Great Ormond Street Hospital for Children NHS Foundation Trust

Meeting of the Trust Board
Wednesday 25 July 2018

Dear Members

There will be a public meeting of the Trust Board on Wednesday 25 July 2018 at 11:30am 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 **STANDARD ITEMS**	Presented by	Attachment	Time
1.	**Apologies for absence**	Chairman	**Verbal**	**11:30am**
Declarations of Interest All members are reminded that if they have any pecuniary interest, direct or indirect, in any contract, proposed or other matter which is the subject of consideration at this meeting, they must disclose that fact and not take part in the consideration or discussion of the contract, proposed contract or other matter, nor vote on any questions with respect to it.				
2.	**Minutes of Meeting held on 23 May 2018**	Chairman	**D**	**11:35am**
3.	**Matters Arising/ Action Checklist** • **Learning Academy**	Chairman Chief Nurse/ Medical Director	**E** **F**	**11:40am**
4.	**Chief Executive Update**	Chief Executive	**Verbal**	**11:45am**
5.	**Patient Story**	Chief Nurse	**G**	**11:55am**
6.	**Board Assurance Committee reports** • **Audit Committee update – May 2018 meeting** • **Quality and Safety Assurance Committee update – July 2018 meeting** • **Finance and Investment Committee Update – July 2018**	Chair of the Audit Committee Chair of the Quality and Safety Assurance Committee Chair of the Finance and Investment Committee	**H** **Verbal** **Verbal**	**12:15pm**
7.	**Draft Constitution including:** • **Code of Conduct for Governors** • **SOP for meetings using electronic communications** • **Lead Governor Role Description** • **Phasing elections and Constitutional Boundary Changes – a discussion paper**	Chairman of the Council of Governors/ Deputy CEO/ Company Secretary	**I & Appendix 1** **Appendix 4** **Appendix 5** **Appendix 6** **3**	**12:30pm**
	STRATEGY and RISK			
8.	**Clinical Operations Restructure**	Deputy Chief Executive	**J**	**12:40pm**

9.	**Strategic nursing workforce update**	Chief Nurse	**N**	**12:50pm**
10.	**CQC Inspection Report Action Plan**	Medical Director/ Company Secretary	**O**	**1:00pm**
	PERFORMANCE			
11.	**Integrated Quality Report – 30 June 2018 including** • **Annual Infection Prevention and Control Report** • **Annual Complaints Report 2017/18** • **Annual PALS report 2017/18** • **Results of the Care Quality Commission National Inpatient and Day Case Experience Survey 2016**	Medical Director/ Chief Nurse Director of Infection, Prevention and Control Chief Nurse Chief Nurse Chief Nurse	**P** **Q** **R** **S** **T**	**1:10pm**
12.	**Learning from Deaths Mortality Review Group - Report of deaths in Q4 2017/2018**	Medical Director	**U**	**1:20pm**
13.	**Integrated Performance Report (30 June 2018)** **Progress with Better Value Programme** **Finance Update (30 June 2018)**	Deputy Chief Executive Deputy Chief Executive Chief Finance Officer	**V** **W** **X**	**1:30pm**
	ASSURANCE			
14.	**Safe Nurse Staffing Report (May and June 2018)**	Chief Nurse	**Y**	**1:40pm**
15.	**Report from the Guardian of Safe Working**	Guardian of Safe Working	**Z**	**1:50pm**
16.	**Annual Report from the Responsible Officer**	Mr Andrew Long, Responsible Officer	**1**	**2:00pm**

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 Trust Board meeting will be held on Wednesday 27 September 2018 in the Charles West Room, Great Ormond Street, London, WC1N 3JH.

ATTACHMENT D

Attachment D

Great Ormond Street Hospital for Children NHS Foundation Trust

DRAFT Minutes of the meeting of Trust Board on 23rd May 2018

Present

Sir Michael Rake	Chairman
Dr Peter Steer	Chief Executive
Lady Amanda Ellingworth	Non-Executive Director
Mr Akhter Mateen	Non-Executive Director
Mr James Hatchley	Non-Executive Director
Professor Rosalind Smyth	Non-Executive Director
Dr Andrew Long	Interim Medical Director
Ms Helen Jameson	Interim Chief Finance Officer
Ms Nicola Grinstead	Deputy Chief Executive
Mr Ali Mohammed	Director of HR and OD
Ms Alison Robertson	Chief Nurse

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)
Ms Herdip Sidhu-Bevan*	Assistant Chief Nurse
Ms Emma James*	Patient Involvement and Experience Officer
Dr Sanjiv Sharma*	Deputy Medical Director for Medical and Dental Education
Ms Lynn Shields*	Associate Director of Education
Mr Luke Murphy*	Freedom to Speak Up Guardian
Dr Renee McCulloch*	Guardian of Safe Working and Consultant in Paediatric Palliative Medicine

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

10	**Apologies for absence**
10.1	Apologies for absence were received from Professor Stephen Smith, Non-Executive Director.
10.2	Sir Michael Rake, Chairman said that the meeting would have been Professor Smith's last as a Non-Executive Director and said that he had written to him thanking him for his contribution.
11	**Declarations of Interest**
11.1	No declarations of interest were received.
12	**Minutes of Meeting held on 28th March 2018**
12.1	The Board **approved** the minutes.
13	**Matters Arising/ Action Checklist**

13.1	The actions taken since the last meeting were noted.
14	**Chief Executive Update**
14.1	Dr Peter Steer, Chief Executive gave an update on the following matters: • The Trust would be working with The King's Fund to undertake a Board development programme which would begin after summer 2018. • The work which had taken place to review the gastroenterology service had received both print and television media coverage. The Board had acknowledged the work of the communications team who had worked hard on managing challenging media issues. It was confirmed a meeting had taken place with the gastroenterology team to reflect on the documentary and to ensure that there was sufficient support available for them should there be any press or parent enquiries. • GOSH had been asked to lead work across the North Thames area around the fragmentation of specialist paediatric services. • Following a commitment to review the divisional structure after two years and feedback from the CQC around a lack of clarity in the operational structure, the Deputy Chief Executive was leading some evaluation work which had engaged around 200 members of staff during a consultation. A divisional structure would be developed following the completion of the feedback period. Ms Nicola Grinstead, Deputy Chief Executive said that focus was being placed on ensuring the clinical specialties were grouped together in a way which was appropriate for patients' pathways.
15	**Patient Story**
15.1	The Board received a patient story by video from five young people who had experienced transition from GOSH to adult services. They provided the following feedback: • GOSH patients are often transitioned to a number of different adult providers where specialist care is available, which can be frightening and challenging especially where transition has not been robust in terms of the receiving adult services not having the relevant medical history or information . • Patients reported that it was daunting to be responsible for their own medication when not having received the relevant information or education to increase their understanding. • The last appointment at GOSH should act as a 'wrap up' session to ensure that the move to a new service was not too fast from a timing perspective and that the patient feels prepared with the relevant information resulting in a good transition to adult services. • GOSH felt very important to patients during their time at the Trust and the services it offers with regards to getting to know the teams that are looking after their health needs compared to some adult services, where you may not get to know all the staff in a timely manner.
15.2	Professor Rosalind Smyth, Non-Executive Director welcomed the patient story which highlighted the importance of patients taking part in a high quality transition process. Mr Matthew Shaw, Medical Director said that a current Quality Improvement Programme was focused on transition and a CQUIN was in place on

	which the Trust had given a positive presentation to NHS England.
15.3	Mr Chris Kennedy, Non-Executive Director asked how the effectiveness of the programme would be measured. Ms Herdip Sidhu-Bevan, Assistant Chief Nurse for Patient Experience and Quality said that part of the project was around ensuring that the Trust was clear which services patients were accessing from age 12 onwards and being aware of their point in the transition pathway. She added that a key part of the programme was ensuring that the receiving adult hospital had access to the relevant patient information as part of that programme. A presentation by GOSH at NHSI highlighted the importance of Trusts using similar approaches to transition across London, this concept was acknowledged by NHSI and they would aim to support this.
15.4	Sir Michael Rake, Chairman emphasised the importance of transition to GOSH patients who had often been treated at the Trust throughout their lives. He said it was important to highlight this issue during discussions with senior NHS leaders.
15.5	**Action:** It was agreed that an update on transition would be provided at the QSAC meeting in July.
16	**Board Assurance Committee reports**
16.1	<u>Audit Committee update – April 2018 meeting</u>
16.2	Mr Akhter Mateen, Chairman of the Audit Committee said that the committee continued to discuss the updates which were received from the Freedom to Speak Up Guardian. He highlighted the small number of cases which were received and said it was important to consider whether the process was robust.
16.3	<u>Quality and Safety Assurance Committee update – May 2018 meeting</u>
16.4	It was reported that the Committee had agreed to raise the following points to the Trust Board: • The work that was taking place to develop consent clinics following learning from a Serious Incident • Mandatory training for honorary contract holders – It had been confirmed that some honorary contract holders had had their contracts ended after repeated contact with no response. The remainder were working with HR to complete the training. • Nursing recruitment and retention: Focus would be placed on retention while continuing with the work that had been implemented to recruit nurses.
16.5	Sir Michael Rake, Chairman asked for a steer on the current feeling of nurses across the Trust. Ms Alison Robertson, Chief Nurse, said that there had been a lack of clarity around nursing leadership which had affected the morale of some colleagues and this had been reflected in the feedback received from the CQC. However she said that divisional re-organisation would provide an excellent opportunity to ensure there was a clear nursing leadership structure which was fully integrated into the medical and operational leadership structures.
16.6	Mr Ali Mohammed, Director of HR and OD said that it was also the case that Healthcare Scientists and Allied Health Professionals required more integration into the structure and this would also be taken into account during the divisional re-organisation.

16.7	Finance and Investment Committee Update – March and May 2018
16.8	Mr James Hatchley, Chairman of the Finance and Investment Committee said that the Committee had considered the year-end position and congratulated the Executive Team on meeting the Control Total which had been challenging. He said that the Committee had emphasised the importance of ensuring that budget holders had the information required to meet their outturn for 2018/19.
16.9	Mr Hatchley said that the committee had reviewed the Interoperative MRI project and agreed that the project should continue ahead with next steps.
16.10	The Committee had noted that IPP had a challenging target for 2018/19 which was likely to require support from the Executive Team. Dr Peter Steer, Chief Executive agreed that it was vital to invest in IPP to provide support as the work would be key to underpinning future NHS activity.
16.11	Lady Amanda Ellingworth, Non-Executive Director asked for a steer on the risk to achieving the Better Value programme. Ms Helen Jameson, Chief Finance Officer highlighted that the Trust had achieved its highest Better Value outturn in 2017/18 however the target had not be reached. She said that although there was greater assurance provided around the ability to deliver existing schemes, the total target had not yet been identified.
17	**Members' Council Update – April 2018 and Update on review of Constitution**
17.1	Dr Anna Ferrant, Company Secretary said that a positive meeting of the constitution working group had been held on 21st May and it was anticipated that the revised constitution would be considered by the Board and Council in July 2018, although this was a challenging timeline. Dr Ferrant said that work was taking place to consider the phasing of Governor elections and that Governors who would take on a shorter term of office would be on a voluntary basis in the first instance as all seats had recently been elected for a three year term.
18	**GOSH Foundation Trust annual financial accounts and annual report 2017/18**
18.1	Mr Akhter Mateen, Chair of the Audit Committee said that the Audit Committee had recommended the annual report and annual financial accounts on a going concern basis to the Board for approval. They had noted that the Trust had delivered the Control Total and had focused on the increase in receivables driven by IPP. Mr Mateen confirmed that the external auditors had been comfortable with the debtor total and the provisioning policy and had provided an unqualified opinion in the review of the accounts.
18.2	**Action:** Mr Chris Kennedy, Non-Executive Director said it would be helpful if the I&E could be presented excluding the impact charitable capital donations, so that the performance against plan could be clearly understood.
18.3	Mr Mateen confirmed that the Head of Internal Audit Opinion had not changed from the draft version reviewed by the Audit Committee at its last meeting and had provided a rating of 'significant assurance with minor improvement opportunities'.
18.4	Dr Anna Ferrant, Company Secretary confirmed that amendments had been

	made as requested by the Audit Committee.
18.5	The Board **approved** the following documents: • annual financial accounts and annual report 2016/17 • Annual Governance Statement • Audit Committee Annual Report • draft Head of Internal Audit Opinion
19	**Compliance with the NHS provider licence – self assessment**
19.1	Dr Anna Ferrant, Company Secretary said that the NHS provider licence was a key tool in the regulation of providers of NHS services. She said that the Board was required, on an annual basis, to declare whether a Trust was compliant with four conditions.
19.2	Dr Ferrant said it was required that the Board took into consideration the views of the Governors. She confirmed that Governors had been presented with the evidence against the three licence conditions and the Health and Social Care Act requirement by email and comments received revealed satisfaction with the evidence presented.
19.3	The Board considered the evidence presented and on the basis of this evidence and taking into account the views of the governors, the Board **agreed** to confirm compliance with the following three licence conditions and one requirement under the Health and Social Care Act: • Condition G6(3): The board has taken all precautions necessary to comply with the licence, NHS Acts and have regard to the NHS Constitution. • Condition CoS7(3): In providing commissioner requested services (CRS), the Trust certifies that has a reasonable expectation that the required resources will be available to deliver the designated service. • Condition FT4(8): Compliance with required governance standards and objectives as follows: o The Board is satisfied that the Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS. o The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time; o The Board is satisfied that the Licensee has established and implements: (a) effective board and committee structures; (b) clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) clear reporting lines and accountabilities throughout its organisation.
19.4	o The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) for timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) to ensure compliance with health care standards binding on the

	Licensee's operations including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; • Section 151(5) HSCA: The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to Governors, as required in s.151(5) of the Health and Social Care Act to ensure that they are equipped with the skills and knowledge they need to undertake their role.
19.5	The Board also **accepted** the recommendation from the Executive Team that the Trust was compliant with the other Monitor licence conditions, although it was noted that no formal declaration was required for these conditions.
19.6	Dr Ferrant confirmed that information on the self-certification process would be provided to governors as part of their development programme.
20	**Compliance with the Code of Governance**
20.1	Dr Anna Ferrant, Company Secretary said that a review had been conducted against all the provisions of the Code of Governance set out by NHS Improvement and evidence to support compliance with each criterion was provided. Dr Ferrant said that in-year, the Board had been compliant with the Code of Governance providing an explanation against the following provisions: • A.4.2: Led by the senior independent director, the non-executive directors should meet without the chairperson present, at least annually, to appraise the chairperson's performance, and on other such occasions as are deemed appropriate and B.6.3: The senior independent director should lead the performance evaluation of the chairperson, within a framework agreed by the council of governors and taking into account the views of directors and governors.- In view of the appointment of a new Chairman and two non-executive directors, the performance evaluation of the Chairman and existing NEDs is being conducted in Q2- Q3 2018/19. The Senior Independent Director (SID) will lead the performance evaluation of the Chairman and the new NEDs in Q4 within a framework agreed by the Council of Governors. • B.1.2: At least half the board, excluding the chairperson, should comprise non-executive directors determined by the board to be independent – From 1 May 2017 to 31 October 2017 the Board comprised 6 executive directors (including the Chief Executive), the Interim Chairman and four non-executive directors. • B.2.2: Directors on the board of directors and governors on the council of governors should meet the "fit and proper" persons test described in the provider licence. For the purpose of the licence and application criteria, "fit and proper" persons are defined as those without certain recent criminal convictions and director disqualifications, and those who are not bankrupt (undischarged). Trusts should also abide by the updated guidance from the CQC regarding appointments to senior positions in organisations subject to CQC regulations - The directors on the Board have all been required to sign a statement declaring that they meet the criteria of a 'fit and proper person'. Following the election to the Council in January 2018, the new governors are in the process of completing the fit and proper persons test. • B.3.3 The board should not agree to a full-time executive director taking on

	more than one non-executive directorship of an NHS foundation trust or another organisation of comparable size and complexity, nor the chairperson of such an organisation - The CEO was invited by the government of Ireland to serve as a NED on the Children's Hospital Group Board, Ireland. This position and time requirement is not considered a conflict of interest. The CEO as a consequence of his position is also a member of the Board of UCLPartners, an academic health science partnership. • B.6.5: Led by the chairperson, the council should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities – An evaluation of Council will be conducted in Q4 2018/19 to provide time for new working arrangements between the Board and the Council (agreed in April 2018) to be established. • B.6.6: There should be a clear policy and a fair process, agreed and adopted by the council, for the removal from the council of any governor who consistently and unjustifiably fails to attend the meetings of the council or has an actual or potential conflict of interest which prevents the proper exercise of their duties- As part of the work of the Constitution Working Group, this policy is being reviewed and updated.
20.2	The Board **noted** the results of the review and the statement to be included in the annual report.
21	**Quality Report 2017/18**
21.1	Mr Matthew Shaw, Medical Director presented the report and thanked the team involved in its development. He highlighted the quality improvement programmes which had taken place in the Trust throughout the year.
21.2	Mr Akhter Mateen, Chair of the Audit Committee gave an overview of the external auditors' review of the Quality Report. He said that an unqualified opinion had been provided on the 31 day cancer wait indicator, however a qualified opinion had been received on the 18 week RTT incomplete pathway indicator. He said that the Audit Committee had expressed disappointment with this outcome due to the significant work which had been undertaken on RTT. It had been noted that the errors highlighted during auditor testing had been corrected by GOSH processes later in the patient pathway with the exception of two errors however audit work was prescribed and the findings had therefore been qualified.
21.3	Mr Shaw said he was satisfied that there had been no patient harm as a result of an errors highlighted by the review.
21.4	The Board **approved** the Quality Report 2017/18.
22	**Board Assurance Framework Update**
22.1	Dr Anna Ferrant, Company Secretary presented the Board Assurance Framework (BAF) for information and confirmed that the Audit Committee and Quality and Safety Assurance Committee led on reviewed the risks. Mr Akhter Mateen, Non-Executive Director said that meeting would take place between the Chairs of the assurance committees at which the BAF would be discussed as well as at the annual Trust Board risk meeting in September 2018.

22.2	The Board reviewed the recommendations made by the Audit Committee around the time horizon over which a gross risk score and net risk score is considered and **approved** the proposal that the gross risk score be over a 3-5 year period and the net risk score be relevant to the individual risk. The Board also **approved** the proposal that the definition of catastrophic for the consequence score in financial terms would be a potential adverse variance of £4.5million.
23	**2017/18 NHSI Plan and budget**
23.1	Miss Nicola Grinstead, Deputy Chief Executive presented the paper and reported that the Trust had met all required submission deadlines from NHS Improvement and the financial plan projected a year end outturn which was in line with the Control Total. Updates to the plans had been primarily around amendments to the outturn given the confirmed contract value of £314million.
23.2	It was confirmed that work was taking place to ensure that the budgets had been agreed at a divisional level and appropriately allocated to individual services.
23.3	The Board **noted** the plans which had been submitted to NHS Improvement and the work taking place to allocate budgets divisionally.
24	**CQC Inspection Report**
24.1	Mr Matthew Shaw, Medical Director presented the report and said that a comprehensive update had also been provided to the Council of Governors meeting in April 2018. He said that work was taking place to develop action plans for all services which would be overseen through the Quality and Safety Assurance Committee and meetings with NHS England on a monthly basis.
24.2	Mr Shaw said that one notice had been served to the Trust around the availability of notes prior to surgical procedures. He said that the Executive Team had been clear about the expectations for the team.
24.3	Sir Michael Rake, Chairman queried the view of clinical staff on the outcome of the report. Mr Shaw said that staff were appropriately focused on achieving excellent outcomes, however it was vital to ensure that the fundamentals were in place as standard and that staff were clear about the CQC requirements which must be met in order to be rated 'good'. Ms Alison Robertson, Chief Nurse said that some issues had been raised from a nursing point of view and it was clear that these issues required focus.
25	**Integrated Quality Report – 30th April 2018**
25.1	Mr Matthew Shaw, Medical Director presented the report and said that it had been noted that GOSH had a greater number of arrests on wards relative to other Trusts. Mr Shaw said that discussions had taken place with the resuscitation team and he had been assured that there were appropriate causes for the greater number of arrests and no underlying themes. The Board noted that the GOSH had the best outcomes nationally for cardiac arrests on wards.
25.2	Ms Alison Robertson, Chief Nurse said that a grade 3 pressure ulcer had occurred which had been declared as a serious incident and was currently being investigated. Good work was taking place to reduce Central Venous Line infections and the patient experience team was considering whether the internally

	agreed 40% completion target for friends and family test was appropriate given that many other Trusts set a lower target and GOSH had not met the higher target.
25.3	Mr Akhter Mateen, Non-Executive Director said that the auditors had reviewed the Central Venous Line data as part of their quality report review and had confirmed that if an opinion had been given it would have been unqualified.
25.4	Learning from Deaths Mortality Review Group - Report of deaths in Q3 2017/2018
25.5	Mr Shaw said that GOSH was a leader in terms of reviewing deaths through a multidisciplinary team of clinicians. He said that the cases reviewed were often very complex and were reviewed for significant modifiable events which would have impacted the patient's outcome, none of which had been found.
25.6	Sir Michael Rake, Chairman, queried whether GOSH was likely to have a higher mortality rate than other Trusts due to the acuity and complexity of patients treated at the Trust. Mr Shaw that in many areas it was possible to adjust to the data for case mix and confirmed that the data was presented at the Patient Safety and Outcomes Committee to review lessons learnt.
25.7	Lady Amanda Ellingworth, Non-Executive Director noted that six deaths out of 27 at GOSH between 1st October 2017 and 31st December 2017 were patients with learning disabilities. She asked whether this was in line with the overall proportion of GOSH patients with learning disabilities and Dr Peter Steer, Chief Executive said that this was likely to be in line with the patient population.
26	**GOSH Learning Academy – Briefing Paper**
26.1	Mr Matthew Shaw, Medical Director said that the aim of the plan was to develop a GOSH Learning Academy that would provide multi-professional paediatric education and training available through state-of-the-art technologies and in modern environments. Mr Shaw emphasised that education was a key component of GOSH's strategy and said that the Learning Academy would enable the Trust to begin to optimise the education that was being offered to staff. He added that the commercial potential of education was not currently being maximised.
26.2	Sir Michael Rake, Chairman asked for the Board's view about providing training to third parties. He suggested that the Trust had an obligation to do this given the skills of GOSH staff. Mr Ali Mohammed, Director of HR and OD said that in the event of a commercial training venture it was vital to be able to offer a high quality experience and added that currently it was not possible to guarantee the use of the facilities to third parties.
26.3	Professor Rosalind Smyth, Non-Executive Director suggested that it was important to separate work on mandatory training for staff and the educational opportunities which could be commercialised. She said she felt that GOSH and the GOS UCL Institute of Child Health could work together in a number of ways and that a strategy was required for this.
26.4	Dr Peter Steer, Chief Executive said that notwithstanding the addition of the potential collaboration with the Institute of Child Health, it was important to move forward at pace with the recommendations. He said that the current agreement with the GOSH Children's Charity (GOSHCC) meant that any space that was owned by GOSHCC and not directly used for patients would incur a rental charge.

	He said it was important to revisit this agreement as education was a core part of the Trust's business.
26.5	Mr James Hatchley, Non-Executive Director said that discussion had taken place at the Finance and Investment Committee and further information had been requested on the third party training financials and the extent to which overheads were added with each development (given the capital costs for each were funded by GOSHCC but the overheads were the responsibility of the hospital).
26.6	The Board **approved** the Learning Academy Strategic Plan and Operating Model and **supported** the move towards a more commercially focused funding model.
27	**Integrated Performance Report (30th April 2018)**
27.1	Ms Nicola Grinstead, Deputy Chief Executive said that the Trust was moving into its fifth month of delivering all access targets which the exception of diagnostics. She said that spinal surgery which had previously been one of the Trust's challenge specialties had made significant improvements and all patients on the waiting list had been given a date for surgery. Improvements had been made in mandatory training and appraisal rates since the last report.
27.2	Mr Akhter Mateen, Non-Executive Director highlighted that some metrics remained consistently rated red such as discharge summaries and theatre utilisation. Ms Grinstead said that a theatre improvement programme was being implemented over the course of a year and a dashboard had been launched which simplified what was required to deliver the key metrics. She added that previous discussion at Board had noted that it would be extremely challenging to deliver further improvements in discharge summary completion rates prior to the implementation of the Electronic Patient Record. Lady Amanda Ellingworth, Non-Executive Director said that it was important to look at consistency across the organisation to ensure that there were not areas of the Trust which were performing significantly worse than others. Ms Grinstead confirmed that metrics were considered by individual service line during divisional performance meetings.
27.3	<u>Finance Update (30th April 2018)</u>
27.4	Ms Helen Jameson, Chief Finance Officer confirmed that the Trust had met its month one budget of £0.2million surplus. Overall, income was £0.6m behind plan driven by non-clinical income and private patient income being below plan offset by lower than anticipated expenditure in pay and non-pay. NHS activity in month one had been above levels anticipated in the contract however IPP activity was lower with increased acuity.
28	**Annual Reports**
28.1	<u>Annual Freedom to Speak Up Report 2017/18</u>
28.2	Mr Luke Murphy, Freedom to Speak Up Guardian said that the Freedom to Speak Up Service (FTSU) at GOSH had traditionally been an advice giving service however it was clear that staff required support to take issues further. He added that there were currently many streams of work at GOSH about encouraging staff to speak up including the work with the Cognitive Institute.
28.3	Mr James Hatchley, Senior Independent Director said that a large proportion of

	the cases reported through the FTSU system were around HR issues. Mr Murphy said that the national data showed that around 50% of cases across the NHS were about bullying and harassment but that the guidance was clear that following a robust process for these issues would encourage staff to speak up about a wide variety of issues.
28.4	Professor Rosalind Smyth, Non-Executive Director said that while she was supportive of the FTSU work, she did not believe this was sufficient to reduce incidences of bullying and harassment at GOSH and said it was vital to be able to measure the impact of this work against information gathered from other sources such as staff surveys. Sir Michael Rake, Chairman said that he felt it was vital for GOSH to be at the forefront of work on culture.
28.5	Mr Chris Kennedy, Non-Executive Director expressed some concern at the low number of issues reported through the process particularly in the context of the feedback from the CQC report and the high prevalence of staff reporting in the staff survey that they had experienced bullying and harassment. He queried how the effectiveness of the process would be measured. Mr Murphy agreed that the number of issues raised should increase but added that responses must be sought from individual contacts about the level of support they had experienced. He added it was key that people who raised concerns received feedback.
28.6	Lady Amanda Ellingworth, Non-Executive said that although different strands of positive work were taking place it was important to draw it together within an overall plan. Sir Michael Rake, Chairman emphasised that the key issue for the Trust was culture change which was vital to achieving many of its objectives.
28.7	Ms Cymbeline Moore, Director of Communications said that the team was working on an umbrella brand around raising concerns.
28.8	<u>Annual Health and Safety and Fire Report 2017/18</u>
28.9	**Action:** Mr Ali Mohammed, Director of HR and OD presented the report. Mr Akhter Mateen, Non-Executive Director highlighted that the completion date for fire risk assessments had been set at April 2018 and it was agreed that an update would be provided on whether this had been completed.
28.10	The Board expressed some concern that two long term members of the health and safety and fire team had taken a leave of absence from the Trust. The importance of ensuring sufficient resources were in place in this vital area was emphasised. Mr Matthew Tulley, Director of Development confirmed that this was the case.
29	**Report from the Guardian of Safe Working**
29.1	Dr Renee McCulloch, Guardian of Safe Working presented the paper and highlighted that overall the Trust was doing well in minimising the number of gaps in rotas, however where gaps did exist this had a significant impact on the working hours of junior doctors. She highlighted the benefit to the Trust of a number of doctors undertook additional shifts as part of the staff bank but added that the existing system did not measure these additional hours so no assurance was available that junior doctors were continuing to work within the upper limit of hours.
29.2	Discussion took place around the on call rest facilities which Dr McCulloch said

	were not sufficient and Mr Matthew Shaw, Medical Director added were inequitably dispersed throughout the Trust and this was being reviewed.
29.3	Professor Rosalind Smyth, Non-Executive Director highlighted that there were some specialties within which a large proportion of junior doctor posts were not being filled. She requested assurance that those who were in post were not being inappropriately burdened as a result. Mr Shaw said that whilst it was not unusual to have a number of unfilled junior doctor posts it was not appropriate and work was taking place to look at ways to fill the gaps.
29.4	Ms Alison Robertson, Chief Nurse said that where there were gaps in junior doctors, nurses had been instrumental in working in the clinical teams to reduce the impact of this. She said if this was likely to continue it would be important to consider a change to the nursing workforce structure to enable nurses to fulfil this role in a planned way.
30	**Annual Safeguarding Report 2017/18**
30.1	Ms Alison Robertson, Chief Nurse said that recruitment to vacant posts was now complete and that the team is up to establishment. She also confirmed that the staff would be further supported following the appointment of three general paediatricians who will, with others, establish a a rota 24 hours a day. One member of the safeguarding team would also lead on adult safeguarding which is
30.2	an important area of focus and work this year.. Activity had risen over 2017/18 by approximately 19% and Ms Robertson said it was important for us to monitor activity increases aagainst available resource
30.3	Ms Robertson said that one of the key recommendations from an internal safeguarding review was to co-locate the safeguarding and social work teams. It was reported that while suitable space was being sourced for full time co-location, this currently took place for two hours per day.
30.4	Lady Amanda Ellingworth, Non-Executive Director asked for a steer on the view of the London Borough of Camden of the quality of GOSH's service. Ms Roberson said that the Local Authority recognised the complexity of GOSH's work and that the service was well led through the Named Doctor for Safeguarding, Dr Alison Steele and Named Nurse, Ms Jan Baker
31	**Safe Nurse Staffing Report (March and April 2018)**
31.1	Ms Alison Robertson, Chief Nurse reported that there had been no unsafe shifts declared since the last report but highlighted that there had been some temporary ward closures due to infection prevention and control issues and temporary bed closures due to an unexpected shortfall in available nurses.
31.2	Excellent work had taken place on nurse recruitment and the Trust was operating a nurse vacancy rate of only 3%. A pipeline of 160 newly qualified nurses would be joining the Trust in September 2018. Ms Robertson said that work was taking place to look at retention, especially of band 6 nurses.
31.3	**Action:** Dr Peter Steer, Chief Executive queried whether there was a correlation between the reduction in bed closures and the starting in post of a large number of newly qualified nurses. It was agreed that an update would be provided at the next meeting.

31.4	Dr Steer added that discussion had previously taken place at Board about an optimum vacancy rate as a number of GOSH nurses relied on taking additional shifts through the staff bank to supplement income. Ms Robertson said that there was not an optimum rate and that best practice would be to appoint to substantive posts.
32	**Annual Staff Survey results 2017**
32.1	Mr Ali Mohammed, Director of HR and OD presented the report which included each area's action plan and how actions were being prioritised.
32.2	Sir Michael Rake, Chairman highlighted the low response rate and Mr Chris Kennedy, Non-Executive Director expressed concern about the level of staff reporting that they had experienced bullying and harassment. He said that this was unacceptable and required benchmarking with other organisations.
32.3	**Action:** It was agreed that the next update would provide the following information: • A breakdown of results via division as well as actions. • A breakdown of responses by key staff groups • A proposal on work to take place in response to the survey
33	**Any other business**
33.1	There were no items of other business.

ATTACHMENT E

Attachment

TRUST BOARD – PUBLIC ACTION CHECKLIST
July 2018

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
135.8	07/02/18	Professor Rosalind Smyth, Non-Executive Director highlighted the important pharmacy review which was taking place and had been discussed by the Quality and Safety Assurance Committee and it was agreed that the Trust Board would receive an update on this work.	Andrew Long/Matthew Shaw	July 2018	On agenda
135.10	07/02/18	Mr David Lomas, Chair of the Finance and Investment Committee said that the meeting had considered the use of Patient Level Costing to allow patient level data to be cut in many ways giving an insight into the negative NHS contribution. The Committee had also reviewed the drivers of revenue in terms of activity volumes and tariff and it was agreed that both these topics would be discussed by the Board during 2018/19.	HJ	November 2018	Not yet due
137.13	07/02/18	It was agreed that a snapshot of current divisional performance for all divisions and targets which were set but had not been achieved would be circulated outside the meeting.	NG	May 2018	On agenda
165.4	28/03/18	Ms Nicola Grinstead, Deputy Chief Executive said that work would take place to look at the appointment booking process as this should take place through the bookings team rather than individual medical secretaries. She said that the pharmacy review project, which was being reviewed by the Quality and Safety	NG	September 2018	Not yet due

Attachment

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
		Assurance Committee, was working to reduce long waits. Educational materials had been purchased and Ms Grinstead confirmed that these could also be used in outpatient areas.			
166.3	28/03/18	It was agreed that the Board would thank the external pharmacist who had been embedded in the pharmacy team to conduct the review.	MR	May 2018	In progress
174.4	28/03/18	The Board discussed the hand hygiene audit results as part of the infection prevention and control report and it was agreed that discussion would take place outside the meeting to look at a different way of presenting the data.	John Hartley	September 2018	Not yet due
181.1	28/03/18	Mr Ali Mohammed, Director of HR and OD said a number of staff in the Trust had been awarded a place on national development programmes which was very positive. Consideration would be given to how this information would be provided to the Board.	AM	July 2018	This information will be included as part of the update on progress with the strategy – see update on 'People' on agenda
15.5	23/05/18	It was agreed that an update on transition would be provided at the QSAC meeting in July.	AR	July 2018	Noted for QSAC – on agenda for July QSAC meeting
18.2	23/05/18	Mr Chris Kennedy, Non-Executive Director said it would be helpful if the I&E could be presented excluding the impact charitable capital donations, so that the performance against plan could be clearly understood.	HJ		On agenda
28.9	23/05/18	Mr Ali Mohammed, Director of HR and OD presented the report. Mr Akhter Mateen, Non-	AM	July 2018	The Health and Safety Manager has confirmed that these risk

Attachment

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
		Executive Director highlighted that the completion date for fire risk assessments had been set at April 2018 and it was agreed that an update would be provided on whether this had been completed.			assessments will be fully up to date by the end of July 2018. The delay is due to the commencement in post of a new Fire Officer and a substantial number of fire risk assessments due at and about the same time.
31.3	23/05/18	Dr Peter Steer, Chief Executive queried whether there was a correlation between the reduction in bed closures and the starting in post of a large number of newly qualified nurses. It was agreed that an update would be provided at the next meeting.	AR	July 2018	On agenda
32.3	23/05/18	The next update on the annual staff survey to provide the following information: • A breakdown of results via division as well as actions. • A breakdown of responses by key staff groups • A proposal on work to take place in response to the survey	AM	July 2018	Noted for next annual staff survey

Attachment F

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
25 July 2018

GOSH Learning Academy – Strategic Plan **Submitted by:** Lynn Shields, Associate Director of Education Sanjiv Sharma, Deputy Medical Director for Medical & Dental Education *Executive Sponsors:* Alison Robertson, Chief Nurse Matthew Shaw, Medical Director Ali Mohammed, Director of HR&OD	**Paper No: Attachment F**

Aims / summary
This is the previously submitted GOSH Learning Academy Strategic Plan for central education and training at GOSH. Review with the UCL GOSH Institute of Child Health (ICH) has been done as directed by Trust Board. Amendments to the document to reflect the strong relationship between GOSH and ICH have been made accordingly on page 7:

Fostering relationships and strengthening partnerships

Continuing to develop relationships and partnerships is a core objective within the Learning Academy strategic plan and our 'Horizon 1' objectives. We are committed to continuing to work closely with the ICH (the UCL Great Ormond Street Institute of Child Health). This important strategic relationship will help us to be successful, while supporting the ICH's mission to "improve the health and well-being of children and the adults they will become, through research, education and public engagement". GOS ICH are currently developing an Education Strategy, which will be integral to their refreshed academic strategy and it is very timely for both organisations to align their strategies in this area. Working in collaboration maximises opportunities to provide education through a cost-effective and accessible way, identifying new market opportunities, and creating high-quality teaching spaces.

Action required from the meeting
1. Approve new content to Strategic Plan, this is highlighted in yellow on page 7 (document attached as appendix for information).

Contribution to the delivery of NHS Foundation Trust strategies and plans
This document supports *Fulfilling Our Potential* through the development of a GOSH Learning Academy that will provide first-choice, multi-professional paediatric education and training, available through state-of-the-art technologies, and in modern environments.

Financial implications
Implications remain the same as in previously submitted papers.

Who needs to be told about any decision?
- Nursing & Non-medical Education
- Postgraduate Medical Education
- Learning & Development
- Redevelopment
- Finance
- Executive Management Team

Attachment F

Who is responsible for implementing the proposals / project and anticipated timescales? Lynn Shields, Associate Director of Education Sanjiv Sharma, Deputy Medical Director for Medical & Dental Education
Who is accountable for the implementation of the proposal / project? Alison Robertson, Chief Nurse Matthew Shaw, Medical Director Ali Mohammed, Director of HR&OD

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
25th July 2018

Patient Story – KB **Submitted on behalf of** Alison Robertson, Chief Nurse	**Paper No: Attachment G**

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 for the Clinical Governance Committee each year, two in writing and two through a patient / family member attending or through a film clip. Each story includes information on actions which were taken to improve aspects of a service, if applicable. Stories which are selected represent a range of families' experiences across a variety of wards and service areas spanning divisions and ensuring that the experience of families is captured.

The story to be shared on 25th July will be in person. The patient will detail their experiences of being a patient and their involvement in research at Great Ormond Street Hospital, for over 7 years. The patient is currently 18 years old; they transitioned in 2016, when they were 16.

The patient has been under the care of the rheumatology department.

3 key messages to take away from this story are:

1. The importance of looking after the mental wellbeing of patients, just as much as their medical conditions
2. Staff Communication with the patients, asking their views
3. The positives of being involved in research e.g. how the patient became involved in groups and talks about her journey and developed much more confidence and other life skills e.g. public speaking

Action required from the meeting

Review and comment

Contribution to the delivery of NHS / Trust strategies and plans

- 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 Behaviors work
- Trust PPIEC strategy
- Quality Strategy

Financial implications

None

Who needs to be told about any decision

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

Emma James – Patient Experience and Engagement Officer

Great Ormond Street Hospital for Children NHS Foundation Trust

Who is accountable for the implementation of the proposal / project Herdip Sidhu-Bevan– Assistant Chief Nurse Quality and Patient Experience
Author and date Emma James – Patient Experience and Engagement Officer – July 2018

Attachment H

Great Ormond Street Hospital for Children NHS Foundation Trust

Summary of the Audit Committee meeting held on 23rd May 2018

The Committee noted the minutes of the Finance and Investment Committee and the summary of the Quality and Safety Assurance Committee.

Chief Financial Officer's review of the Annual Financial Accounts 2017/18, including the Going Concern assessment

The Committee noted that GOSH had a year-end outturn for 2017/18 of £0.2million surplus to Control Total and approved the going concern statement.

Annual Financial Accounts 2017/18 and GOSH Draft Annual Report 2017/18

It was confirmed that the immediate depreciation of the Premier Inn Clinical Building once it came into use had been anticipated and the external auditors confirmed that the amount had been reviewed and was within an acceptable range. Discussion took place around the ageing of impaired and non-impaired receivables and it was agreed that the timing of customers in year played a key role in the division of impaired and non-impaired sums. The external auditors confirmed that the Trust's IPP debt was consistent with that of other healthcare organisations including the private sector. The Committee agreed that consideration would be given to requesting an internal audit of sustainability as this was an important section of the Annual Report.

The Committee agreed to recommend the annual accounts, annual report, annual governance statement and annual audit committee report to the Board for approval.

Representation Letter in relation to the accounts and quality report for the year ended 31 March 2018

The Committee agreed to confirm within the letter itself that there were no disclosure deficiencies and remove the appendices. It was agreed that the representation letter would be recommended to the Board for approval.

Quality Report 2017/18

The quality improvements throughout the year were highlighted and the committee agreed to recommend the report to the Board for approval.

Final Report on the financial statement audit for the 12 month period ended 31 March 2018 and 2017/18 Quality Report Quality Assurance Review

The external auditors confirmed that the review annual financial accounts 2017/18 had provided an unqualified opinion as had the review of 31 day cancer waits as part of the Quality Report however the review of 18 week RTT incomplete pathways had provided a qualified opinion due to errors identified during testing. It was confirmed that the team had not been able to quantify the impact of the errors without significant additional testing which was outside the prescribed remit of the auditors. The committee expressed disappointment at this outcome given the significant work which had taken place on data quality however it was noted that external assurance had been provided on the Trust's processes and GOSH was now seen as an exemplar in this area. It was reported that it had been shown that all but two errors would have been identified during GOSH's validation

process. Discussion took place around the statement included in the report by the auditors and it was agreed that a reference to the response provided by GOSH would be added.

Internal Audit Progress Report

The Committee noted that two reports remained outstanding which was unsatisfactory and stressed that the executive team and auditors must ensure that reports were finalised in a timely fashion. It was reported that a review of divisional governance and financial management had provided a rating of partial assurance with improvements required and it was noted that substantial work had taken place since the review was undertaken. A review of nursing recruitment and retention had also provided a rating of partial assurance with improvements required and the committee expressed disappointment at this outcome. The auditors confirmed that they were assured that although gaps in HR processes had been identified as a result of work being divided by HR and nursing, they were assured that key employment checks were being undertaken.

