan by £6.3m.

The Trust was meeting weekly with International and Private Patients to review the £30.5m of outstanding debt.

Integrated Performance Report

The Trust achieved RTT Incomplete Pathway national standard for the 9th consecutive month. However, for October two patients were reported waiting 52 weeks and over. The patients have dates in November and December respectively.

Achieving the performance target for the Friends and Family Test continued to be a challenge for the Trust. The Trust lowered its target to 25% (to be in line with its peers) but has not achieved it to date. The Chief Nurse had initiated work with the Directorate Heads of Nursing and Patient Experience to improve performance. It was noted that, 97.79% of the 550 patients that provided feedback would recommend the Trust, which was positive.

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Productivity and Efficiency (Better Value) update

The Trust needs to disseminate the message that the £15m of savings needed to be delivered this year. The 2019/20 better value target was estimated to be around £20m and planning for 2019/20 was underway.

Project updates / reviews

Theatre utilisation programme action plan

Committee members noted that the modelled process map of a single inpatient's care over 18 weeks including theatre was complex. Actions considered to improve theatre utilisation included: an 'Operations Control Centre' or cross learning from a commercial industry where flow was commercially critical (such as hotels or airlines).

The Committee requested the three year vision for improving theatre utilisation be presented to FIC and then the Trust Board in future.

EPR Programme Update – December 2018

Although there were a number of issues like statutory reporting that were on the critical time line; overall, the programme was controlled and the areas of risk all have remedial plans. The Committee discussed EPIC's potential to generate savings through a modernisation of the workforce.

Annual Update on Patient Level Costing Reference Cost Submission

The Trust had risen from the 18th to the 10th highest overall Reference Cost Index nationally. Whilst this was concerning it was agreed that the data was not a pure measure and cross-hospital comparisons were hard to make; it did however give further ammunition to continue to focus on the larger better value target for 2019/20). Moving forward, the Trust would benchmark its costs where applicable and with the aim to be more increasingly competitive and continually demonstrating value for money to commissioners.

End of report

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Trust Board 7 February 2018	
Trust Board Code of Conduct	Paper No: Attachment Z
Submitted by: Anna Ferrant, Company Secretary	
<p>Aims / summary Monitor's Code of Governance states that a Foundation Trust Board:</p> <p><i>“should establish the constitution and standards of conduct for the NHS foundation trust and its staff in accordance with NHS values and accepted standards of behaviour in public life, which includes the principles of selflessness, integrity, objectivity, accountability, openness, honesty and leadership (The Nolan Principles).</i></p> <p><i>The board of directors should operate a code of conduct that builds on the values of the NHS foundation trust and reflect high standards of probity and responsibility. The board of directors should follow a policy of openness and transparency in its proceedings and decision-making unless this is in conflict with a need to protect the wider interests of the public or the NHS foundation trust (including commercial-in-confidence matters) and make clear how potential conflicts of interest are dealt with.”</i></p> <p>(Paragraphs A1.8 and A1.9)</p> <p>Following a review and update to the Trust's Constitution last year, the Council of Governors' Code of Conduct was also updated and approved. The attached Code of Conduct for Trust Board members has been revised in light of the changes to the Constitution and is in line with the Council of Governors' revised Code.</p> <p>Trust Board members are asked to consider and approve the attached revised code of conduct for the Trust Board (Appendix 1).</p> <p>Directors are asked to note the following:</p> <ul style="list-style-type: none"> • This Code applies to Directors when they are acting in the capacity of a Trust Director and also applies to Directors when acting in other capacities (including a personal capacity). • The Code requires directors to adopt the seven Principles of Public Life (also known as the Nolan Principles). • The Code acknowledges the condition of the Trust's NHS Provider Licence that each Director serving on the Trust Board is a 'fit and proper person' and will need to certify this on appointment and annually. • When taking decisions all Directors must have regard for their statutory duties including ensuring that the decisions which they take are in the best interests of the Trust. They must be able to critically examine the information available as well as have due regard to all of the information and/or advice provided. NEDs especially must seek to challenge information if necessary, although, all Directors should challenge information if they consider it to be insufficient to come to a decision. 	