Internal Audit Annual Report 2017/18 including Head of Internal Audit Opinion 2017/18

It was confirmed that the Head of Internal Audit remained at significant assurance with minor improvement opportunities.

Presentation of high level risks

- Risk 11: The risk that the EPR programme will not be delivered on time or within budget. (last = Oct 2017)

Discussion took place around the process for 'go live' and it was noted that substantial work had taken place to review lessons learnt from other organisations and in terms of visiting other organisations during their 'go live' phase. It was noted that external assurance continued to be provided on the project through gateway reviews. Discussion took place around the importance of training staff and the importance of doing this in a timely manner in order to begin to achieve the anticipated benefits.

Local Security Manager Work-plan 2018/19

Recent training had taken place with outpatient staff around personal safety and handling unacceptable behaviour from families and work was taking place to tender for an access control system as the Trust's current system would reach the end of its technical support licence in 2020. Asset tracking would be built in to this system.

Trust preparation for General Data Protection Regulation

Working was taking place to update the Trust's privacy statements which would be published on the website and work to prepare for GDPR was being overseen by the GDPR Delivery Group reporting to the Information Governance Steering Group. GOSH continued to be engaged in the London wide information governance group and it was confirmed that the Trust's progress and readiness continued to be in line with that of other organisations.

Trust litigation and benchmarking of claims

The Committee reviewed the Trust's current cover and requested additional information about the impact of the Serious Incident review process in minimising claims.

Attachment H

Audit Committee Annual Effectiveness Survey Results

Discussion took place about potentially including a clinician in the committee's terms of reference and it was agreed that this would be discussed further outside the meeting.

Revised Audit Committee Terms of Reference and Workplan

The Committee approved the revised terms of reference and workplan.

Review of non-audit work conducted by the external auditors

The committee noted that one small piece of non-audit work had been conducted in year by the external auditors and that the auditor was satisfied that its independence was not compromised by this work.

Update on Freedom to Speak Up at GOSH

Work was taking place to review the routes available for staff to raise concerns throughout the Trust and simplify them. The importance of aggregating cases raised through all routes to consider any themes or patterns.

It was agreed that the following matters would be raised at Trust Board:

- Annual report and accounts
- No post financial year events.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
25 July 2018

Revised GOSH Constitution **Submitted by:** Anna Ferrant, Company Secretary/ Nicola Grinstead, Deputy Chief Executive	**Paper No: Attachment I**

Aims / summary

In 2017, the Council and Trust Board agreed that it a fundamental review was required of the Constitution. The Constitution Working Group was established and the terms of reference for the Group were to review the Constitution and appendices in light of:

- best practice guidance including that set out in the Foundation Trust Code of Governance (July 2014)
- changes to strengthen governance arrangements for the membership, Council of Governors and Trust Board.
- changes to the structure of the Council of Governors or Trust Board.
- Relevant recommendations and resolutions arising from internal reviews and reports to the Council of Governors and Trust Board and,
- Make recommendations to the Trust Board and Council of Governors on changes to the Constitution and appendices.

The Group met 8 times between January and July 2018. Minutes are available on request. Regular membership of the Group was as follows (Board, Council and staff representatives):

Nicola Grinstead	Deputy Chief Executive (Chairman)
Mariam Ali	Patient and carer constituency (and Lead Governor)
Fran Stewart	Public constituency
Paul Gough	Staff constituency
George Howell	Ex councillor, young person representative
Akhter Mateen	Deputy Chairman
Jon Schick	Director, Programme Management Office
Anna Ferrant	Company Secretary

DAC Beachcroft provided detailed governance and legal advice.

The Group agreed a set of key matters to review and update (as referenced in this document). A workplan was developed and worked through during the meetings.

The draft, revised Constitution is attached at **Appendix 1**. A tracked version of the document is attached at **Appendix 2** (for information) to show where changes have been made.

All amendments to the constitution require approval by the Council and the Board. The document attached to this coversheet highlights the key areas of change for consideration by the Council and the Board. A separate paper is on the agenda to consider changes to the classes within the Public and Patient and Carer constituencies and proposed implementation of phasing of Council elections.

Action required from the meeting To review and approve the recommendations from the Constitution Working Group on all proposed amendments to the Constitution. To note that every amendment in the Constitution requires approval from the Board via a majority of directors present and voting at the meeting. The amendments will also require approval by the Council of Governors via a majority of governors present and voting at the Council meeting on 24 July 2018.
Contribution to the delivery of NHS Foundation Trust strategies and plans Good governance
Financial implications Legal advice
Who needs to be told about any decision? The Council of Governors and members.
Who is responsible for implementing the proposals / project and anticipated timescales? Anna Ferrant, Company Secretary
Who is accountable for the implementation of the proposal / project? Chief Executive

Revised GOSH Constitution

Amendments to the Constitution Document for approval

1. Revised membership constituencies at GOSH and governor representation

Purpose: As part of the review of the Constitution, the Committee agreed that it was appropriate that a review was conducted of the GOSH membership constituencies, to ensure they accurately represent the electoral areas in which GOSH patients and the GOSH membership are located. This review would aid the proposed staggering of governor tenures (see separate paper on agenda).

Proposals including rationale for each proposed change: The Group proposes that there should be no increase in the number of governors so the Council should continue to comprise 27 in total. This ensures that the Council is of an appropriate size and not unwieldy (as recommended in the Foundation Trust Code of Governance published by NHS Improvement). Whilst there is no proposal to increase the total number of governors, the Group recommends changes to the number of seats within the constituent parts, principally by reducing by one the number of appointed governors and increasing by one the number of elected governors. This is shown at **Appendix 3** (to follow).

Public and Patient/ carer governors: A separate paper is on the agenda to discuss how these constituencies could be realigned to ensure that both consistencies are aligned and consistent in electoral areas covered.

Staff governors: The Group agrees that the number of staff governors is retained (5). It has considered whether the staff constituency should be divided into classes based on professions (doctors, nurses, allied health professionals etc.). However, the Group recommends that that each staff governor should continue to represent the interests of all staff, regardless of profession or team. This avoids any confusion with other roles in the hospital (for example trade union representatives) and allows all staff the opportunity to vote for a staff member regardless of their profession. This approach accords with the Always Values 'One Team'.

Appointed governors – The Group considered each of the appointed governor roles and recommended the following changes (rationales explained for each one below):

- Local authority governor – a statutory requirement under the NHS Act 2006 (as amended by the Health and Social Care Act 2012) (the "2006 Act") to have a governor appointed by a local authority within the Trust's public constituency: Although GOSH is a tertiary/quaternary trust, it sits within Camden and has links with the local authority via the Camden Health and Adult Social Care Scrutiny Committee, safeguarding networks and planning networks. The Group proposes that an appointed governor from Camden Council, the local Trust Council is retained.
- Institute of Child Health Governor – a requirement from the 2006 Act for a Trust whose hospitals include a medical school provided by a university to have a governor appointed by that university. Although the Trust does not have a "medical

school", the Trust has extremely strong links with GOSH UCL ICH. The Group proposes that an appointed governor from GOSH UCL ICH is retained.

- NHS England commissioning governor – there is no requirement to have a commissioning governor on the Council. The seat is currently vacant. With 90% of the Trust's commissioning conducted by NHSE, the position on the Council can create a conflict in that the person put forward by NHSE is often involved in performance and planning discussions with the Trust outside of the Council and holds the executive team to account for delivery of its contract. The Group proposes that this appointed governor seat is removed.
- Selfmanagement UK and GOSH School – The purpose of both of these seats was to enable young people to sit on the Council. This has proven a challenge for the GOSH School to find a young person with the time available to be appointed in the role and as a result, the GOSH School seat is currently vacant. The selfmanagement UK position is taken by a manager representing that organisation. The Group proposes that the appointed governor seat from selfmanagement UK and the GOSH School is removed and replaced with young people from the YPF as outlined below.
- The Group proposes that two new governors from the Young People's Forum (YPF) are appointed. The Group strongly recommends that links with the YPF should be strengthened in all areas, at Council level and through proactive engagement with young people as a default approach to all relevant work. This will help increase the young person's voice at the Council. Currently the Chair of the YPF is a patient governor, however, there will be no requirement for one of the YPF appointed governors to be the Chair.
- These proposals provide 4 appointed seats on the Council of Governors (previously 5 seats).

Recommendation for approval by the Trust Board:
The Constitution Working Group recommends the following:
Appointed Governors:

- RETAIN appointed governor from Camden Council, the local Trust Council.
- RETAIN appointed governor from GOSH UCL ICH
- REMOVE appointed governors representing selfmanagement UK and the GOSH School
- APPOINT two new governors from the Young People's Forum and strengthen links between the Council and the YPF.

2. Minimum age of membership

Purpose: To review the minimum age of GOSH membership (currently 10 years of age) and consider whether this should be lowered.

Proposal including rationale: The Group agreed that as a children's hospital, a lower minimum age would arguably be more representative of the users of the Trust's services. The Group considered that members have a vote on changes to the constitution that relate to the powers or duties of the COG, vote on the election of the governors and receive the annual accounts and report at the Annual Members' Meeting. They are also invited to attend member engagement events. The committee carefully considered and agreed that

there is quite a jump in development between a 7/8 year old and 10 year old and that new materials would likely need to be produced if the minimum age of members was lowered. The Trust would also need to recruit members from the new lower age range and to do this in sufficient numbers (recruiting young people has been a challenge over the past 6 years).

The Group was advised that other NHS foundation trusts which are, or contain, children's hospitals have similar or higher age limits than 10 years old for the minimum age of members.

The Group proposed that it was preferable to increase engagement with younger users of the Trust's services through the Young People's Forum (YPF). The YPF already engages with young service users and is run in an age appropriate way. The Group agreed to formalise the YPF's involvement with the Trust for example, by considering appointment as governors on the Council (see above) and requiring the COG to consider YPF's views on certain matters that are of particular pertinence to young persons.

Recommendation for approval by the Trust Board:
The Constitution Working Group recommends that the minimum age of members remains at 10 years of age but that the relationship with the YPF is formalised and the YPF is approached to gather young peoples' views of relevant issues.

3. The 'six year rule' for patient and carer constituency membership

Purpose: To review the period of time a member can remain a patient/ parent / carer member following their final contact with the hospital (currently 6 years) and consider whether this should be amended.

Proposal including rationale: The Constitution states "*An individual who has, within the period specified below, attended any of the Trust's hospitals as either a patient or as the carer of a patient may become a member of the Trust.*" The period referred to is "*6 years immediately preceding the date of an application by the patient or carer to become a member of the Trust*" (the six year rule). Those individuals who are eligible for membership of the Trust by virtue of these provisions are in the Patient and Carer Constituency.

The Group reviewed a variety of proposals including:

- Removing the 6 year rule completely for patients and carers;
- Specifying an upper age limit for patients to be eligible to be a member of the patient and carer constituency, to reflect the fact that the Trust is a children's hospital;
- defining a constituency class according to age;
- removing parents/ carers from the constituency.

The Group strongly felt that the Patient and Carer Constituency should be retained to ensure individuals are appropriately represented. The views of young people are particularly important and any revision to the criteria should support this principle.

The 2006 Act requires that definition of the patient and carer constituency specifies a period within which an individual has attended the Trust as a patient or carer of a patient. It would

therefore not be possible to remove the six year rule entirely. The Group was advised that this period should be a time period and therefore it would not be possible to provide for an upper age limit for patients to be a member in place of a specified time period within which they attended the hospital.

On this basis, the Group agreed that the 6 year rule should be amended to a 10 year rule as it was felt that such an extension continued to support the principle of capturing recent experience of hospital services, whilst enabling more individuals who had been patients as young children at the Trust to become members of the patient and carer constituency and stand for election as governors in that constituency. Members would be asked to verify they can be placed in the patient /carer constituency on joining the Trust and if they were eligible placed there unless they personally asked to be placed in the Public Constituency. Reminders would also be sent out during the year asking members to update their personal details to validate membership constituency. Any members applying to be a Governor are also asked at the nomination phase.

Para	Page no. clean	Page no. redline	Recommendation for approval by the Trust Board:
9.2 9.7	5 6	6 6	The Constitution Working Group recommends approval of the following: • the 6 year rule should be amended to a 10 year rule for members in the Patient and Carer Constituency. • The inclusion of the paragraph on the requirement to become a member of the patient and carer constituency (where valid) in the first instance, unless otherwise informed in writing by an individual.

4. Voting and written resolutions

Purpose: To ensure that voting requirements throughout the Constitution are appropriate and consistent.

Proposal including rationale: The Group considered the voting requirements throughout the Constitution on a case by case basis. It became evident that there was limited clarity on what the voting requirements were and the extent to which these were appropriate for the type of resolution being put to the Council.

The group proposes clarification of the position unless otherwise specified in the constitution, questions arising at a meeting of the Council of Governors shall be decided by a majority of votes of those governors present and voting. The following amendments to voting (note all other voting requirements remain the same) are therefore proposed in the Constitution:

- Annex 8, paragraph 3.1.2: The Council of Governors may resolve by a majority of two thirds of governors present and voting, to exclude members of the public from any meeting or part of a meeting (originally stated "two thirds" and so was not clear

on whether this was two-thirds of the entire Council of Governors or two thirds of those governors present and voting)

- Under the current Constitution (Annex 6), it states that "*No resolution of the Members' Council shall be passed if it is opposed by all of the public councillors present at the meeting*." The Group considered the reason for this provision and felt that the risk of giving a veto to one group of governors was unfair and inequitable, when all governors are equal (elected (public/ patient/ parent/carer, public and staff) and appointed). In addition, there is a risk that only one or two governors from the public constituency are present at the meeting and have the authority to overturn a resolution that has been voted on by all other governors present. The group proposed to remove this provision
- A revised section on investigating and resolving complaints against a governor has been included under annex 6 (see below). The process involves a three stage vote –
    - one vote of a simple majority of those present and voting on whether there is a case to answer
    - one vote of a simple majority of those present and voting of whether to uphold the statement of case and, where passed,
    - a final vote of a simple majority of those present and voting on the sanctions (if any) to be imposed, with the exception of where the sanction proposed is the removal of a governor, in which case a three-quarter majority of those present and voting is required.

The Group considered the current flexibility afforded by the Constitution to allow effective conduct of business, noting that there will be few occasions where written resolutions will need to be put to the Council (generally between meetings when it is difficult for a meeting to be called within sufficient time) to seek their approval/ views and enable business to proceed. On this basis, a new clause has been added to Annex 8 which allows for such written resolutions, requires a signature from governors (individually or as a group) and requires at least three quarters of the governors to respond in writing within the timescales outlined in the notice.

Para	**Page no. clean**	**Page no. redline**	**Recommendation for approval by the Trust Board:**
Annex 8, para 3.8.1 Annex 8, para 3.8.6	82 82	91 92	The Constitution Working Group recommends • the inclusion of wording clarifying that unless otherwise specified in the constitution, questions arising at a meeting of the Council of Governors shall be decided by a majority of votes of those governors present and voting; • The inclusion of a paragraph clarifying the use and voting requirements for a written resolution.

5. Tenure of governors

Purpose: To consider the maximum length of time a person can hold office as a governor and ensure that the Trust adopts good corporate governance practice by balancing

continuity with renewal in the membership of the Council. **Proposal including rationale:** The Constitution currently states: *"An elected or appointed councillor: … shall not hold office for longer than six continuous years, without having an interval of not less than two years before holding office again as a Councillor for a further term or terms"*. The effect of this is that no governor may serve a continuous term of office of more than six years but there is no maximum period for which a governor may serve during his/her lifetime, provided that there is a two-year break between any six-year term served and any further period in office.

The Group agreed it was important to ensure good corporate governance as explained above. It is good corporate governance practice for non-executive directors to serve no longer than six years in office; whilst the governor role is very different from the non-executive director role, the Group agreed that it would be helpful to align the maximum terms of office so that any term of office longer than six years is regarded as exceptional. On this basis, the Group proposes that the maximum term of office for governors should be defined in aggregate terms, i.e. the total number of years which any person may serve during his/her lifetime. This provides for a person to serve one or two terms of office of three years, subject to the maximum term of 6 years, with or without a break between periods in office. (Legislation requires that each elected governor must be subject to re-election at intervals of not more than three years.)

If a governor does step down after the first three year tenure, they could only stand again for a further three years at a later date (i.e. not go over the 6 year lifetime maximum). This approach will ensure that the membership of the Council is refreshed, with new members having an opportunity to stand and bring their experience to the Council. It will also retain the independence of governors and remain in line with the tenure for NEDs (two three year periods).

Para	Page no. clean	Page no. redline	Recommendation for approval by the Trust Board:
14.7	7	8	The Constitution Working Group recommends that the Council approves the tenure for governors as 6 years total as a lifetime maximum with no return after this period of appointment has been served.

6. Disqualification of governors for failure to attend meetings or refusal to undertake training

Purpose: The Constitution states that:

4.3 *A person holding office as a councillor shall immediately ceases to do so if*

> *4.3.2. he fails to attend two meetings of the Members' Council for a period of one year unless the other members of the Members' Council are satisfied that:*
>
> > *4.3.2.1 the absence was due to a reasonable cause; and*
> >
> > *4.3.2.2 s/he will be able to start attending meetings of the Trust again within such a period as they consider reasonable.*

4.3.3 he has refused without reasonable cause to undertake any training which the Members' Council requires all councillors to undertake.

The Group was concerned that this provision was not being robustly enforced; that there was no consensus as to what amounted to a 'reasonable cause'; and, even if a governor had a good reason for missing meetings, a governor's continued absence meant that they were unable to properly fulfil their duties as a councillor and it made it more difficult to conduct the business of the Council.

Proposal including rationale: The Group considered how this rule should be implemented fairly and, taking into account legal advice and reviewing the rules applied by other Trusts, concluded that:

- The Chairman, Lead Governor and Company Secretary should consider whether the reasons for non-attendance by a governor is 'reasonable';
- The number of meetings required for attendance will remain at 2 out of 4 meetings a year
- Examples of accepted reasons for non-attendance (reasonable cause) would be included in the Constitution – a conflict with personal or work commitments where a date of the meeting has been changed by the Trust at short notice; ill health; or, a personal or family emergency.
- The Company Secretary would contact a governor to request reasons for on-going non-attendance.
- A governor's refusal to undertake any training would remain a reason for disqualification (subject to an understanding of reasonable cause)

Annex 6, paragraphs 4.3.3, 4.3.4 and 4.4 of the Constitution provides the revised wording (page 69 of the clean version and page 73 of the redline version).

Para	Page no. clean	Page no. redline	Recommendation for approval by the Trust Board:
Annex 6, paras 4.3.3, 4.3.4 and 4.4	69	73	The Constitution Working Group recommends that the Council approve adoption of the revised wording under annex 6, paragraph 4.3.3, 4.3.4 and 4.4 of the Constitution (as outlined above).

7. Further provisions as to eligibility to be a governor

Purpose: To review the provisions as to eligibility to be a governor and ensure that they are practical and clear.

Proposal including rationale: Currently a governor can be removed from the Council on the following grounds:

- a serious breach of the code of conduct;
- acting in a manner detrimental the interests of the Trust; or
- if it is not in the Trust's best interests for him/her to continue as a governor (Annex 6, para 4.4).

The Group reviewed the above grounds for removal of a governor and proposes that:

- they are retained and that examples of instances where it is not in the Trust's best interests for an individual to continue as a governor similar to those used by other trusts are added for purposes of clarity; and,
- the three-quarter majority required for removal be retained, but it be changed to three-quarters of governors present and voting to bring voting in line with other voting requirements in the Constitution.

Annex 6, paragraph 5.1.3 provides these examples and wording (page 70 in the clean version and pages 74-75 of the redline version).

Para	Page no. clean	Page no. redline	Recommendation for approval by the Trust Board:
Annex 6, para 5.1.3	70	74-75	The Constitution Working Group recommends approval of that revised wording under annex 6, paragraph 5 including examples of material or serious breaches and the revised voting requirements.

8. Investigation of complaints against governors and removal/ suspension of governors

Purpose: To review the process for investigating complaints against governors and ensure it is robust, practical and clear.

Proposal including rationale: The Group considered the wording of the current process and, following consideration of the practical implications of this process, proposed revisions to it which would ensure the following:

- Emphasis on resolving matters informally where appropriate.
- Where informal resolution is not appropriate or has failed to resolve the issue to consider other actions such as mediation, suspension or commissioning an investigation.
- Clarity for the individual against which a complaint is made on the process.
- Clarity for the individual raising the concern that the matter is being taken seriously and being appropriately dealt with.
- Clarity for the Council on how decisions will be reached and the authority afforded to individuals, including the requirement for the Chair as the ultimate decision maker to consult with others on all decisions.
- Transparency of the process so that decisions taken by the Chair, including the terms of reference of an investigation are consulted with the Lead Governor and shared with the Council, unless there is a good reason not to do so (the usual presumption will be that such matters will be shared with the LG and Council except in

circumstances where the speed of decision is required on a matter or where police or other advice precludes this). The Chair will subsequently provide an explanation as to why could not share with Lead Governor / Council of Governors at a later time.

- Where the Chair (following the request consultation) considers that a governor has failed to comply with the Constitution or the Code of Conduct/ Standing Orders a three stage process is proposed:
    - a Council vote on whether there is a case to answer;
    - following a response from the governor in question, a Council vote on whether to uphold the statement of case and, where passed;
    - a final vote on the sanctions (if any) to be imposed.

Para	Page no. clean	Page no. redline	Recommendation for approval by the Trust Board:
Annex 6, para 6	71-72	75-77	The Constitution Working Group recommends that the wording included in the Constitution as a new section under annex 6 paragraph 6 is adopted.

9. Eligibility criteria for directors and governors

Purpose: To update the eligibility criteria for directors and governors.

Proposal including rationale: The Group considered the current criteria around eligibility for individuals to become or continue as directors or governors. The Group recommended that the eligibility criteria for governors and directors should be broadly the same.

One of the directors eligibility requirements states:

- A person may not become or continue as a director of the Trust if they are a member of the Members' Council or a councillor or director of an NHS body.

Following consideration of the above requirements the Group understood that there is no statutory requirement to prevent a director from being a director on another health service body, only that the 2006 Act requires that directors should avoid conflicts of interest and the Code of Governance recommends that non-executive directors should retain their independence (as defined in the Code of Governance) so that at least half the board, excluding the Chair, comprises independent non-executive directors. On this basis, it was proposed that the following:

- the Chair has the authority to determine whether an executive director or non-executive director may hold another director or governor position of another Health Service Body. The Chairman will consult with the Chief Executive for the executives, the Board for the Chief Executive and the governors for the NEDs.
- When the matter relates to the Chair, the Senior Independent Director has the authority to determine whether the Chair may hold another director or governor position of another Health Service Body. The SID will consult with the Board and the governors.

In respect of the equivalent eligibility criterion for the council of governors it was proposed that the Chair would determine whether a governor may hold another director or governor position at another Health Service Body.

Any such interests would be reported to the Council and the Board.

The Group recommended deleting the requirement that:

- A person may not become or continue as a director if they are a person whose tenure of office as a chairman or as a member or director of an NHS body has been terminated on the grounds that his appointment is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest.

The Group recommended replacing it with a requirement that a person must satisfy the fit and proper persons' requirements under Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because these requirements cover, and are broader, than the above.

In respect of the equivalent eligibility requirement for governors, it was recommended that this be retained; the fit and proper persons requirements for governors are those contained in the Trust's Provider Licence and do not cover dismissal from paid employment.

It was recommended to add the following further ineligibility criteria for both the governors and directors. The following persons may not become or continue as governors/ directors:

- people who have been removed from any of the primary medical service, primary dental service or ophthalmic service list;
- people who fail to repay monies properly owed to the Trust; and
- people who lack capacity within the meaning of the Mental Capacity Act 2005, to carry out the duties and responsibilities of a director or governor.

Para	Page no. clean	Page no. redline	Recommendation for approval by the Trust Board:
Annex 6, para 4.1 Annex 7, para 2	67-69 75-77	71-73 81-83	The Constitution Working Group recommends that the wording in the Constitution under: • annex 6, paragraph 4; and • annex 7, paragraph 2 is adopted as outlined above.

10. Provisions for when the Constitution is silent on a particular matter that arises

Purpose: A well-drafted NHS foundation trust constitution should provide a process for dealing with all matters that arise normally in the course of such a trust's business. However, like all NHS foundation trusts the Trust is a large and complex organisation so it is possible that it will face circumstances not addressed by the Constitution. The Group has

decided, therefore, that the Constitution should provide a process by which any such matters should be addressed.

Proposal including rationale: By definition it is impossible to provide specifically for unknown circumstances. It is necessary, therefore, to set out arrangements which are robust but appropriately flexible and which recognise the specific responsibilities of the fora and individuals who are charged with the governance of the Trust, i.e. the Trust Board (the Board), the Council, the Chairman, the Chief Executive (in his capacity as Accounting Officer, as defined in the Accounting Officer Memorandum published by NHS Improvement), the Deputy Chairman and the Senior Independent Director. The roles of individuals who provide advice and support should also be recognised in such a procedure, i.e. the Company Secretary and the Lead Governor.

It is good corporate governance practice for an individual, or a group of individuals, to be assigned responsibility for addressing key matters in the governance of an organisation. The individual(s) are required to exercise their professional judgement, after taking advice if necessary, to address the matters concerned.

It is likely that material matters arising for the Trust (which are not addressed specifically in the Constitution) may impact its governance or its compliance with statutory or regulatory requirements. Given that the Chairman is the leader of the Board (which is responsible for the governance of the Trust) and the Council, it is appropriate for him to have lead responsibility for resolving matters, subject to any specific matters which fall within the responsibilities of the Chief Executive as Accounting Officer. However, the procedure provides for the Chair to consult with the governors where matters relate to them.

Relevant wording is included in the draft Constitution at paragraph 48 on page 19 of the clean version and pages 21-22 of the redline version.

Para	Page no. clean	Page no. redline	Recommendation for approval by the Trust Board:
48	19	21-22	The Constitution Working Group recommends that the Council approve inclusion of the proposed paragraph and the wording of that paragraph.

11. Evaluation of the Council of Governors

Purpose: The Group proposes that the revised Constitution sets out a process through which the Council may evaluate itself. The Foundation Trust Code of Governance (the Code), published by Monitor (now part of NHS Improvement), makes the following recommendations in section B.6:

"The council of governors should assess its own collective performance and its impact on the NHS foundation trust"

"Led by the chairperson, the council of governors should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities, including their impact and effectiveness on:

- *holding the non-executive directors individually and collectively to account for the performance of the board of directors*
- *communicating with their member constituencies and the public and transmitting their views to the board of directors*
- *contributing to the development of forward plans of NHS foundation trusts*

The council of governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice."

Proposal including rationale: It is clear from the Code that the recommendations in respect of evaluation relate to the Council as a whole, not to the performance of each Governor individually.

It is proposed that the performance of the Council should be evaluated regularly, normally at intervals not exceeding 18 months, and where possible should coincide with any similar evaluation of the board of directors. However, the Council may decide at any time to evaluate a specific aspect of its performance – for example, to learn from its handling of a matter or where specific concerns are raised. Such annual (or other) evaluations should be internal to the Trust.

At a minimum, the Council should be evaluated against their general statutory duties (set out at paragraph 16 of the constitution).

Relevant wording has been included under annex 6, paragraph 8 of the constitution (page 73 of the clean version and pages 78-79 of the redline version).

Para	Page no. clean	Page no. redline	Recommendation for approval by the Trust Board:
Annex 6, para 8	73	78-79	The Constitution Working Group recommends adoption of paragraph 8 in Annex 6 of the constitution.

12. Other minor revisions to the Constitution

Purpose: To update the Constitution and ensure that all naming conventions of individuals and committees are accurate and that the order of the document is consistent.

Proposal including rationale: The following amendments are proposed:

- Amendment of the name of the Council from 'Members' Council' to 'Council of Governors' and 'councillor' to 'governor' as agreed at the April 2018 meeting.
- Removal of reference to all Board subcommittees except those stated in the Code of Governance (the Audit Committee and the Nominations Committee) (Annex 9, paragraph 19, pages 93-94 of the clean version and pages 109-110 of the redline) – this means that when other subcommittees change or change name a constitutional amendment will not be required.
- Amendments to and movement of the section on membership dispute resolution procedure (Annex 10 updated (page 101 of the clean version and page 119 of the redline) and Annex 11 deleted (pages 124-125 of the redline)). The procedure has been revised – originally it provided for mediators to be appointed and the Group

was not assured of how this would resolve the issues quickly and effectively. Under the revised wording, the Company Secretary will make a determination on the point in issue. If the member is not satisfied with the Company Secretary, they may appeal in writing within 14 days of the Company Secretary's decision to the Chair whose decision shall be final.

- Updated section on the revised declaration of interest section for governors (Annex 8, paragraph 6, pages 84-87 clean version, pages 95-98 of the redline) – this is to reflect new NHS England guidance on conflicts of interest and to allow scope for a revision of the Trust's policy in light of this guidance.
- Updated section on the revised declaration of interest section for directors (Annex 9, paragraph 23, pages 95-98 clean version, pages 111-116 of the redline) - – as with the directors' declaration of interests this is to reflect new NHS England guidance on conflicts of interest and to allow scope for a revision of the Trust's policy in light of this guidance.
- A review of the constitution is required every three years (paragraph 44, page 17 of the clean version and page 19 of the redline version (see further below).

Recommendation for approval by the Trust Board:
The Constitution Working Group recommends approval of the above amendments to the Constitution.

Other matters of administration

13. Code of Conduct

Purpose: To review the Code of Conduct (**see Appendix 4**) and ensure it reflects current good governance and best practice and is clear about responsibilities for elected/ appointed governors. All governors will be required to sign the Code of Conduct. The revised code will be used to update the Code of Conduct for Directors.

The revised Code of Conduct draws on examples from several other NHS foundation trusts, including experience of dealing with a range of issues that have arisen.

Proposal including rationale: To approve the revised Code of Conduct - this includes:

- Clarity about the expected role and conduct of governors
- Clarity about when the Code is applicable to governors
- Further detail about the Trust Always Values.

Recommendation for approval by the Trust Board:
The Constitution Working Group recommends approval of the draft Code of Conduct for Governors.

14. Standard Operating Procedure for Meetings by Electronic Communication

Purpose: To produce a Standard Operating Procedure includes provisions around convening a meeting and conduct during a meeting so that there is clarity for all involved about the expected standards for enabling such communications and etiquette around managing a meeting with participants engaged via these means.

Proposal including rationale: The attached procedure (**Appendix 5**) makes clear that electronic communications will be made available at all meetings. Where he considers it appropriate, the Chair may convene a meeting at which all of the persons attending participate by electronic communication (but the chair may not direct that all persons shall participate by electronic communication).

Recommendation for approval by the Trust Board:
The Constitution Working Group recommends approval of the attached Standard Operating Procedure for Meetings by Electronic Communication.

15. Regular review of the Constitution

Purpose: To ensure that a process is put in place to regularly review the Constitution and ensure it is reflective of the needs of the Board and Council and in line with any statutory changes or new guidance issued by the Regulator (NHS Improvement) or other relevant bodies.

Recommendation for approval by the Trust Board:
The Constitution Working Group recommends that the Council have an annual standing agenda item to discuss any matters that may require amendment in the Constitution and clarify any changes in guidance etc. (This discussion may be prompted by a change in guidance or an issue arising during a year). On a three-yearly basis the Council reconvene the Constitution Working Group to undertake a wholesale review of the Constitution.

16. Revised Lead Governor and Deputy Lead Governor Role Descriptions

Purpose: To review and update the Lead Governor and Deputy Lead Governor Role Description.

Proposal including rationale: The Council proposed that the Group consider the revised role description and propose an updated, shorter version at the July 2018 Council meeting. An updated version is attached at **Appendix 6**.

Recommendation for approval by the Trust Board:
The Constitution Working Group recommends approval of the revised Lead Governor and Deputy Lead Governor Role Description.

Great Ormond Street Hospital for Children NHS Foundation Trust (A Public Benefit Corporation) Constitution

July 2018

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1. **Interpretation and definitions**

Unless otherwise stated, words or expressions contained in this constitution shall bear the same meaning as in the National Health Service Act 2006, as amended by the Health and Social Care Act 2012.

Words importing the masculine gender only shall include the feminine gender and vice versa; words importing the singular shall import the plural and vice-versa.

References to any statute or statutory provision shall be deemed to include any instrument, order, regulation or direction issues under it and shall be construed to include a reference to the same as it may have been, or may from time to time be, amended, modified, consolidated, re-enacted or replaced.

Any reference to a public body shall include any statutory successor which has taken over either or both the functions or responsibilities of that body.

the 2006 Act	is the National Health Service Act 2006;
the 2012 Act.	is the Health and Social Care Act 2012;
Accounting Officer	is the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act;
Annual Members' Meeting	has the meaning given to it in paragraph 11 of the constitution;
appointed governors	means those governors appointed by the appointing organisations;
appointing organisations	means those organisations named in Annex 4 of this constitution who are entitled to appoint governors;
Audit Committee	means a committee of the Trust Board as established pursuant to paragraph 39 of the constitution;
authorisation	is the authorisation issued by Monitor under Section 35 of the 2006 Act
Chair	means the person appointed by the Council of Governors as the Chair of the Trust;
Chief Executive	means the chief executive officer of the Trust appointed in accordance with the constitution;
Company Secretary	means the Secretary of the Trust or any other person, appointed to perform the duties of the Trust's corporate secretary

	from time to time;
constitution	means this constitution and all annexes to it;
Council of Governors	means the Council of Governors as constituted pursuant to this constitution;
Deputy Chair	means the non-executive director appointed by the Council of Governors to exercise the Chair's functions if the Chair is absent for any reason;
Deputy Lead Governor	means the governor elected by the Council of Governors as Deputy Lead Governor in accordance with paragraph 3 of Annex 6;
director	means a member of the Trust Board;
director of finance	means the chief financial officer of the Trust;
elected governors	means those governors elected by classes of the public and patient and carer constituency and the staff constituency;
executive director	means a member of the Trust Board who is an officer of the Trust;
financial year	means: (a) the period beginning with the date on which the Trust is authorised and ending with the next 31 March; and (b) each successive period of twelve months beginning with 1 April;
governor	means a person elected or appointed to the Council of Governors in accordance with the terms of this constitution (such person being, for the avoidance of doubt, a governor for the purposes of the 2006 and 2012 Act);
Health Service Body	means an NHS Foundation Trust, an NHS Trust, a Special Health Authority, NHS England, NHS Improvement and the Care Quality Commission or any successor bodies;
Lead Governor	means the governor elected by the Council of Governors as Lead Governor

	in accordance with paragraph 3 of Annex 6;
member	means those persons who are registered, on application, as members of one of the constituencies detailed below in accordance with the provisions of this constitution;
Monitor or the regulator	is the body corporate known as Monitor, as provided by Section 61 of the 2012 Act;
non-executive director	means a member of the Trust Board appointed as a non-executive director in accordance with the constitution;
officer	means employee of the Trust or any other person holding a paid position with the Trust;
patient and carer governor	means a governor elected by the members of the classes of the patient and carer constituency;
PSAA	means Public Sector Audit Appointments Limited;
public governor	means a governor elected by the members of one of the areas of the public constituency;
Senior Independent Director	means the non-executive director appointed by the Trust Board in consultation with the Council of Governors;
staff governor	means a governor elected by the members of the staff constituency;
Trust	means Great Ormond Street Hospital for Children NHS Foundation Trust;
Trust Board	means the board of directors of the Trust as constituted in accordance with the constitution and referred to in paragraph 22 of this constitution;
voluntary organisation	means a body, other than a public or local authority, the activities of which are not carried on for profit.

2. **Name**

The name of the foundation trust is Great Ormond Street Hospital for Children NHS Foundation Trust.

3. **Principal purpose**

3.1 The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England.

3.2 The Trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

3.3 The Trust may provide goods and services for any purposes related to:

3.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness; and

3.3.2 the promotion and protection of public health.

3.4 The Trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order better to carry on its principal purpose.

4. **Powers**

4.1 The powers of the Trust are set out in the 2006 Act.

4.2 All the powers of the Trust shall be exercised by the Trust Board on behalf of the Trust.

4.3 Any of these powers may be delegated to a committee of directors or to an executive director.

5. **Membership and constituencies**

The Trust shall have members, each of whom shall be a member of one of the following constituencies:

5.1 a public constituency;

5.2 a staff constituency; and

5.3 a patient and carer constituency.

6. **Application for membership**

An individual who is eligible to become a member of the Trust may do so on application to the Trust.

7. **Public Constituency**

7.1 An individual who lives in an area specified in Annex 1 as an area for a public constituency may become or continue as a member of the Trust.

7.2 Those individuals who live in an area specified as an area for any public constituency are referred to collectively as the Public Constituency.

7.3 The minimum number of members in each area for the Public Constituency is specified in Annex 1.

8. **Staff Constituency**

8.1 An individual who is employed by the Trust under a contract of employment with the Trust may become or continue as a member of the Trust provided:

8.1.1 they are employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

8.1.2 they have been continuously employed by the Trust under a contract of employment for at least 12 months.

8.2 Those individuals who are eligible for membership of the Trust by reason of paragraphs 8.1.1 and 8.1.2 are referred to collectively as the Staff Constituency.

8.3 The minimum number of members in the Staff Constituency is specified in Annex 2.

8.4 An individual who is:

8.4.1 eligible to become a member of the Staff Constituency; and

8.4.2 invited by the Trust to become a member of the Staff Constituency,

shall become a member of the Trust as a member of the Staff Constituency without an application being made, unless they inform the Trust that they do not wish to do so.

9. **Patient and Carer Constituency**

9.1 An individual who has, within the period specified below, attended any of the Trust's hospitals as either a patient or as the carer of a patient may become a member of the Trust.

9.2 The period referred to in paragraph 9.1 shall be the period of 10 years immediately preceding the date of an application by the patient or carer to become a member of the Trust.

9.3 Those individuals who are eligible for membership of the Trust by reason of paragraph 9.1 are referred to collectively as the Patient and Carer Constituency.

9.4 The Patient and Carer Constituency shall be divided into 4 descriptions of individuals who are eligible for membership of the Patient and Carer Constituency, each description of individuals being specified within Annex 3 and being referred to as a class within the Patient and Carer Constituency.

9.5 An individual providing care in pursuance of a contract (including a contract of employment) with a voluntary organisation, or as a volunteer for a voluntary

organisation, does not come within the category of those who qualify for membership of the Patient and Carer Constituency.

9.6 The minimum number of members in each class of the Patient and Carer Constituency is specified in Annex 3.

9.7 Where an individual is eligible to become a member of the Public Constituency or the Patient and Carers' Constituency that individual shall in the first instance become a member of the Patients and Carers' Constituency unless they have informed the trust in writing that they wish instead to become a member of the Public Constituency.

10. **Restriction on membership**

10.1 An individual who is a member of a constituency, or of a class within a constituency, may not while membership of that constituency or class continues, be a member of any other constituency or class.

10.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency.

10.3 An individual must be at least 10 years old to become a member of the Trust.

10.4 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Trust are set out in Annex 10 – Further Provisions.

11. **Members' Meetings**

1.1 The Trust shall hold an Annual Members' Meeting.

1.2 The Annual Members' Meeting must be held within nine months of the end of each financial year.

11.1 The Annual Members' Meeting shall be open to members of the public.

11.2 Further provisions about members' meetings are set out in Annex 10 – Further Provisions – Members.

12. **Council of Governors – composition**

12.1 The Trust is to have a Council of Governors, which shall comprise both elected and appointed governors.

12.2 The composition of the Council of Governors is specified in Annex 4.

12.3 The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of governors to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in Annex 4.

13. **Council of Governors – election of governors**

13.1 Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Election Rules.

13.2 The Model Election Rules as published from time to time by NHS Providers form part of this constitution. The Model Election Rules current at [x], and as amended by the Trust, are attached at Annex 5. A variation of the Model Election Rules shall not constitute a variation of the terms of this constitution.

13.3 A subsequent variation of the Model Election Rules by the Department of Health shall not constitute a variation of the terms of this constitution for the purposes of paragraph 45 of the constitution (amendment of the constitution).

13.4 An election, if contested, shall be by secret ballot.

14. Council of Governors- tenure

14.1 An elected governor may hold office for a period of up to 3 years.

14.2 An elected governor shall cease to hold office if they cease to be a member of the constituency or class by which they were elected.

14.3 An elected governor shall be eligible for re-election at the end of their term.

14.4 An appointed governor may hold office for a period of up to 3 years.

14.5 An appointed governor shall cease to hold office if the appointing organisation withdraws its sponsorship of them.

14.6 An appointed governor shall be eligible for re-appointment at the end of their term.

14.7 The maximum aggregate term of office for any elected governor or appointed governor is six years.

15. Council of Governors– disqualification and removal

15.1 The following may not become or continue as a member of the Council of Governors:

15.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

15.1.2 a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986);

15.1.3 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it; or

15.1.4 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on them.

15.2 Governors must be at least 16 years of age at the date that their term of office commences.

15.3 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Council of Governors are set out in Annex 6.

16. **Council of Governors – duties of governors**

16.1 The general duties of the Council of Governors are –

16.1.1 to hold the non-executive directors individually and collectively to account for the performance of the Trust Board, and

16.1.2 to represent the interests of the members of the Trust as a whole and the interests of the public.

16.2 The Trust must take steps to secure that the governors are equipped with the skills and knowledge they require in their capacity as such.

17. **Council of Governors – meetings of governors**

17.1 The Chair of the Trust (i.e. the Chair of the Trust Board, appointed in accordance with the provisions of paragraph 25.1 below) or, in their absence the Deputy Chair (appointed in accordance with the provisions of paragraph 26 below), shall preside at meetings of the Council of Governors.

17.2 Meetings of the Council of Governors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

17.3 Further provisions as to the exclusion of members of the public are set out in Annex 8.

17.4 The provisions of this paragraph shall be without prejudice to the power of the Council of Governors, as exercised by the Chair or other governors, to exclude, suppress or prevent disorderly conduct or other misbehaviour at a meeting.

17.5 For the purposes of obtaining information about the Trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the Trust's or directors' performance), the Council of Governors may require one or more of the directors to attend a meeting.

18. **Council of Governors – Standing Orders**

The Standing Orders for the practice and procedure of the Council of Governors, as the same may be varied from time to time subject to applicable law and guidance are attached at Annex 8.

19. **Council of Governors - conflicts of interest of governors**

Each governor shall comply with the provisions as to the disclosure of interests by governors set out at Annex 8.

20. **Council of Governors – expenses**

The Trust may pay travelling and other reasonable expenses to members of the Council of Governors at rates determined by the Trust.

21. **Council of Governors – further provisions**

Further provisions with respect to the Council of Governors are set out in Annex 6.

22. **Trust Board – composition**

22.1 The Trust is to have a Trust Board, which shall comprise both executive and non-executive directors.

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.

22.3 One of the executive directors shall be the Chief Executive.

22.4 The Chief Executive shall be the Accounting Officer.

22.5 One of the executive directors shall be the finance director.

22.6 One of the executive directors is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).

22.7 One of the executive directors is to be a registered nurse or a registered midwife.

23. **Trust Board – general duty**

The general duty of the Trust Board and of each director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

24. **Trust Board – qualification for appointment as a non-executive director**

24.1 A person may be appointed as a non-executive director only if –

24.1.1 they are a member of the Public Constituency; or

24.1.2 they are a member of the Patient and Carer Constituency; or

24.1.3 where any of the Trust's hospitals includes a medical or dental school provided by a university, they exercise functions for the purposes of that university; and

24.1.4 they are not disqualified by virtue of paragraph 29 below or Annex 7.

25. **Trust Board – appointment and removal of Chair and other non-executive directors**

25.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chair of the Trust and the other non-executive directors.

25.2 Removal of the Chair or another non-executive director shall require the approval of three-quarters of the members of the Council of Governors.

25.3 Further provisions as to the process for the appointment and removal of the Chair or other non-executive directors are set out in Annex 7.

26. **Trust Board – appointment of Deputy Chair**

26.1 The Council of Governors at a general meeting of the Council of Governors shall appoint one of the non-executive directors as a Deputy Chair.

26.2 If the Chair is unable to discharge their office for any reason the Deputy Chair shall be acting Chair of the Trust.

26.3 Any director so appointed may at any time resign from the office of Deputy Chair by giving notice in writing to the Chair. The Council of Governors may thereupon appoint another non-executive director as Deputy Chair in accordance with the constitution.

27. **Senior Independent Director**

27.1 The Trust Board shall appoint one of the independent non-executive directors to be the "Senior Independent Director" (as defined in the NHS Foundation Trust Code of Governance) in consultation with the Council of Governors, for such a period not exceeding the remainder of their term as a non-executive director, as they may specify on appointing them.

27.2 The Senior Independent Director will be available to governors if they have concerns that the Chair is unable to resolve.

28. **Trust Board - appointment and removal of the Chief Executive and other executive directors**

28.1 The non-executive directors shall appoint or remove the Chief Executive.

28.2 The appointment of the Chief Executive shall require the approval of the Council of Governors.

28.3 A committee consisting of the Chair, the Chief Executive and the other non-executive directors shall appoint or remove the other executive directors.

29. **Trust Board – disqualification**

29.1 The following may not become or continue as a member of the Trust Board:

29.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

29.1.2 a person in relation to whom a moratorium period under a debt relief order applied (under Part 7A of the Insolvency Act 1986);

29.1.3 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it; or

29.1.4 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on them.

29.2 Further provisions as to the circumstances in which a person may not become or continue as a member of the Trust Board are set out in Annex 7.

30. **Trust Board – meetings**

30.1 Meetings of the Trust Board shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

30.2 Before holding a meeting, the Trust Board must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Trust Board must send a copy of the minutes of the meeting to the Council of Governors.

31. **Trust Board – Standing Orders**

The Standing Orders for the practice and procedure of the Trust Board are set out in Annex 9.

32. **Trust Board - conflicts of interest of directors**

32.1 The duties that a director of the Trust has by virtue of being a director include in particular –

32.1.1 a duty 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.

32.1.2 a duty not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity.

32.2 The duty referred to in sub-paragraph 32.1.1 is not infringed if –

32.2.1 the situation cannot reasonably be regarded as likely to give rise to a conflict of interest; or

32.2.2 the matter has been authorised in accordance with the constitution.

32.3 The duty referred to in sub-paragraph 32.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

32.4 In sub-paragraph 32.1.2, "third party" means a person other than –

32.4.1 the Trust; or

32.4.2 a person acting on its behalf.

32.5 If a director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the director must declare the nature and extent of that interest to the other directors.

32.6 If a declaration under this paragraph proves to be, or becomes, inaccurate, incomplete, a further declaration must be made.

32.7 Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement.

32.8 Paragraph 32.5 does not require a declaration of an interest of which the director is not aware or where the director is not aware of the transaction or arrangement in question.

32.9 A director need not declare an interest –

32.9.1 if it cannot reasonably be regarded as likely to give rise to a conflict of interest;

32.9.2 if, or to the extent that, the directors are already aware of it;

32.9.3 if, or to the extent that, it concerns terms of the director's appointment that have been or are to be considered –

32.9.3.1 by a meeting of the Trust Board, or

32.9.3.2 by a committee of the directors appointed for the purpose under the constitution.

32.10 A matter shall be authorised for the purposes of paragraph 32.2.2 if it has previously been approved by the Trust Board at a meeting and the minutes of the meeting shall be conclusive evidence of such approval having been given.

32.11 Further provisions as to the disclosure of interests by directors are set out in Annex 9.

33. Trust Board – remuneration and terms of office

33.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other non-executive directors.

33.2 The Trust shall establish a committee of non-executive directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other executive directors.

34. Registers

The Trust shall have:

34.1 a register of members showing, in respect of each member, the constituency to which they belong and, where there are classes within it, the class to which they belong;

34.2 a register of members of the Council of Governors;

34.3 a register of interests of governors;

34.4 a register of directors; and

34.5 a register of interests of the directors.

35. Admission to and removal from the registers

35.1 The Company Secretary shall add to the register of members the name of any individual who is accepted as a member of the Trust under the provisions of this constitution as soon as is reasonably practicable and in any event within fourteen (14) days of the Company Secretary being notified of the requirements for such amendment.

35.2 The Company Secretary shall remove from the register of members the name of any member who ceases to be entitled to be a member under the provisions of this constitution as soon as is reasonably practicable and in any

event within fourteen (14) days of the Company Secretary being notified of the requirement for such amendment.

36. **Registers – inspection and copies**

36.1 The Trust shall make the registers specified in paragraph 34 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.

36.2 The Trust shall not make any part of its registers available for inspection by members of the public which shows details of –

36.2.1 any member of the Patient and Carers' Constituency; or

36.2.2 any other member of the Trust, if they so requests.

36.3 So far as the registers are required to be made available:

36.3.1 they are to be available for inspection free of charge at all reasonable times; and

36.3.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

36.4 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

37. **Documents available for public inspection**

37.1 The Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

37.1.1 a copy of the current constitution;

37.1.2 a copy of the latest annual accounts and of any report of the auditor on them; and

37.1.3 a copy of the latest annual report;

37.2 The Trust shall also make the following documents relating to a special administration of the Trust available for inspection by members of the public free of charge at all reasonable times:

37.2.1 a copy of any order made under section 65D (appointment of trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L(trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act;

37.2.2 a copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act;

37.2.3 a copy of any information published under section 65D (appointment of trust special administrator) of the 2006 Act;

37.2.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act;

37.2.5 a copy of any statement provided under section 65F(administrator's draft report) of the 2006 Act;

37.2.6 a copy of any notice published under section 65F(administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA(Monitor's decision), 65KB (Secretary of State's response to Monitor's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act;

37.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act;

37.2.8 a copy of any final report published under section 65I (administrator's final report);

37.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act; and

37.2.10 a copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

37.3 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy.

37.4 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

38. Auditor

38.1 The Trust shall have an auditor.

38.2 The Council of Governors shall appoint or remove the auditor at a general meeting of the Council of Governors.

38.3 A person may only be appointed as the auditor if they (or, in the case of a firm, each of its members) are a member of one or more of the bodies referred to in paragraph 23 (4) of Schedule 7 to the 2006 Act.

38.4 An officer of PSAA may be appointed as auditor with the agreement of the PSAA. Where an officer of PSAA is appointed as auditor, PSAA may charge the Trust such fees for their services as will cover the full cost of providing them.

38.5 The auditor is to carry out his or their duties in accordance with Schedule 10 to the 2006 Act and in accordance with any directions given by the regulator as to standards, procedures and techniques to be adopted.

39. Audit committee

The Trust shall establish a committee of non-executive directors as an audit committee to perform such monitoring, reviewing and other functions as are appropriate.

40. **Accounts**

40.1 The Trust must keep proper accounts and proper records in relation to the accounts.

40.2 Monitor may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts.

40.3 The accounts are to be audited by the Trust's auditor.

40.4 The Trust shall prepare in respect of each financial year annual accounts in such form as Monitor may with approval of the Secretary of State direct.

40.5 The functions of the Trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

40.6 The following documents will be made available to the Comptroller and Auditor General for examination at their request:

40.6.1 the accounts;

40.6.2 any records relating to them; and

40.6.3 any report of the auditor on them.

40.7 In preparing its annual accounts, the Accounting Officer shall cause the Trust to comply with any directions given by the regulator with the approval of the Secretary of State as to:

40.7.1 the methods and principles according to which the accounts are to be prepared;

40.7.2 the content and form of the accounts,

and shall be responsible for the functions of the Trust as set out in paragraph 25 of Schedule 7 to the 2006 Act.

40.8 The Accounting Officer shall cause the Trust to:

40.8.1 lay a copy of the annual accounts, and any report of the auditor on them, before Parliament; and

40.8.2 once it has done so, send copies of those documents to the regulator within such a period as the regulator may direct.

41. **Annual report, forward plans and non-NHS work**

41.1 The Trust shall prepare an annual report and send it to Monitor.

41.2 The annual reports are to give:

41.2.1 information on any steps taken by the Trust to secure that (taken as a whole) the actual membership of the public constituency and of the classes of the staff constituency is representative of those eligible for such membership; and

41.2.2 any other information which the regulator requires.

41.3 The Trust is to comply with any decision which the regulator makes as to:

41.3.1 the form of the reports;

41.3.2 when the reports are to be sent to it; and

41.3.3 the periods to which the reports are to relate.

41.4 The Trust shall give information as to its forward planning in respect of each financial year to Monitor.

41.5 The document containing the information with respect to forward planning (referred to above) shall be prepared by the directors.

41.6 In preparing the document, the directors shall have regard to the views of the Council of Governors.

41.7 Each forward plan must include information about –

41.7.1 the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on; and

41.7.2 the income it expects to receive from doing so.

41.8 Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in sub-paragraph 41.7.1 the Council of Governors must –

41.8.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions; and

41.8.2 notify the directors of the Trust of its determination.

41.9 Where the Trust proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England it may implement the proposal only if more than half of the members of the Council of Governors of the Trust voting approve its implementation.

42. Presentation of the annual accounts and reports to the Council of Governors and members

42.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:

42.1.1 the annual accounts;

42.1.2 any report of the auditor on them; and

42.1.3 the annual report.

42.2 The documents shall also be presented to the members of the Trust at the Annual Members' Meeting by at least one member of the Trust Board in attendance.

42.3 The Trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 42.1 with the Annual Members' Meeting.

43. **Instruments**

43.1 The Trust shall have a seal.

43.2 The seal shall not be affixed except under the authority of the Trust Board.

44. **Review of the constitution**

44.1 The constitution shall be reviewed at least every three years by the Trust.

44.2 A review of the constitution shall include consideration of any matters arising under paragraph 48 below.

45. **Amendment of the constitution**

45.1 The Trust may make amendments of its constitution only if –

45.1.1 More than half of the members of the Council of Governors of the Trust voting approve the amendments, and

45.1.2 More than half of the members of the Trust Board of the Trust voting approve the amendments.

45.2 Amendments made under paragraph 45.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.

45.3 Where an amendment is made to the constitution in relation the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust):

45.3.1 At least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment; and

45.3.2 The Trust must give the members an opportunity to vote on whether they approve the amendment.

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

45.5 Amendments by the Trust of its constitution are to be notified to Monitor. For the avoidance of doubt, Monitor's functions do not include a power or duty to determine whether or not the constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

46. **Officers' indemnity and insurance**

46.1 Members of the Trust Board and Council of Governors who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution of their functions, save where they have acted recklessly. Any costs arising in this way will be met by the Trust.

46.2 The Trust may purchase and maintain for members of the Trust Board and Council of Governors insurance in respect of liability.

47. Mergers etc. and significant transactions

47.1 The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors.

47.2 The Trust may enter into a significant transaction only if more than half of the members of the Council of Governors of the Trust voting approve entering into the transaction.

47.3 In paragraph 47.2, the following words have the following meanings:

47.3.1 "Significant transaction" means a transaction which meets any one of the tests below:

47.3.1.1 the total asset test; or

47.3.1.2 the total income test; or

47.3.1.3 the capital test (relating to acquisitions or divestments).

47.3.2 The total asset test is met if the assets which are the subject of the transaction exceed 25% of the total assets of the Trust;

47.3.3 The total income test is met if, following the completion of the relevant transaction, the total income of the Trust will increase or decrease by more than 25%;

47.3.4 The capital test is met if the gross capital of the company or business being acquired or divested represents more than 25% of the capital of the trust following completion (where "gross capital" is the market value of the relevant company or business's shares and debt securities, plus the excess of current liabilities over current assets, and the Trust's total taxpayers' equity).

47.3.5 For the purposes of calculating the tests in this paragraph 47.3 figures used for the Trust assets, total income and taxpayers' equity must be the figures shown in the latest published audited consolidated accounts.

47.4 A transaction:

47.4.1 excludes a transaction in the ordinary course of business (including the renewal, extension or entering into an agreement in respect of healthcare services carried out by the Trust;

47.4.2 excludes any agreement or changes to healthcare services carried out by the Trust following a reconfiguration of services led by the commissioners of such services;

47.4.3 excludes any grant of public dividend capital or the entering into of a working capital facility or other loan, which does not involve the acquisition or disposal of any fixed asset of the Trust.

48. Procedure to address a matter on which the constitution is silent

48.1 This procedure applies to any matter arising in relation to the governance of the Trust but in respect of which this constitution is silent.

48.2 At the earliest opportunity the Chair shall be made aware of the matter(s) concerned.

48.3 The Chair shall normally inform the Chief Executive of the matter(s) and must inform them where the matters fall solely within the responsibilities of the Accounting Officer.

48.4 The Chair shall take initial advice as appropriate from the Chief Executive and the Company Secretary.

48.5 The Chair shall normally inform the Trust Board about the matters and the initial steps that they propose to take to address them.

48.6 Where the matters concern the Council of Governors, the Chair shall:

48.6.1 inform, and receive advice from, the Lead Governor; and

48.6.2 normally inform the Council of Governors about the matters and the initial steps that they propose to take to address them.

48.7 The Chair shall have authority to determine, after taking appropriate advice, the action that is necessary to address the matters raised and the timetable over which such action will be taken.

48.8 The Chair shall liaise as necessary with the Chief Executive, the Company Secretary and the Lead Governor as matters proceed, and shall keep the Trust Board and the Council of Governors informed as appropriate.

48.9 Where the matters raised fall solely within the responsibilities of the Accounting Officer they must take lead responsibility for the matters (and any action that they put into place for doing so supersedes this procedure).

48.10 Where the matters raised concern the Chair, the Deputy Chair shall have authority to implement this procedure (and shall fulfil the other responsibilities of the Deputy Chair as set out in the Constitution).

48.11 In taking any action under this paragraph 48 the Chair, or Deputy Chair, as the case may be, shall act proportionately.

ANNEX 1

The Public Constituency

(Paragraphs 7.1 and 7.3)

The public constituency shall be divided into the following classes:

Name	**Areas**	**Governors**	**Minimum Number of members**
North London and surrounding area	Comprising the following electoral areas in North London: Barking & Dagenham; Barnet; Brent; Camden; City of London; Hackney; Ealing; Enfield; Hammersmith & Fulham; Haringey; Harrow; Havering; Hillingdon; Hounslow; Islington; Kensington & Chelsea; Newham; Redbridge; Tower Hamlets; Waltham Forest; Westminster. Comprising the following electoral areas in Bedfordshire: Bedford; Central Bedfordshire; Luton; Hertfordshire: Broxbourne; Dacorum; East Hertfordshire; Hertfordshire; Hertsmere; North Hertfordshire; St Albans; Stevenage; Three Rivers; Watford; Welwyn Hatfield; Buckinghamshire: Aylesbury Vale; Buckinghamshire; Chiltern; Milton Keynes; South Bucks; Wycombe; Essex: Basildon; Braintree; Brentwood; Castle Point; Chelmsford; Colchester; Epping Forest; Essex; Harlow; Maldon; Rochford; Southend on Sea; Tendring; Thurrock; Uttlesford.	4	300
South London and surrounding area	Comprising the following electoral areas in South London: Bexley; Bromley; Croydon; Greenwich; Royal Borough of Kingston upon Thames; Lambeth; Lewisham; Merton; Richmond upon Thames; Southwark; Sutton; Wandsworth. Comprising the following electoral areas in: Surrey: Elmbridge; Epsom and Ewell; Guildford; Mole Valley; Reigate and Banstead; Runnymede; Spelthorne;	1	300

Name	Areas	Governors	Minimum Number of members
	Surrey Heath; Tandridge; Waverley; Woking; Kent: Ashford; Canterbury; Dartford; Dover; Gravesham; Maidstone; Medway; Sevenoaks; Shepway; Swale; Thanet; Tonbridge and Malling; Tunbridge Wells; Sussex: Brighton and Hove; East Sussex; Eastbourne; Hastings; Lewes; Rother; Wealden; Adur; Arun; Chichester; Crawley; Horsham; Mid Sussex; West Sussex; Worthing.		
Rest of England and Wales	All electoral areas in England and Wales not falling within one of the areas referred to above.	2	300
Total		**7**	**900**

ANNEX 2
The Staff Constituency

The staff constituency will comprise one class.

The minimum number of members in this constituency shall be 2000.

ANNEX 3

The Patient and Carer Constituency

The patient and carer constituency shall be divided into the following classes:

Name of class within the constituency	**Minimum number of members**
Patients from London	150
Patients from outside London	150
Parents and Carers from London	300
Parents and Carers from outside London	300
Total	**900**

A “Parent” is defined as any person with a child who has been a patient at the Trust (as defined above) and who has attended the Trust with the patient within the 10 years immediately preceding the date of application of the parent to become a member of the Trust.

A “Carer” must be the parent or person acting in loco parentis for an inpatient or outpatient **of any age** and have attended the Trust with the patient within the 10 years immediately preceding the date of application of the carer to become a member of the Trust.

ANNEX 4

Composition of Council of Governors

Constituency	**Number of seats on the Council of Governors**
Elected governors	
Patient and carer constituency	
Patients from London	2
Patients from outside London	2
Parents and carers from London	3
Parents and Carers from outside London	3
Public constituency	
North London and Surrounding Area	4
South London and Surrounding Area	1
The rest of England and Wales	2
Staff constituency	5
Appointed governors	
University College London, Institute of Child Health	1
London Borough of Camden	1
Young People's Forum	2
Total	**26**

ANNEX 5
The Model Election Rules (2014)

PART 1: INTERPRETATION

PART 2: TIMETABLE FOR ELECTION

PART 3: RETURNING OFFICER

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

PART 5: CONTESTED ELECTIONS

Action to be taken before the poll

The poll

PART 1: INTERPRETATION

1. Interpretation

1.1 In these rules, unless the context otherwise requires:

"*2006 Act*" means the National Health Service Act 2006;

"*corporation*" means the public benefit corporation subject to this constitution;

"*Council of Governors*" means the council of governors of the corporation;

"*declaration of identity*" has the meaning set out in rule 21.1;

"*election*" means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the Council of Governors;

"*e-voting*" means voting using either the internet, telephone or text message;

"*e-voting information*" has the meaning set out in rule 24.2;

"*ID declaration form*" has the meaning set out in Rule 21.1; "internet voting record" has the meaning set out in rule 26.4(d);

"*internet voting system*" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

"*lead governor*" means the governor nominated by the Council of Governors to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (Monitor, December 2013) or any later version of such code.

"*list of eligible voters*" means the list referred to in rule 22.1, containing the information in rule 22.2;

"*method of polling*" means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;

"*Monitor*" means the corporate body known as Monitor as provided by section 61 of the 2012 Act;

"*numerical voting code*" has the meaning set out in rule 64.2(b)

"*polling website*" has the meaning set out in rule 26.1;

"*postal voting information*" has the meaning set out in rule 24.1;

"*telephone short code"* means a short telephone number used for the purposes of submitting a vote by text message;

"*telephone voting facility*" has the meaning set out in rule 26.2;

"*telephone voting record*" has the meaning set out in rule 26.5 (d);

"*text message voting facility*" has the meaning set out in rule 26.3;

"*text voting record*" has the meaning set out in rule 26.6 (d);

"*the telephone voting system*" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;

"*the text message voting system*" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

"*voter ID number*" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,

"*voting information*" means postal voting information and/or e-voting information

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

PART 2: TIMETABLE FOR ELECTIONS

2. Timetable

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination forms to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3. Computation of time

3.1 In computing any period of time for the purposes of the timetable:

(a) a Saturday or Sunday;

(b) Christmas day, Good Friday, or a bank holiday, or

(c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, “bank holiday” means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

PART 3: RETURNING OFFICER

4. Returning Officer

4.1 Subject to rule 69, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

5.1 Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure

6.1 The corporation is to pay the returning officer:

(a) any expenses incurred by that officer in the exercise of his or her functions under these rules,

(b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation

7.1 The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

8. **Notice of election**

8.1 The returning officer is to publish a notice of the election stating:

(a) the constituency, or class within a constituency, for which the election is being held,

(b) the number of members of the Council of Governors to be elected from that constituency, or class within that constituency,

(c) the details of any nomination committee that has been established by the corporation,

(d) the address and times at which nomination forms may be obtained;

(e) the address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer,

(f) the date and time by which any notice of withdrawal must be received by the returning officer

(g) the contact details of the returning officer

(h) the date and time of the close of the poll in the event of a contest.

9. **Nomination of candidates**

9.1 Subject to rule 9.2, each candidate must nominate themselves on a single nomination form.

9.2 The returning officer:

(a) is to supply any member of the corporation with a nomination form, and

(b) is to prepare a nomination form for signature at the request of any member of the corporation,

but it is not necessary for a nomination to be on a form supplied by the returning officer and a nomination can, subject to rule 13, be in an electronic format.

10. **Candidate's particulars**

10.1 The nomination form must state the candidate's:

(a) full name,

(b) contact address in full (which should be a postal address although an e-mail address may also be provided for the purposes of electronic communication), and

(c) constituency, or class within a constituency, of which the candidate is a member.

11. **Declaration of interests**

11.1 The nomination form must state any financial interest that the candidate has in the corporation. If the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

12.1 The nomination form must include a declaration made by the candidate:

(a) that he or she is not prevented from being a member of the Council of Governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,

(b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. **Signature of candidate**

13.1 The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:

(a) they wish to stand as a candidate,

(b) their declaration of interests as required under rule 11, is true and correct, and

(c) their declaration of eligibility, as required under rule 12, is true and correct.

13.2 Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

14. **Decisions as to the validity of nomination**

14.1 Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand,

(b) decides that the nomination form is invalid,

(c) receives satisfactory proof that the candidate has died, or

(d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:

(a) that the form is not received on or before the final time and date for return of nomination forms, as specified in the notice of the election,

(b) that the form does not contain the candidate's particulars, as required by rule 10;

(c) that the form does not contain a declaration of the interests of the candidate, as required by rule 11,

(d) that the form does not include a declaration of eligibility as required by rule 12, or

(e) that the form is not signed and dated by the candidate, if required by rule 13.

14.3 The returning officer is to examine each nomination form as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an e-mail address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

15. **Publication of statement of candidates**

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:

(a) the name, contact address (which shall be the candidate's postal address), and constituency or class within a constituency of each candidate standing, and

(b) the declared interests of each candidate standing,

as given in their nomination form.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after publishing the statement.

16. **Inspection of statement of nominated candidates and nomination forms**

16.1 The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2 If a member of the corporation requests a copy or extract of the statement of candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge.

17. Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the Council of Governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the Council of Governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be Council of Governors, then:

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

PART 5: CONTESTED ELECTIONS

19. **Poll to be taken by ballot**

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.

19.4 The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.

19.5 Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:

(a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate internet voting record in respect of any voter who casts his or her vote using the internet voting system;

(b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate telephone voting record in respect of any voter who casts his or her vote using the telephone voting system;

(c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate text voting record in respect of any voter who casts his or her vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter (other than a voter who casts his or her ballot by an e-voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the Council of Governors to be elected from that constituency, or class within that constituency,

(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available,

(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and

(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public and patient constituencies)

21.1 The corporation shall require each voter who participates in an election for a public or patient constituency to make a declaration confirming:

(a) that the voter is the person:

(i) to whom the ballot paper was addressed, and/or

(ii) to whom the voter ID number contained within the e-voting information was allocated,

(b) that he or she has not marked or returned any other voting information in the election, and

(c) the particulars of his or her qualification to vote as a member of the constituency or class within the constituency for which the election is being held,

("declaration of identity")

and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

21.2 The voter must be required to return his or her declaration of identity with his or her ballot.

21.3 The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

Action to be taken before the poll

22. **List of eligible voters**

22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member:

(a) a postal address; and,

(b) the member's e-mail address, if this has been provided

to which his or her voting information may, subject to rule 22.3, be sent.

22.3 The corporation may decide that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

23. Notice of poll

23.1 The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the Council of Governors to be elected from that constituency, or class with that constituency,

(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,

(f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3,

(g) the address for return of the ballot papers,

(h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located;

(i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located,

(j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located,

(k) the date and time of the close of the poll,

(l) the address and final dates for applications for replacement voting information, and

(m) the contact details of the returning officer.

24. **Issue of voting information by returning officer**

24.1 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by post to each member of the corporation named in the list of eligible voters:

(a) a ballot paper and ballot paper envelope,

(b) the ID declaration form (if required),

(c) information about each candidate standing for election, pursuant to rule 61 of these rules, and

(d) a covering envelope;

("postal voting information").

24.2 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast his or her vote by an e-voting method of polling:

(a) instructions on how to vote and how to make a declaration of identity (if required),

(b) the voter's voter ID number,

(c) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate,

(d) contact details of the returning officer,

("e-voting information").

24.3 The corporation may determine that any member of the corporation shall:

(a) only be sent postal voting information; or

(b) only be sent e-voting information; or

(c) be sent both postal voting information and e-voting information;

for the purposes of the poll.

24.4 If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list, then the returning officer shall only send that information by e-mail.

24.5 The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

25. **Ballot paper envelope and covering envelope**

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:

(a) the address for return of the ballot paper printed on it, and

(b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer:

(a) the completed ID declaration form if required, and

(b) the ballot paper envelope, with the ballot paper sealed inside it.

26. **E-voting systems**

26.1 If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as “the telephone voting facility”).

26.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as “the text message voting facility”).

26.4 The returning officer shall ensure that the polling website and internet voting system provided will:

(a) require a voter to:

(i) enter his or her voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the Council of Governors to be elected from that constituency, or class within that constituency,

(iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(v) instructions on how to vote and how to make a declaration of identity,

(vi) the date and time of the close of the poll, and

(vii) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote,

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this; and

(f) prevent any voter from voting after the close of poll.

26.5 The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

(a) require a voter to

(i) enter his or her voter ID number in order to be able to cast his or her vote; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the Council of Governors to be elected from that constituency, or class within that constituency,

(iv) instructions on how to vote and how to make a declaration of identity,

(v) the date and time of the close of the poll, and

(vi) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

26.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

(a) require a voter to:

(i) provide his or her voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(c) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote

(d) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(e) prevent any voter from voting after the close of poll.

The poll

27. **Eligibility to vote**

27.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28. **Voting by persons who require assistance**

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

29. **Spoilt ballot papers and spoilt text message votes**

29.1 If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she:

(a) is satisfied as to the voter's identity; and

(b) has ensured that the completed ID declaration form, if required, has not been returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

(a) the name of the voter, and

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and

(c) the details of the unique identifier of the replacement ballot paper.

29.5 If a voter has dealt with his or her text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.

29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if he or she can obtain it.

29.7 The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless he or she is satisfied as to the voter's identity.

29.8 After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter in a list ("the list of spoilt text message votes"):

(a) the name of the voter, and

(b) the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it), and

(c) the details of the replacement voter ID number issued to the voter.

30. **Lost voting information**

30.1 Where a voter has not received his or her voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2 The returning officer may not issue replacement voting information in respect of lost voting information unless he or she:

(a) is satisfied as to the voter's identity,

(b) has no reason to doubt that the voter did not receive the original voting information,

(c) has ensured that no declaration of identity, if required, has been returned.

30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list ("the list of lost ballot documents"):

(a) the name of the voter

(b) the details of the unique identifier of the replacement ballot paper, if applicable, and

(c) the voter ID number of the voter.

31. **Issue of replacement voting information**

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

31.2 After issuing replacement voting information under this rule, the returning officer shall enter in a list ("the list of tendered voting information"):

(a) the name of the voter,

(b) the unique identifier of any replacement ballot paper issued under this rule;

(c) the voter ID number of the voter.

32. ID declaration form for replacement ballot papers (public and patient constituencies)

32.1 In respect of an election for a public or patient constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity as outlined in paragraph 21.

Polling by internet, telephone or text

33. Procedure for remote voting by internet

33.1 To cast his or her vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2 When prompted to do so, the voter will need to enter his or her voter ID number.

33.3 If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4 To cast his or her vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom he or she wishes to cast his or her vote.

33.5 The voter will not be able to access the internet voting system for an election once his or her vote at that election has been cast.

34. **Voting procedure for remote voting by telephone**

34.1 To cast his or her vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2 When prompted to do so, the voter will need to enter his or her voter ID number using the keypad.

34.3 If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.

34.4 When prompted to do so the voter may then cast his or her vote by keying in the numerical voting code of the candidate or candidates, for whom he or she wishes to vote.

34.5 The voter will not be able to access the telephone voting facility for an election once his or her vote at that election has been cast.

35. **Voting procedure for remote voting by text message**

35.1 To cast his or her vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2 The text message sent by the voter must contain his or her voter ID number and the numerical voting code for the candidate or candidates, for whom he or she wishes to vote.

35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

36. **Receipt of voting documents**

36.1 Where the returning officer receives:

(a) a covering envelope, or

(b) any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) the candidate for whom a voter has voted, or

(b) the unique identifier on a ballot paper.

36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

37. **Validity of votes**

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) put the ID declaration form if required in a separate packet, and

(b) put the ballot paper aside for counting after the close of the poll.

37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) mark the ballot paper “disqualified”,

(b) if there is an ID declaration form accompanying the ballot paper, mark it “disqualified” and attach it to the ballot paper,

(c) record the unique identifier on the ballot paper in a list of disqualified documents (the “list of disqualified documents”); and

(d) place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been

received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5 Where the returning officer is satisfied that rule 37.4 has been fulfilled, he or she is to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6 Where the returning officer is not satisfied that rule 37.4 has been fulfilled, he or she is to:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents; and

(c) place the document or documents in a separate packet.

38. **Declaration of identity but no ballot paper (public and patient constituency)**[1]

38.1 Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:

(a) mark the ID declaration form "disqualified",

(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper, and

(c) place the ID declaration form in a separate packet.

39. **De-duplication of votes**

39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election he or she shall:

(a) only accept as duly returned the first vote received that was cast using the relevant voter ID number; and

(b) mark as "disqualified" all other votes that were cast using the relevant voter ID number

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:

(a) mark the ballot paper "disqualified",

(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,

(c) record the unique identifier and the voter ID number on the ballot paper in the list of disqualified documents;

[1] It should not be possible, technically, to make a declaration of identity electronically without also submitting a vote.

(d) place the document or documents in a separate packet; and

(e) disregard the ballot paper when counting the votes in accordance with these rules.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) “disqualified”,

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;

(c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and

(d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

40. **Sealing of packets**

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:

(a) the disqualified documents, together with the list of disqualified documents inside it,

(b) the ID declaration forms, if required,

(c) the list of spoilt ballot papers and the list of spoilt text message votes,

(d) the list of lost ballot documents,

(e) the list of eligible voters, and

(f) the list of tendered voting information

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

PART 6: COUNTING THE VOTES

41. Interpretation of Part 6

41.1 In Part 6 of these rules:

"*ballot document*" means a ballot paper, internet voting record, telephone voting record or text voting record.

"*continuing candidate*" means any candidate not deemed to be elected, and not excluded,

"*count*" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

"*deemed to be elected*" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

"*mark*" means a figure, an identifiable written word, or a mark such as "X",

"*non-transferable vote*" means a ballot document:

(c) on which no second or subsequent preference is recorded for a continuing candidate,

or

(b) which is excluded by the returning officer under rule 49,

"*preference*" as used in the following contexts has the meaning assigned below:

(a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference,

(b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and

© in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on,

"*quota*" means the number calculated in accordance with rule 46,

"*surplus*" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus,

"*stage of the count*" means:

(a) the determination of the first preference vote of each candidate,

(b) the transfer of a surplus of a candidate deemed to be elected, or

(c) the exclusion of one or more candidates at any given time,

"*transferable vote*" means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

"*transferred vote*" means a vote derived from a ballot document on which a second or subsequent preference is recorded for the candidate to whom that ballot document has been transferred, and

"*transfer value*" means the value of a transferred vote calculated in accordance with rules 47.4 or 47.7.

42. **Arrangements for counting of the votes**

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the Trust Board and the Council of Governors of the corporation have approved:

(i) the use of such software for the purpose of counting votes in the relevant election, and

(ii) a policy governing the use of such software, and

(b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

43. **The count**

43.1 The returning officer is to:

(a) count and record the number of:

(i) ballot papers that have been returned; and

(ii) the number of internet voting records, telephone voting records and/or text voting records that have been created, and

(b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

44. **Rejected ballot papers and rejected text voting records**

44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

44.2 The returning officer is to endorse the word "rejected" on any ballot paper which under this rule is not to be counted.

44.3 Any text voting record:

(a) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(b) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(c) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the text voting record shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

44.4 The returning officer is to endorse the word "rejected" on any text voting record which under this rule is not to be counted.

44.5 The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule 44.1 and the number of text voting records rejected by him or her under each of the sub-paragraphs (a) to (c) of rule 44.3.

45. **First stage**

45.1 The returning officer is to sort the ballot documents into parcels according to the candidates for whom the first preference votes are given.

45.2 The returning officer is to then count the number of first preference votes given on ballot documents for each candidate, and is to record those numbers.

45.3 The returning officer is to also ascertain and record the number of valid ballot documents.

46. **The quota**

46.1 The returning officer is to divide the number of valid ballot documents by a number exceeding by one the number of members to be elected.

46.2 The result, increased by one, of the division under rule 46.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as "the quota").

46.3 At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules 47.1 to 47.3 has been complied with.

47. **Transfer of votes**

47.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot documents on which first preference votes are given for that candidate into sub- parcels so that they are grouped:

(a) according to next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

47.2 The returning officer is to count the number of ballot documents in each parcel referred to in rule 47.1.

47.3 The returning officer is, in accordance with this rule and rule 48, to transfer each sub-parcel of ballot documents referred to in rule 47.1(a) to the candidate for whom the next available preference is given on those ballot documents.

47.4 The vote on each ballot document transferred under rule 47.3 shall be at a value ("the transfer value") which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and

(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot documents on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

47.5 Where at the end of any stage of the count involving the transfer of ballot documents, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot documents in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

47.6 The returning officer is, in accordance with this rule and rule 48, to transfer each sub-parcel of ballot documents referred to in rule 47.5(a) to the candidate for whom the next available preference is given on those ballot documents.

47.7 The vote on each ballot document transferred under rule 47.6 shall be at:

(a) a transfer value calculated as set out in rule 47.4(b), or

(b) at the value at which that vote was received by the candidate from whom it is now being transferred,

whichever is the less.

47.8 Each transfer of a surplus constitutes a stage in the count.

47.9 Subject to rule 47.10, the returning officer shall proceed to transfer transferable ballot documents until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

47.10 Transferable ballot documents shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or

(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

47.11 This rule does not apply at an election where there is only one vacancy.

48. **Supplementary provisions on transfer**

48.1 If, at any stage of the count, two or more candidates have surpluses, the transferable ballot documents of the candidate with the highest surplus shall be transferred first, and if:

(a) The surpluses determined in respect of two or more candidates are equal, the transferable ballot documents of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and

(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballot documents of the candidate on whom the lot falls shall be transferred first.

48.2 The returning officer shall, on each transfer of transferable ballot documents under rule 47:

(a) record the total value of the votes transferred to each candidate,

(b) add that value to the previous total of votes recorded for each candidate and record the new total,

(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and

(d) compare:

(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

48.3 All ballot documents transferred under rule 47 or 49 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot document or, as the case may be, all the ballot documents in that sub-parcel.

48.4 Where a ballot document is so marked that it is unclear to the returning officer at any stage of the count under rule 47 or 49 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot document as a non-transferable vote; and votes on a ballot document shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

49. **Exclusion of candidates**

49.1 If:

(a) all transferable ballot documents which under the provisions of rule 47 (including that rule as applied by rule 49.11) and this rule are required to be transferred, have been transferred, and

(b) subject to rule 50, one or more vacancies remain to be filled,

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule 49.12 applies, the candidates with the then lowest votes).

49.2 The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule 49.1 into two sub-parcels so that they are grouped as:

(a) ballot documents on which a next available preference is given, and

(b) ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who are deemed to be elected or are excluded).

49.3 The returning officer shall, in accordance with this rule and rule 48, transfer each sub-parcel of ballot documents referred to in rule 49.2 to the candidate for whom the next available preference is given on those ballot documents.

49.4 The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

49.5 If, subject to rule 50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which had been transferred to any candidate excluded under rule 49.1 into sub-parcels according to their transfer value.

49.6 The returning officer shall transfer those ballot documents in the sub-parcel of transferable ballot documents with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballot documents (thereby passing over candidates who are deemed to be elected or are excluded).

49.7 The vote on each transferable ballot document transferred under rule 49.6 shall be at the value at which that vote was received by the candidate excluded under rule 49.1.

49.8 Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.

49.9 After the returning officer has completed the transfer of the ballot documents in the sub-parcel of ballot documents with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot documents with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under rule 49.1.

49.10 The returning officer shall after each stage of the count completed under this rule:

(a) record:

(i) the total value of votes, or

(ii) the total transfer value of votes transferred to each candidate,

(b) add that total to the previous total of votes recorded for each candidate and record the new total,

(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and

(d) compare:

(i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

49.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules 47.5 to 47.10 and rule 48.

49.12 Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

49.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and

(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

50. **Filling of last vacancies**

50.1 Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

50.2 Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

50.3 Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

51. **Order of election of candidates**

51.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule 47.10.

51.2 A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

51.3 Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

51.4 Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

52. Declaration of result for contested elections

52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,

(b) give notice of the name of each candidate who he or she has declared elected:

(i) where the election is held under a proposed constitution pursuant to powers conferred on Great Ormond Street Hospital for Children NHS Foundation Trust by section 33(4) of the 2006 Act, to the Chair of the NHS Foundation Trust, or

(ii) in any other case, to the Chair of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

52.2 The returning officer is to make:

(a) the number of first preference votes for each candidate whether elected or not,

(b) any transfer of votes,

(c) the total number of votes for each candidate at each stage of the count at which such transfer took place,

(d) the order in which the successful candidates were elected, and

(e) the number of rejected ballot papers under each of the headings in rule 44.1,

(f) the number of rejected text voting records under each of the headings in rule 44.3,

available on request.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,

(b) give notice of the name of each candidate who he or she has declared elected to the Chair of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

PART 8: DISPOSAL OF DOCUMENTS

54. **Sealing up of documents relating to the poll**

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records,

(b) the ballot papers and text voting records endorsed with “rejected in part”,

(c) the rejected ballot papers and text voting records, and

(d) the statement of rejected ballot papers and the statement of rejected text voting records,

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

54.2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it,

(b) the list of spoilt ballot papers and the list of spoilt text message votes,

(c) the list of lost ballot documents, and

(d) the list of eligible voters,

or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

54.3 The returning officer must endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

55. **Delivery of documents**

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56. **Forwarding of documents received after close of the poll**

56.1 Where:

(a) any voting documents are received by the returning officer after the close of the poll, or

(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or

(c) any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the Chair of the corporation.