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<ul style="list-style-type: none"> • An explicit section is included on declaring gifts and hospitality. In relation to the Bribery Act 2010, recent case law has not shed any light on what “adequate procedures” really means, however, it has confirmed the need to ensure employees expressly confirm their acceptance of anti-corruption policies. • An explicit section is included stating directors must take care when expressing views on social media or other platforms which may compromise their position at the Trust or the interests of the Trust. <p>Once approved, Board members will be asked to sign the code.</p>
<p>Action required from the meeting Board members are asked to approve the adoption of the revised Trust Board Code of Conduct.</p>
<p>Contribution to the delivery of NHS Foundation Trust strategies and plans Ensure corporate support processes are developed and strengthened in line with the changing needs of the organisation</p>
<p>Financial implications None</p>
<p>Who needs to be told about any decision? The Council will be updated on the revised Code.</p>
<p>Who is responsible for implementing the proposals / project and anticipated timescales? Company Secretary</p>
<p>Who is accountable for the implementation of the proposal / project? All directors</p>

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GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST
CODE OF CONDUCT FOR DIRECTORS

1. Introduction

- 1.1 It is important that Great Ormond Street Hospital for Children NHS Foundation Trust (the “**Trust**”) enjoys the confidence of its stakeholders so it is essential that each person involved in the governance of the Trust adopts the highest standards of conduct.
- 1.2 This document is the Code of Conduct for the Trust's Directors (the “**Code**”) who are appointed in accordance with the Constitution. The Trust is governed by the National Health Service Act 2006, the Health and Social Care Act 2012 and its Constitution (together the “**Governance Framework**”). All Directors are required to act in accordance with the provisions of the Governance Framework and this Code.
- 1.3 This Code should be read in conjunction with Governance Framework of the Trust and the documents listed in Appendix A. If there is any discrepancy between this Code and the Constitution or any document defined in Appendix A, those documents shall prevail.

2. Application of this Code

- 2.1 This Code applies to Directors when they are acting in the capacity of a Trust Director and outlines the behaviour expected of persons holding such office within the Trust.
- 2.2 This Code also applies to Directors when acting in other capacities (including a personal capacity) in the event that there are concerns about a Director's conduct when they are acting in such other capacity and those concerns are relevant to the person's role as a Director. The Trust will act proportionately and reasonably when applying this Code in any such circumstances.

3. Values and Principles

- 3.1 As holders of office in the Trust, a public authority, Directors are required to adopt the seven Principles of Public Life (also known as the Nolan Principles)¹ which are as follows:
 - 3.1.1 Selflessness: Holders of public office should act solely in terms of the public interest.
 - 3.1.2 Integrity: Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.
 - 3.1.3 Objectivity: Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.
 - 3.1.4 Accountability: Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.
 - 3.1.5 Openness: Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the

¹ The Principles of Public Life are defined [here](#).

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public unless there are clear and lawful reasons for so doing.

3.1.6 Honesty: Holders of public office should be truthful.

3.1.7 Leadership: Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.

3.2 Directors are also expected to support the core principles of the NHS as defined in the NHS Constitution and summarised below:

3.2.1 The NHS provides a comprehensive service, available to all.

3.2.2 Access to NHS services is based on clinical need, not an individual's ability to pay.

3.2.3 The NHS aspires to the highest standards of excellence and professionalism.

3.2.4 The NHS aspires to put patients at the heart of everything it does.

3.2.5 The NHS works across organisational boundaries and in partnership with other organisations in the interests of patients, local communities and the wider population.

3.2.6 The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.

3.2.7 The NHS is accountable to the public, communities and patients that it serves.

3.3 Directors are also required to adopt the Trust's values (the "**Always Values**"), which, with the associated behavioural standards, are as follows:

3.3.1 Always Welcoming: respect, smiles, friendly.

3.3.2 Always Helpful: understanding, helps others, patient, reliable.

3.3.3 Always Expert: professional, safe, excellence, improving.

3.3.4 Always One Team: listen, communicate, involve, open.

3.4 Each value is underpinned by behavioural standards which Directors are expected to display at all times. A full description of the Always Values and the associated behaviours will be given to Directors by the Company Secretary.

3.5 Directors are also expected to adopt and comply with any codes of conduct or policies of the Trust which describe standards of behaviour that are relevant to employees and other individuals involved in the governance or operation of the Trust. The relevant policies are listed at Appendix B and a copy of each will be given to each Director at the time of their induction.

4. The role and conduct of Directors

4.1 The role of each Director and of the Trust Board is defined in the Trust's Constitution and in relevant terms of reference and role descriptions. Directors are required to comply with these documents (and others defined in Appendix A) and any relevant policies and procedures issued to them. Any Director who is non-compliant with any of these requirements, or is aware of non-compliance by others, must notify the Company Secretary immediately.