57. **Retention and public inspection of documents**

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the Trust Board of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. **Application for inspection of certain documents relating to an election**

58.1 The corporation may not allow:

(a) the inspection of, or the opening of any sealed packet containing:

(i) any rejected ballot papers, including ballot papers rejected in part,

(ii) any rejected text voting records, including text voting records rejected in part,

(iii) any disqualified documents, or the list of disqualified documents,

(iv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or

(v) the list of eligible voters, or

(b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage,

by any person without the consent of the Trust Board of the corporation.

58.2 A person may apply to the Trust Board of the corporation to inspect any of the documents listed in rule 58.1, and the Trust Board of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The Trust Board of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to:

(a) persons,

(b) time,

(c) place and mode of inspection,

(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the Trust Board of the corporation must:

(a) in giving its consent, and

(b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

(i) that his or her vote was given, and

(ii) that Monitor has declared that the vote was invalid.

PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

59. Countermand or abandonment of poll on death of candidate

59.1 If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) publish a notice stating that the candidate has died, and

(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that:

(i) ballot documents which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and

(ii) ballot documents which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

59.2 The ballot documents which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot documents pursuant to rule 54.1(a).

PART 10: ELECTION EXPENSES AND PUBLICITY

Election expenses

60. Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to Monitor under Part 11 of these rules.

61. Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses,

(b) travelling expenses, and expenses incurred while living away from home, and

(c) expenses for stationery, postage, telephone, internet(or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or

(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:

(a) compile and distribute such information about the candidates, and

(b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

(a) objective, balanced and fair,

(b) equivalent in size and content for all candidates,

(c) compiled and distributed in consultation with all of the candidates standing for election, and

(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. **Information about candidates for inclusion with voting information**

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words, and

(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code").

65. **Meaning of "for the purposes of an election"**

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

PART 11: QUESTIONING ELECTIONS AND THE CONSEQUENCE OF IRREGULARITIES

66. **Application to question an election**

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to Monitor for the purpose of seeking a referral to the independent election arbitration panel (IEAP).

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to Monitor by:

(a) a person who voted at the election or who claimed to have had the right to vote, or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and

(b) be in such a form as the independent panel may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election. Monitor will refer the application to the independent election arbitration panel appointed by Monitor.

66.6 If the independent election arbitration panel requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 Monitor shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the IEAP shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 The IEAP may prescribe rules of procedure for the determination of an application including costs.

PART 12: MISCELLANEOUS

67. **Secrecy**

67.1 The following persons:

(a) the returning officer,

(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted,

(ii) the unique identifier on any ballot paper,

(iii) the voter ID number allocated to any voter,

(iv) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68. **Prohibition of disclosure of vote**

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

69. **Disqualification**

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation,

(b) an employee of the corporation,

(c) a director of the corporation, or

(d) employed by or on behalf of a person who has been nominated for election.

70. **Delay in postal service through industrial action or unforeseen event**

70.1 If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24, or

(b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as he or she considers appropriate.

ANNEX 6
Additional Provisions – Council of Governors

(Paragraphs 15.3 and 21)

1. **Elected governors**

1.1 A member of the public constituency may not vote at an election for a public governor unless at the time of voting they have made and returned a declaration in the form specified in Annex 5, paragraph 21, that they are qualified to vote as a member of the relevant area of the public constituency.

1.2 A member of the patient and carer constituency may not vote at an election for a patient and carer governor unless at the time of voting they have made and returned a declaration in the form specified in Annex 5, paragraph 21, that they are qualified to vote as a member of the relevant area of the patient and carer constituency.

2. Appointed governors

2.1 The Company Secretary, having consulted the Chair and the London Borough of Camden, is to adopt a process for agreeing with that local authority the appointment of the governor appointed by it.

2.2 The Company Secretary, having consulted the Chair and the University of London, Institute of Child Health, is to adopt a process for agreeing with that university the appointment of the governor appointed by it.

2.3 The Young Peoples' Forum governors are to be appointed by the Young Peoples' Forum, in accordance with a process agreed with the Chair and the Company Secretary.

3. Lead Governor and Deputy Lead Governor

3.1 The Council of Governors shall elect one of the elected governors as the Lead Governor in accordance with the conditions of appointment set out in the Lead Governor role description approved by the Council of Governors.

3.2 The Lead Governor shall have the responsibilities, and perform the tasks, set out in the Lead Governor role description.

3.3 The Council of Governors shall elect one of the elected governors as the Deputy Lead Governor in accordance with the conditions of appointment set out in the Deputy Lead Governor role description approved by the Council of Governors.

3.4 The Deputy Lead Governor shall have the responsibilities, and perform the tasks, set out in the Deputy Lead Governor role description.

4. Further provisions as to eligibility to be a governor

4.1 In addition to paragraph 15 of the constitution, a person may not become or continue as a governor if:

4.1.1 they are not a member of the Trust;

4.1.2 in the case of a public governor, or patient and carer governor, or staff governor they cease to be a member of the constituency or class of constituency from which they were elected;

4.1.3 in the case of an appointed governor, if the organisation which appointed them terminates that appointment;

4.1.4 they have been required to notify the police of their name and address as a result of being convicted or cautioned under the Sex Offenders Act or other relevant legislation or their name appears on the Protection of Children Act List;

4.1.5 they are the spouse, partner, parent, child of, or occupant of the same household as, a member of the Trust Board or the Council of Governors of the Trust;

4.1.6 they are a member of a local authority's Overview and Scrutiny Committee covering health matters;

4.1.7 they are an executive or non-executive director of the Trust;

4.1.8 they are a governor, non-executive director (including the chair) or, executive director (including the chief executive officer) of another Health Service Body, unless they are appointed by an appointing organisation which is a Health Service Body or the Chair agrees to them becoming, or continuing as, a governor of the Trust;

4.1.9 they have within the preceding two years been dismissed, otherwise than by reason of redundancy or ill health, from any paid employment with a Health Service Body;

4.1.10 they are a person whose tenure of office as a Chair or as a member or director of a Health Service Body has been terminated on the grounds that their appointment is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;

4.1.11 they have previously been removed as a governor pursuant to paragraph 5 of this Annex;

4.1.12 they have previously been removed by as a governor from another NHS foundation trust by resolution of the Council of Governors of that NHS foundation trust;

4.1.13 they have failed to sign and deliver to the Company Secretary a statement in the form required by the Company Secretary confirming acceptance of the code of conduct for governors;

4.1.14 they lack capacity within the meaning of the Mental Capacity Act 2005 to carry out all the duties and responsibilities of a governor;

4.1.15 they are the subject of a disqualification order made under the Company Directors Disqualification Act 1986;

4.1.16 they have had their name removed from a list maintained under regulations pursuant to sections 91, 106, 123, or 146 of the 2006 Act, or the equivalent lists maintained by Local Health Boards in Wales under the National Health Service (Wales) Act 2006, and

they have not subsequently had their name included in such a list; or

4.1.17 they have failed to repay (without good cause) any amount of monies properly owed to the Trust.

4.2 All non-staff candidates for election to the Council of Governors and prospective appointees to the Council of Governors will undergo Disclosure and Barring Service checks. The Chair will after taking appropriate advice determine instances in which criminal records will preclude election or appointment to the Council of Governors.

4.3 A person holding office as a governor shall immediately cease to do so if:

4.3.1 they resign by notice in writing to the Company Secretary;

4.3.2 they become disqualified from office under paragraph 15 of the constitution or under paragraph 4.1 of this Annex;

4.3.3 they fail to attend two meetings of the Council of Governors in a period of one year unless the Chair, Lead Governor and Company Secretary are satisfied that:

4.3.3.1 the absence was due to a reasonable cause; and

4.3.3.2 they will be able to start attending meetings of the Trust again within such a period as they consider reasonable.

4.3.4 they have refused to undertake any training which the Council of Governors requires all governors to undertake unless the Chair, Lead Governor and Company Secretary are satisfied that the refusal was due to a reasonable cause; or

4.3.5 they are removed from the Council of Governors by a resolution passed under paragraph 5 below.

4.4 For the purposes of 4.3.3.1 and 4.3.4:

4.4.1 an absence will ordinarily be considered to be due to a reasonable cause if it is due to:

4.4.1.1 a conflict with work or personal commitments in circumstances where the Trust has changed the date of the meeting of the Council of Governors [or the required training] at short notice;

4.4.1.2 ill health; or

4.4.1.3 a personal or family emergency.

4.4.2 For the avoidance of doubt, work commitments will not be considered a reasonable cause unless the Trust has changed the date of the meeting of the Council of Governors or the required training at short notice.

4.5 Where a governor becomes disqualified for appointment under this paragraph 4 or paragraph 15 of the constitution, they shall notify the Company Secretary or the Chair in writing of such disqualification.

4.6 If it comes to the notice of the Company Secretary or the Chair that at the time of their appointment or later the governor is so disqualified, they shall immediately declare that the person in question is disqualified and notify them in writing to that effect.

5. Removal of governor from office

5.1 A governor may be removed from the Council of Governors by a resolution approved at a meeting of the Council of Governors by not less than three-quarters of the governors present and voting on the grounds that:

5.1.1 they have committed a serious breach of the code of conduct; or

5.1.2 they have acted in a manner detrimental to the interests of the Trust; or

5.1.3 the Council of Governors consider that it is not in the best interests of the Trust for them to continue as a governor, for example because:

5.1.3.1 the individual's continuation as a governor would likely prejudice the ability of the Trust to fulfil its principle purpose or discharge its duties and functions;

5.1.3.2 the individual's continuation as a governor would likely prejudice the Trust's work with other persons or body within whom it is engaged or may be engaged in the provision of goods and services;

5.1.3.3 the individual's continuation as a governor would be likely to adversely affect public confidence in the goods and services provided by the Trust;

5.1.3.4 the individual's continuation as a governor would otherwise bring the Trust into disrepute;

5.1.3.5 it would not be in the best interests of the Council of Governors for the individual to continue as a governor / the individual has caused or is likely to cause prejudice to the proper conduct of the Council of Governors affairs; or

5.1.3.6 the individual has failed to comply with the values and principles of the National Health Service, the Trust or the Constitution.

5.2 A resolution under paragraph 5.1 of this Annex may only be proposed where a statement of case under paragraph 6.8 has been upheld.

5.3 Where a resolution under paragraph 5.1 of this Annex is proposed and the governor concerned does not believe that the proposal is justified, the Chair shall offer the governor in question the opportunity to have the reasonableness of their proposed removal reviewed by an independent assessor. The Chair and the governor shall seek to agree on a mutually

acceptable independent assessor. If no agreement can be reached within 14 days of the governor requesting an independent review, then the Chair, following consultation with the Company Secretary and Senior Independent Director, shall decide on the assessor.

5.4 If any resolution proposing to remove a governor under paragraph 5.1 of this Annex is not passed at a meeting of the Council of Governors, no further resolution can be put forward to remove that governor based upon the same reasons within 12 months of the meeting at which the resolution was first put forward.

6. Process for investigating and resolving complaints against a governor

6.1 A complaint concerning the conduct of a governor shall be made in confidence, in writing to the Chair.

6.2 Where a complaint is made under paragraph 6.1 above:

6.2.1 The Chair, shall, if in their opinion it is appropriate do so, take fair and reasonable steps to resolve the matter informally within 10 working days from receipt of the written complaint.

6.2.2 The Chair, may choose to delegate their responsibility under paragraph 6.2.1 above to another person.

6.3 Only if the complaint cannot be resolved by informal resolution under paragraph 6.2 above, or the Chair decides that informal resolution is not appropriate, the Chair may take such action as they consider is appropriate and proportionate in the circumstances, including, but not limited to:

6.3.1 the suspension of the governor against whom the complaint has been made from the Council of Governors so that the matter can be investigated. Any suspension of a governor shall be confirmed to them in writing;

6.3.2 commissioning an investigation into the complaint, to be conducted by individuals with relevant experience from either within or outside of the Trust; and/or

6.3.3 requiring the parties concerned to seek to resolve their dispute through formal mediation.

6.4 Any decision taken by the Chair under paragraph 6.3 above, including setting the terms of reference in respect of any investigation, must be taken following consultation with the Lead Governor and Company Secretary. If in the circumstances it is not reasonably practicable for the Chair to consult with the Lead Governor and/or Company Secretary the Chair must consult with their deputies or, if it is not reasonably practicable to consult with their deputies, such other appropriate persons as the Chair determines.

6.5 As soon as reasonably practicable following any decision taken by the Chair under paragraph 6.3 above, the Chair shall:

6.5.1 inform the Council of Governors that such a decision has been taken, and, to the extent appropriate the reasons for it; and

6.5.2 provide the Council of Governors with a copy of the terms of reference of any investigation, unless there is a good reason not to do so.

6.6 Where an investigation identifies, or, if no investigation is commissioned, the Chair following consultation with the persons specified in paragraph 6.4 above believes, a governor has failed to comply with this Constitution and/or any code of conduct applying to Governors, and/or the Standing Orders, the Council of Governors shall be asked to decide by a simple majority of those present and voting whether there is a case to be answered.

6.7 The governor concerned shall be notified in writing that there is a case to be answered and provided with a statement setting out that case (the "**statement of case**"). The governor concerned will be invited to respond within an appropriate and reasonable timescale as determined by the Council of Governors in the statement of case. The governor shall be invited to address the Council of Governors in person if the matter cannot be resolved satisfactorily through correspondence.

6.8 Having considered the governor's response, the Council of Governors shall decide by a majority of those present and voting whether to uphold the statement of case.

6.9 If the statement of case is upheld:

6.9.1 subject to paragraph 6.9.2 below, the Council of Governors may pass a resolution by a majority of those present and voting imposing such sanctions as it deems appropriate. This may include a written warning, non-payment of expense suspension from office; and/or

6.9.2 the Chair or a governor may propose a resolution to remove the governor in question from office in accordance with paragraph 5 above.

7. Vacancies amongst governors

7.1 Where a vacancy arises on the Council of Governors for any reason other than expiry of term of office, the following provisions will apply.

7.2 Where the vacancy arises amongst the appointed governors, the Company Secretary shall request that the appointing organisation appoints a replacement to hold office for the remainder of the term of office or to commence a new term of office.

7.3 Where the vacancy arises amongst the elected governors, the Council of Governors shall be at liberty either:

7.3.1 to call an election within three months to fill the seat for the remainder of that term of office;

7.3.2 to call an election to fill the seat for a new term of office;

7.3.3 to invite the next highest polling candidate for that seat at the most recent election, who is willing to take office, to fill the seat until the next annual election, at which time the seat will fall vacant and subject to election for any unexpired period of the term of office;

7.3.4 to invite the next highest polling candidate for that seat at the most recent election, who is willing to take office, to fill the seat until the next annual election, at which time the seat will fall vacant and subject to election for a new term of office; or

7.3.5 if the unexpired period of the term of office is less than twelve months, to leave the seat vacant until the next elections are held.

7.4 All decisions taken in good faith at a meeting of the Council of Governors or of any committee shall be valid even if it is discovered subsequently that there was a defect in the calling of the meeting, or in the appointment or election of the governors attending the meeting.

8. Procedure for evaluation of the Council of Governors

8.1 The performance of the Council of Governors shall be evaluated regularly, normally at intervals not exceeding 18 months, and where possible shall coincide with any similar evaluation of the Trust Board. However, the Council of Governors may decide at any time to evaluate a specific aspect of its performance. Such annual (or other) evaluations shall be internal to the Trust.

8.2 The Council of Governors shall participate to the extent appropriate in any external reviews of governance or leadership within the Trust.

8.3 The Chair shall be responsible for leading all reviews of the Council of Governors, supported and advised by the Company Secretary and the Lead Governor.

8.4 For each review the Chair, advised by the Company Secretary and the Lead Governor, shall develop and propose for approval by the Council of Governors the scope and methodology of the review. The review shall at a minimum:

8.4.1 evaluate the performance of the Council of Governors against their general duties as set out in paragraph 16.1 of the constitution; and

8.4.2 take into account any material issues raised about the performance of the Council of Governors since the previous review was completed.

8.5 Along with proposals for the scope of the evaluation the Chair shall prepare the process by which the views of Governors and others may be sought and considered. The Chair may also propose that the Council of Governors should establish a working group comprising Governors and others support him by discussing the issues raised and to develop proposals in response.

8.6 At the conclusion of the review the Chair shall present to the Council of Governors the findings, outcomes, and proposals for action. Subject to the Council of Governors approval of the actions, the Chair shall be responsible for ensuring that they are implemented in a timely manner and should report this to the Council of Governors.

ANNEX 7
Additional Provisions – Trust Board

(Paragraphs 24.1.4, 25.3, 29.2)

1. Appointment and removal of Chair and other non-executive directors

1.1 The process for appointing new non-executive directors and the Chair will be as follows:

1.1.1 the Council of Governors will maintain a policy for the composition of the non-executive directors which takes account of the views of the Trust Board and the Trust's membership strategy, and which it shall review from time to time and in any event not less than once every three years;

1.1.2 the Council of Governors will appoint a nominations and remuneration committee;

1.1.3 the committee may work with an external organisation recognised as expert in relation to appointments to identify the skills and experience required for non-executive directors;

1.1.4 where the nominations and remuneration committee considers that either the Chair or the non-executive director coming to the end of their term of office should be reappointed for a further term, the committee shall, following consultation with the Chair or in the case of the Chair's re-appointment the Deputy Chair, make a recommendation to the Council of Governors to that effect;

1.1.5 subject to paragraph 1.1.4, appropriate candidates (not more than five for each vacancy) will be identified by the committee through a process of open competition, which will take account of the policy maintained from time to time by the Council of Governors and the skills and experience required (in which respect the Council of Governors will consult the Trust Board);

1.1.6 the nominations and remuneration committee will comprise the Chair, the Deputy Chair, the Lead Governor, two governors from the public constituency and/or the patient and carer constituency, one staff governor and one other governor from any constituency. Each member of the committee shall have one vote;

1.1.7 the committee will normally be chaired by the Chair of the Trust. Where the Chair has a conflict of interest, for example when the committee is considering the Chair's re-appointment or salary, the committee will be chaired by the Deputy Chair unless they are also standing for appointment, in which case another independent non-executive director;

1.1.8 the nominations and remuneration committee will convene an interview panel, conduct interviews and recommend a candidate to the Council of Governors for approval; and

1.1.9 the Chair and other non-executive directors may not serve on the Trust Board for a period of more than 6 years from the date of their first appointment.

1.2 The removal of the Chair or another non-executive director shall be in accordance with the following procedures:

1.2.1 any proposal for removal must be proposed by the Chair, or if the proposal is to remove the Chair, the Deputy Chair;

1.2.2 written reasons for the proposal shall be provided to the non-executive director in question, who shall be given the opportunity to respond to such reasons;

1.2.3 in making any decision to remove a non-executive director, the Council of Governors shall take into account at least the annual appraisal carried out by the Chair and advice from the Council of Governors nominations and remuneration committee and the Company Secretary;

1.2.4 removal of the Chair or another non-executive director shall require the approval of three-quarters of the members of the Council of Governors; and

1.2.5 if any proposal to remove a non-executive director is not approved at a meeting of the Council of Governors, no further proposal can be put forward to remove such non-executive director based upon the same reasons within 12 months of the meeting.

2. **Further provisions as to the disqualification of directors**

2.1 In addition to paragraph 29 of the constitution, a person may not become or continue as a director of the Trust if:

2.1.1 they have been required to notify the police of their name and address as a result of being convicted or cautioned under the Sex Offenders Act or other relevant legislation or their name appears on the Protection of Children Act List;

2.1.2 they are the spouse, partner, parent, child of, or occupant of the same household as, a member of the Trust Board or the Council of Governors of the Trust;

2.1.3 they are a member of a local authority's Overview and Scrutiny Committee covering health matters;

2.1.4 they are a governor of the Trust;

2.1.5 they are a governor, non-executive director (including the Chair) or, executive director (including the chief executive officer) of another Health Service Body, unless:

2.1.5.1 in the case of an executive director other than the Chief Executive, the Chair, following consultation with the Chief Executive;

2.1.5.2 in the case of the Chief Executive, the Chair, following consultation with the Trust Board;

2.1.5.3 in the case of a non-executive director other than the Chair, the Chair following consultation with the Council of Governors; or

2.1.5.4 in the case of the Chair, the Senior Independent Director, following consultation with the Trust Board and the Council of Governors,

agrees to them becoming, or continuing as, a director of the Trust;

2.1.6 they are a person whose tenure of office as a Chair or as a member or director of a Health Service Body has been terminated on the grounds that their appointment is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;

2.1.7 they have refused to sign and deliver to the Company Secretary a statement in the form required by the Trust Board confirming acceptance of the code of conduct for directors as is in force from time to time;

2.1.8 in the case of a non-executive director, they have refused without reasonable cause to fulfil any training requirement established by the Trust Board;

2.1.9 they lack capacity within the meaning of the Mental Capacity Act 2005 to carry out all the duties and responsibilities of a director;

2.1.10 they are the subject of a disqualification order made under the Company Directors Disqualification Act 1986;

2.1.11 they have had their name removed from a list maintained under regulations pursuant to sections 91, 106, 123, or 146 of the 2006 Act, or the equivalent lists maintained by Local Health Boards in Wales under the National Health Service (Wales) Act 2006, and they have not subsequently had their name included in such a list;

2.1.12 they have failed to repay (without good cause) any amount of monies properly owed to the Trust; or

2.1.13 they fail to satisfy the fit and proper persons requirements for directors as detailed in Regulation 5 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as may be amended from time to time.

2.2 Where a director becomes disqualified for appointment under paragraph 2 of this Annex or paragraph 29 of the constitution, they shall notify the Company Secretary or the Chair in writing of such disqualification.

2.3 If it comes to the notice of the Company Secretary or the Chair that at the time of their appointment or later the director is so disqualified, they shall immediately declare that the director in question is disqualified and notify them in writing to that effect.

2.4 A disqualified person's tenure of office shall automatically be terminated and they shall cease to act as a director.

3. Expenses

3.1 The Trust may reimburse executive directors travelling and other costs and expenses incurred in carrying out their duties at such rates as the remuneration committee of non-executive directors decides. These are to be disclosed in the annual report.

ANNEX 8

Standing Orders for the Practice and Procedure of the Council of Governors

1. Interpretation and definitions

1.1 The definition and interpretation of words and expressions contained in these Standing Orders are as set out at paragraph 1 of the constitution.

1.2 Save as otherwise permitted by law, the Chair of the Trust shall be the final authority on the interpretation of these paragraphs and the Standing Orders (on which they should be advised by the Chief Executive or Company Secretary).

2. General information

2.1 The purpose of these Standing Orders is to ensure that the highest standards of corporate governance and conduct are applied to all Council of Governors meetings, proceedings and associated deliberations. The Council of Governors shall at all times seek to comply with the NHS Foundation Trust Code of Governance (as the same is in issue from time to time).

2.2 The roles and responsibilities of the Council of Governors which are to be carried out in accordance with the constitution and the Trust's authorisation include:

2.2.1 to hold the Trust Board to account for the performance of the Trust, including ensuring that the Trust Board acts so that the Trust does not breach its authorisation;

2.2.2 to respond as appropriate when consulted by the Trust Board in accordance with the constitution;

2.2.3 to undertake such functions as the Trust Board shall from time to time request;

2.2.4 to prepare and from time to time review the Trust's membership strategy and the policy for the composition of the Council of Governors and of the non-executive directors; and

2.2.5 when appropriate, to make recommendations for the revision of the constitution.

2.3 All business shall be conducted in the name of the Trust.

3. Meetings of the Council of Governors

3.1 Council of Governors meetings

3.1.1 Subject to paragraph 3.1.2 below, all meetings of the Council of Governors are to be open to members of the public.

3.1.2 The Council of Governors may resolve by a majority of two thirds of governors present and voting, to exclude members of the public from any meeting or part of a meeting on the grounds that:

3.1.2.1 publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be

transacted following an appropriate resolution by the Council of Governors; or

3.1.2.2 there are special reasons stated in the resolution and arising from the nature of the business of the proceedings.

3.1.3 The Chair may exclude any member of the public from a meeting of the Council of Governors if they are interfering with, or preventing the proper conduct of, the meeting.

3.1.4 The Council of Governors may invite the Chief Executive, and other appropriate directors, to attend any of its meetings to assist it in fulfilling its responsibilities.

3.2 Calling and Notice of Meetings

3.2.1 The Council of Governors is to meet a minimum of four times in each financial year.

3.2.2 Save in the case of emergencies or the need to conduct urgent business, the Company Secretary shall give at least fourteen clear days' written notice of the date and place of every meeting of the Council of Governors to all governors. Notice will be given by post or by email and also be published on the Trust's website and in the Trust's membership newsletter if practicable. Lack of service of the notice on any governor shall not affect the validity of a meeting.

3.2.3 Meetings of the Council of Governors may be called by the Company Secretary, the Chair, or by ten governors (including at least two elected governors and two appointed governors) who give written notice to the Company Secretary specifying the business to be carried out. The Company Secretary shall send a written notice to all governors as soon as possible after receipt of such a request and will call a meeting on at least fourteen clear days' (but not more than twenty eight days') notice. Notice by post, delivery in person, fax or email shall constitute written notice.

3.2.4 The Council of Governors may agree that its governors can participate in its meetings by means of electronic communication. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting. The Council of Governors shall agree a protocol to be applied in the case of such meetings.

3.3 Setting the agenda

3.3.1 No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under paragraph 3.4.1 below.

3.3.2 A governor desiring a matter to be included on an agenda shall make his/her request in writing to the Chair at least seven clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information.

3.3.3 Where a request for an item of business to be included on an agenda is made less than seven clear days but more than three clear days before a meeting such item of business may, at the discretion of the Chair, be included and shall be tabled as an agenda item at the commencement of the relevant meeting.

3.4 Chair of the Meeting

3.4.1 At a Council of Governors meeting, the Chair, if present, shall preside. If the Chair is absent from the meeting the Deputy Chair, shall preside.

3.4.2 If the Chair is absent from part of a meeting of the Council of Governors due to a conflict of interest, the Deputy Chair shall preside. If the Deputy Chair is absent, or unable to participate in that part of the meeting due to a conflict of interest, then the Lead Governor or, if the Lead Governor is absent or unable to participate in that part of the meeting due to a conflict of interest, the Deputy Lead Governor, shall preside for that part of the meeting.

3.5 Notices of motions

3.5.1 A governor desiring to move or amend a motion shall send a written notice thereof at least seven clear days before the meeting to the Chair, who shall insert it into the agenda for the meeting. This Standing Order 3.5.1 shall not prevent any motion being moved during the meeting, without notice, on any business mentioned on the agenda subject to Standing Order 3.5.5 of these Standing Orders.

3.5.2 A motion or amendment, once moved and seconded, may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

3.5.3 Notice of a motion to amend or rescind any resolution or the general substance of any resolution, which has been passed within the preceding six calendar months, shall bear the signature of the governors who give it and also the signature of four other governors. When any such motion has been disposed of by the Council of Governors it shall not be for any governor, other than the Chair, to propose a motion to the same effect within six months; however the Chair may do so if they consider it appropriate.

3.5.4 The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

3.5.5 When a motion is under discussion or immediately prior to discussion it shall be open to a governor to move:

3.5.5.1 an amendment to the motion;

3.5.5.2 the adjournment of the discussion or the meeting;

3.5.5.3 the appointment of an ad hoc committee to deal with a specific item of business;

3.5.5.4 that the meeting proceed to the next business;

3.5.5.5 that the motion be now put; or

3.5.5.6 a motion resolving to exclude the public, including the press.

3.5.6 Such a motion, if seconded, shall be disposed of before the motion which was originally under discussion or about to be discussed. No amendment to the original motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the original motion. In the case of motions under 3.5.5.4 or 3.5.5.5 to ensure objectivity motions may only be put by a governor who has not previously taken part in the debate on the original motion.

3.6 Chair's ruling

3.6.1 The decision of the Chair of the meeting (with advice of the Company Secretary) on questions of order, relevancy and regularity (including procedure on handling motions) and their interpretation of the Trust's Standing Orders and Standing Financial Instructions, at the meeting, shall be final.

3.7 Quorum

3.7.1 No business shall be transacted at a meeting of the Council of Governors unless:

3.7.1.1 at least one third of the Council of Governors are present, a majority of whom must be public or patient and carer governors; and

3.7.1.2 one of the Chair or Deputy Chair are present, unless either are absent for part of a meeting due to a conflict of interest, in which case, during that part of the meeting the Lead Governor or Deputy Lead Governor must be present.

3.7.2 In the event that there is no quorum, in respect of any matters upon which decisions are to be made, the meeting may only make recommendations for consideration at the next quorate meeting of the Council of Governors (or by other means as defined in the constitution).

3.7.3 If a governor has been disqualified from participating in the discussion on any matter and/or from other voting on any resolution by reason of the declaration of an interest (Standing Order 6.1.3) they shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3.7.4 The Chief Executive or any other member(s) of the Trust Board or a representative of the Trust's external auditors or other advisors may attend a meeting of the Council of Governors by invitation.

3.8 Voting

3.8.1 Unless otherwise specified in the constitution or these Standing Orders, questions arising at a meeting of the Council of Governors shall be decided by a majority of votes of those governors present and voting.

3.8.2 All questions put to the vote shall, at the discretion of the Chair of the Council of Governors (or in their absence the person presiding in their place), be determined by a show of hands.

3.8.3 The Council of Governors may agree that its governors can vote electronically or by post. In no circumstances may an absent governor vote by proxy. “Absent” is defined as being absent at the time of the vote.

3.8.4 In case of an equality of votes the Chair of the Council of Governors (or in their absence the Deputy Chair) shall have a casting vote except when the Chair (or the Deputy Chair) has a conflict of interest. If the Chair (or the Deputy Chair) has a conflict of interest in the vote which prohibits them from voting under the constitution, the Lead Governor (or in their absence the Deputy Lead Governor) shall have a casting vote. For the avoidance of doubt the Chair shall not participate in votes at Council of Governors meetings, other than in the circumstances to which this paragraph 3.8.4 relates and in accordance with its terms.

3.8.5 A governor elected to the Council of Governors may not vote at a meeting of the Council of Governors unless, within the last three years made a declaration stating which constituency or section they are a member of and is not prevented from being a member of the Council of Governors.

3.8.6 Any matter which could be decided by the Council of Governors in a meeting may be determined by written resolution. A written resolution shall, with any accompanying papers which are relevant, describe the matter to be decided and provide for governors to sign the resolution to confirm their agreement. A written resolution may comprise identical documents sent to all governors, each to be signed by a governor, or one document to be signed by all governors voting. A written resolution shall be passed only when at least three quarters of the governors approve the resolution in writing within the timescale imposed in such a notice. The Company Secretary shall keep records of all written resolutions.

3.9 Suspension of council Standing Orders

3.9.1 Except where this would contravene any statutory provision, any one or more of these Standing Orders may be suspended at any meeting, provided that at least two-thirds of members of the Council of Governors are present and that a majority of those present vote in favour of suspension.

3.9.2 A decision to suspend any Standing Order shall be recorded in the minutes of the relevant meeting.

3.9.3 A separate record of matters discussed during the suspension of any Standing Order(s) shall be made and shall be available to the directors and governors.

3.9.4 No formal business may be transacted by the Council of Governors while any Standing Order is suspended.

3.9.5 The Trust's audit committee shall review every decision to suspend any Standing Order.

3.10 Record of attendance

3.10.1 The minutes of each meeting of the Council of Governors shall record the name of each governor in attendance as well as the name of their constituency or, in the case of appointed governors, the name of the appointing organisation. The names (and any other relevant details) of any other persons in attendance shall also be recorded in the minutes.

3.11 Minutes

3.11.1 The minutes of the proceedings of the meeting shall be drawn up and maintained as a public record. They will be submitted for agreement at the next meeting of the Council of Governors where they will be signed by the person presiding at it.

3.11.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at such next meeting.

3.11.3 Minutes shall be circulated in accordance with a decision of the governors. The minutes of the meeting shall be made available to the public except for minutes relating to business conducted when members of the public are excluded under the terms of Council of Governors Standing Order 3.1.2.

4. Committees

4.1 The nominations and remuneration committee will comprise the Chair, the Deputy Chair, two public governors and/or patient and carer governors, one staff governor and one appointed governor. When the Chair is being appointed or reappointed, the Deputy Chair shall take his or her place, unless they are standing for appointment, in which case another non-executive director shall take his or her place, and, when the Chair's remuneration is being considered, the Deputy Chair shall take their place.

4.2 The Council of Governors may not delegate any of its powers to a committee or sub-committee, but it may appoint committees to assist the Council of Governors in carrying out its functions. Such committees established by the Council of Governors may meet in private for reasons of commercial confidentiality or other special reasons if the members of the committee so decide.

4.3 The Council of Governors may appoint committees of the council consisting wholly of persons who are governors. Persons who are not governors may

attend such committees if appropriate under the committee's terms of reference but they shall have no vote.

4.4 A committee so appointed may appoint sub-committees consisting wholly of persons who are governors. Persons who are not governors may attend such committees if appropriate under the committee's terms of reference but they shall have no vote.

4.5 These Council of Governors Standing Orders, as far as they are applicable, shall apply also, with appropriate alteration, to meetings of any committees or sub-committees so established by the Council of Governors.

4.6 Each such committee or sub-committee shall have such terms of reference and be subject to such conditions as the council shall decide. Such terms of reference shall have effect as if incorporated into these Standing Orders.

4.7 The Council of Governors shall approve the membership of all committees and sub-committees that it has formally constituted and shall approve the recommendation from the relevant committee to appoint the Chair and, if applicable, the Deputy Chair of each committee and sub-committee.

4.8 Any member of a committee may participate in a duly convened meeting of a committee or sub-committee by means of a video conference, telephone or any other communications equipment which allows all persons to hear and speak to one another subject to reasonable notice and availability of the necessary equipment. Any such meetings shall adopt the procedure agreed by the Council of Governors.

4.9 The Council of Governors may, through the Company Secretary, request that external advisors assist them or any committee they appoint in carrying out duties. Advisers will:

4.9.1 not be designated governors;

4.9.2 not have voting rights; and

4.9.3 provide such assistance as the Council of Governors may agree.

5. Confidentiality

5.1 In the event of the Council of Governors, or any Committee established by the Council of Governors, meeting in private for all or part of a meeting, governors shall not disclose the contents of the papers considered, discussions held or minutes of the items taken in private.

6. Declaration of interests

6.1 Declaration of interests

6.1.1 Each governor shall declare:

6.1.1.1 any actual or potential, direct or indirect, financial interest which is material to any discussion or decision they are involved, or likely to be involved, in making, as described in Standing Orders 6.2.2 and 6.2.6 (subject to Standing Order 6.2.3);

6.1.1.2 any actual or potential, direct or indirect, non-financial

professional interest, which is material to any discussion or decision they are involved, or likely to be involved, in making, as described in Standing Orders 6.2.4 and 6.2.6; and

6.1.1.3 any actual or potential, direct or indirect, non-financial personal interest, which is material to any discussion or decision they are involved, or likely to be involved, in making, as described in Standing Orders 6.2.5 and 6.2.6.

6.1.2 The responsibility for declaring an interest is solely that of the governor concerned and shall be declared to the Company Secretary:

6.1.2.1 within 28 days of commencement of that governor's term of office; or

6.1.2.2 if arising later, within 5 days of the governor becoming aware of the interest.

6.1.3 If during the course of a Council of Governors meeting a governor has an interest of any sort in a matter which is the subject of consideration the governor concerned shall disclose the fact, and the Chair shall decide what action to take. This may include excluding the governor from the discussion of the matter in which the governor has an interest and/or prohibiting the governor from voting any such matter.

6.1.4 Subject to Standing Order 6.2.3, if a governor has declared a financial interest in a matter (as described in Standing Order 6.2.2) they shall not take part in the discussion of that matter nor vote on any question with respect to that matter.

6.1.5 Any interest declared at a meeting of the Council of Governors and subsequent action taken should be recorded in the Council of Governors' meeting minutes. Any changes in interests should be declared at the next Council of Governors meeting following the change occurring.

6.2 Nature of interests

6.2.1 Interests which should be regarded as "material" are ones which a reasonable person would take into account when making a decision regarding the use of taxpayers' money because the interest has relevance to that decision. Material interests are to be interpreted in accordance with guidance issued by Monitor.

6.2.2 A financial interest is where a governor may receive direct financial benefits (by either making a gain or avoiding a loss) as a consequence of a decision that the Council of Governors makes. This could include:

6.2.2.1 directorships, including non-executive directorships held in any other organisation which is doing, or is likely to be doing business with the Trust;

6.2.2.2 employment in an organisation other than the Trust; or

6.2.2.3 a shareholding, partnerships, ownership or part ownership of an organisation which is doing, or is likely to do business with the Trust.

6.2.3 A governor shall not be treated as having a financial interest in any a matter by reason only:

6.2.3.1 of their membership of a company or other body, if they have no beneficial interest in any securities of that company or other body;

6.2.3.2 of shares or securities held in collective investment or pensions funds or units of authorised unit trusts;

6.2.3.3 of an interest in any company, body or person with which they are connected which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a governor in the consideration or discussion of or in voting on, any question with respect to that contract or matter; or

6.2.3.4 of any travelling or other expenses or allowances payable to a governor in accordance with the constitution.

6.2.4 A non-financial professional interest is where a governor may receive a non-financial professional benefit as a consequence of a decision that the Council of Governors makes, such as increasing their professional reputation or status or promoting their professional career. This could include situations where a governor is:

6.2.4.1 an advocate for a particular group of patients;

6.2.4.2 a clinician with a special interest;

6.2.4.3 an active member of a particular specialist body; or

6.2.4.4 an advisor for the Care Quality Commission or National Institute of Health and Care Excellence.

6.2.5 A non-financial personal interest is where a governor may benefit personally as a consequence of a decision that the Council of Governors makes in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include where a governor is:

6.2.5.1 a member of a voluntary sector board or has a position of authority within a voluntary sector organisation with an interest in health and/or social care; or

6.2.5.2 a member of a lobbying or pressure group with an interest in health and/or social care.

6.2.6 A governor will be treated as having an indirect financial interest, indirect non-financial professional interest or indirect non-financial

personal interest where they have a close association with another individual who has a financial interest, non-financial professional interest or a non-financial personal interest in a decision that the governor is involved in making. This includes material interests of:

6.2.6.1 close family members and relatives, including a spouse or partner or any parent, child, brother or sister of a governor;

6.2.6.2 close friends and associates; and

6.2.6.3 business partners.

6.2.7 If governors have any doubt about the relevance or materiality of an interest, this should be discussed with the Chair. Influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest.

6.3 Register of interests

6.3.1 The Company Secretary will ensure that a register of interests is established to record formally declarations of interests of governors.

6.3.2 Details of the register will be kept up to date and reviewed annually by the Council of Governors.

6.3.3 The register will be available to the public.

7. Compliance

7.1 All members of the Council of Governors are required to comply with Standing Financial Instructions approved by the Trust Board from time to time for the guidance of all staff employed by the Trust.

7.2 All members of the Council of Governors should act at all times in accordance with the Trust's schedule of reservation and delegation of powers as the same may be adopted by the Trust from time to time.

7.3 All members of the Council of Governors are required to comply with any Code of Conduct adopted by the Council of Governors.

8. Resolution of disputes with the Trust Board

8.1 Should a dispute arise between the Council of Governors and the Trust Board this disputes resolution procedure shall apply.

8.2 The Chair, or Deputy Chair if the dispute involves the Chair, shall first endeavour through discussion with appropriate representatives of the governors and the directors to achieve the earliest possible resolution of the matter in dispute to the reasonable satisfaction of both parties.

8.3 Failing resolution under Standing Order 8.2 above, the Trust Board or the council, as appropriate, shall at its next formal meeting approve the precise wording of a disputes statement setting out clearly and concisely the issue or issues giving rise to the dispute.

8.4 The Chair or Deputy Chair (if the dispute involves the Chair) shall ensure that the disputes statement, without amendment or abbreviation in any way, shall

be submitted to the next formal meeting of the Trust Board or the Council of Governors as appropriate. That meeting shall agree the precise wording of a response to disputes statement.

8.5 The Chair or Deputy Chair (if the dispute involves the Chair) shall immediately or as soon as is practical, communicate the outcome to the other party and deliver the written response to the disputes statement. If the matter remains unresolved or only partially resolved then the procedure outlined in Standing Order 8.2 above shall be repeated.

8.6 If, in the opinion of the Chair or Deputy Chair (if the dispute involves the Chair), and following the further discussions prescribed in council Standing Order 8.5, there is no further prospect of a full resolution or, if at any stage in the whole process, in the opinion of the Chair or Deputy Chair (as the case may be), there is no prospect of a resolution (partial or otherwise) then they shall appoint a special committee comprising equal numbers of directors and governors to consider the circumstances and to make recommendations to the council and the Trust Board with a view to resolving the dispute.

8.7 On the satisfactory completion of this disputes procedure the Trust Board shall implement agreed changes.

8.8 If the recommendations (if any) of the special committee are unsuccessful in resolving the dispute, the decision of the Trust Board shall prevail.

8.9 In the event that the Council of Governors is of the opinion that the Trust has breached, or is about to breach, the terms of its authorisatiion, nothing in this procedure shall prevent the Council of Governors from informing Monitor to that effect.

9. Variation and amendment of these Standing Orders

9.1 These Standing Orders shall be amended only if:

9.1.1 a notice of motion has been given pursuant to Standing Order 4.5 of this Annex 8;

9.1.2 more than half the total of the governors voting approve the amendment;

9.1.3 more than half of the members of the Trust Board voting approve the amendment; and

9.1.4 members' approval is obtained for any amendment to the role or duties of the Council of Governors.

ANNEX 9

Standing Orders for the Practice and Procedure of the Trust Board

1. Interpretation and definitions

1.1 The definition and interpretation of words and expressions contained in these Standing Orders are as set out at paragraph 1 of the constitution.

1.2 Save as otherwise permitted by law, the Chair of the Trust shall be the final authority on the interpretation of these paragraphs and the Standing Orders (on which they should be advised by the Chief Executive or Company Secretary).

2. Meetings of the Trust Board

2.1 Subject to paragraph 2.2 below, all meetings of the Trust Board are to be open to members of the public.

2.2 The Trust Board may resolve to exclude members of the public or staff from any meeting or part of meeting on the grounds that:

2.2.1 publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted following an appropriate resolution by the Trust Board; or

2.2.2 there are special reasons stated in the resolution and arising from the nature of the business of the proceedings.

2.3 The Chair may exclude any member of the public or staff from a meeting of the Trust Board if that person is interfering with or preventing the proper conduct of the meeting.

2.4 Nothing in the Standing Orders shall require the Trust Board to allow members of the public, staff or representatives of the press to record proceedings in any manner whatsoever, other than in writing, or to make any oral report of proceedings as they take place, without the prior agreement of the Trust Board.

2.5 The Trust will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Trust Board's meetings and may change, alter or vary these terms and conditions as it sees fit.

3. Calling and Notice of Meetings

3.1 Save in the case of emergencies or the need to conduct urgent business, the Company Secretary shall give at least fourteen clear days' written notice of the date and place of every meeting of the Trust Board to all directors. Notice will be given by post or by email and also be published on the Trust's website.

3.2 Meetings of the Trust Board may be called by the Company Secretary, the Chair, or by four directors who give written notice to the Company Secretary specifying the business to be carried out. The Company Secretary shall send a written notice to all directors as soon as possible after receipt of such a request and shall call a meeting on at least fourteen clear days' but not more than twenty eight days' notice.

3.3 Lack of service of such a notice on any director shall not affect the validity of a meeting.

4. Agenda and supporting papers

4.1 A director desiring other matters to be included on an agenda shall make his or her request known to the Chair, in writing at least seven (7) clear days before the meeting. The director should indicate whether the item of business is to be transacted in the presence of the public and should provide the appropriate paper, document or supporting information. Where a request for an item of business to be included on an agenda is made less than seven clear days but more than three clear days before a meeting such item of business may, at the discretion of the Chair, be included and shall be tabled as an agenda item at the commencement of the relevant meeting.

5. Petitions

5.1 Where a petition has been received by the Trust, the Chair shall include the petition as an item for the agenda of the next meeting.

6. Chair of the Meeting

6.1 At a meeting of the Trust Board, the Chair, if present, shall preside. If the Chair is absent from the meeting the Deputy Chair shall preside.

6.2 If the Chair is absent from part of a meeting of the Trust Board due to a conflict of interest the Deputy Chair shall preside. If the Deputy Chair is absent, or unable to participate in that part of the meeting due to a conflict of interest, then the remaining non-executive directors present shall choose which non-executive director present shall preside for that part of the meeting.

7. Notices of motion

7.1 A director desiring to move or amend a motion shall send a written notice thereof at least seven clear days before the meeting to the Chair. The Chair shall insert in the agenda for the meeting all notices so received. This Standing Order 7.1 shall not prevent any motion being moved during the meeting, without notice, on any business mentioned on the agenda.

8. Withdrawal of motion or amendments

8.1 A motion or amendment once moved and seconded may be withdrawn by the proposer, with the concurrence of the seconder and the consent of the Chair.

9. Motion to rescind a resolution

9.1 Notice of a motion to amend or rescind any resolution, or the general substance of any resolution passed within the preceding 6 calendar months, shall bear the signature of the director who gives it and also the signature of 4 other directors. When any such motion has been disposed of by the Trust Board, it shall not be for any directors' other than the Chair to propose a motion to the same effect within 6 months. The Chair may do so, however, if they consider it appropriate.

10. Motions

10.1 The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

10.2 When a motion is under discussion, or immediately prior to discussion, it shall be open to a director to move:

10.2.1 an amendment to the motion;

10.2.2 the adjournment of the discussion or the meeting;

10.2.3 the appointment of an ad hoc committee to deal with a specific item of business;

10.2.4 that the meeting proceed to the next business;

10.2.5 that the motion be now put; or

10.2.6 a motion resolving to exclude the public, including the press.

10.3 Such a motion, if seconded, shall be disposed of before the motion which was originally under discussion or about to be discussed. No amendment to the original motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the original motion. In the case of motions under Standing Order 10.2.4 and Standing Order 10.2.5, to ensure objectivity motions may only be put by a director who has not previously taken part in the debate on the original motion.

11. Chair's ruling

11.1 The decision of the Chair of the meeting (with advice from the Company Secretary) on questions of order, relevancy and regularity (including procedure on handling motions) and their interpretation of the Standing Orders and Standing Financial Instructions, at the meeting, shall be final and observed at the meeting.

12. Voting

12.1 Questions arising at a meeting of the Trust Board shall be decided by a majority of votes.

12.2 In the case of an equality of votes the person presiding at or chairing the meeting shall have a second and casting vote.

12.3 No resolution of the Trust Board shall be passed if it is opposed by all of the independent non-executive directors present or by all of the executive directors present.

12.4 At the discretion of the Chair, all questions put to the vote shall be determined by a show of hands, unless the Chair directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.

12.5 If a director so requests, his vote shall be recorded by name.

12.6 Subject to Standing Order 12.7 below, in no circumstances may an absent director vote by proxy. Absence is defined as being absent at the time of the vote.

12.7 An officer, who has been appointed formally by the Trust Board to act up for an executive director of the Trust Board during his or her absence, or to cover a vacant executive director post, shall be entitled to exercise the voting rights of the executive director.

12.8 An officer attending the Trust Board to represent an executive director without formal acting up status may not exercise the voting rights of the executive director. An officer's status when attending a meeting shall be recorded in the minutes.

13. Minutes

13.1 The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where the person presiding at it shall sign them. The signed minutes will be conclusive evidence of the events of that meeting.

13.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

13.3 Minutes shall be circulated in accordance with directors' wishes. The minutes of the meeting shall be made available to the public except for minutes relating to business conducted when members of the public are excluded under the terms of Trust Board Standing Order 2.2.

14. Record of Attendance

14.1 The names and job titles of the Chair and the other directors present at the meeting shall be recorded in the minutes.

15. Quorum

15.1 No business shall be transacted at a meeting unless at least five directors are present including:

15.1.1 at least two non-executive directors, one of whom must be the Chair or the Deputy Chair, unless either of them are absent for part of a meeting due to a conflict of interest; and

15.1.2 not less than two executive directors, one of whom must be the Chief Executive or another executive director nominated by the Chief Executive.

15.2 An officer in attendance for an executive director but without formal acting up status may not count towards the quorum.

15.3 If the Chair or director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see Standing Order 23), that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

15.4 The Trust Board may agree that its members can participate in its meeting by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting. However, subject to Standing Order 12.7 above, in no circumstances shall this paragraph be construed as allowing an absent director to vote by proxy.

16. Joint directors

16.1 Where more than one person is appointed jointly as a member of the Trust Board, those persons shall count as one person.

16.2 Where the office of a member of the Trust Board is shared jointly by more than one person:

16.2.1 either or both those persons may attend or take part in meetings of the Trust Board;

16.2.2 if both are present at a meeting they should cast one vote if they agree;

16.2.3 in the case of disagreements no vote should be cast; and

16.2.4 The presence of either or both those persons should count as the presence of one person for the purpose of Trust Board Standing Order 15.

17. Urgent decisions

17.1 Where a matter requiring decision arises for which, under normal circumstances, the approval of the Trust Board would be appropriate but which could not be obtained in the timescale within which action is required, either the Chair or the Chief Executive is authorised to act (the latter with the prior consent of the Chair or, in the absence of the Chair, the Deputy Chair). When action is taken under this authority, the Chair or Chief Executive shall seek endorsement of the Trust Board at its next formal meeting.

18. Delegation to committees

18.1 Any of these powers may be delegated to a committee of directors or to an executive director.

18.2 The Trust Board shall establish committees, including an audit committee, a Board of Director's nominations committee (appointment of executive directors and recommending appointment of non-executive directors to the next general meeting of the Council of Governors) and a Trust Board remuneration committee.

18.3 Each such committee, and any sub-committee, shall have such terms of reference and powers as the Trust Board shall determine from time to time. Such terms of reference shall have effect as if incorporated into these Standing Orders.

18.4 Where committees are authorised to establish sub-committees, they may not delegate executive powers to the sub-committee unless expressly authorised by the Trust Board.

18.5 The Trust Board shall have the power to approve appointments and dismiss the members of any committee or subcommittee that is established under the power afforded to the Board under Standing Order 18, as applicable.

19. Committees established by the Trust Board

19.1 The committees to be established by the Trust Board shall include the following:

19.1.1 Audit Committee

An audit committee will be established and constituted to provide the Trust Board with an independent and objective review on its financial systems, financial information and compliance with relevant laws and guidance. Its Terms of Reference will be approved by the Trust Board and reviewed on a periodic basis.

The NHS Foundation Trust Code of Governance recommends a minimum of three independent non-executive directors be appointed, of which one must have significant, recent and relevant financial experience.

The duties and decisions to be taken by the committee are contained in the relevant part of the schedule of reservation and delegation of powers.

19.1.2 Trust Board Remuneration Committee

A Trust Board remuneration committee will be established and constituted. The duties and decisions to be taken by the committee are contained in the relevant part of the schedule of reservation and delegation of powers.

The NHS Foundation Trust Code of Governance recommends the committee be comprised exclusively of non-executive directors, and should include at least three independent non-executive directors.

19.1.3 Trust Board' Nominations Committee

A Trust Board' nominations committee will be established and constituted. The duties of and decisions to be taken by the committee are contained in the relevant part of the schedule of reservation and delegation of powers.

The committee, with external advice as appropriate, is responsible for the identification and nomination of executive directors.

20. Delegation to officers

20.1 Those functions of the Trust which have not been retained as reserved by the Trust Board or delegated to a committee or sub-committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions they will perform personally and shall nominate officers to undertake the remaining functions for which they will still retain accountability to the Trust Board.

20.2 The Chief Executive shall prepare a scheme of delegation identifying his or her proposals, which shall be considered and approved by the Trust Board, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendments to the scheme of delegation that shall also be considered and approved by the Trust Board, as it see fit.

20.3 Nothing in the scheme of delegation shall impair the discharge of the direct accountability to the Trust Board of the director responsible for finance to provide information and advise the Trust Board in accordance with statutory or regulatory requirements. Outside these statutory or regulatory

requirements, the role of the director responsible for finance shall be accountable to the Chief Executive for operational matters.

21. Confidentiality

21.1 A member of a committee shall not disclose a matter dealt with by or brought before the committee without its permission until the committee has reported back to the Trust Board or shall otherwise have concluded the matter.

21.2 A director of the Trust or a member of a committee shall not disclose any matter reported to the Trust Board or otherwise dealt with by the committee notwithstanding that the matter has been reported or action has been concluded if the Trust Board or committee shall resolve that it is confidential.

22. Additional Provisions

22.1 The Trust Board may establish additional protocols and procedures for the operation of the Trust Board, and the economic, effective and efficient operation and good governance of the Trust generally from time to time as appropriate.

23. Declaration of interests

23.1 Declaration of interests

23.1.1 Each director shall comply with paragraph 32 of the constitution regarding conflicts of interest.

23.1.2 Interests that a required to be declared by a director in accordance with paragraph 32.5 of the constitution are:

23.1.2.1 any actual or potential, direct or indirect, financial interest which is material to any discussion or decision they are involved, or likely to be involved, in making, as described in Standing Orders 23.2.2 and 23.2.6 (subject to Standing Order 23.2.3); and

23.1.2.2 any actual or potential, direct or indirect, non-financial professional interest, which is material to any discussion or decision they are involved or likely to be involved in making, as described in Standing Orders 23.2.4 and 23.2.6; and

23.1.2.3 any actual or potential, direct or indirect, non-financial personal interest, which is material to any discussion or decision they are involved or likely to be involved in making, as described in Standing Orders 23.2.5 and 23.2.6.

23.1.3 An interest must be declared under paragraph 32.5 of the constitution to the Company Secretary:

23.1.3.1 within five days of the director's appointment; or

23.1.3.2 if arising later, as soon as reasonably practicable following that director becoming aware of the interest.

23.1.4 If during the course of a meeting the Trust Board, a director has an interest of any sort in a matter which is the subject of consideration the director concerned shall disclose the fact, and the Chair shall decide what action to take. This may include excluding the director from the discussion of the matter in which the director has an interest and/or prohibiting the governor from voting any such matter.

23.1.5 Subject to Standing Order 23.2.6, if a director has declared a financial interest in a matter (as described in Standing Order 23.2.2) they shall not take part in the discussion of that matter nor vote on any question with respect to that matter.

23.1.6 Any interest declared at a meeting of the Trust Board and subsequent action taken should be recorded in the meeting minutes of the meeting. Any changes in interests should be declared at the next Trust Board meeting following the change occurring.

23.1.7 This Standing Order 23.1 applies to a committee or sub-committee and to a joint committee or sub-committee as it applies to the Trust Board and applies to a member of any such committee or sub-committee (whether or not they are also a member of the Trust) as it applies to a member of the Trust.

23.2 Nature of interests

23.2.1 Interests which should be regarded as "material" are ones which a reasonable person would take into account when making a decision regarding the use of taxpayers' money because the interest has relevance to that decision. Material interests are to be interpreted in accordance with guidance issued by Monitor.

23.2.2 A financial interest is where a director may receive direct financial benefits (by either making a gain or avoiding a loss) as a consequence of a decision that the Trust Board makes. This could include:

23.2.2.1 directorships, including non-executive directorships held in any other organisation which is doing, or is likely to be doing business with the Trust;

23.2.2.2 employment in an organisation other than the Trust; or

23.2.2.3 a shareholding, partnerships, ownership or part ownership of an organisation which is doing, or is likely to do business with the Trust.

23.2.3 A director shall not be treated as having a financial interest in any a matter by reason only:

23.2.3.1 of their membership of a company or other body, if they have no beneficial interest in any securities of that company or other body;

23.2.3.2 of shares or securities held in collective investment or pensions funds or units of authorised unit trusts;

23.2.3.3 of an interest in any company, body or person with

which they are connected which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a governor in the consideration or discussion of or in voting on, any question with respect to that contract or matter; or

23.2.3.4 of any remuneration or allowances payable to a director in accordance with the constitution.

23.2.4 A non-financial professional interest is where a director may receive a non-financial professional benefit as a consequence of a decision that the Trust Board makes, such as increasing their professional reputation or status or promoting their professional career. This could include situations where a director is:

23.2.4.1 an advocate for a particular group of patients;

23.2.4.2 a clinician with a special interest;

23.2.4.3 an active member of a particular specialist body; or

23.2.4.4 an advisor for the Care Quality Commission or National Institute of Health and Care Excellence.

23.2.5 A non-financial personal interest is where a director may benefit personally as a consequence of a decision that the Trust Board makes in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include where a governor is:

23.2.5.1 a member of a voluntary sector board or has a position of authority within a voluntary sector organisation with an interest in health and/or social care; or

23.2.5.2 a member of a lobbying or pressure group with an interest in health and/or social care.

23.2.6 A director will be treated as having an indirect financial interest, indirect non-financial professional interest or indirect non-financial personal interest where they have a close association with another individual who has a financial interest, non-financial professional interest or a non-financial personal interest in a decision that the director is involved in making. This includes material interests of:

23.2.6.1 close family members and relatives, including a spouse or partner or any parent, child, brother or sister of the director;

23.2.6.2 close friends and associates; and

23.2.6.3 business partners.

23.2.7 If directors have any doubt about the relevance or materiality of an interest, this should be discussed with the Chair. Influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest.

23.3 Register of interests

23.3.1 The Company Secretary will ensure that a register of interests is established to record formally declarations of interests of directors.

23.3.2 Details of the register will be kept up to date and reviewed annually by the Trust Board.

23.3.3 The register will be available to the public.

24. Canvassing of and Recommendations by Members in Relation to Appointments

24.1 Canvassing of members of the Trust or of any committee of the Trust directly or indirectly for any appointment with the Trust shall disqualify the candidate for such appointment. The contents of this paragraph shall be included in application forms or otherwise brought to the attention of candidates.

24.2 A member of the Trust Board shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph shall not preclude a member from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

24.3 Informal discussions outside appointment panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

25. Relatives of Members of the Board or Officers of the Trust

25.1 The Chair and every member and officer of the Trust shall disclose to the Trust Board any relationship between themselves and a candidate of whose candidature that member or officer is aware. It shall be the duty of the Chief Executive to report to the Trust Board any such disclosure made.

25.2 On appointment, members (and, prior to acceptance of an appointment in the case of executive directors) should disclose to the Trust whether they are related to any other member or holder of any office of the Trust.

25.3 Where the relationship to a member of the Trust is disclosed, the provisions of Standing Orders 31 and 32 may apply.

26. Standards of business conduct

26.1 Directors of the Trust shall comply with standing financial instructions prepared by the director of finance and approved by the Trust Board for the guidance of all staff employed by the Trust.

26.2 Directors of the Trust must behave in accordance with the NHS Foundation Trust Code of Governance or its equivalent(s) from time to time.

26.3 Each director will uphold the seven principles of public life as detailed by the Nolan Committee.

27. Gifts and Hospitality

27.1 Directors must comply with the Trust's policy on gifts and hospitality as is in place from time to time.

28. Custody of Seal

28.1 The common seal of the Trust shall be the responsibility of the Company Secretary and kept in a secure place.

29. Sealing of Documents

29.1 Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of two executive directors duly authorised by the Chief Executive, and shall be attested by them.

29.2 Before any building, engineering, property or capital document is sealed it must be approved and signed by the director of finance, or an officer nominated by the director of finance and authorised and countersigned by the chief executive, or an officer nominated by the Chief Executive who shall not be within the originating directorate.

29.3 All deeds entered into by the Trust and all documents conveying an interest in land must be executed by the application of the Trust's seal.

30. Register of Sealing

30.1 An entry of every sealing shall be made and numbered consecutively in a record provided for that purpose, and shall be signed by the persons who shall have approved and authorized the document and those who attested the seal. A report of all sealing shall be made to the Trust Board at the next meeting of the Trust Board.

31. Signature of documents

31.1 Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any nominated executive director or the Trust Board shall have delegated the necessary authority to some other person for the purpose of such proceedings.

31.2 In land transactions, the signing of certain supporting documents will be delegated to managers and set out clearly in the scheme of delegation but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

31.3 The Chief Executive or nominated officers shall be authorized, by resolution of the Trust Board, to sign on behalf of the Trust any agreement or other document (not required to be executed as a Deed) the subject matter of which has been approved by the Board or committee or sub-committee to which the Board has delegated appropriate authority

32. Schedule of Matters Reserved to the Trust and Scheme of Delegation of powers

32.1 The arrangements made by the Board as set out in the "Schedule of Matters Reserved to the Board" and "Scheme of Delegation" of powers shall have effect (as adopted from time to time) as if incorporated in these Standing Orders.

33. Suspension of Standing Orders

33.1 Except where this would contravene any statutory provision or any direction made by the regulator or any term or condition set out in the Trust's constitution, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the whole number of the members of the Board are present (including at least one executive director and one non-executive director) and that a majority of those members present vote in favour of the suspension.

33.2 The reason for the suspension shall be recorded in the Board minutes.

33.3 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chair and members of the Trust.

33.4 No formal business may be transacted while Standing Orders are suspended.

33.5 The Audit Committee shall review every decision to suspend Standing Orders.

34. Variation and amendment of these Standing Orders

34.1 These Standing Orders shall be amended only if:

34.1.1 a notice of motion has been given pursuant to Standing Order 7 of this Annex; and

34.1.2 more than half the total of governors voting approve the amendment;

34.1.3 more than half of the members of the Trust Board voting approve the amendment (including no fewer than half the total of the Trust's independent non-executive directors);

34.1.4 members' approval is obtained (if required by statute); and

34.1.5 the variation proposed does not contravene a statutory provision, a direction made by the regulator, or any term or condition set out in the constitution

35. Duty to report non-compliance with Standing Orders and Standing Financial Instructions

35.1 If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Trust Board for action or ratification. All members of the Trust Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive or Company Secretary as soon as possible.

36. Review of Standing Orders

36.1 These Standing Orders shall be reviewed periodically by the Trust Board. The requirement for review extends to all documents having the effect as if incorporated in Standing Orders.

ANNEX 10

Further Provisions – Members

1. Restriction on membership

1.1 In addition to paragraph 10 of the constitution, the following restrictions on membership apply:

1.1.1 The following will not be eligible to become or continue a member of the Trust:

1.1.1.1 a person who is subject to a sex offenders order or appears on the Protection of Children Act List (POCAL);

1.1.1.2 an individual who exhibits inappropriate conduct (as agreed by a majority of the governors present and voting at a meeting of the Council of Governors), including those who have been identified as the perpetrators of a serious incident involving violence, assault or harassment against Trust staff;

1.1.1.3 a person who is a deemed a vexatious or persistent complainant or litigant against the Trust without reasonable cause, as determined by the Trust Board for initial members, and thereafter by the Council of Governors.

1.1.2 The Trust is not entitled to co-opt Members or appoint 'associates' or other types of Members other than as set out in this Constitution.

2. Termination of Membership

2.1 A member shall cease to be a member if:

2.1.1 they resign by notice in writing to the Company Secretary or Chair;

2.1.2 they cease to be eligible to continue to as a member under paragraph 1.1.1 of this Annex;

2.1.3 they are expelled from membership under paragraph 3 of this Annex;

2.1.4 they cease to be entitled under this constitution to be a member of the public constituency, patient and carer constituency or of any of the classes of the staff constituency;

2.1.5 if it appears to the Company Secretary that they no longer wish to be a member of the Trust, and after enquiries made in accordance with a process approved by the Council of Governors, they fail to demonstrate that they wish to continue to be a member of the Trust; or

2.1.6 they die.

3. Removal from the Membership Register

3.1 A member may be expelled by a resolution approved by not less than two thirds of the governors present and voting at a general meeting of the Council of Governors. The following procedure is to be adopted.

3.1.1 any member may complain to the Company Secretary that another member has acted in a way detrimental to the interests of the Trusts;

3.1.2 if a complaint is made, the Council of Governors may itself consider the complaint having taken such steps as it considers appropriate to ensure that each member's point of view is heard and may either:

3.1.2.1 dismiss the complaint and take no further action;

3.1.2.2 for a period not exceeding twelve months, suspend the rights of the member complained of to attend members' meetings and vote under this constitution; or

3.1.2.3 arrange for a resolution to expel the member complained of to be considered at the next General Meeting of the Council of Governors.

3.1.3 If a resolution to expel a member is to be considered at a General Meeting of the Council of Governors, details of the complaint must be sent to the member complained of not less than one calendar month before the meeting with an invitation to answer the complaint and attend the meeting.

3.1.4 At the meeting, the Council of Governors will consider evidence in support of the complaint and such evidence as the member complained of may wish to place before them.

3.1.5 If the member complained of fails to attend the meeting without due cause, the meeting may proceed in his absence.

3.2 A person expelled from membership will cease to be a member upon the declaration by the Chair of the meeting that the resolution to expel such member is carried.

3.3 No person who has been expelled from membership is to be re-admitted except by a resolution passed by a majority vote of two-thirds of the Council of Governors present and voting at a general meeting.

4. Membership disputes

4.1 In the event of any dispute about the entitlement to membership the dispute shall be referred to the Company Secretary who shall make a determination on the point in issue. If the member is not satisfied with the Company Secretary's decision they may appeal in writing within 14 days of the Company Secretary's decision to the Chair whose decision shall be final.

5. Members' meetings

5.1 All members meetings other than Annual Members' Meetings are called special members' meetings.

5.2 Members meetings are open to all members of the Trust, governors and directors, and representatives of the auditor, and to members of the public unless the Council of Governors decides otherwise

5.3 The Council of Governors may invite representatives of the media and any experts or advisors whose attendance they consider to be in the best interests of the Trust to attend a members' meeting.

5.4 All members' meetings are to be convened by the Company Secretary by order of the Council of Governors.

5.5 The Council of Governors may:

5.5.1 arrange for a members' meeting to be held in different venues each year;

5.5.2 make provisions for a members' meeting to be held at different venues simultaneously or at different times. In making such provision the Council of Governors shall also fix an appropriate quorum for each venue, provided that the aggregate of the quorum requirements shall not be less than the quorum set out below.

5.6 At the members' meeting:

5.6.1 the Trust Board shall present to the members:

5.6.1.1 the annual accounts;

5.6.1.2 any report of the auditor; and

5.6.1.3 forward planning information for the next financial year;

5.6.2 the Council of Governors shall present a report on:

5.6.2.1 steps taken to secure that (taken as a whole) the actual membership of the public constituency and of the classes of the staff constituency is representative of those eligible for such membership;

5.6.2.2 the progress of the membership strategy; and

5.6.2.3 any proposed changes to the policy for the composition of the Council of Governors and of the non-executive directors; and

5.6.3 the results of the election and appointment of governors and the appointment of non-executive directors will be announced.

5.7 Notice of a members' meeting is to be given:

5.7.1 by notice to all members;

5.7.2 by notice prominently displayed at the head office and at all of the Trust's places of business; and

5.7.3 by notice on the Trust's website

at least 14 clear days before the date of the meeting. The notice must:

5.7.4 be given to the Council of Governors and the Trust Board, and to the auditor;

5.7.5 state whether the meeting is an Annual Members Meeting or a special members' meeting;

5.7.6 give the time, date and place of the meeting; and

5.7.7 indicate the business to be dealt with at the meeting.

5.8 The Trust may make arrangements for members to vote by post, or by using electronic communications.

5.9 It is the responsibility of the Council of Governors, the Chair of the meeting and the Company Secretary to ensure that at any members' meeting:

5.9.1 the issues to be decided are clearly explained;

5.9.2 sufficient information is provided to members to enable rational discussion to take place.

5.10 No business may be conducted at a members' meeting unless a quorum is present. The quorum for members' meetings is the Chair (or Deputy Chair) and at least one member from each of the public constituency, patient and carer constituency and staff constituency.

5.11 At a members' meeting the Chair, if present, shall preside. If the Chair is absent from the meeting the Deputy Chair shall preside. If the Chair and Deputy Chair are absent then another non-executive director shall preside. If no non-executive directors are available the Lead Governor shall preside for that part of the meeting.

5.12 If the Chair is absent temporarily on the grounds of a declared conflict of interest the Deputy Chair, if present, shall preside. If the Chair and Deputy Chair are disqualified from participating, then another non-executive director shall preside. If all the non-executive directors are disqualified the Lead Governor shall preside for that part of the meeting.

5.13 If no quorum is present within half an hour of the time fixed for the start of the meeting, the meeting shall stand adjourned to the same day in the next week at the same time and place or to such time and place as the Council of Governors may determine. If a quorum is not present within half an hour of the time fixed for the start of the adjourned meeting, the number of members present during the meeting is to be a quorum.

5.14 A resolution put to the vote at a members' meeting shall be decided upon by a poll.

5.15 Every member present and every member who has voted by post or using electronic communications is to have one vote. In the case of an equality of votes the Chair of the meeting is to have a second and casting vote.

5.16 The result of any vote will be declared by the Chair and entered in the minutes. The minutes will be conclusive evidence of the result of the vote.

GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST

CODE OF CONDUCT FOR GOVERNORS

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 Governors (the Code), the members of the Council of Governors (the COG) which is part of the Trust's governance structure as defined in its Constitution. The Code sets out the standards of conduct which the Trust expects of its Governors.

1.3 This Code should be read in conjunction with the Constitution and other documents relevant to the governance of the Trust, as defined in Appendix A, as well as the Foundation Trust Code of Governance[1]. 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 Governors when they are acting in that capacity.

2.2 Whilst this is the case, the Trust recognises that the Governor role is part-time and unpaid so the Trust will act proportionately and reasonably when applying the expectations set out in this Code while also maintaining standards of conduct that are commensurate with the important role which Governors have in the governance of the Trust.

2.3 This Code applies to Governors when acting in any another capacity only in the event that there are concerns about a Governor's conduct when they are acting in such other capacity and those concerns are relevant to the person's role as a Governor. 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, Governors are required to adopt the Principles of Public Life[2] 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

[1] The Foundation Trust Code of Governance is available here.
[2] The Principles of Public Life are defined here.

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 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 Governors are also expected to support the core principles of the NHS as defined in the NHS Constitution[3] 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 Governors 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 Governors are expected to display at all times. A full description of the Always Values and the associated behaviours will be given to Governors by the Company Secretary.

3.5 Governors 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 Governor at the time of their induction.

4. The role and conduct of Governors

4.1 The role of each Governor and of the Council of Governors is defined in the Trust's Constitution and in relevant terms of reference and role descriptions. Governors are required to comply with these documents (and others defined in Appendix A) and any

[3] The NHS Constitution is available here.

relevant policies and procedures issued to them. Any Governor 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 The Governors recognise that the Council of Governors is an important part of the Trust's governance structure and as such it must work constructively and collaboratively with the Board of Directors (the Board), which, as required by the Trust's Constitution and NHS Provider Licence[4], is responsible for the governance of the Trust. Governors therefore commit to developing (with the Board) and adopting arrangements to facilitate such a relationship between the Council of Governors and the Board, and with relevant members of staff.

4.3 In order to discharge their roles effectively, Governors are expected to adopt good standards of conduct. Therefore, in addition to adopting the values and principles set out above, Governors are expected to:

4.3.1 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 Governors may have (in which respect refer to section 8 below);

4.3.2 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;

4.3.3 Recognise that the Trust is fully committed to the protection of children and as such all Governors are required to participate in appropriate assessments relevant to child protection.

4.3.4 Understand the role and authority of the Council of Governors and the governance of the Trust;

4.3.5 Recognise that the Council of Governors acts collectively and corporately such that each Governor must adopt and support its decisions;

4.3.6 Accept that no Governor has any individual responsibilities or authority and must not seek to act other than through the Council of Governors;

4.3.7 Contribute to the development of and support the Trust's mission, vision, and strategy;

4.3.8 Give thorough consideration to information and advice provided in the course of the business of the Council of Governors such that no Governor should adopt a position that is unreasonably contrary to such advice or to recommendations, or unreasonably withhold approval on any matter;

4.3.9 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);

4.3.10 Obtain and have regard to advice from the Chairman, the Chief Executive (including in his 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;

4.3.11 Participate in training and development provided by or through the Trust, whether for individual Governors or for the Council of Governors as a whole;

[4] The Trust's NHS Provider Licence is available here.

4.3.12 Commit the necessary time to the role, including attendance at general meetings of the Council of Governors, seminars, and training and development events.[5]

5. **Fit and proper person**

5.1 It is a condition of the Trust's NHS Provider Licence that each Governor serving on the Council of Governors is a 'fit and proper person' (as defined in the Trust's NHS Provider Licence). Governors 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).

6. **Accountability of Governors**

6.1 Each Governor is accountable to the Council of Governors and, through arrangements put into place by the Trust, to the members who elected them, or the organisation that appointed them, for his/her performance and conduct.

6.2 The Governors collectively are accountable for the effectiveness of the Council of Governors as an important part of the Trust's governance, for which the Board is responsible.

6.3 In connection with this, Governors accept the role of the Chairman as the leader of the Council of Governors as defined in the Constitution and other governance documents (at Appendix A).

7. **Confidentiality**

7.1 The Council of Governors 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.

7.2 Governors must comply with the Trust's policies and procedures in respect of confidentiality, as provided to them. Therefore, Governors must not disclose information which is stated as being confidential, other than when it is lawful to do so.

7.3 Governors recognise that any disclosure of confidential information puts at risk the Trust's compliance with its duties of confidentiality and, where such data is personal data, the General Data Protection Regulation (*Regulation (EU) 2016/679*),Data Protection Act 2018 (or any future data protection legislation) and other relevant law. 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.

7.4 In accordance with the Constitution the Trust will investigate any breaches of confidentiality on the part of Governors and will take appropriate action.

7.5 No provision of this Code shall preclude any Governors from making a protected disclosure within the meaning of the Public Disclosure Act 1998 but where a governor is considering making any such disclosure, they should seek advice should from the Company Secretary.

8. **Governors' interests**

8.1 The Trust recognises that some Governors hold roles in other organisations or have other interests; it values these where they enable Governors to make an informed

[5] During elections the Trust will communicate to members the time commitment associated with the Governor role so that members who nominate themselves as candidates understand the Trust's expectations. The Trust will make clear that a Governor may be removed from office if he/she fails to comply with requirements in the constitution with respect to attendance at meetings. The Trust expects that staff who are elected as Staff Governors will be allowed appropriate time to fulfil their duties in that role (and will not be required to use annual leave for this purpose).

contribution to the governance of the Trust.

8.2 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 Governors (and others), and to address any conflicts between such interests and those of the Trust. Governors are required to comply with these arrangements as defined in the Constitution and relevant policies and procedures (which are provided to Governors).

8.3 Where there is any doubt as to the relevance of an interest for any Governor, or the process through which an interest should be addressed, advice must be sought from the Company Secretary.

8.4 Governors must not seek to use their position improperly to confer any advantage or disadvantage on any person.

9. **Representing the Trust**

Media

9.1 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.

9.2 Where the work of the Council of Governors is relevant to a matter that is the subject of reporting in the media, or discussions with stakeholders, the Chairman, supported by the Trust's Communications Department, will speak on behalf of the Governors. In doing so the Chairman may consult with the Lead Governor or other Governors as appropriate.

9.3 To protect Governors and to ensure a co-ordinated and managed approach to media and stakeholder relations, no Governor may approach the media or any other stakeholder, or respond to requests for comment, or otherwise seek to represent the Trust. Any Governor receiving a request for comment must, without responding, refer it immediately for action by the Trust's Company Secretary.

9.4 Any Governor 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 Governors should seek advice from the Trust's Company Secretary but where no such advice is sought Governors should notify the department after making comment.

Visits to premises of the Trust or other organisations

9.5 In connection with the work of the Council of Governors the Trust may from time to time invite Governors to visit the Trust's services or facilities, including premises which are not open to members of the public, or premises operated by other organisations. Governors must comply with any arrangements put into place by the Trust (or the other organisation concerned) for such visits, including requirements in respect of infection control and dress.

9.6 In order to ensure the privacy of patients and so that the Trust's services function effectively, Governors may not otherwise visit any of the Trust's premises in their capacity as Governors. Governors may not in that capacity visit the premises of any other organisation without the permission of the Trust and the other organisation concerned.

9.7 The above provisions do not prevent any Governor from visiting the Trust in a personal or other capacity, including as a patient, a carer of a patient, or as a volunteer.

10. **Training & development**

10.1 The Trust is committed to providing appropriate induction, training and development opportunities for Governors to enable them to carry out their role effectively. This ensures compliance with the statutory duty which the Trust has to take steps to ensure that the Governors are equipped with the skills and knowledge they require. Each Governor is, therefore, required to participate in training and development opportunities that have been identified as appropriate for him/her (except with reasonable cause in the opinion of the Chairman, Company Secretary and Lead Governor).

11. **Interpretation of this Code, and compliance**

11.1 Any Governor who requires advice on the provisions or application of this Code should obtain it from the Company Secretary.

11.2 All Governors are required to comply with this Code. Each Governor must confirm this within 28 days of his election or appointment by signing and returning to the Company Secretary a copy of this Code.

11.3 Any suspected or actual non-compliance with this Code will be addressed in accordance with the Constitution.

12. **Approval and review of this Code**

12.1 This Code was approved by the:

12.1.1 Board on [insert date].

12.1.2 Council of Governors on [insert date].

12.2 This Code will be subject to review, led by the Chairman and Company Secretary, not more than one year from its date of approval.

Declaration

I …… [insert name] have read, understood and agree to comply with this Code of Conduct for the Council of Governors of Great Ormond Street Hospital for Children NHS Foundation Trust.

Signature Date

…… …….

APPENDIX A

GOVERNANCE DOCUMENTS

1. Constitution, including its appendices
2. Standing Orders
3. Standing Financial Instructions
4. Any terms of reference for the Council of Governors or any committees established by it
5. Schedule of matters Reserved to the Board and Council of Governors
6. Foundation Trust Code of Governance
7. Code of Conduct for Governors
8. Standard Operating Procedure on Electronic Communications
9. Any role descriptions or similar for Governors

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

GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS

STANDARD OPERATING PROCEDURE FOR MEETINGS AT WHICH PARTICIPANTS ATTEND BY ELECTRONIC COMMUNICATION

1. General provisions

1.1 In this procedure "communication" and "electronic communication" shall mean communication by telephone conference or video conference.

1.2 A person in electronic communication with the chair and all other parties to a meeting of the council of governors or of a committee or sub-committee of the governors shall be regarded for all purposes as personally attending such a meeting provided that, but only for so long as, at such a meeting they have the ability to communicate interactively and simultaneously with all other parties attending the meeting including all persons attending by way of electronic communication. The Trust shall ensure that appropriate electronic communication systems are available for such meetings.

1.3 Meetings held in accordance with this procedure are subject to the Constitution and the Standing Orders for the governors. For such a meeting to be valid, a quorum must be present and maintained throughout the meeting.

2. Convening a meeting utilising electronic communication

2.1 It shall be open to any person to participate in any meeting of the governors by electronic communication, with prior notice to the chair. Where he considers it appropriate to do so, the chair may convene a meeting at which some or all of the persons attending participate by electronic communication (but the chair may not direct that all persons shall participate by electronic communication).

2.2 The chair shall ensure that the agenda and papers, including any papers to be tabled or presentations to be delivered, are issued in accordance with the standing orders to any person who is to participate in a meeting by electronic communication. The standing orders for the governors shall apply in respect of the publication of the agenda and papers for meetings utilising electronic communication.

3. Conduct of the meeting

3.1 At any meeting which utilises electronic communication the chair shall introduce the agenda by stating for the record that one or more person(s) is/are participating by those means. At this time the chair shall ensure that each participant can hear clearly all the others.

3.2 The chair shall inform the persons present of any matters of conduct – for example, by asking each participant to give his/her name when speaking on any matter.

3.3 The meeting shall be deemed to be held at the place (if any) where a majority of the governors attending the meeting are physically present, or in default of such a majority, the place at which the chair is physically present.

3.4 The chair shall conduct the meeting according to the agenda and the standing orders, ensuring that all persons, including those participating by electronic communication, are able to speak to and to hear all other participants throughout the meeting. At each appropriate point the chair shall summarise the discussions and any decisions (particularly for the benefit of persons participating by electronic means).

3.5 Voting shall take place in accordance with the standing orders, subject to arrangements which the chair shall describe to ensure that persons participating by electronic communication may express their votes.

3.6 Any meeting utilising electronic communication must be recorded in minutes.

3.7 The minutes of a meeting held in this way must state that it was held by electronic communication and that the participants were all able to hear each other and were present throughout the meeting. The minutes must state the names of the persons present by electronic means.

3.8 The governors may agree that an audio recording may be made of any meeting utilising electronic communication (for the purposes of writing minutes).

4. Approval

4.1 This procedure was approved by the Council of Governors on [insert date].

[Final draft, 2 July 2018]

Great Ormond Street Hospital for Children NHS Foundation Trust

LEAD GOVERNOR ROLE DESCRIPTION

Principal responsibilities

- To support the Chairman in facilitating a continuing good relationship between the Council of Governors (CoG) and the Board of Directors (the Board).[1]
- To bring to the Chairman's attention any material issues from the Governors.
- To work towards the effectiveness of the CoG and its subcommittees, including supporting the Chairman and Company Secretary in organising any evaluation of the CoG.
- Contribute to the induction process for newly appointed or elected Governors.
- To act as the point of contact between the Governors and NHS Improvement[2].