4.2 In order to discharge their roles effectively, Directors are expected to adopt high standards of conduct. Therefore, in addition to adopting the values and principles set

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out above, Directors are expected to:

- 4.2.1 Demonstrate commitment to the Trust as a whole and act in its best interests at all times, including in relation to any other interests which Directors may have (in which respect refer to section 8 below);
- 4.2.2 Conduct themselves in a manner that reflects positively on the Trust and in accordance with the Trust's Always Values as outlined above and not in any way that would reasonably be regarded as bringing their office or the Trust into disrepute;
- 4.2.3 Recognise that the Trust is fully committed to the protection of children and as such all Directors are required to participate in appropriate assessments relevant to child protection.
- 4.2.4 Understand the role and authority of the Trust Board and the governance of the Trust;
- 4.2.5 Contribute to the development of and support the Trust's mission, vision, and strategy;
- 4.2.6 Give thorough consideration to information and advice provided in the course of the business of the Trust such that no Director should adopt a position without fully considering (and if necessary challenging) all of the information available, while always acting in the best interests of the Trust;
- 4.2.7 Focus on the key issues for the Trust and not give undue attention to any single issue, or act in support of or advocate for any member, group of members, campaign (or similar);
- 4.2.8 Obtain and have regard to advice from the Chair, the Chief Executive (including in his/her capacity as Accounting Officer) or the Company Secretary, particularly in respect of matters of conduct, responsibilities and compliance with the Constitution and other relevant governance requirements;
- 4.2.9 Participate in training and development provided by or through the Trust, whether for individual Directors or for the Trust Board as a whole;
- 4.2.10 Commit the necessary time to the role, including attendance at meetings of the Trust Board and seminars (where practicable), and training and development events.
- 4.2.11 Acknowledge the responsibility of the Council of Governors to hold the non-executive directors individually and collectively to account for the performance of the Trust Board, (including representing the interests of the Trust's members and partner organisations in the governance and performance of the Trust), and to have regard to the views of the Council of Governors.

5. Fit and proper person

- 5.1 It is a condition of the Trust's NHS Provider Licence that each Director serving on the Trust Board is a 'fit and proper person' (as defined in the Trust's NHS Provider Licence). Directors must certify on appointment, and each year, that they are/remain a fit and proper person. The provisions of the Constitution apply in respect of determining whether or not a person is fit and proper (and, if they are not, in respect of disqualification from office).

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6. **Accountability of Directors**

- 6.1 Each Director is accountable to the Trust Board for his/her performance and conduct.
- 6.2 The Directors collectively are accountable for the effectiveness of the Trust Board, the exercise of its powers and the performance of the Trust.

7. **Confidentiality, Data Protection and Freedom of Information**

Confidentiality

- 7.1 Directors may receive information which is not publically available, including information relating to individuals (including patients or employees of the Trust) and sensitive commercial information relating to the Trust's business.
- 7.2 Directors are required to observe and follow the requirements set out by information governance rules, policies, standards and procedures. Directors must ensure that they are aware of the handling requirements, take personal responsibility for the quality of data recorded and protect information at all times. Directors must not attempt to breach information security in any way. Further information can be obtained from the Trust's Information Governance department or Caldicott Guardian.
- 7.3 The Trust Board must work openly and transparently. The majority of its business is conducted in public, including through the publication of meeting papers, but in specific circumstances it may be necessary for briefings to be provided in confidence or for confidential matters to be considered.

Data Protection

- 7.4 Directors recognise that any disclosure of confidential information (unless required by law) puts at risk the Trust's compliance with its duties of confidentiality and, where such data is personal data, the General Data Protection Regulation and the Data Protection Act 2018 (or any future data protection legislation) and other relevant law (the "**Data Protection Legislation**"). Such a disclosure may also undermine the Trust's ability to function effectively and/or its reputation and may therefore be contrary to the requirements of this Code.
- 7.5 Directors must comply, at all times, with the Data Protection Legislation.

Freedom of Information

- 7.6 Directors acknowledge that the Trust is subject to the Freedom of Information Act 2000 ("**FOIA**"), and shall comply with the Trust's policy relating to freedom of information requests at all times. If a director receives a request for information under FOIA he or she must not reply to such a request and must instead follow Trust procedure.

General

- 7.7 Information may be received by Directors pursuant to the Trust's whistleblowing policy. The Trust openly encourages all members of staff to raise any concerns they may have about patient care openly and honestly. There are clear processes for raising concerns in this regard and it is vital that where a Director is involved with a complaint received under the Trust's whistleblowing policy such information is dealt with strictly in accordance with the aforementioned policy.
- 7.8 In accordance with the Constitution, the Trust will investigate any breaches of confidentiality on the part of Directors and will take appropriate action.
- 7.9 No provision of this Code shall preclude any Directors from making a protected disclosure within the meaning of the Public Disclosure Act 1998 but where a Director is considering making any such disclosure, they should seek advice from the

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Company Secretary.