Specific Lead Governor tasks

- To chair the CoG pre-meeting[3] as required and to ensure that any material matters discussed there are brought to the attention of the CoG and the Chairman.
- To chair meetings of the COG that cannot be chaired by the Chairman, Deputy Chairman or Non-Executives due to a conflict of interest or any other absence.
- To be a member of the Nominations & Remunerations Committee and any other committees established by the CoG.[4]
- In accordance with the process approved by the CoG, to collate the input of Governors for the senior independent director of chairman for the Non-Executive Directors' and Chairman's annual appraisals.
- To liaise with the Company Secretary/ Deputy Company Secretary as and when concerns are raised by Governors.
- Be involved with setting the agendas for the Council of Governors.
- Support the Chair in acting to remove a Governor due to unconstitutional behaviour.

The Person Specification

To be able to fulfil this role effectively, the Lead Governor will:

- Have integrity in accordance with the Nolan Principles (*The 7 Principles of Public Life*), the Code

[1] To include: Where requested by the Chairman, supporting him/her in contacting the CoG or groups of Governors, or in understanding Governors' views on any matter and where approved by the COG and the Chairman, speaking for and represent the COG at the Trust's Annual Members' Meeting or any other occasion.

[2] The Lead Governor may only contact NHS Improvement (NHSI), the organisation which includes Monitor, after authorisation from the Council of Governors (COG) and only when all reasonable efforts have been made to resolve the matters that are of concern to the COG. The Lead Governor may only act as a contact between the Governors and NHSI when the normal channels of communication are unavailable.

[3] This meeting takes place prior to a Council meeting and the Chairman briefing meeting. It is attended by governors only. The purpose of the pre-meeting is to provide a forum to discuss the Council agenda and papers and can receive updates on specific topics as determined by the Governor Development Work Programme.

[4] The COG may agree that the Lead Governor must share this responsibility with the Deputy Lead Governor.

of Conduct for Governors and be committed to the values of the Foundation Trust.

- Enjoy the confidence of the CoG and the Chairman.

- Have an understanding of the statutory duties of Governors, the Trust's Constitution and how the Trust is influenced or regulated by other organisations including the role of and basis that NHS Improvement may take action.

- Have the ability to chair meetings in a manner that works in the best interests of patients and of the Foundation Trust in accordance with the Code of Conduct for Governors.

- Have a willingness to challenge constructively and the ability to influence, negotiate and present a well-reasoned argument.

- Be able to commit the time necessary to represent the position and wishes of Governors in a manner that has their confidence.

- Maintain the confidentiality of information.

Conditions of appointment and Term of Office

- A Governor will nominate themselves for the position of Lead Governor and/or Deputy Lead Governor (including providing an outline of the relevant experience). Separate elections will be conducted for both positions and the elections conducted by the CoG by a 'show of hands' or a secret ballot (as determined by the Chairman).

- The Lead Governor (and the Deputy Lead Governor) must be elected governors and will be appointed to via separate elections at a Council meeting. A staff governor may only be appointed as Lead or Deputy in a situation where he/ she will serve with a publicly appointed governor. Thus a staff governor may stand for election as Deputy only if the Lead is a publicly elected governor.[5] In circumstances where two staff governors each stand for both positions, should the highest voted governor be a staff governor, he/she will be elected as Lead Governor. In this circumstance, the highest voted publicly elected governor will be elected as Deputy Lead Governor.

- The tenure is for 12 months with the option for re-election annually in accordance with due process, for up to the full tenure period of the elected Governor's 'appointment' (subject to removal from office, removal as a Governor or member or any resignation)

- The Lead Governor will be supported and deputised for by a Deputy Lead Governor whose appointment will follow the same procedure above. It is anticipated, where terms of office accord, that the Deputy Lead Governor will put themselves forward for Lead Governor position when that position becomes vacant,. Should a vacancy for the Lead Governor role arise mid-term, the Deputy Lead Governor will be required to step up as Lead Governor until the next election for the Lead Governor and Deputy Lead Governor positions.

- Individuals elected to the Lead Governor and Deputy Lead Governor roles are required to fulfil all relevant requirements as outlined in the Constitution.

Approval and review of this document

[5] Where the Lead Governor is a staff governor, in any situation where the Lead Governor's position as an employee of the Trust gives rise to a position of potential conflict, the Deputy Lead shall act as Lead until the next meeting of the Council, when the situation shall be considered and a decision made as to how it shall be handled.

This document will be reviewed not less than annually.

Deputy Lead Governor

The role of the Deputy Lead Governor is to support the Lead Governor and deputise for him or her when necessary.

Should a vacancy for the Lead Governor role arise mid-term, the Deputy Lead Governor will be required to step up as Lead Governor until the next election for the Lead Governor and Deputy Lead Governor positions.

Final June 2018

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
25 July 2018

Phasing governor elections and changes to constituency boundary changes **Submitted by: Anna Ferrant, Company Secretray**	**Paper No: Attachment 3**

Aims / summary

The Council and the Board are keen to ensure that the framework by which governors are elected/ appointed is revised so as to prevent a major turnover of the majority of governors in one election. This happened at the last election held in January 2018, when 22 seats (public, patient/carer and staff) were subject to election and of these, 18 new governors were appointed because the majority of the governors at the time of the election (then called councillors) had reached their 6 year maximum tenure (two three year terms) and were not permitted to stand. This meant that skill and knowledge of governors was lost. Phasing elections (and holding them more frequently for smaller numbers of seats) will ensure that there is a gradual turnover of governors, retaining experience, providing for secession planning going forward and ensuring good corporate governance.

The Constitution Working Group (The Group) considered as part of their review how best to avoid a reoccurrence of the above situation by considering introduction of phasing elections as well potential changes to Constituencies to better reflect where members reside. The rest of the paper explores these options in more detail.

Action required from the meeting

The Board is asked to consider the options proposed for phasing and changes to constitutional boundaries. The Group recommends that option 3a or 3b is considered for further review and workup as it mitigates for the risks posed by the changes and brings the most benefits. Should the option be approved, the Group proposes that over the Summer, governors (and the Board for information) are provided with more detailed information on how the proposed changes will impact on them personally as well as on the Council elections process and membership boundaries.

The Council is considering the attached proposal at its meeting on 24 July 2018. A final proposal for approval will be brought to the November 2018 Council meeting, voted on by a simple majority of governors present and voting. Approval will also be sought from the Board.

Contribution to the delivery of NHS Foundation Trust strategies and plans

Good governance

Financial implications

Phasing will result in annual elections and incur election and administrative cost

Who needs to be told about any decision?

The Council of Governors and the members

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

Anna Ferrant, Company Secretary

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

Chief Executive

Phasing governor elections and constituency boundary changes

The Constitution Working Group (the Group) considered whether phasing elections and changes to constituency boundaries should be implemented and, if so, how they could be implemented with the least impact and most benefit. The following was noted/ commented on and proposed for discussion by the Council:

Matters proposed for the revised framework

Phasing

1. The Group proposed that a third of all governors should be subject to election every year, in order to maintain an appropriate balance between refreshing and retaining the knowledge and experience of the Council. In order to introduce this, elections would need to be initially held for seats with a mixture, 1, 2 and 3 year terms (depending on the option adopted). This would be a change from the current Trust policy of all elected seats being set up for 3 year terms. The current Constitution states (at paragraph 14.1) that "*an elected councillor may hold office for a period of up to 3 years*". Although this permits any Councillor (now called Governor) to serve a term of office of up to three years, the Trust policy has been to apply this as a 3 year term.

2. The Group agreed that
    a. Phasing should, wherever possible, be implemented equally across the consistencies and classes (unless there is a good reason to not do this, as highlighted later under option 3 below).
    b. Phasing should be applied to all elected seats only (staff constituency, public constituency, patient and carer constituency).

    This would mean, once implemented, that 5-6 governors a year would be subject to election (dependent on whether the Council approves the revised classes).

3. Phasing should be determined by the number of votes received by a candidate in their constituency during an election, with the highest polled candidate receiving a three year tenure, the next highest polled candidate a two year tenure and the lowest polled candidate a one year tenure. This would only be for the first election when phasing is introduced within a constituency. After that, all tenures will be for 3 years. The constitution currently provides that a governor may hold office of a period of up to three years. This allows the Trust the flexibility to hold elections for shorter terms of office to introduce the phasing.

4. The Group suggested that the phasing proposed should be introduced as soon as practical (March 2020) and in any event, no later than March 2021 at the end of the current terms of the majority of governors. The phasing could be implemented from 1 March 2020 (allowing existing governors the time to have served as a governor under their current tenure) and time to plan for a new election running from December 2019 through to end January 2020. However, the ability to do this depends on the changes to classes and some governors

voluntarily shortening their terms of office (see below). Note 1 Governor has already resigned due to various circumstances and more may resign in the intervening period.

Constituency classes

5. At the time of considering how phasing could be implemented, the Group also reviewed the make-up of the constituencies to check they were reflective of current electoral areas and of the population base from where members may originate. Issues have previously arisen with how the current constituencies are mapped and the inconsistent and confusing way in which public and patient/ carer members are allocated to classes within their constituency that map to different locations, despite individuals from the same house living in the same place.

6. Following consideration of the number of members within each constituency and the number of outpatient appointments mapped to a constituency (used as a proxy of the demand from these areas for the hospital's services and the possible number of members that could be represented), the Group agreed to recommend the following:
    a. The Council does not appoint more than 27 governors (as current) for purposes of ensuring the Council is of an appropriate size and not unwieldy.
    b. The electoral areas that constitute each class for the patient and carer constituency and public constituency are updated in line with current electoral boundaries.
    c. In order to provide consistency of approach and clarity for members and governors, the public, patient and carer classes are aligned so that they cover the same electoral areas.
    d. The split between North and South London is removed.
    e. The associated surrounding areas to North and South London are moved into new public and patient/carer classes as follows (for public and patient/carer. Please note that the patient and carer constituency would remain sub-divided in patient classes and parent/carer classes so that for the patient/carer constituency, there would be six classes) (see Appendix 1):
        i. London (covering all 32 London Boroughs plus the City of London)
        ii. Home Counties that send a relative number of patients to GOSH (called Trust Home Counties constituency). This would reflect the current electoral constituencies listed under surrounding areas plus Berkshire (as a number of patients attend from Berkshire)
        iii. The Rest of England and Wales.

7. The Group proposed allocating a number of governor seats to each class which broadly reflected the relative proportions of members in each of the proposed classes. It was therefore recommended that three governors be allocated to each London class (public, patient and carer), two to each Trust Home Counties class and one to each Rest of England and Wales class (see Appendix 1).

8. The Group proposes that the proposed revised classes are implemented at the same time as the phasing of the governor seats, which would ensure members match constituencies in a consistent way, reduces impact and ensures economies of scale in planning and communicating any changes.

9. All elections should be held at the same time every year, as far as possible, to try to maintain order to the election timetable process for members and governors alike.

For noting:

1. Rather than bring worked-up options for the Council to consider at the July meeting, the Group agreed to provide a high level options paper for the Council to consider on phasing for governors' elections. Should governors and the Board agree with changing constituency boundaries and phasing, any option would have a personal impact for each elected governor and as such it was felt that all governors should be given sufficient time to be consulted with over the Summer on the preferred option, with the final discussion and approval being sought at the November Council meeting.
2. All governors elected currently have been elected for 3 year terms. Current terms can only be changed where an individual governor volunteers to step down from their current seat and be subject to a further election. It is only at this point that phasing can be implemented.
3. There is no requirement for members to vote on any of these proposed changes as they do not relate to the powers and duties of the Council.
4. The paper on the July Council agenda proposes that Governor tenures are set for 6 years maximum over a lifetime and for the purposes of this paper and the work of the Group in reviewing the options available, a 6 year maximum has been used to consider how phasing will be implemented.
5. When considering changes to the constituencies, the NHS Act 2006 determines how the Trust will need to apply this as follows:
    a. Under the Act, a person who is a member of a constituency, or of a class within a constituency, may not, while that membership continues, be a member of any other constituency or class i.e. members cannot belong to two classes simultaneously. This means that if the Trust decides to change the classes, this must be done wholesale for each constituency – the old classes and new classes cannot co-exist as they would overlap and cause members to belong to more than one class at the same time. For example, a member from the North London class of the public constituency would also be a member of the new London class.
    b. When the classes change the Trust cannot simply move each governor from their old class into the new class for which they are eligible; the Trust must hold elections for each of the new classes: The Act provides that governors must be elected by members of the class that they belong to. When the classes are changed, the original classes from which the governors were elected from will cease to exist and the governors will therefore no longer have been elected by the class they belong to – the membership of which will have changed.
    c. This means that if the Trust is going to change the classes, there is no benefit to trying to bring in phasing prior to changing the classes as once the classes change all governor seats in the affected constituency will be up for election again.
    d. This also means that, during the period when the new classes of members are electing governors, there will technically not be any governors in the constituency in which the classes are being changed – the old governors will have been disqualified and the new governors will not yet have been elected.

e. The NHS Act 2006 (the 2006 Act) requires that at least half of the Council are elected from the public and/or patient and carer constituencies. Given (d) above, changes to the classes could result in the Council no longer meeting this requirement during the election period. This means that any changes to constituencies needs to be carefully planned and timetabled to avoid impacting on any decisions required by the Council during a period where the Council was not properly constituted.

Taking all of the above matters into account, the Group has considered how phasing of elections can be implemented in an efficient manner, meeting the needs of the Board and Council and complying with statutory requirements. Three possible options are proposed below, outlining the risks and benefits to each:

Option	Risks	Benefits
1. Do nothing – do not implement phasing of elections and do not change the constituencies	At the end of the six year tenures for current governors (assuming that the current governors are re-elected at the end of their three year term), the Council will face another majority turnover of governors, losing knowledge, experience and preventing succession planning. The constituency boundaries will remain inaccurate and inconsistent between the public and patient and carer constituencies. Certain electoral areas will remain inaccurately mapped to classes, causing confusion for conducting governor elections.	No benefits except that there will be a reduced cost due to less elections over the 6 year period.
2. Implement phasing of elections and maintain existing constituencies and classes	The phasing of elections prior to 2021 will require governors to volunteer to step down early from their current terms of office. If some governors refuse to do so, then, as the classes are not changing, the implementation of the phasing could still start to be implemented prior to 2021 if some governors (but not all) stepped down early, however, it would prevent the phasing from working smoothly and would be difficult to achieve an even split of phasing between	Phasing could be implemented under one full governor election. If governors do not wish to step down early, the phasing could be introduced in any event in 2021 when the majority of the current governors' terms come to an end at which point the next elections would be for a mixture of 3, 2 and 1 year terms of office. There would be no time period without a properly constituted

Option	Risks	Benefits
	the classes and constituencies. The phasing of elections will require a communications strategy to inform members of the phasing and would be a missed opportunity to delay communications on changes to constituency classes at the same time. The constituency classes will remain inaccurate and inconsistent between the public and patient and carer constituencies. Certain electoral areas will remain inaccurately mapped to classes, causing confusion for conducting governor elections.	Council (as opposed to Option 3 below).
3. Implement phasing based on new classes from 2020 in a staggered way to manage statutory compliance for the Council	The proposed class changes will reduce seats in the public constituency and increase seats in the patient/ carer constituency meaning that if governors choose to re-stand in the public constituency, they will be competing with others for fewer seats. Implementing the class changes could impact on the Council's statutory compliance and therefore its ability to operate. This risks impacting on business continuity if the Council is not operational for certain statutory approvals that it must make. If the classes in both the public and patient/carer constituencies were changed simultaneously, the Council would be without any governors in these constituencies and would be in breach of the 2006 Act. The class changes could be	Staggering the phasing and constitutional boundary changes as proposed would: • Enable current governors to serve almost two years of their current three year tenure and help mitigate the risk of governors feeling they have had their tenure cut short; • Manage the impact on the Council maintaining compliance to operate • Manage implementation of elections every year for a third of seats per year. • Help manage communications more effectively with members and allow the admin team to deal with queries and communications more effectively and in a controlled way per constituency, ensuring any learning for the patient and carer election.

Option	Risks	Benefits
	staggered so that the classes are changed in one constituency at a time. This would help implement the phasing of elections sooner. However, staggering the class changes would require all of either the public or patient /carer governors to volunteer to step down from their current positions before the end of their three year terms. If some governors refuse to do so, it would still be possible to implement the class changes and phasing in 2021 when the majority of the Council governors' current terms of office come to end.	

Action for Council

The Council is asked to consider the above options proposed for phasing and simultaneously making changes to constitutional boundaries. The Group recommends that option 3a or 3b is considered for further review and workup as it mitigates for the risks posed by the changes and brings the most benefits.

The Group has considered how option 3 could be implemented and proposes two sub-options - either:

Option 3a: Changes to the classes in each of the public and patient and carer constituencies could be implemented with the phasing of elections in a 'staggered' way:

- 7 public governor seats are subject to the class reorganisation (to become 6) and phasing for an implementation date of 1 March 2020 (noting the election will be held over December 2019/January 2020 and the communications plan will be implemented from July 2019.). The Council would remain compliant with the 2006 Act at this stage as there would still be 10 patient and carer governors in place (in the current classes), 5 staff and 4 appointed governors).
- 10 patient and carer governor seats are subject to class reorganisation (to become 12) and phasing for an implementation date of 1 March 2021 (noting the election will be held over December 2020/January 2021 and the communications plan will be implemented from July 2020.). The Council would not be compliant with the 2006 Act for the period of the election (around 40 days) as there would only be 6 public governors in place (in the new constituency), 5 staff and 4 appointed governors).

This option would manage the implementation of the new classes and it would start phasing earlier, in 2020. It would avoid having a period with no public or patient/carer governors at all for a period (in comparison to 3b), although it would still involve a period during which the Council would not be compliant with the 2006 Act and therefore unable to act. However, this would only be for the period of the election and could be appropriately timetabled.

Option 3b: Changes to the classes in each of the public and patient and carer constituencies could be implemented with the phasing of election in one go in 2021.

This would allow current governors to see out their three year term and would not be reliant on governors needing to volunteer to step down for re-election. If the classes in both the public and patient/carer constituencies were changed simultaneously and phased elections introduced, the Council would be without any governors in these constituencies and would technically be in breach of the 2006 Act, however this would only be for the period of the election and could be appropriately timetabled. This option would however mean that there is an election involving the majority of governors on the Council. However, most of the current governors will be eligible to put themselves forward for re-election for another term.

The Council is asked to note that if the Council and Board approve phasing and simultaneously making changes to constitutional boundaries (whether from 2020 or 2021), a whole constituency of governors must be 'phased' for election at one time and the members moved to their new class within their constituency. This is because the Trust cannot have a situation where members (and governors) co-exist in two different classes within a constituency at one time. So, if governor vacancies arise between now and 2020 or 2021, the Council would have to consider how to take this forward, noting they will have approved new constitutional boundaries from 2020 or 2021.

Attachment J

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
25 July 2018

Clinical Operations Restructure **Submitted by: Nicola Grinstead, Deputy CEO**	**Paper No: Attachment J**

Aims / summary

- In May 2016 when the current Trust structure was implemented, a commitment was made to evaluate it after 2 years
- Consequently, in April 2018, the Trust carried out an evaluation into the Clinical Operations structure
- The Deputy CEO led 10 workshops and shared a series of questions across the Trust. Over 300 staff members directly participated with others joining discussions in local team meetings.
- Based on feedback received a draft structure was proposed and over 200 staff joined in an exercise to make final adjustments.
- This proposed structure was then shared with the entire Trust for formal consultation with over 300 responses received.
- The new structure achieves the following important points which emerged from the various consultation exercise;
    - A larger number of smaller directorates making roles more manageable and achievable
    - Clarity on reporting lines and accountability
    - Clinical groupings based on patient pathways and clinical connections rather than people and politics
    - An increase in senior nursing roles
    - Parity in senior nursing pay with senior management pay
    - Clinical leadership at speciality level
    - Integration across the offices of the DCEO, CNO and MDO
    - The introduction of some new, strategically important, roles including a Chief of Mental Health Services and a Chief AHP
- It is acknowledged that the structure cannot please every single staff member; some suggestions submitted by staff were in direct contradiction to each other.
- However, it is acknowledged broadly that the new proposals bring considerable benefit and improvement
- Interviews for the new roles take place in the fortnight commencing 30th July and the new structure 'goes live' on 1st October
- Between now and the go live date, the DCEO/CN/MD will deliver induction and preparation sessions to ensure the new leadership teams are supported and prepared.

Action required from the meeting
The Trust Board is asked to note the approach to consultation and to endorse the final structure and consultation response.

Contribution to the delivery of NHS Foundation Trust strategies and plans
Provides the framework for clear accountabilities to deliver the GOSH strategy

Financial implications
The restructure is cost neutral.

Attachment J

Who needs to be told about any decision? All GOSH staff have been informed by email and all decision documents are available on the Trust intranet
Who is responsible for implementing the proposals / project and anticipated timescales? Deputy CEO with support from Chief Nurse, Medical Director and HR&OD
Who is accountable for the implementation of the proposal / project? Deputy CEO

Who's who at Great Ormond Street Hospital

JULY 2018

NHS
Great Ormond Street Hospital for Children
NHS Foundation Trust

Chairman

Sir Michael Rake

Non-executive Directors

Deputy Chairman
Akhter Mateen ♦

Senior Independent Director
James Hatchley ♦

Non-Executive Director and Director
UCL Great Ormond Street Institute of Child Health
Professor Rosalind Smyth ♦

Non-Executive Director
Lady Amanda Ellingworth ♦

Non-Executive Director
Chris Kennedy ♦

Non-Executive Director
Vacant

♦ Denotes voting member of Board of Directors.

Council of Governors

Lead Governor
Mariam Ali

Patients: London
Elena-May Reading
Zoe Bacon

Patients: outside London
Alice Rath
Faiza Yasin

Parents and Carers: London
Emily Shaw
Stephanie Nash

Parents and Carers: outside London
Claire Cooper-Jones
Lisa Allera

Public: North London and surrounding area
Simon Hawtrey-Woore
Teskeen Gilani
Theo Kayode-osiyemi
Simon Tan

Public: South London and surrounding area
Fran Stewart

Public: Rest of England and Wales
Colin Sincock
Julian Evans

Staff
Michael Glynn
Nigel Mills
Paul Gough
Quen Mok
Sarah Aylett

Appointed Governors

UCL GOS Institute of Child Health
Jugnoo Rahi

self management UK
Lucy Moore

London Borough of Camden
Lazzaro Pietragnoli

Chief Executive

Dr Peter Steer ♦

Company Secretary
Dr Anna Ferrant

Senior Advisor
Louisa Desborough

Deputy Chief Executive

Nicola Grinstead ♦

Director of Operational Performance and Information
Peter Hyland

Director of ICT
Ward Priestman

Director of PMO
Jon Schick

Director of Operations IPP
Trevor Clarke

Clinical Director of Operations

Nursing Director of Operations

Director of Operations – NHS

Chief Nurse

Alison Robertson ♦

Deputy Chief Nurse
Polly Hodgson

Assistant Chief Nurse for Patient Experience, Engagement & Quality
Herdip Sidhu-Bevan

Assistant Chief Nurse for Education
Lynn Shields

Assistant Chief Nurse for Workforce
Tricia Bennett

Deputy Chief Nurse for Research and Orchid
Faith Gibson

Chaplaincy
James Linthicum

Director of Infection Prevention and Control
John Hartley

Chief Nursing Information Officer
Sarah Newcombe

Medical Director

Matthew Shaw ♦

Deputy Medical Director & Responsible Officer
Andrew Long

Deputy Medical Director
Sanjiv Sharma

Head of Quality and Safety
Salina Parkyn

Caldicott Guardian
Rob Evans

Chief Clinical Information Officer
Shankar Sridharan

Chief Research Information Officer
Neil Sebire

Associate Medical Directors
Daljit Hothi
Sophie Skellett

Guardian of Safe Working
Renee McCulloch

Freedom to Speak Up Guardian
Luke Murphy

Chief Finance Officer

Helen Jameson ♦

Deputy Chief Finance Officer
Tom Burton

Head of Financial Management
Jonathan Wharton

Head of Contracts
Vacant

Head of Financial Control
Neil Redfern

Head of Procurement
Diane Wilson

Director of HR and Organisational Development

Ali Mohammed ♦

Deputy Director of HR and Organisational Development
Alison Hall

Assistant Director of HR and Organisational Development
Sarah Ottaway

Acting Assistant Director of HR and Organisational Development
Matt Guilfoyle

Assistant Director of Development
Vacant

Director of Development

Matthew Tulley

Deputy Director of Redevelopment
Stephanie Williamson

Clerk of Works
Joe McGonagle

Director of Estates & Facilities
Graham Sherlock

Director of research and Innovation

David Goldblatt

Deputy Director of Research and Innovation
Emma Pendleton

Director of NIHR GOSH Clinical Research Facility
Dr William van't Hoff

Director of NIHR GOSH Biomedical Research Centre
Professor Thomas Voit

Director of Communications

Cymbeline Moore

Deputy Director of Communications
Katie Morrison

Commercial Director

Brain

Chief of Service, Head of Nursing, General Manager

Services: Neurology, Neurosurgery, Neuromuscular, Epilepsy, Neuro-disability, Neurophysiology, Endocrinology, Metabolic

Body and Bones

Chief of Service, Head of Nursing, General Manager

Services: Nephrology, Urology, Gastro, SNAPS, CAMHS, General Paediatrics, Orthopaedics, Spinal, Adolescent Medicine

Peri-operative Care

Chief of Service, Head of Nursing, General Manager

Services: Theatres, Anaesthetics, Radiology, Interventional Radiology, Nuclear Medicine, Pain, Pre-op assessment, Cath Labs, Neuro-radiology

Sight and Sound

Chief of Service, Head of Nursing, General Manager

Services: ENT, Audiology, Cochlear, Opthalmology, Plastics, Craniofacial, Cleft, Dental and Maxilofacial, Outpatients

Cancer and Blood

Chief of Service, Head of Nursing, General Manager

Services: Oncology, Haematology, Haemophilia, Palliative Care, Immunology, Bone Marrow Transplant (BMT), Infectious Diseases, Rheumatology, Dermatology

Heart and Lung

Chief of Service, Head of Nursing, General Manager

Services: Cardiology, Cardiac Surgery, Respiratory, PICU/NICU/CICU, CATS

International and Private Patients

Chief of Service, Head of Nursing, General Manager

Services: International and Private inpatients and outpatients

Specialised Hospital Services

Group Director, General Manager, Chief Pharmacist, Chief Allied Health Professional, Chief Labs / Scientist, Chief Genetics, Chief of Mental Health Services

Services: Pharmacy/BME, Physiotherapy, Occupational Therapy, Speech & Langauge Therapy, Dietics, Psychology, Lab Medicine, Genetics

The child first and always Our Always values: Always **welcoming** • Always **helpful** • Always **expert** • Always **one team**

Who's who at Great Ormond Street Hospital

JULY 2018

NHS
Great Ormond Street Hospital for Children
NHS Foundation Trust

Chairman

Non-executive Directors

Council of Governors

- Chief Executive
- Deputy Chief Executive
- Chief Nurse
- Medical Director
- Chief Finance Officer
- Director of HR and Organisational Development
- Director of Development
- Director of research and Innovation
- Director of Communications
- Commercial Director

Brain

Body and Bones

Peri-Operative Care

Sight, Sound and Skin

Cancer and Blood

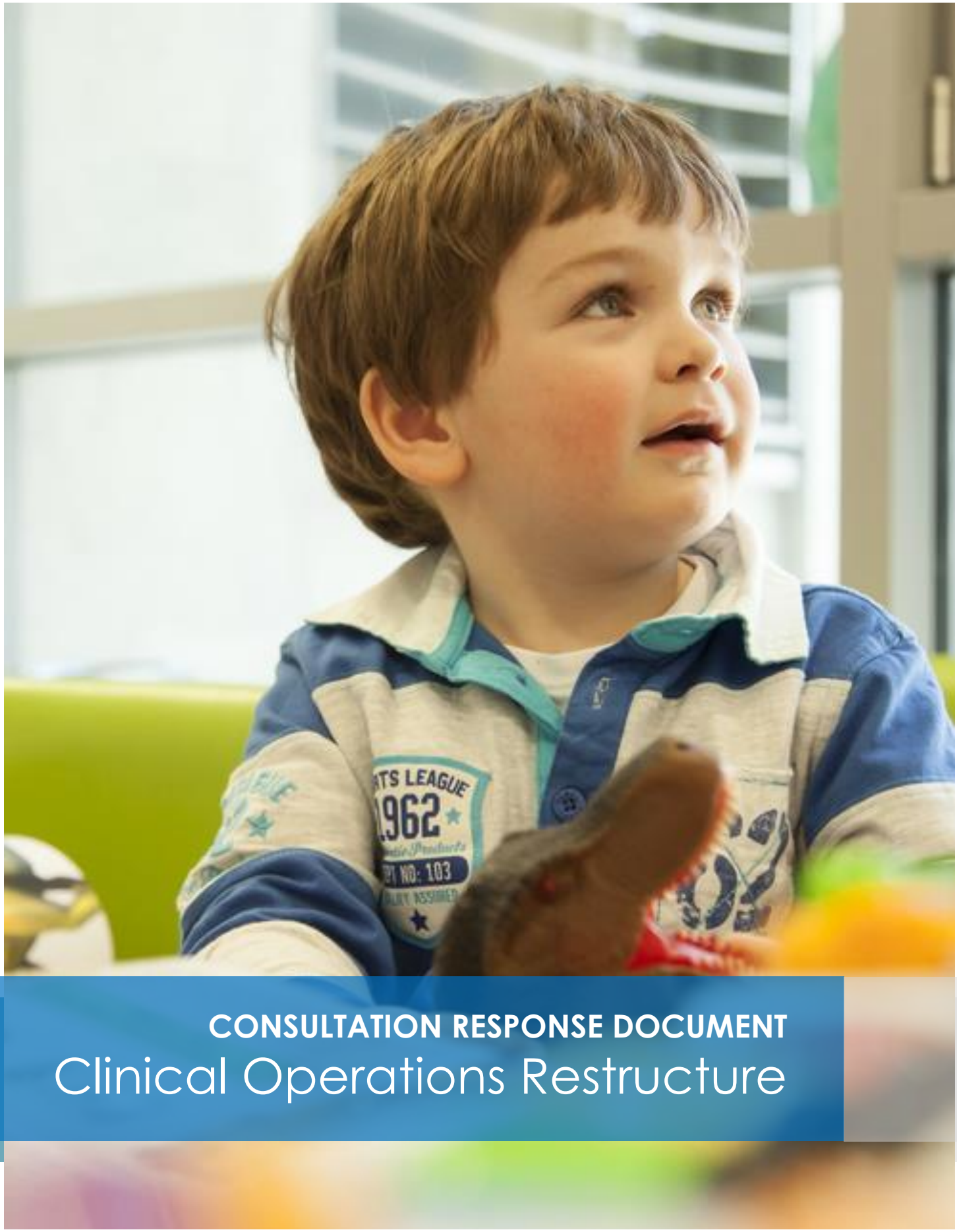
Heart and Lung

IPP

Specialised Hospital Services

The child first and always

Our Always values: Always **welcoming** • Always **helpful** • Always **expert** • Always **one team**



CONSULTATION RESPONSE DOCUMENT

Clinical Operations Restructure

Great Ormond Street Hospital for Children NHS
NHS Foundation Trust

The child first and always

Introduction

Following the close of the consultation period regarding the clinical operations restructure, this document provides a summary of the key themes arising from the feedback, together with confirmation of the leadership structures and specialties that sit within the new directorate model at Great Ormond Street Hospital.

Fulfilling our potential

We began this restructure process several months ago, with a clear commitment to evaluate the way our clinical divisions are working. The aim has always been to ensure that our structure best supports our vision to help children with the most complex health needs fulfil their potential.

The consultation period for our clinical restructure closed on Friday 6 July and I'd like to reiterate my thanks to everyone who has provided input. Your time and energy has been very much appreciated and the feedback has been honest and constructive. We've really worked hard to get the clusters of services in the right place, and we've made it a priority to ensure there is clear accountability across the new structure.

I'm really pleased to be able to share the hospital's new clinical operations structure with you, along with several other important pieces of information:

- A summary the key themes raised through the consultation and our official response
- Confirmation of specialty groupings within the new directorates
- Details of the 'expressions of interest' and appointment process for new roles
- A time line of next steps
- A commitment schedule

Between now and Monday 1 October, when the new structure will become operational, we will turn our focus to ensuring the appropriate support and ways of working are in place to ensure a smooth transition for our new leadership teams – and we will of course keep you updated on how you can engage with and contribute to these plans.

This is a really exciting time for us at GOSH, and to make this new structure work, we need to call on the broad diversity of skills, experience, and knowledge we hold here at the hospital. This is your chance to put yourself forward and make a difference to our future and the exemplary care we offer all of the children and young people who come through our doors.

Thanks once again for your engagement and commitment.

Best wishes

Nicola Grinstead
Deputy Chief Executive

16th July 2018

1. Feedback themes and responses

During the consultation period, over 100 comments and questions were received; some of these were comments agreeing with aspects of the proposals or requiring clarification; others were more detailed in providing alternative suggestions with regard to structure or where specialities sit within the directorates.

Below is a summary of the key suggestions and questions, the response and rationale for decision.

Suggestion/Question	Decision &/or Answer	Rationale
Can we move dermatology into 'Cancer & Blood' with rheumatology	Yes	• Multiple staff contacted us to suggest this change • Rheumatology and Dermatology share resources and staff and as such there is a practical benefit in keeping them together in the same place • The Clinical Leadership has confirmed their agreement with this approach
Can we move Nightingale out of 'peri-operative care' and into a 'ward driven' directorate	Yes	• When we meet with the matrons to determine the final allocation of services in their portfolios we will also discuss and agree which directorate can best support Nightingale.
Can we keep 'play' services with psychology	No	• A meeting was held with the Chief Nurse, DCEO and Head of Play. • Pro's and con's of moving into the CNO were discussed. • Given the agreed focus required to support the development of Mental Health Services and also the links across play and patient experience and play and GOSHCC it is preferred to place the Play Service in the CNO
Can we move the cath labs into 'peri-operative'	Yes	• This has been suggested by multiple staff and is particularly supported by the nursing workforce who see alignment across the nursing roles in theatre and the cath labs • Cath lab nursing and budgets will therefore transfer into the peri-operative division
Can we move neuro-radiology to 'Brain'	No	• A meeting was held on Monday 9th July with DCEO, MD, DD, HOCS for imaging and representatives from neuro-radiology • The pros and cons of moving neuro-radiology were discussed in full. Benefits include continued relationships with current DD, alignment with clinical teams in 'brain'. Disadvantages include fragmentation of imaging, separation of neuro-radiology from professional imaging colleagues • It was discussed that the neuro-radiology service would benefit from specific focus and leadership as it recruits new staff and builds a new team. It is proposed, as an alternative to moving into 'Brain', that neuro-radiology stays in 'peri-operative' but appoints its own specialty lead.
Can we move cardiac anaesthesia into 'Heart & Lung'	No	• This suggestion was put to the cardiac anaesthesia team who confirmed preference to remain with the rest of anaesthetics in peri-operative

Suggestion/Question	Decision &/or Answer	Rationale
Can Haemophilia/cleft/neurophysiology/audiology have its own Speciality Lead?	TBC	• The consultation paper allocates an indicative number of Specialty Leads to each directorate • Now that the final allocation of services to each directorate is confirmed we will determine the portfolios for matrons, service managers and specialty leads. An indicative list has been shared with the consultation documentation for review. • We have agreed a principle that those specialties with less than 5 consultants will not have an individual specialty lead
Can we be assured that the 'Heads of Service' roles in therapies are not being removed and that therapies staff will not be down banded?	Yes	• The Heads of Service roles in therapies stay in the structure. • There are no plans to down band any roles. • In addition we are introducing a new 'Chief AHP' who will be directly line management accountable for AHPs in 'Specialised Hospital Services' and a professional representative for AHP's across the whole Trust. This post-holder will have a voting seat at the Trust's Operational Performance and Delivery Group to ensure representation on AHPs in key decision making
The directorates do not appear equal in terms of staff numbers/budgets. Can we have assurance they are all manageable?	Yes	• Some services (theatres, intensive care) will inevitably have higher WTE numbers than other services as a consequence of the type of services they are • These services have well established and effective team leadership structures and we do not plan to change these • In addition to WTE count and budget size there are a range of other factors which contribute to the complexity of a directorate; for example the number of outreach clinics run, the number of commissioned highly specialised services, the interface with other Trusts, the level of research activity etc • We believe each directorate is manageable with the resources we have available and we are committed to ensuring our new leadership teams have the support and development opportunities that they need to succeed
Can transition/adolescent medicine sit in the Chief Nurses Office?	TBC	• We have received several comments on the placement of adolescent medicine and transition services; some suggesting movement to the Chief Nurses Office, some suggesting placement in 'Body and Bones'. • We have a meeting with the relevant staff scheduled for 19th July to make a final decision
Can PICU/NICU/CICU & CATS become a separate directorate in their own right?	No	• There was not a consensus view on this request with some staff setting out their support to keep critical care, cardiac and respiratory together • There was significant support for the three ICU's to be together in one directorate – particularly from nursing staff • There was support for CICU to stay with the rest of cardiac services • To establish a 9th Directorate requires investment in additional overheads costs making the model unaffordable

Suggestion/Question	Decision &/or Answer	Rationale
Can renal move to 'Cancer and Blood'?	No	• There has been consistently strong feedback to keep urology and nephrology together and in this context the preferred outcome is for both services to stay with 'Body & Bones'
Can we change the names of the directorates?	Yes	• Naming convention really matters and we want to get this right! We also know it will be impossible to please everyone! • We have received multiple suggestions including colours, numbers, names of famous people, medical terminology and child friendly words • The most important thing to remember is that these names serve only to describe how we group services together for line management and accountability purposes; they are not names we would expect to use with children and families or at conferences etc • Names need to be short and descriptive (otherwise they get abbreviated anyway!) and to avoid acronyms which become meaningless • To make our final decision on the names we will use we are asking GOSH Arts, YPF and a small staff group to help us
Can we ensure QI is embedded in the directorates and is clinically driven?		• This consultation paper focuses on the accountability structure in clinical operations – it does not include, within its scope, a review of the QI team or the QI methodology used across the Trust. • The importance of QI is acknowledged and recognised and is embedded into the JDs of the new Deputy Chief of Service role. • The Medical Director will meet with the staff putting forward this proposal.
Can we move DCAMHS to 'Brain'?	No	• This is the service which has generated by far the largest response within the consultation from a range of stakeholders • There is not a consensus view with some suggesting DCAMH move into 'Brain', other suggesting it move to 'Specialised Hospital Services' and others suggesting it stay in 'Body and Bones' • The links with Neurosciences academically are acknowledged and this accountability structure should not prevent ongoing research and academic opportunities • It is clear that DCAMHS interfaces with a number of clinical services across the Trust – this new accountability structure should not prevent DCAMHS from continuing to support patient pathways across the Trust and to work with clinical colleagues from all services • There is significant support from nursing staff for Mildred Creek Unit to continue to come under joint nursing leadership with gastro and not with neurosciences • Body & Bones focuses on supporting the provision of care for children with complex and perplexing conditions and there is a real opportunity for us to strengthen our pathway management for these children

Suggestion/Question	Decision &/or Answer	Rationale
Can we have further clarity on what the Chief AHP will be responsible for – and be involved in shaping this new role?	Yes	• On 19th July we will be holding a workshop with a range of AHP representatives to develop the new role and to be clear about its roles and responsibilities • New nationally published guidance has been made available and we will use this to guide our discussions and decision making
Can we have further clarity on what the Chief of Mental Health services will be responsible for?	Yes	• This is a new role being created to really demonstrate the Trust's support to further developing mental health services across the Trust and to greater integration between physical and mental health. • The post will be a clinical post and interest is welcome from doctors, nurses and AHP's • The post holder will be responsible for setting and driving the Trust's Mental Health Plan and for engaging with key stakeholders internally and externally
Can we have clarity on what happens to the existing 'division specific' roles?	Yes	• There are approximately 30 people who have specific 'Charles West' or 'JM Barrie' responsibilities including practice educators, clinical governance co-ordinators, data teams, administrative support, deputy general managers, division research leads • All of these post holders will come under the central line management of one of the newly appointed senior operational team (i.e. Clinical Director of Operations, Nursing Director of Operations or Director of Operations) or a central corporate function such as Nursing Education and will work in support of the 8 directorates. • Individual staff members will be engaged in discussions on the development of their roles
Can we have confirmation that research isn't lost? It is not mentioned in the new structure. Can we be assured we stay a research hospital?	Yes	• Currently there is a Director of Research and Innovation reporting directly into the CEO with responsibility for the Trusts research strategy, its operational delivery and oversight of the BRC and CRF. This will not change. • In addition, Orchid reports directly to the Chief Nurse and this will not change. • Senior representatives from the research teams will continue to be invited to and to attend forums such as the Matrons Forum, SMT and the Trust's Operational Performance and Delivery Group • The two divisional research leads will continue to support the work of the new directorates. • Research monies will continue to be allocated out to directorates so that Directorate Leadership teams can invest in research activities • Specific research responsibilities will be detailed in the Job Descriptions for each leadership role in the new structure
Can general paediatrics move into 'Specialised Hospital Services?'	No	• There were several conflicting views on the placement of General Paediatrics in the directorates • After further exploration, it has been decided to leave General Paediatrics in the 'Body and Bones' directorate

Suggestion/Question	Decision &/or Answer	Rationale
Can imaging (including IR) move into Specialised Hospital Services? – this way they will be with the Chief AHP	No	• There were several suggestions on the placement of imaging; ranging from the whole service moving to Specialised Hospital Services, to keeping IR with theatres but moving other services, to separating neuro-radiology into Brain. • There has been much support for keeping IR with theatres • Not all AHP's need to be line managed by the Chief AHP to access their support – the Chief AHP will have a professional role to support AHP's from all professionals regardless of directorate.
Can we be assured there is sufficient service manager support in our services – it doesn't look like there is	Yes	• We have been clear in the consultation documentation that the allocation of service managers to directorates has not yet been completed – the consultation paper describes an indicative allocation only. • When we met with the service managers (and other professional groups) we explained that the SM roles would be finalised as the soon as the final directorate structure was confirmed – and that we would work in partnership with the GMs and Service Managers to allocate responsibilities fairly across the services • We will not be adding any additional SMs into the structure – but we will ensure they are fairly distributed amongst the services • We remain committed to this approach and plan to complete it in the next couple of weeks
Can we know who the genetics CNS and counsellors will report to in the nursing structure?	Yes	• Currently there are genetics CNS/Counsellors who need nursing line management and accountability. • In this structure these individuals will be professionally accountable to the newly created Nursing Director of Operations role. • We did not prescribe who the operational nursing lead will be and we have set up a meeting with the team directly impacted, the DCEO and the Chief Nurse to ensure clarity on this point
Can we be assured that the new genetics tender has been taken into consideration in developing this restructure?	Yes	• This structure does not reflect the arrangements that will need to be put in place subsequent to the current genetics tendering process taking place nationally – and the Trust will absolutely support putting in place the resources and infrastructure mandated and required by the genetics tendering process. • It will be important to ensure a connection for the genetics team into clinical services and to ensure the structure supports the new team running a larger service
Can one of the directorate leadership roles have a specific responsibility to support Apprenticeships?	Yes	• This is a great idea – and extends to other topics such as Epic, digital etc too • When the new Directorate Leadership teams are appointed, we plan to have a series of induction and preparation days. In these discussions we will encourage the new leadership teams to ensure the appropriate individuals are identified to fulfil these champion roles

Suggestion/Question	Decision &/or Answer	Rationale
Can we put additional matrons into critical care?	TBC	• The allocation of matrons across the directorates has not yet been determined – it did not make sense to finalise the portfolios and allocation of the matrons until the final distribution of services across directorates was confirmed. The PowerPoint slides accompanying the consultation paper makes this clear. • When we met with the matrons to launch the consultation, we explained that as soon as the directorates were confirmed we would meet with the matrons as a group to determine the portfolio for each job and the allocation of matrons across directorates. We remain committed to this approach. • We absolutely do not intend for any area to have insufficient Senior Nursing Leadership and this is underpinned by our commitment to introduce 6 new 8c roles.

2. Alignment of Specialties

The tables below confirms the alignment of specialties within the new directorate model:

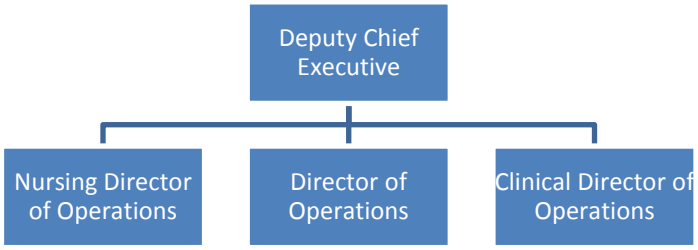
Brain Directorate	Sight & Sound Directorate	Specialised Hospital Services
Neurology	ENT	Pharmacy / BME
Neurosurgery	Audiology	Physiotherapy
Neuromuscular	Cochlear	Occupational Therapy
Epilepsy	Ophthalmology	Speech & Language Therapy
Neuro-disability	Plastics	Dietetics
Neurophysiology	Craniofacial	Psychology
Endocrinology	Cleft	Lab Medicine
Metabolic	Dental & Maxillofacial Outpatients	Genetics
Body & Bones Directorate	**Cancer & Blood Directorate**	**Peri-operative Care Directorate**
Nephrology	Oncology	Theatres
Urology	Haematology	Anaesthetics
Gastroenterology	Haemophilia	Radiology
SNAPS	Palliative Care	Interventional Radiology
CAMHS	Immunology	Nuclear Medicine
General Paediatrics	Bone Marrow Transplant	Pain
Orthopaedics	Infectious Diseases	Pre-op assessment
Spinal	Rheumatology	Cath Labs
Adolescent Medicine	Dermatology	Neuro-Radiology
Heart & Lung Directorate	**IPP Directorate**	
Cardiology	International and Private Inpatients and Outpatients	
Cardiac Surgery		
Respiratory		
PICU		
NICU		
CICU		
CATS		

3. Leadership structures and reporting lines

It is confirmed the current Divisional Leadership Teams comprising Division Chairs, Divisional Directors, Divisional Assistant Chief Nurses and Divisional Directors of Operations, will be disestablished.

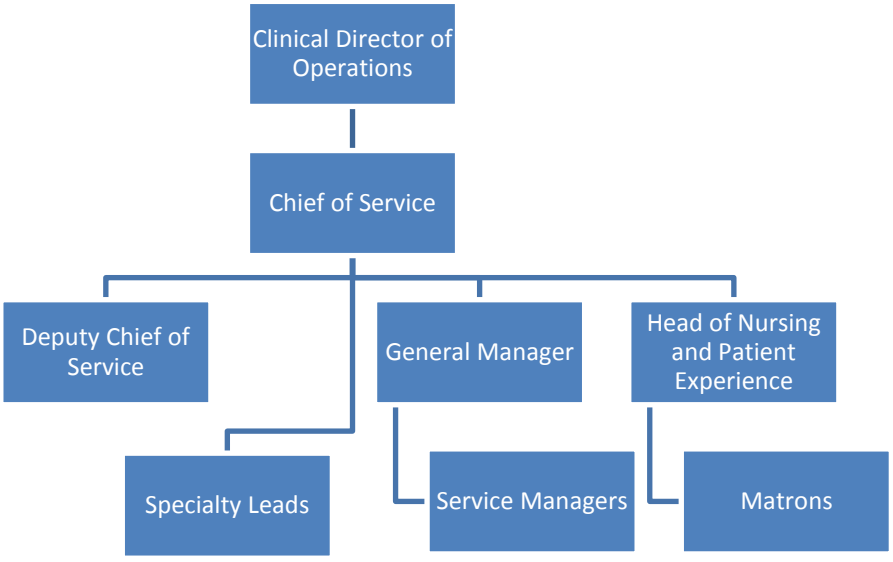
In their place will be a new senior operational leadership team comprised of a Clinical Director of Operations, a Nursing Director of Operations and a Director of Operations, and eight Directorate Leadership Teams.

3.1 Operational Leadership Team and reporting lines:



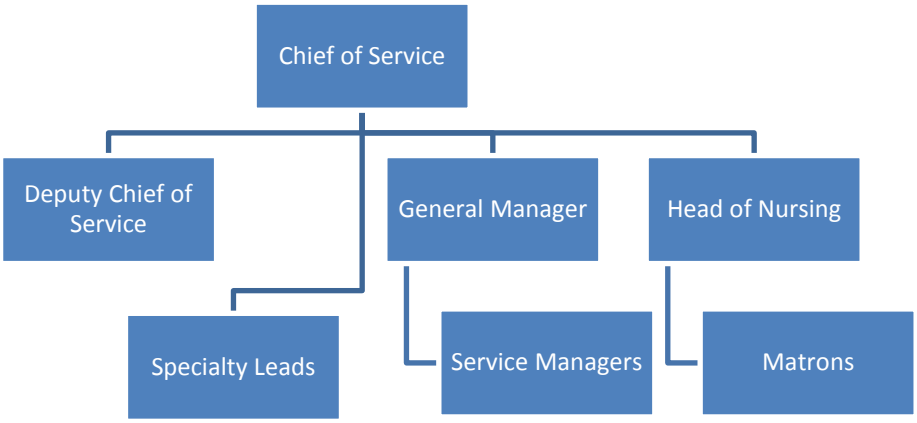
- Clinical Director of Operations – Consultant salary plus £50,000k non-pensionable leadership allowance
- Nursing Director of Operations – Band 8d (or Trust salary scale)
- Director of Operations – Trust salary scale

3.2 Directorate leadership structure and reporting lines:



- Chief of Service – 5 PAs plus £25,000 (non-pensionable) leadership allowance if Consultant, or 1 FTE at Band 8c if Agenda for Change
- Deputy Chief of Service – 3 PAs plus £15,000 (non-pensionable) leadership allowance
- Head of Nursing and Patient Experience – Band 8c
- General Manager – Band 8c

3.3 Specialty leadership structure and reporting lines



- Specialty Lead – 1 PA plus £5,000 (non-pensionable) leadership allowance, or relevant Agenda for Change band
- Matrons – Band 8a
- Service Managers – Band 8a

3.4 The confirmed leadership roles for each directorate are:

Body and Bones	**Brain**	**Sight and Sound**
Chief of Service Deputy Chief of Service Head of Nursing General Manager Specialty Lead (x7)	Chief of Service Deputy Chief of Service Head of Nursing General Manager Specialty Lead (x7)	Chief of Service Deputy Chief of Service Head of Nursing General Manager Specialty Lead (x4)
Cancer and Blood	**Heart and Lung**	**Peri-Operative Care**
Chief of Service Deputy Chief of Service Head of Nursing General Manager Specialty Lead (x7)	Chief of Service Deputy Chief of Service Head of Nursing General Manager Specialty Lead (x7)	Chief of Service Deputy Chief of Service Head of Nursing General Manager Specialty Lead (x4)
Specialised Hospital Services	**International & Private Patients**	
Group Director Chief Pharmacist Chief AHP Chief Laboratory Medicine Chief Mental Health Services Chief of clinical and laboratory genetics	Clinical Director General Manager Head of Nursing Specialty Lead (x1)	

To ensure best fit, the final configuration of Matron and Service Manager roles to Specialties and Services within each Directorate will be determined during the first two weeks in August – through discussions between Directorate Leadership Teams, Matrons and Service Managers.

4. Process for making appointments to leadership roles in new structure

4.1 Appointment Phases

The appointments process will be in two phases; 1) Operational Directors and Directorate Leadership Teams, 2) Specialty Leadership Teams and Deputy Chiefs of Service.

The window for expressions of interest will open for all roles on 16th July, closing dates will be based on phase:

		Roles	Expression of Interest closing date
Phase 1	Operational Directors & Directorate Leadership Teams	• Clinical Director of Operations • Director of Operations • Nursing Director of Operations • Chief of Service • Head of Nursing • General Manager	9am, Monday 23rd July
Phase 2	Special Leadership Teams & Deputy Chief of Service	• Specialty Lead • Deputy Chief of Service • Matron • Service Manager	9am, Monday 30th July

4.2 Directly Impacted Postholders

Staff who are substantively employed in the roles below are directly impacted by the change of structure and will need to submit a "redeployment expression of interest" form to confirm their preference for a new portfolio of work.

New portfolios of work will be confirmed at redeployment slot in meetings, with the post holder and proposed new line manager. These meetings are not interviews, but a discussion with the purpose of confirming all parties are in agreement with the proposed slot in.

Current Substantive Role	New Structure Role	Expression of Interest closing date
Divisional Director	Chief of Service / Group Director	9am, Monday 23rd July
Divisional Assistant Chief Nurse	Head of Nursing	9am, Monday 23rd July
General Manager	General Manager	9am, Monday 23rd July
Service Manager	Service Manager	9am, Monday 30th July
Matron	Matron	9am, Monday 30th July

For Chief of Service/Group Director, Head of Nursing and General Manager roles, slot in meetings will be concluded by 30th July.

For Matron and Service Manager roles, slot in meetings will take place in the first two weeks in August – during this period Directorate Leadership Teams, in conjunction with Matrons and Service Managers, will agree final configuration of Matron and Service Manger roles to Specialties and Services within each Directorate.

4.3 New Posts

The updated structure has created a number of new roles which are **open to any member of GOSH staff** who meets the essential criteria set out in the person specification. To apply for one of the roles below, a "new post expression of interest" form should be submitted along with an up to date CV.

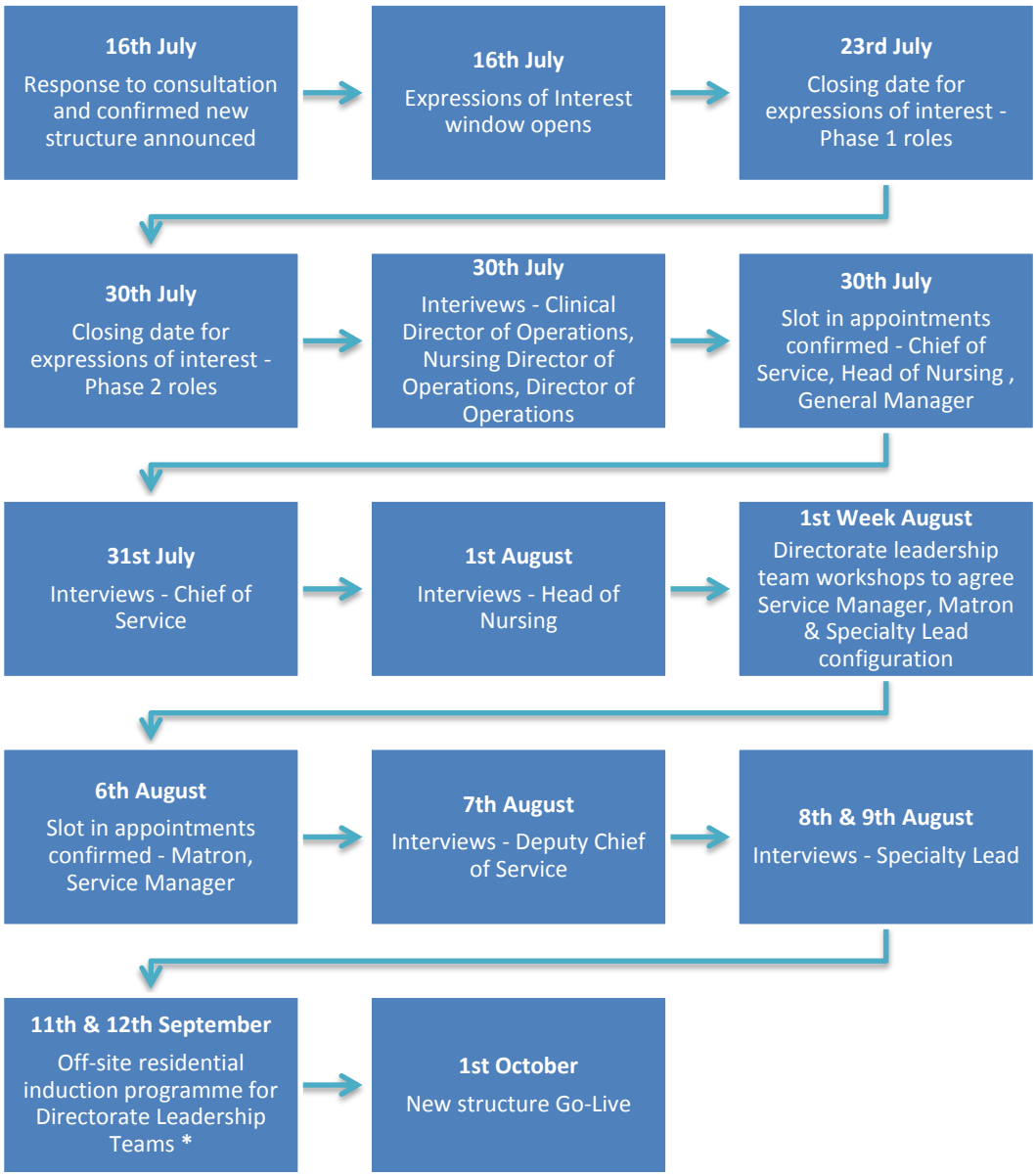
Role	Expression of Interview Closing date	Interview date
Clinical Director of Operations	9am, Monday 23rd July	Monday 30th July
Director of Operations	9am, Monday 23rd July	Monday 30th July
Nursing Director of Operations	9am, Monday 23rd July	Monday 30th July
Chief of Service /Group Director	9am, Monday 23rd July	Monday 30th July
Head of Nursing	9am, Monday 23rd July	Wednesday 1st August
Deputy Chief of Service	9am, Monday 30th July	Tuesday 7th August
Specialty Lead	9am, Monday 30th July	8th & 9th August

Staff who are directly impacted by change of portfolio, who also wish to apply for one of the new roles above, will need to submit both a "redeployment expression of interest" and a "new post expression of interest (with CV)".

Appointments via redeployment slot in will be completed before making posts at the same level available for appointment as new posts i.e. Head of Nursing redeployment slot-ins will be confirmed, then remaining Head of Nursing posts will be appointed via interview

Guidance and templates to support writing CVs will be made available via the intranet

5. Next steps timeline



6. Schedule of Leadership Commitments

To make this structure work we recognise the need to achieve getting people together regularly, and key to creating the conditions for leaders to thrive is ensuring they have dedicated time to commit to leadership responsibilities.

We therefore plan to be slightly more directive about expectations on fixed time commitments and a consistent approach across all directorates.

These expectations are being shared now, to allow sufficient time for reconfiguration of job plans, ahead of the 1st October go live date.

Directorate Leadership Teams	Chief of Service Deputy Chief of Service General Manager Head of Nursing	Need to be available on Wednesday and Thursday mornings for management commitments – this is when core meetings will take place and key business will be done
Specialty Leadership Teams	Specialty Lead Service Manager Matron	Need to be available Thursday mornings for management commitments

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **25 July 2018**	
Recruitment and Retention Plan for Nursing **Submitted by:** Alison Robertson, Chief Nurse	**Paper No: Attachment N**
Aims / summary The aim of the presentation is to provide Trust Board with: • An oversight of the recently updated recruitment and retention plan for Nursing at GOSH	
Action required from the meeting The presentation is provided for information.	
Contribution to the delivery of NHS Foundation Trust strategies and plans People Pillar – *attracting and retaining the right people through creating a culture of that enables us to thrive and learn*	
Financial implications None requested	
Who needs to be told about any decision? Divisional teams and Recruitment Team (HR) – already very well engaged	
Who is responsible for implementing the proposals / project and anticipated timescales? Tricia Bennett – Interim Assistant Chief Nurse for Nursing Workforce	
Who is accountable for the implementation of the proposal / project? Alison Robertson, Chief Nurse	

Great Ormond Street Hospital for Children NHS Foundation Trust

2018/19 Action Plan

Recruitment and Retention for Nursing

Recruitment 1/2

	Objective	Actions Required	Progress
1	To fill 90% of all Pick 'n' Mix vacancies. Pick 'n' Mix is a new incentive to recruit experienced nurses to work on our Wards at times that are convenient to their other commitments or lifestyles.	• Results of PMO "Deep dive" assessed and vacancies recognised. Advert to press including Metro, Mums Net, Local papers and NHS Jobs. • Healthroster agree that P&M Staff can be accommodated in System. • Real-time vacancy factor ongoing • Liaise with Resourcing Team regarding recruitment process	First Pick 'n' Mix application received and interview arranged. Real-Times vacancy information received by the beginning of each month. Regular 1:1 Meeting set up between ACN Workforce and Head of Resourcing to ensure better communication and understandings of pressure points and delays in processing. 1:1 Regular Meeting set up between Deputy Director od HR/OD and ACN Workforce to review Trustwide Workforce agenda and the needs of the Nursing workforce, also to review and scrutinise the resourcing processes. ACN Workforce to present the Pick 'n' Mix concept at the next CapitalNurse Showcase for pan London
2	To fill 95% of all declared Junior Band 5 vacancies pan Trust annually.	• Continue with collaboration with CapitalNurse and early recruitment from feeder Universities. • Re-advertise vacancies, in line with other specialist hospitals. • Work collaboratively with Resourcing Team to ensure clear and defined processes for recruitment pathways. • Work with Accommodation Team to ensure appropriate accommodation is available and appropriate. • Work with the uniform room to ensure new, properly sized and quantity of stock is available. • Contracts Of employment are ready for "New Starters" • Work collaboratively with the Matrons/Ward Managers to ensure local inductions are fit for purpose. • Keep the Education Team fully updated regarding numbers and start dates. • Create a WhatsApp Group to support the new staff prior to arriving. • Offer flexible starts date if needed. • Survey the current candidates to understand both the positives and the negative experiences.	All new B5 starters have been allocated, except five. All Matrons, Ward Managers and Practice Educators have been informed. The outstanding allocations are being allocated to wards that are recognised as being a "hot spot" areas including Sky, Koala, PICU and CICU. Theatres have been allocated to their request level however, after their establishment review on the 18/06/18, there is an anticipated expectation of an increase in needs. Alligator and Bear Wards are also being kept on the radar All induction processes were discussed at the Workforce Advisory Board this week and a consensus was discussed and agreed. A Report will be forwarded to CNO Office for her perusal and approval. Education Team fully briefed on all allocation and induction discussion and are fully engaged

Recruitment 2/2

	Objective	Actions Required	Progress
3	To fill 95% of all quarterly declared Band 2 HCSW Apprenticeship Vacancies	• Work with both Dynamic and Apprenticeship Lead to ensure a clear and appropriate recruitment process. • Help place the HCSW into wards and departments that will support and train the candidate. • Survey the current candidates to understand both the positive and the negative experiences. • Ensure that the HCSW is welcomed and attends induction as required.	Eight new candidates interviewed and offered positions for the next cohort for an August/September start date. Plans are ready to start the process again for the next cohort.
4	To successfully facilitate 2x GOSH nurses' external secondments to partnership Trusts and to welcome in 2x external nurse secondees to GOSH from partnership Trusts.	• Continue the placements and the work already completed. • Survey the current candidates to understand both the positive and the negative experiences. • Explore the possibilities of expanding the secondment opportunities in the future.	The secondments are underway and the feedback from both internal and external currently is very positive. To discuss the development, through CapitalNurse, a pan London Memorandum of Understanding to cut down on inter-Hospital HR administration delays Part of the Snakes and Ladder career pathway or nurses to include secondments to associated District General Hospitals to gain other leadership and managerial experience

Retention 1/2

	Objective	Actions Required	Progress
1	Increase Band 6 tenure from 2 years to 5 years over a period of 3 years. • 2018/19 : 2 – 3 years • 2019/20 : 3 - 4 years • 2020/21 : 4 – 5 Years	• Finalise the Snakes and Ladders career pathways. • Have listening events with Education Team to assess the perception and realism of what academic support is available to staff. • Use the CapitalNurse Network to share ideas and new incentives regarding retention. • Recognition of professional development and embed this into the culture at both corporate and local level. • Recognition of Preceptors and those completing Preceptorship periods within the Trust • Understand issues regarding "Moral Distress"	Work has started on the Snakes and Ladders concept Meeting between Education Lead for Barrie Division and ACN Workforce to adapt and to develop work already started on Sky and Koala regarding career pathways. Attend "Moral Distress" Study Day. Feed learning from this day into future work Explore the *SALS/NALS* concept suggested. Empower staff to be heard, with the possible introduction of "pop up" Schwartz Rounds.

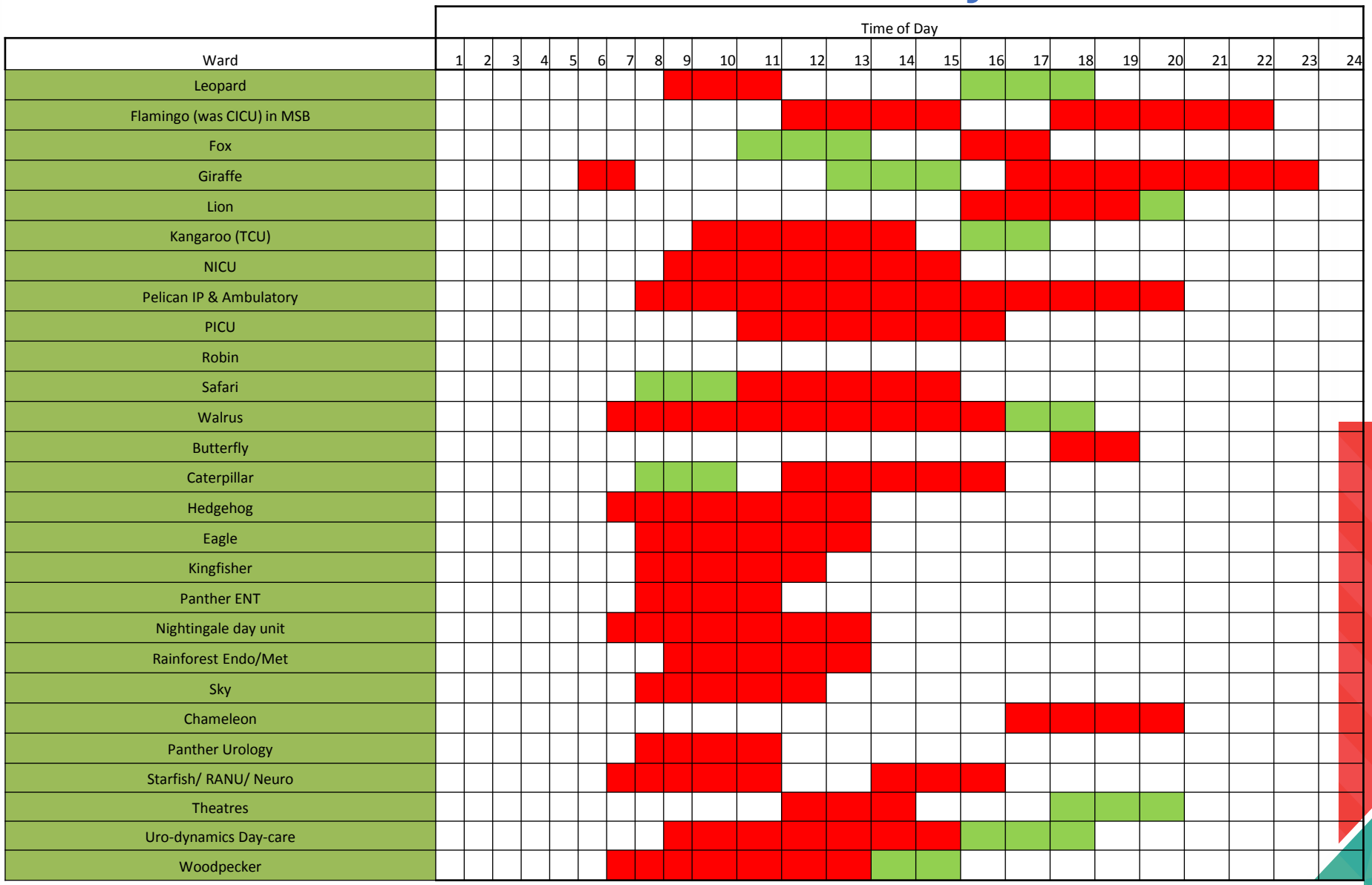
2	Reduce our Band 5 turnover and tenure within the organisation.
	• First 12 months >90%
	• Two years >80%
	• Four years >70%
		• Introduce dedicated support and career services including: -
		  • Internal Transfers,
		  • Wobblers Email
		  • External Rotations.
		  • In collaboration with the Education Team and funding from HEE
			First Internal Transfer window open and 10 candidates have applied.
			
			Wobblers email continues to be monitored and support and advice offered and using the Real-time vacancy information appropriate advice can be given

3	Continue to develop a dedicated Career Clinic and Internal Transfer scheme.	• Scheme commenced June 2018. • Assess the positive and the negative feedback from staff and learn • Create and promote the Career Clinics practices and guidelines.	Accommodation review is under way for the Career Clinic. Concept and processes including frequency and content tentatively discussed at Workforce Advisory Board.
4	Improve the internal promotion including the introduction of the Junior Sister role.	• Discuss with Divisional ACN's, Matrons, HR and General Managers the role of the Junior Ward Sister. • Work with the Education Team and HR to develop the Snakes and Ladders concept. • Ensure the potential staffs to be promoted are supported in their aspirations and their chosen pathway. • Offer any help and guidance to both the Managers and the candidates.	Discussed at Workforce Advisory Board and with the CN, all in favour. Workforce Team to collate some Job Descriptions /Personal Specifications from other Trusts. Introduce the role after the restructure in October

Retention 2/2

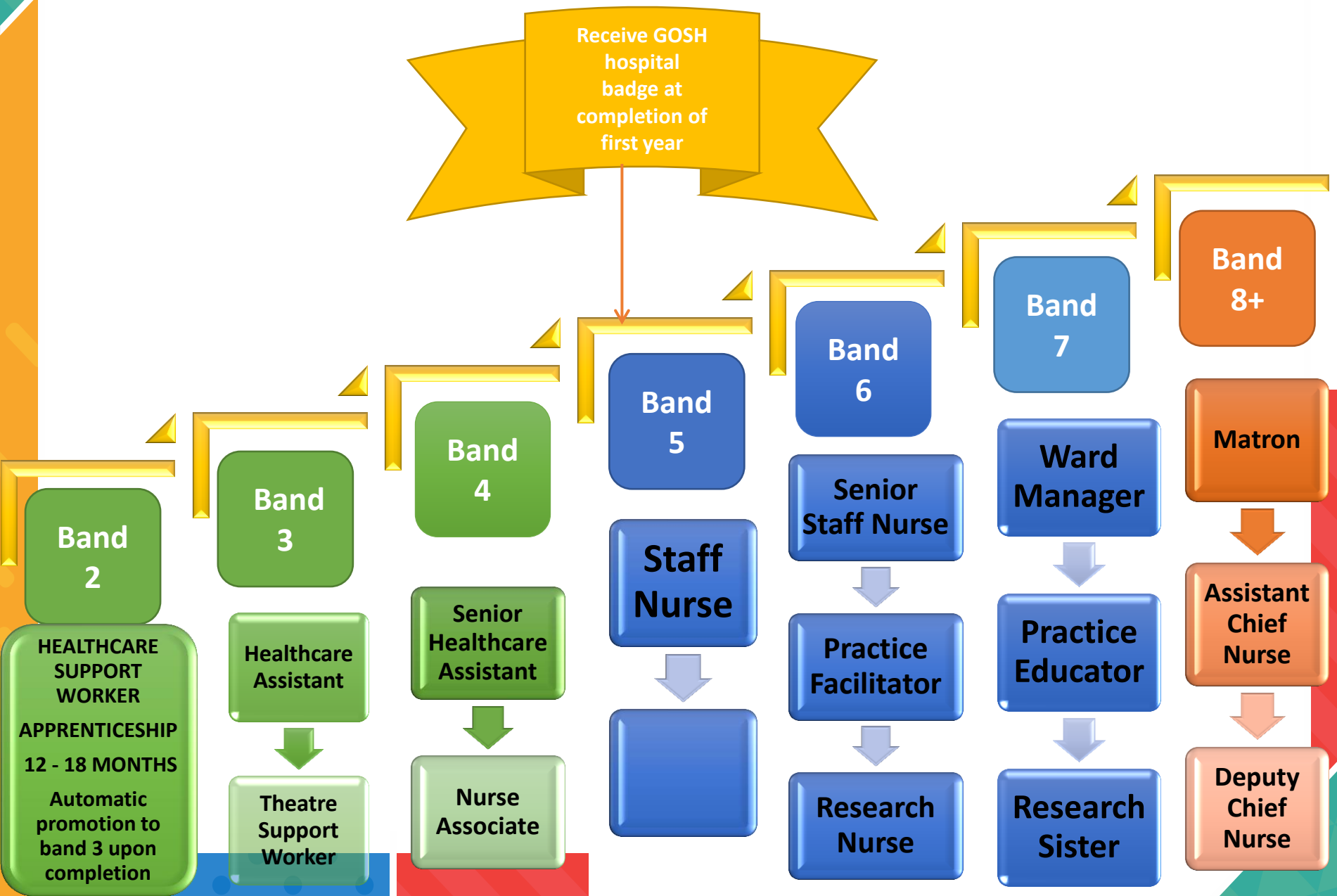
	Objective	Actions Required	Progress
5	Review of the CNS/A/NP role	• Scope the role of the CNS/A/NP to ensure equity and appropriateness of role in all Specialities • Terms of Reference shared with all ACN's, Matrons, CNS's and A/NP. • Create a Task and finish Group • Review Job Descriptions /Personal Specifications	Draft TOR's presented at both Nursing Board and ODPG Expressions of interest received to join the T&F Group.
6	Valuing The older worker, creating a culture that supports staff who works later in life. "Perennial" staff	• Pension advice • Retire and return pathway. • Cotton uniforms • Pre- Retirement Planning (inc: - Pension advice) or Getting Ready for Retirement • Flexible working • Planning of long & rewarding Careers (Recognition & Reward) • Health & wellbeing (? Keeping healthy)	Contact RCN for Pension advice Invite HR/OD to a planning meeting regarding pension pathway and end of career pathway, Career Clinic specifically for our "Valuing the older worker" population If requested act as liaison service between staff member and Operational Management. Work closely with Occupational Health to publicise services offered.

Ward Pinch Points Summary



Great Ormond Street Hospital

Snakes and Ladders Career Pathway



Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
25th July 2018

CQC inspection report Action plan **Submitted by:** Matthew Shaw, Medical Director	**Paper No: Attachment O** CQC Action Plan attached.

Aims / summary

The CQC visited the Trust in January and early February 2018 as part of its rolling schedule of inspections. The summary report was published in April 2018; the CQC rated the Trust as 'good' overall with two domains being rated as 'outstanding' (Effective and Caring), two as 'good' (Safe and Responsive) and Well Led being rated as 'requires improvement'.

The inspection report highlighted non-compliance with Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance. The regulation was not being met as the report outlined that "*Clinicians did not always have access to each patient's medical history and clinical notes before carrying out a procedure.*" Immediate action was taken, the action plan was complete and as part of that action plan an audit was required. The key findings of that audit show:

- 34,202 theatre procedures were completed from April 2016 to April 2018. Four procedures were cancelled on the day due to missing notes in that period. There is no significant incidence of missing medical history and notes that result in the cancellation of surgery.
- In May 2017 an audit identified that 79% of operating cases had previous GOSH anaesthetic records scanned on EDM. Following this audit there has been a project initiated to roll out real time scanning of anaesthetic charts to all recovery areas. The target date for full roll out is July 2018. An update will be provided in due course.
- The Clinical Audit Manager completed an audit of the availability of anaesthetic charts for procedures on the week of the 4th June 2018. All cases had previous anaesthetic charts available at the time of the procedure.

In July 2018 the accountability and responsibility for the CQC was transferred to the Medical Director who will be supported by the Head of Quality and Safety. The vacant band 7 post has been advertised and is in the process of being recruited to. The Medical Director and the Head of Quality and Safety meet with the owners of the action plans on a monthly basis to monitor progress, this is then reported to the Patient Safety and Outcomes Committee (PSOC) monthly.

The Company Secretary will continue to work on the Well-led action plan with the Chief Nurse.

The short term risks to the completion of the action plans include the implementation of the divisional restructure and recruiting to the vacant band 7 post, however once the restructure is complete the lines of responsibility and accountability will be robust.

Action required from the meeting
To note the update

Contribution to the delivery of NHS Foundation Trust strategies and plans Compliance with CQC registration
Financial implications None
Who needs to be told about any decision? Relevant staff are aware of the actions and updates are shared via PSOC to divisional representatives
Who is responsible for implementing the proposals / project and anticipated timescales? Salina Parkyn, Head of Quality and Safety
Who is accountable for the implementation of the proposal / project? Matthew Shaw, Medical Director

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ACTIONS LOG - CQC QI actions incorporating CQC actions

ID	Service	Recommendation or Issue	Responsible Director	Actions	Closed Date
Rec1	Surgery	The trust must establish safe systems of working for access to medical records and patient medical histories.	Matthew Shaw, Medical Director	Immediate action was taken, the action plan was complete and as part of that action plan an audit was required and completed. The rpeort is due at the Patient Safety and Outcomes Committee in July 2018	
Rec2	Outpatients	Improve staff hand hygiene and adherence to bare below the elbows. The trust submitted hand hygiene audits from January to December 2017 following our inspection. The average compliance rate was 78%, with results varying between 50% and 96%. We saw there were between seven and 30 hand hygiene observations had been made of a range of staff each month.	Alison Robertson, Chief Nurse	Education including visible leadership and feedback sessions have taken place in the Outpatients department. Observational audits of hand washing are taking place and will be reported to the Infection Control Committee.	
Rec3	Outpatients	Consider the use of disposable tourniquets. We noted there were no single use tourniquets in use which increased the possibility of infection. We noted that the department used multiple-use tourniquets. The NHS product suppliers recommended the use of disposable tourniquets in 2010 when clinical studies demonstrated how reusable alternatives could be infected with harmful bacteria.	Matthew Shaw, Medical Director	The disposable touinquest are currently going through the relevant procurement process. This will be monitored via the Medical Equipment and Supplies Group (MESG)	
Rec4	Outpatients	Ensure procedure rooms are clutter free and not used to store staff clothing. We noted that one of the procedure rooms had several pieces of equipment and items of outdoor clothing which reduced the available space in the room and presented a cross contamination risk.	Nicola Grinstead, Deputy CEO	The Outpatient Service Manager and Matron have carried out a review of the procedure rooms and will continuew to do so on a rolling basis. The visible leadership and executive safety walkrounds will visit the Outpatient areas to continue to review the impact of changes.	

Rec5	Outpatients	Ensure there is consistent fridge temperature monitoring and actions taken where temperatures are regularly outside of the recommended range. We found inconsistencies in fridge temperature monitoring; we also saw that ambient temperature monitoring was not taking place in areas where medicines were being stored. There was no action plan in place to address this issue. We found that ambient temperature monitoring was not taking place in areas where medicines were stored. We also found inconsistencies in fridge temperature monitoring; where fridge temperatures were outside of the recommended range, no action was taken and the pharmacy team was not involved. For example, fridge temperatures on Hedgehog and Panther wards exceeded the manufacturer's recommended maximum on seven occasions in the three months leading up to our inspection. There was no evidence staff had taken corrective action and nurses we asked said they would not escalate temperature problems to the pharmacy team. On one ward staff referred to a safety policy for fridges related to food storage, not medicines. This meant that staff could not be assured that medicines were fit for use. For example there was no documented evidence available of daily checks of the medicines fridge in anaesthetic room four or the HDU on Sky ward. We found inconsistencies in fridge temperature monitoring and saw that ambient temperature monitoring was not taking place	Nicola Grinstead, Deputy CEO	A Medicines Mangement Committee has been created of which the terms of reference includes the process for monitoring and managing fridge temperatures for medicines. The DPS team have a BMS for monitoring fridge alarms for non medicines (e.g mortuary, laboratory). The committee will feed into the Patient Safety and Outcomes Committee on a quarterly basis.	
Rec6	Outpatients	Ensure patient identifiable information is kept confidential and secured at all times. Hospital-only outpatient prescription pads were left out on desks in all consulting rooms we visited. We found patient-identifiable information on view in offices, including a patient identifiable letter on an unlocked computer screen and clinic lists with patient names on desks in three consulting rooms.	Nicola Grinstead, Deputy CEO	Hospital only presecription pads have been removed. Information Governance training has been reviewed and renewed in line with the GDPR and will be rolled out. A patient safety alerts ws created by the Safety team in conjunction with the Information Governance team reminding staff to ensure PC's are locked when away from the desk.	

Rec7	Surgery	The trust should improve opportunities for engagement and communication between the executive team and clinical teams. Staff did not always feel engaged or that they had a say in decisions taken by senior leaders of the organisation. Staff said that major decisions were made by the board and then communicated to them to implement. There was no clear strategy for staff engagement and organisational development. Staff on wards did not always feel engaged in the decision making process and felt that some of the decisions affecting their day to day job were taken without them being consulted on the issue. They spoke of issues such as ward mergers and redevelopments were they did not fully understand reasoning behind decisions taken and felt that they could not influence those changes.	Cymbeline Moore, Director of Comms	Since the time of the Inspection the Trust has undergone a divisional consultation, for this a Trust wide communication plan was made including lunch time talks, attendance at team meetings, senior meetings being dedicated to the topic (EMT, SMT and ODGP).	
Rec8	Surgery	The trust should ensure the transfer processes for patients moving from or to IPP inpatient wards continue to improve to ensure transfers are always led by a medical fellow.	Nicola Grinstead, Deputy CEO	The Patient Placement project continues to review the process of internal transfers and the medical cross cover for all areas.	

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **25 July 2018**	
Integrated Quality Report **Submitted by:** Mr Matthew Shaw, Medical Director Alison Robertson, Chief Nurse	**Paper No: Attachment P**

Aims / summary

The Integrated Quality Report will provide information on:

- 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)
- data quality kite-marking has now been added to the report as per the Trust Board's request

Action required from the meeting

To note the style of the report, providing any feedback or requested changes to the Medical Director and Chief Nurse to note the on-going work supporting any suggested changes to work streams.

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

No additional resource requirements identified

Who needs to be told about any decision?