8. Directors' interests

- 8.1 Directors of the Trust have a duty under the Governance Framework to "avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests" of the Trust.
- 8.2 The Trust recognises that some Directors hold roles in other organisations or have other interests and welcomes the experience this can bring to the Trust, provided any potential conflicts are recorded and avoided.
- 8.3 It is important that all decision-making in the Trust is robust and based upon openness and transparency. The Trust therefore has in place arrangements to ensure that relevant interests are declared by Directors, and to address any conflicts between such interests and those of the Trust. Directors are required to comply with these arrangements, as defined in the Constitution, and relevant policies and procedures (which are provided to Directors).
- 8.4 Where there is any doubt as to the relevance of an interest for any Directors, or the process through which an interest should be addressed, advice must be sought from the Company Secretary before the relevant Director is involved in taking a decision or participating in a discussion.
- 8.5 Directors must not seek to use their position improperly to confer any advantage or disadvantage on any person.

9. Gifts and Hospitality

- 9.1 Directors must at all times adhere to the Trust's Declarations of Interest and Gifts and Hospitality Policy. Directors must ensure they are not placed in a position which compromises their role, or may give the appearance that their role has been compromised, or that compromises the position of the Trust with regard to its statutory duties.
- 9.2 No Director should, or should appear, to secure gifts or hospitality by virtue of their role at the Trust. There may be serious consequences for Directors and the Trust if gifts or hospitality are accepted in certain situations. If any Director has any doubt as to whether or not a gift may be accepted it should be refused or advice should be sought from the Company Secretary before the gift and/or hospitality is accepted.

10. Equality

- 10.1 Directors are expected to understand and promote the policies of the Trust which relate to equality and diversity.
- 10.2 The Trust has a duty under the Equality Act 2010 ("**EA 2010**") to:
 - 10.2.1 eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the EA 2010;
 - 10.2.2 advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and
 - 10.2.3 foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

11. Representing the Trust

- 11.1 The Trust has in place policies and arrangements to manage its relations with the media and other stakeholders to ensure that its reputation is protected and to enable the organisation to function effectively.

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- 11.2 Where the work of the Trust Board is relevant to a matter that is the subject of reporting in the media, or discussions with stakeholders, the Chair or another nominated Director, supported by the Trust's Communications Department, will speak on behalf of the Directors.
- 11.3 To protect Directors and to ensure a co-ordinated and managed approach to media and stakeholder relations, no Director may approach the media or any other stakeholder, or respond to requests for comment, or otherwise seek to represent the Trust. Any Director receiving a request for comment must, without responding, refer it immediately for action by the Trust's Company Secretary.
- 11.4 Any Director who is approached in a personal capacity by the media or any other stakeholder may respond but must make it clear that he/she is doing so in that capacity, not as a representative of the Trust, and must have regard to this Code and in particular to the reputation of the Trust when doing so. Before making such comments Directors should seek advice from the Trust's Company Secretary.
- 11.5 Directors must also take care when expressing views on social media or other platforms which may compromise their position at the Trust or the interests of the Trust.

12. **Training & development**

- 12.1 The Trust is committed to providing appropriate induction, training and development opportunities for Directors to enable them to carry out their role effectively. This ensures compliance with the statutory duty which states that the Trust has to take steps to ensure that the Directors are equipped with the skills and knowledge they require. Each Director is, therefore, required to participate in training and development opportunities that have been identified as appropriate for him/her.

13. **Interpretation of this Code, and compliance**

- 13.1 Any Director who requires advice on the provisions or application of this Code should obtain it from the Company Secretary.
- 13.2 All Directors are required to comply with this Code. Each Director must confirm this within 7 days of his or her appointment by signing and returning to the Company Secretary a copy of this Code.
- 13.3 Any suspected or actual non-compliance with this Code will be addressed in accordance with the Constitution.

14. **Approval and review of this Code**

- 14.1 This Code was approved by the Trust Board on [INSERT DATE]
- 14.2 This Code will be subject to review, led by the Chair and Company Secretary, not more than two years from its date of approval.

Declaration

I [insert name] have read, understood and agree to comply with this Code of Conduct for the Trust Board of Great Ormond Street Hospital for Children NHS Foundation Trust.

Signature

Date

.....

.....

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APPENDIX A
GOVERNANCE DOCUMENTS

1. GOSH Constitution, including its appendices
2. Standing Orders
3. Standing Financial Instructions
4. Any terms of reference for the Trust Board or any committees established by it
5. Schedule of matters Reserved to the Trust Board and Council of Governors
6. Foundation Trust Code of Governance
7. Provider Licence of the Trust
8. Any role descriptions or similar for Directors

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APPENDIX B
POLICIES AND PROCEDURES

1. Declarations of Interest and Gifts and Hospitality Policy
2. Confidentiality Policy
3. Disclosure and Barring Service Policy
4. Fire Policy
5. Health and Safety Policy
6. Media Policy
7. Safeguarding Children and Young People Policy

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