Quality and Safety team, Patient Experience team, Divisional Management teams

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

Divisional Management teams with support where needed, Quality and Safety team, Patient Experience team

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

Medical Director and Chief Nurse

Great Ormond Street Hospital for Children NHS
NHS Foundation Trust

Integrated Quality Report

Mr Matthew Shaw, Medical Director
Alison Robertson, Chief Nurse

July 2018
(covering April - June 2018)

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Great Ormond Street Hospital for Children NHS Foundation Trust

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Outcomes/ Effectiveness

Improvement

Has patient care been safe in the past?

Measures where we have no concerns

Great Ormond Street Hospital for Children NHS Foundation Trust

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

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

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

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

	Cardiac arrests outside of ICU	Respiratory Arrests outside of ICU
April 2018	0	4 (Sky, Koala, Bumblebee and Main Reception)
May 2018	0	2 (both Leopard)
June 2018	2 (both in theatres)	3 (Koala, Outpatients and Bear)

Has patient care been safe in the past?

Measures where we have no concerns

Great Ormond Street Hospital for Children NHS Foundation Trust

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Data Quality Kite-Mark	Measure	Comment
	**Never Events**	The last Never Event was on 23rd March 2018. The mean time between never events is unchanged at 220 days. The baseline for this data is from 2010 until 2014. The Never Event declared in March 2018 was for retained foreign object while the previous never event in October 2017 was for wrong site surgery.
	**Serious Incidents** ****by date of incident not declaration of SI**	The number of serious incidents remains stable, with a mean of 0.76 per month. This mean is based on a baseline between September 2016 and January 2018, and is a statistically significant reduction compared to the previous mean (taken from a baseline ending in August 2016, which was also a reduction compared to the previous baseline). There were 2 SIs reported in May and none for June.
	**Mortality**	The data remains stable at 6.3 deaths per 1000 discharges; the process is in normal variation and has been since 2014. The rate for May was 2.77 per 1000 discharges and 6.25 per 1000 discharges in June. There have been no runs, trends or outliers identified. Over 80% of GOSH inpatient deaths are on ICU, and ICU deaths must be risk adjusted to properly determine a trend. Raw survival/mortality rates do not take account of severity of illness and case mix so outcome data needs to be adjusted to take these factors into account. All ICU data is submitted, after risk adjustment, to the national Paediatric Intensive Care Audit Network (PICANET). This process will allow any trends or outlier performance to be determined. Internal monitoring of Variable Life Adjusted Plots (VLAD) from January – June 2017 showed an increase in the number of deaths on PICU compared to expected. A comprehensive internal review of cases did not suggest any obvious patterns or concerns about the quality of care in PICU/NICU, and no single cause that could explain the trend. GOSH has been informed by PICANET it will not be a statistical outlier for 2017 and the full PICANET data for the calendar year 2017 is due to be published on 31 March 2018. The most recent VLAD data suggests that the negative trend has not continued.

Has patient care been safe in the past?

Measures where we have no concerns

Great Ormond Street Hospital for Children NHS Foundation Trust

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

Data Quality Kite-Mark	Measure	Comment		
	**Hospital acquired pressure ulcers reported (grades 2+)**	Performance remains within normal variation at 6.67 per month.		
		April 2018	**May 2018**	**June 2018**
	Grade 2 hospital acquired pressure ulcers	**11**	**2**	**1**
	Grade 3 hospital acquired pressure ulcers	**1**	**0**	**0**
	Grade 4 hospital acquired pressure ulcers	**0**	**0**	**0**
	**GOSH-acquired CVL infections**	We have identified a reduction in the measure of CVL infections per 1000 line days. This reduction started in January 2017 and has been sustained – the current baseline mean from January 2017 to January 2018 shows a rate of 1.38 CVL infections per 1000 line days, compared to a previous mean of 1.78 CVL infections per 1000 line days. The figure for April is 1.11. **June data not yet available**		
	**The number of PALS cases**	The number of PALS cases reported per month remains stable, with an average of 149. Since the outliers in summer 2017 (June and July), the process is currently in normal variation; there have been no runs, trends or recent outliers identified. There were 170 cases in May 2018 and 159 cases in June 2018 – these are both within expected limits based on previous baseline data.		

Has patient care been safe in the past?

Learning from closed Serious Incidents and Never Events

Great Ormond Street Hospital for Children NHS Foundation Trust

Serious Incidents and Never Events April - June 2018			
No of new SIs declared in April - June 2018:	7	No of new Never Events declared in April - June 2018:	0
No of closed SIs/ Never Events in April - June 2018:	2	No of de-escalated SIs/Never Events in April - June 2018:	0

SIs/Never Events declared in April – June (7)

STEIS Ref	Incident Date	Date Report Due	Description of Incident	Divisions Involved	Senior Responsible Officer (SRO)	Patient Safety Manager	Executive Sign Off	Divisional Contact
2018/10352	06/04/18	20/07/2018	Potential missed opportunities to identify patient deterioration	JM Barrie	AMD	Patient Safety Manager	Medical Director	General Manager
2018/10554	21/04/18	23/07/2018	Patient fall	IPP	AMD	Patient Safety Manger	Medical Director	Interim Head of Nursing for IPP
2018/11435	16/04/18	01/08/2018	Delay in responding to diagnostic results	JM Barrie	Medical Director	Patient Safety Manager	Medical Director	General Manager
2018/11637	03/05/18	03/08/2018	Information governance breach – spread sheet containing immunology research data sent to unknown Gmail account	Charles West	AMD	Patient Safety Manager	Medical Director	Divisional Co-Chair
2018/11980	16/03/18	07/08/2018	Pressure Ulcer	Charles West	Chief Nurse	Patient Safety Manager	Chief Nurse	Director of Operations
2018/13847	25/05/18	29/08/18	Wrong size implant	JM Barrie	Medical Director	Patient Safety Manager	Medical Director	Neurology Consultant
2018/15216	01/08/16	13/09/18	Glosair SOP	DPS	Associate Medical Director	Patient Safety Manager	Medical Director	Director of Estates and Facilities

Has patient care been safe in the past?

Learning from closed Serious Incidents and Never Events

Great Ormond Street Hospital for Children NHS Foundation Trust

Learning from closed/de-escalated SIs/Never Events in April – June 2018 (2):

Ref:	Summary:	Root Cause:	Action to Remedy Root Cause:	Trust Wide Learning:
2018/ 7616	**Information Governance Breach:** Letters containing sensitive diagnosis sent to old patient address. Associated with previous SI in 2013	PiMs stipulates that the patient did not want correspondence to be sent to her home in various places apart from the front page in the 'patient details' tab. Had the nephrology administrative staff checked the Family/Carer details tab on PiMs as advised in the enhanced PiMs training this would have flagged to them that correspondence should not have been sent out of the trust.	In the short term the secure address procedure needs to be reviewed again to try to ensure that staff understand the process on PiMs and are empowered to seek advice or help if they are unsure of what to do. a) Secure address QI project implemented. Process mapping has been undertaken. **Action Update: 11/06/18: Update:** • **A working group has been set up between EPIC, Central Booking Office, Information Governance and a Medical Secretary representative to design new robust process within future EPR system, informed by the outcomes of the process mapping session.** • **Information sheet for patients and families explaining what a 'Secure Address' is and how they are managed in the hospital has been drafted and is currently going through an approval process, this will be made available to families in July 2018 once approved.** • **Flow diagram and FAQ sheet has been designed for medical secretaries to provide them with easily accessible information on how to correctly manage any secure contact information and who to refer any queries on to. This will be disseminated in early July 2018 once approved.** • **A communications strategy is in the planning phase to target key staff groups with refresher information about the secure addresses process and will be launched in combination with the resources above in July 2018.** In the long term, the trust will implement a new hospital electronic system called the Electronic Patient Record (EPR). This will provide the trust with improved functionality. The EPR team will need to work closely with the Information Governance team to ensure that the process around secure addresses remains in place but with significant improvement for users of this system. a) The Information Governance Manager to work with the EPIC team regarding the requirements needed for the secure address process. **Action Update: EPR to be disseminated trust wide in April 2019. Meetings continue to take place between the EPR project teams and the information governance teams at GOSH.** Patients and their families need to be able to provide the trust with their address changes in an easy and user friendly way. a) Implementation of patient kiosks in outpatients which will allow patients to check in for their appointment electronically. This will prompt patients to check their address details and change them when they attend for an appointment. **Action Update: Not yet due.**	Whilst enhanced training was implemented in 2016, there continues to be confusion around the process for sending correspondence to patients who have a secure address on PiMs. This is compounded by the later part of the processes for finding and checking additional information on PiMs which lengthens the time for sending out correspondence.

Has patient care been safe in the past?

Learning from closed Serious Incidents and Never Events

Great Ormond Street Hospital for Children NHS Foundation Trust

Learning from closed/de-escalated SIs/Never Events in April – June 2018 (2):

Ref:	Summary:	Root Cause:	Action to Remedy Root Cause:	Trust Wide Learning:
2018/ 7556	**Information Governance Breech:** Aged debt report sent to BUPA, contained details of a large volume of non BUPA patients.	The wrong attachment was emailed as the master spreadsheet was saved with the title 'BUPA queries' in error, and therefore inadvertently selected.	Staff members within the Trust will be reminded that it is good practice to check all attachments containing sensitive or patient identifiable information and recipient addresses before sending an email a) The Communications team will be asked to create a screensaver summarising this incident and this recommendation **Action Update: This is currently being developed** There will be Trust wide communications highlighting the extra risk of breaches when working with excel spreadsheets as there could be data on hidden tabs a) This risk is highlighted in the Trust induction. b) Risk was highlighted in the Trust Brief April2018. c) All user communications will be sent by Information Governance Officer **Action Update: Actions a) and b) Complete, Action c) due July 2018** The GOSH IPP Credit Control Team will ensure the Aged Debtor report contains no separate tabs for different sponsors within this file. Each sponsor's information will be extracted from the master spreadsheet and saved in a folder created for that sponsor. a) Aged Debtor report master spreadsheet will be amended to remove provider tabs and team will be informed of this change in practice . **Action Update: Completed- Team informed of required change in practice and future weekly reports will be compliant with this recommendation.** Amend the 'Email Use Policy' to include a recommendation that attachments are opened to confirm they are correct before sending a) Ensure that the policy which will be written for the Trust's new secure email system will include this recommendation **Action Update: Following the initial panel recommendation, it has been discussed that as the Trust is currently moving towards introducing a new email system, amending the current policy (which was last reviewed in November 2017 and is not due for review until November 2019) is not a feasible action. In the interim the Information Governance and local teams will focus on the above communications. This recommendation will be included in the new policy which will be written when the new email system is Introduced.**	When you are sending an email to an external address, please check that the recipients address and any attachments are correct

Are we responding and Improving?

Patient and Family Feedback: Red Complaints

Great Ormond Street Hospital for Children NHS Foundation Trust

Red Complaints in April - June 2018

No of new red complaints declared in April-June 2018:	2	No of re-opened red complaints in April-June 2018:	0
No of closed red complaints in April-June 2018:	0		

New Red Complaints declared April – June 2018 (2)

Ref	Opened Date	Report Due	Description of Complaint	Divisions Involved	Exec Lead	Division Lead
18/004	16/04/18	08/05/18	Concerns about failures to identify dislocated hip shown in X-ray, to respond to queries from the family, and to carry out surgery without delay.	JM Barrie	Medical Director	Matron
18/014	04/06/18	16/07/18	Concerns raised by patient's mother regarding communication and medical care of a patient, in particular weekend medical cover on Sky Ward.	JM Barrie and Charles West	Chief Nurse	DGM

Are we responding and Improving?

Patient and Family Feedback: Learning from Red Complaints

Great Ormond Street Hospital for Children NHS Foundation Trust

Learning from closed red complaints in April – June 2018 (1):

Ref:	Summary of complaint:	Outcomes/Learning:

17/027	Father of a deceased patient raised concerns regarding two surgical episodes and subsequent care on the Ward.	• Complaint about care and treatment provided to a patient with complex clinical conditions by GOSH throughout her life.
		• Specifically the family raised concerns about two rounds of cardiac surgery, communication from the clinical teams, and the care provided to the patient in the time before she sadly died (aged 1 year old).
		• Investigation confirmed that care was appropriate and in line with her care plan and that staff were responsive to changes in the patient's condition. It was not possible to determine the patient's cause of death.
		• There was nevertheless learning for the teams:
		  ◦ Record keeping was not as good as it should have been on the ward
		  ◦ Information was not recorded on Nerve Centre as it should have been
		• In response to this, staff have been reminded of the importance of properly recording information on Nerve Centre and additional IPADs have been obtained in support of this.

Comparison of PALS cases received by the Trust during Q1 18/19

Great Ormond Street Hospital for Children NHS Foundation Trust

Table showing PALS cases by grading comparing Q1 in 18/19 in comparison to previous quarters. *Date range for Q1: 01/04/18 - 22/06/18

Cases	Q1 17/18	Q4 17/18	Q1 18/19*
Promptly resolved	372	474	386
Complex cases	65	90	36
Escalated to formal complaints	6	5	3
Compliments about specialities	12	18	17
*Special cases	1037	8	0
Total	1492	595	442

*See Appendix at the end for definitions

Top 5 Specialties arising in PALS cases received	Q1 17/18	Q4 17/18	Q1 18/19
Cardiology	15	39	36
Urology	17	16	24
Rheumatology	24	17	18
Neurology	22	22	17
Oncology	5	11	17

Top 5 themes arising in PALS cases received	Q1 17/18	Q4 17/18	Q1 18/19
Outpatient (Cancellation; Failure to arrange appointment; poor communication)	139	121	104
Lack of communication (lack of communication with family, telephone calls not returned; incorrect information sent to families)	81	134	102
Inpatients (lack of communication; environment of the parents kitchens; accommodation)	43	57	37
Referrals (Waiting times; Advice on making a NHS referral; advice on making an IPP referral)	40	37	34
Admission/Discharge (Cancellation; waiting times to hear about admissions; lack of communication with families)	48	59	32

Are we responding and improving?

Learning from Friends and Family Test- Inpatient Data

Great Ormond Street Hospital for Children NHS Foundation Trust

Data Quality Kite-Mark	Inpatient Results May 2018	Inpatient Results June 2018

May 2018
Overall FFT Response Rate = 24.4%
Overall % to Recommend = 98.2%

June 2018
June data is currently unavailable. The Real Time system went live on 6th June and due to it's infancy, early indicators show that current numbers have been affected.

FFT Responses over time

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2014				27%	26%	28%	24%	27%	25%	26%	27%	30%
2015	29%	34%	35%	32%	32%	32%	35%	33%	13%	18%	21%	19%
2016 revised	23%	24%	26%	24%	28%	25%	22%	17%	14%	25%	25.50%	27.3%
2017 revised	28%	25%	26%	27%	28%	30%	23%	23%	23%	21%	24%	22%
2018	25%	23%	24%	24.5%	24.2%							

May 2018 Top 3 Themes (by %)

Positive Themes:	No +ve comments	Total comments
Always Helpful	320	321
Always Expert	180	184
Always Welcoming	157	162
Negative Themes:	**No -ve comments**	**Total comments**
Staffing Levels	1	1
Catering / Food	5	12
Always One Team	4	11

June 2018 Top 3 Themes (by %)

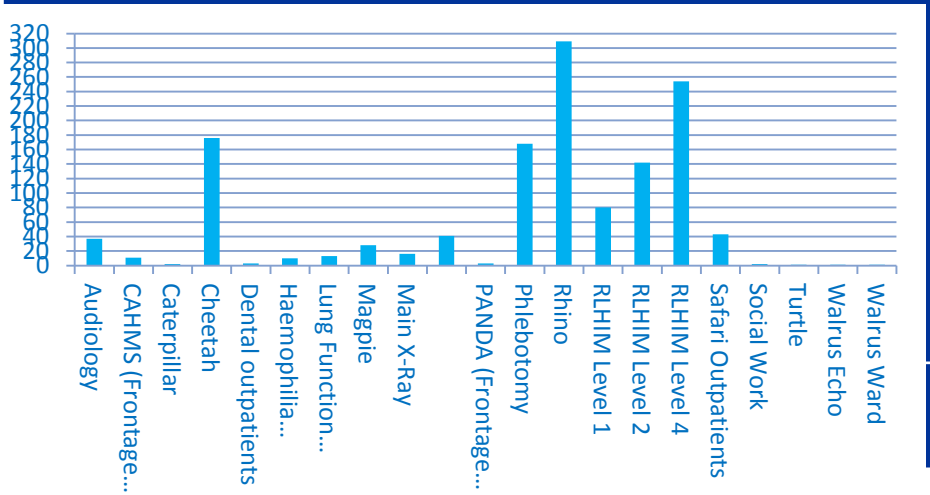
Positive Themes:	No +ve comments	Total comments
Negative Themes:	**No -ve comments**	**Total comments**

Are we responding and improving?

Learning from Friends and Family Test- Outpatient Data

Great Ormond Street Hospital for Children NHS Foundation Trust

Data Quality Kite-Mark	Narrative:
	The June data is unavailable at this moment in time. The total number of cards from April & May for Outpatient has increased from the previous quarter to 2,297 compared to the previous quarter of 1,665. The percentage to recommend in Outpatients has also increased so far in this quarter from 93% to 94.5%.

Outpatient Results January 2018	Outpatient Results February 2018
May 2018 Overall % to Recommend = 95%	**June 2018** Overall % to Recommend =
	June data was unavailable at this time.

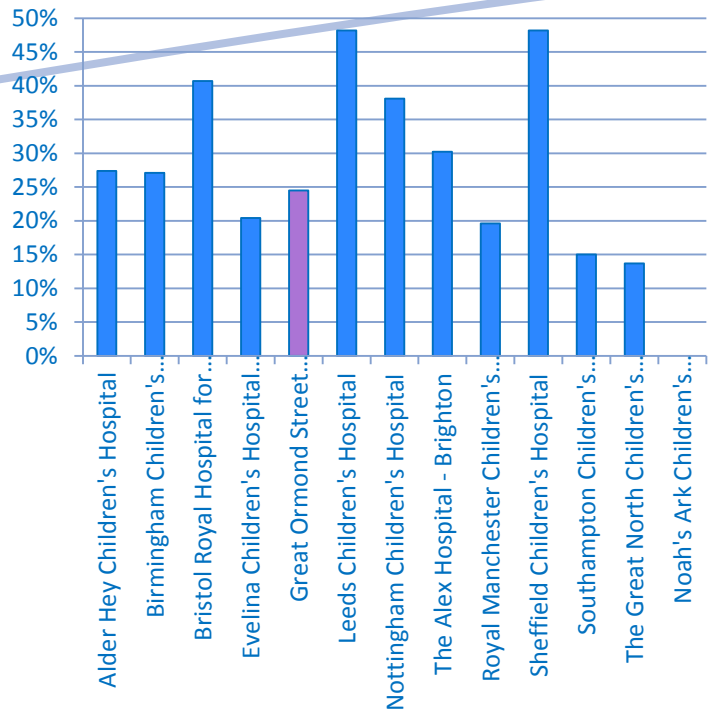
Are we responding and improving?

Benchmarking

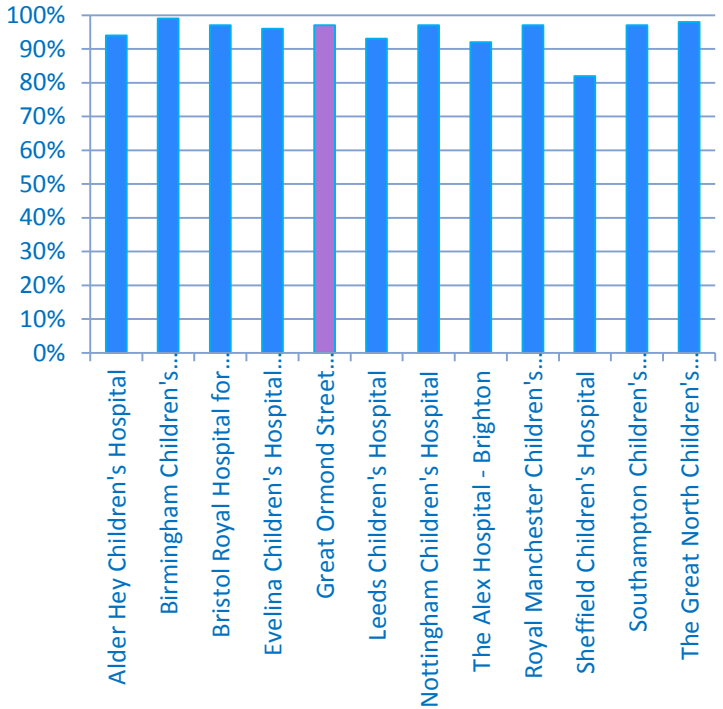
Great Ormond Street Hospital for Children NHS Foundation Trust

Data from NHS Choices – April 2018

Response Rates



Percentage to Recommend



Are we responding and improving?

Learning from Friends and Family Test

Great Ormond Street Hospital for Children NHS Foundation Trust

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

Patient Feedback

Nurses are good and kind and funny!

I love playing with the playworker!

Nurses doctors and interpreters are good!

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

Parent/Carer Feedback

We were ready to be discharged and were told we just had to wait for the discharge letter which then took over 2 hours while we just sat and waited. We did not want a copy of the letter and it could have just been sent to us later. (Koala)

One are of improvement would be less contact from family liaison. At times came across as intrusive. (NICU)

Bathroom is limited to the toilet. Nowhere to change apart from using the bed. (Kangeroo)

My son is a power chair user we were not unfortunately provided with a commode that would go over the toilet. This was a really awful situation as we were unable to put the sling back under him to hoist due to the bowl. (Respiratory Sleep Unit)

Are we responding and improving?

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

Great Ormond Street Hospital for Children NHS Foundation Trust

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

'You Said'

We did

Parent who stayed on Eagle Ward:

Services are excellent and doctors are amazing, Some points which need to be improved, e.g. Clean the cot, changing the bedding everyday to feel comfortable and homely for the patients. I am here about a month but I haven't seen a nurse on duty everyday clean the patients cot and change the bedding, even if we ask to change the bedding (as some drops of blood on sheet) they just say okay. So this needs improvement.

.

Response from the Eagle Ward sister:

I have spoken to the parents and have apologised for the poor service they have received. I have reminded staff and the housekeeping team of the procedures and need to change bedding often. The parents are currently on the ward staying as Inpatient and have not experienced the same and have no concerns in their stay this time.

Flow Huddles (Patient Placement Programme)

Great Ormond Street Hospital for Children NHS Foundation Trust

Project aim:
To increase inpatient throughput across the Trust

Project Initiation and Leadership:
Project sits within the Patient Placement Programme, currently led by Nicola Grinstead

Background:

A patient's admission pathway is not always simple or limited to one ward or service. Navigating the often complex hospital processes can cause unnecessary delays in their admission plan, and effect ongoing arrangements at patient, family, ward and trust level. To improve patient flow across the Trust, the Patient Placement Programme, led by Charles West Division with support by PMO & QI, was commenced.

What is a flow huddle?

A Flow Huddle is a daily 10-15 minute discussion, held around the Flow Board (part of the ePSAG boards) n a confidential space. It involves an MDT presence including both Medical and Nursing representation and any other relevant team members.

Its aim is to create a daily focus on the review of each patient's pathway by proactively problem solving barriers to care and working together towards achieving key milestones in the patient's admission plan.

Progress

QI is supporting roll-out of flow huddles on Leopard, Kangaroo, Chameleon, Bumblebee, Butterfly, Hedgehog and Rainforest (Gastro/Endo) wards. The PMO is rolling out flow huddles on all other wards.

Chameleon PSAG Flow Board

Back to main whiteboard | Last updated: 11/04/18 11:56 | Theatres | Flow | Font size | Display | Help

THIS IS A TEST SYSTEM SQL-APP-TEST01 - PSAG2

Bed	Patient	LoS	Consultant	Original EDD	EDD	Patient D/C status	D/C time	Waiting for?	Discharge to	Bed arranged	Training	BLS Training	Supplies	TTO	Dis sum
1	Test T	11	Cross	07/04/18	08/02/2019	On track	Before 14:00	Cons review	GOSH Ward	Started	Required	NA	NA	Needs prescribing	
2	Closed														
3	Test T	18	Cross	30/03/18	14/09/2018	Off pathway	After 14:00	MDT date	Other	Required	NA	Required	Started	No TTO	
4	Test T	34	De Coppi	11/03/18	28/04/2018	On track	Before 14:00	Reg bloods	Home via Hosp	NA	Started	Started	NA	Prescribe close to d/c	Not started
5	Test T	31	Cross	05/03/18	22/11/2018	On track	After 14:00	Surgical date	Home	Completed	Completed	Started	Completed	Prescribe close to d/c	
6	Test T	8	Blackburn	04/04/18	21/04/2018	Off pathway	After 14:00	Blood results	Hospital	Not known	Not known	Completed	Not known	Prescribe close to d/c	
7	Test T	9	Blackburn	30/04/18	27/04/2018	On track	Before 14:00	Bloods	Home	Not known	Completed	Not known	Completed	Ready on ward	Not started
8	Test T	8	Blackburn	16/04/18	13/04/2018	Off pathway	Before 14:00	Cons Discharge criteria	Other	Started	Completed	Not known	Completed	Ready on ward	Not started
9															

Measurements

- The Patient Flow Dashboard details existing Trust-wide outcome measures for the QI roll-out wards: NHS patient ward throughput (ward discharges excluding day cases), median ward length of stay, and % of Patients with discharge summary sent within 1 day of discharge: http://qst/spcworks/dashboard#dashboardid=-255
- The IPP Flow dashboard details IPP ward throughput and median patient length of stay (hospital discharges): http://qst/spcworks/dashboard#dashboardid=-238
- Process measures gather data from PSAG on the reason for EDD change, frequency of EDD change per patient per week, and the accuracy of original EED for planned admissions.
- Data is being gathered on time of discharge, and a parent feedback questionnaire and staff survey have been tested on Leopard ward to capture qualitative feedback on staff experience of flow huddles and parent experiences of discharge.

Next Steps

- Monitor wards where flow huddles are established (IPP, Leopard)
- Continue to support new roll-out wards (Chameleon, Kangaroo, Rainforest)

Are we responding and improving?

Quality Improvement Project Status Update (with Executive sponsorship)

Great Ormond Street Hospital for Children NHS Foundation Trust

Project	Project Aims	Project Leads	Project Timescales and Progress
PEWS	To Implement PEWS across all inpatient wards at GOSH by April 2018.	Executive Sponsor- Alison Robertson (Chief Nurse) Medical Lead - Mark Peters (ITU Consultant Intensivist) Nursing Lead – Sarah Newcombe (Chief Nursing Information Officer)	Progress to date: • PEWS went live on 7th March 2018 • Staff Feedback received and change request submitted to Nervecentre. Changes expected to be implemented July 2018. • On-going work with cardiac to support the identification and escalation of the deteriorating child • Device Availability audit underway • PEWS Dashboard Measures developed - http://sql-rep01/ReportServer/Pages/ReportViewer.aspx?%2fQI%2fProduction%2fReports%2fCEWSToPEWS%2fPEWS+Post+Rollout+Reports&rs:Command=Render
Extravasation	To reduce the incidence of extravasation injury at GOSH by 30st September 2018	Executive Sponsor- Chief Nurse Clinical Lead- Consultant Anaesthetist	Progress to date: • VHP Framework & Tool - Trust-wide roll-out on track for completion by July 2018 • Vessel Health Roadshow education and engagement event held across the Trust 25 June to 6 July – to launch VHP and raise awareness of good practice in IV access. Interactive teaching sessions delivered to over 100 staff • New cannulation training pathway for junior doctors currently being piloted • Review and consolidation of all policy, procedure and care bundle related to IV access • Anaesthetic audit of all ward requests for IV access (unscheduled) • Consolidation of all medical and nursing cannulation education underway. • Comparison work underway between plastics referrals and Datix. • First pilot of VAF system to log referrals to VAF team in June 2018 to enable prioritization and oversight from CSP team. • Acyclovir study now supported by QI data analyst using data from EP. • Play team developing suite of resources on distraction techniques for cannulation training and online resource pages.

Are we responding and improving?

Quality Improvement Project Status Update (with Executive sponsorship)

Great Ormond Street Hospital for Children NHS Foundation Trust

Project	Project Aims	Project Leads	Project Timescales and Progress
Transition	To enable clinicians to start all young people a Transition Plan by the age of 14 in line with NICE recommendations Ensure young people and their families are adequately prepared for the move to adolescent or adult health services	Executive Sponsor- Chief Nurse	On-going project Progress to date: • Growing Up, Gaining Independence (GUGI) programme developed • Successful pilot of reporting tab on eCOF • Successful pilot of information sheets in clinics • GUGI Part 2 template being sent to all specialties • TIM attending specialty meetings • Draft of teaching /information video completed and has been presented to NHSI Next steps: • Further information videos for YP and families • LD information • Staff training needs analysis • Template for 'Welcome to the XYZ service at GOSH' to include information about age limit of service and set expectations from outset being developed • Transition Policy update • Develop sustainability plan
Lab samples	To reduce the number of Laboratory Sample Rejection due to Pre-analytical Errors	Project Leads - Wisdom Musabaike & Janet Yuen Wu, Pathology Quality Team	Scoping phase Project objectives: • To identify areas for improvement and quality indicators in pre-analytical processes and implement solutions to the findings • To develop an effective communication mechanisms across the clinical teams and the laboratory, and include patients and their families if possible for communicating information, outcomes and learning • To establish policies and procedures on pre-analytical processes that are compliant to the laboratory accreditation standards • To contribute to the education of staff members involved in pre-analytical procedures to ensure their understanding of the effects of pre-analytical variables on specimen quality • To liaise with clinical staff and EPR team to improve the ordering, collecting, labelling of laboratory samples under the future EPR system Next steps • Project diagnostics • Establishing governance and steering group membership • Establishing measurement plan

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 25 July 2018	
Annual Infection Prevention and Control report **Submitted by: John Hartley Director of Infection Prevention and Control**	**Paper No: Attachment Q**
Aims / summary To present to the Board the progress and issues in Infection Prevention and Control in 2017/18	
Action required from the meeting Feed back Approval for display on public web site	
Contribution to the delivery of NHS Foundation Trust strategies and plans Prevention and control of health care associated infections prevents harm and reduces cost.	
Financial implications Failure to prevent avoidable infection leads to harm and cost.	
Who needs to be told about any decision? Infection prevention and control is the responsibility of all staff	
Who is responsible for implementing the proposals / project and anticipated timescales? On-going programmes implemented by all Divisions and Corporate units, supported by IPC Team	
Who is accountable for the implementation of the proposal / project? Director of Infection Prevention and Control	

GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST

INFECTION PREVENTION AND CONTROL ANNUAL REPORT

April 17 - March 18 (Part A)

and

ACTION PLAN April 18 - March 2019

(Part B)

Compiled by: Dr John Hartley - Director of Infection Prevention and Control
Helen Dunn- Lead Nurse Infection Prevention Control

(Format - Modified from the template recommended in Health and Social Care Act 2008)

GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST
INFECTION PREVENTION AND CONTROL ANNUAL REPORT
April 17 - March 18

Summary

There is a fully functioning Infection Prevention and Control programme established at GOSH, with involvement of all staff.

Many of the children are susceptible to infection because of their illness or the treatment and are often already infected or colonised. We strive to protect them from their own and each other's bugs – especially respiratory and enteric viruses and antibiotic resistant organisms. The latter is a major challenge as the worldwide threat from antibiotic resistance increases.

Overall this year we have continued to provide a safe passage for the majority of the 40 000+ admissions cared for, with provision of clean safe environment and equipment and the avoidance of infection. We have also reduced serious blood stream infections form gram negative (GN) antimicrobial resistance organisms to the lowest ever, which represents the outcome of an enormous control effort by patients, families, staff, labs, estates, facilities and all. However, health care associated infections still occur. We had an increase in blood stream infections (from non-resistant organisms) some of which may be explained by case mix, and we still have some preventable line infection.

We have had an increase in cross infection and colonisation, with respiratory and enteric viruses, MDR-GNs and VRE. While more children were admitted with infection, subsequent lack of control may arise from failure to consistently recognise and contain the risk early and, possibly, from less efficient cleaning.

A successful reconfiguration of hand hygiene audit process, with audit days, has been undertaken.

Team expansion will enable greater focus on AMS, but there is currently a shortage of responsible persons in estates and surgical site infection surveillance is hard to maintain.

Detailed scientific investigation is being undertaken by the department to help understand transmission, but meanwhile we continue to stress the importance of a full assessment of infection risk and implementation of standard precautions, with additional actions when a patient is symptomatic, and the maintenance of a clean environment.

Above all, children are children, with very different needs to adults that have to be sympathetically incorporated into the care environment – often with great difficulty as love, attention and toys are perfect routes for cross infection.

We strive to keep the right balance.

J C Hartley DIPC

Part A Executive summary of full report

1 Introduction

Great Ormond Street Hospital for Children NHS Trust recognises the obligation placed upon it by the Health and Social Care Act Code of Practice of the prevention and control of infections and related guidance.

2) Description of infection control arrangements
Director of Infection Prevention and Control (DIPC) and ICD Dr John Hartley
Executive lead for IPC - Chief Nurse, Alison Robertson
Lead Nurse for Infection Prevention and Control – 1 wte, Helen Dunn
Deputy Lead Nurse in IP&C 1 wte; IPC nurse 1;
Clinical Scientist in IP&C 1wte (currently 0.4 in place as scientist on NIHR fellowship 0.6)
Other 2 consultant microbiologists – 3 PAs
IPC Administrative support and Data Management **–** 0.6 wte filled May 2017
IPC Data analyst – 2 years fixed contract commenced Mar 2018
Infectious Diseases CNS leads on Tuberculosis related issues;
ID consultants contribute to the out of hour's advice
Antibiotic pharmacist **–** 1 day of time, post within pharmacy

Development of IPC Team - New antibiotic pharmacist starting July 2018
ID Consultants – new post with time allocated for stewardship, commencing June 2018
New Microbiology Consultant advertising now (July 2018). New part time IPC team member to work with Development and Property Service – as part of phase 4 business case

Data analysis - Quality Improvement team – dashboard development and display.
New data analyst to develop service and transition to new integrated system (RLSolutions)

2.3 Divisional Responsibility
Each Division has a local group to drive local planning and implementation of IPC actions. This will need to be revised when the new structure is implemented in October 2018.

2.4 The Infection Prevention and Control Committee (IPCC) meets every month (except Aug). Committee reports to Patient Safety and Outcome Committee.

2.5 Reporting lines
The DIPC is accountable to the CEO and reports regularly to the Board.
The DIPC and Lead nurse for IPC meet bi-weekly with Executive lead.
A report of all significant IPC issues is presented weekly to the Safety Team.
Significant IPC issues are entered on Datix, collated and passed through reporting line.
An annual plan is written and included in each annual report.

***2.6* Antimicrobial stewardship and Sepsis**
There is an antimicrobial steward ship committee and Surviving Sepsis QI Programme

2.8* IPC advice and On-call service*.
Continuous advice service provided by IPC Team, Microbiology and ID consultants

***3.3 Outbreak Reports*, Serious incidents and investigations**
Contemporaneous outbreak reports are written by the IPCT and fed back to clinicians and managers and disseminated through the IPC Committee. There were no IPC SI's in 2017/18. A performance review was required for cleaning services.

4 Budget allocation to IP&C activities

4.1 Staff
IPC Team Staff budget in Department of Microbiology, Virology and IPC
Divisions fund own audit and surveillance staff, including surgical site infection surveillance
4.2 Support
IT Support and hardware: is supplied within the departmental budget.
There is no separate IPC budget, but emergency outbreak funding is provided by the Trust.

5 HCAI Statistics Mandatory reporting for *2017/18*

5.1 **MRSA bacteraemia** = 1 episodes attributed to trust (3 previous year)
5.2 MSSA bacteraemia = 20 episodes (36 previous year)
5.3 E. coli bacteraemias = 18 episodes (21 previous year)
5.4 **Klebsiella species** = 19 episodes (20 previous year)
5.5 **Pseudomonas aeruginosa** = 13 (12 previousyear)
5.6 ***Glycopeptide resistant enterococcal bacteraemia (GRE)*** = *6* (2previous year)
5.7 Clostridium difficile **associated disease** = 11 reported; 3 lapse in care.

Local surveillance
5.10 GOS acquired Central Venous Catheter related bacteraemia
1.5/1000 line days (82 episodes). 1.7 last year. Highest area NICU.

5:8 Other bacteraemia episodes and antimicrobial resistance
430 clinical episodes. Similar to last year. Low rate of resistance, except to ciprofloxacin

5:10 Surgical Site Infection Surveillance and Prevention
5.11 J M Barrie -continuous active surveillance. Nationally we were an outlier for spinal surgery; variation maybe explained by the complex case mix. A specific programme has helped reduce unintentional hypothermia. Further work planned to improve standardisation
5.12 Cardiothoracic – For 445 procedures, 10 infections (one deep) at rate of 2.2%.

It is difficult for the Divisions to maintain surveillance, especially due to staff turnover, and alternative structure may be needed in the long term, for which a proposal will be developed.

5:14 Viral infections detected while at hospital
There was an increase in admitted and potentially 'acquired in hospital' infection with outbreaks requiring ward restrictions (but no closures).
Failure to identify and isolate symptomatic children is a recurrent problem.

Respiratory viral infections detected:			
	Total	Community onset	Hospital onset
Total in 2016/17	374	262	112
Total in 2017/18	526	364	162
Enteric viral infections detected			
Total in 2016/17	499	281	218
Total in 2017/18	527	287	240

5:16 MRSA Admission Screening and colonisation/carriage
We continue with a universal admission screening policy, with improved daily report to wards introduced to facilitate compliance (> 80% all wards; > 95% ICUs).
In 2016/17 there were 234 children with first detections, 18 acquired in the hospital. In 2017/18 this was 209 and 9. There were 2 linked cases and a staff member in one unit.

5:17 Multiple resistant 'gram negative' (MDRGN) organisms screening and rates
Universal admission faecal screening is advocated. Compliance has reached 45%.
MDR-GN carriage/colonisation – has increased, both on admission and acquired while in hospital. In 2017 247 children were detected, 66 acquired while in (compared to 44 in 2016).
Highly resistant, carbapenemase producing organisms, reached 23 in 2017, the highest yet.

5.18 Vancomycin resistant enterococci – an increase in carriage has been detected, cross infection has occurred this year (confirmed by whole genome sequencing). As with the increase in other cross infection, cause will be multifactorial, including cleaning efficacy.

5.19 Serious Untoward incidents and complaints involving Infection, major outbreaks and threats
No S/I's in 2017/18, although recognition and management of sepsis featured in 2.
An OCS Performance review was initiated due to concern in pan trust cleaning.

6 Hand Hygiene and CVC on going care guidelines
Appropriate guidelines are in place and audited. They will be updated in line with new national saving lives guidelines.

7) <u>Facilities</u>
Cleaning Soft FM Services are provided by Outsourced Client Solutions (OCS) (contract commenced 1 August 2016). Completion of work plans and schedules was slow; concerns regarding quality of cleaning lead to a service review and improvement plan in Feb 2018.
The recent PLACE inspection (April 26 2018) gave good verbal feedback.

Decontamination Provision of Sterile services, endoscopy and medical equipment decontamination unit (MEDU) for GOSH has been successfully transitioned to Steris IMS on 1 November 2017. Services remain compliant but risks exist over continuity planning of staff and need to address outdated endoscopy and non-compliant MEDU areas.
The CJD/vCJD Policy has been successfully implemented.

8. <u>Estates</u>
Ventilation: The Estates team continue to work closely with clinical areas and IPC in the satisfactory annual verification of specialist ventilation.
Water: The Water Safety Management Group continues to develop and manage risk associated with water. Risk from heater cooler units has been controlled.
Redevelopment / projects - PICB commissioning of water and ventilation did not go smoothly from an IPC stance. Increased work load suggests additional IPC staff, to be part of the IPC team but located predominately within DPS are needed. Job specification being developed.

<u>9 Trust wide audit</u>
A Trust annual IPC audit programme is followed with results on KPI dashboards.

Due to falling compliance, a successful reconfiguration of hand hygiene audit process, with audit days, has been undertaken. This includes generation of contemporaneous action plans. Data from the audit days showed compliance dropped further initially but now has a real improvement. CVC on going care is 86% % and requires improvement.

'Bare-below-the-elbows' component of hand hygiene remains good - at > 97%.
Central venous line care bundle audit **-** 86% and we continue to focus on this.

9:5 Antimicrobial stewardship and Sepsis

Antimicrobial Stewardship – the 17/18 CQUINS were met. A successful business case was adopted and increased staffing will enable significant AMS activity in 18/19.
9.6 Sepsis report: A Quality Improvement programme was established in September 2016 under leadership of Ms Claire Rees. This is ongoing, and now lead by Dr Karyn Moshal.

10 Occupational Health

OH continues to provide 'new entrants' screening ,"Exposure Prone Procedures" clearance, staff immunisation (including influenza, final uptake 61% (62% previous year) and blood borne virus exposure follow up (91 events, compared to 74 in previous year).

11 Targets and Outcomes	Target	Outcome
MRSA bacteraemia –	0	1
Clostridium difficile infection lapses in care	<14	3
Rate of GOS acquired line infection /1000 days	< 1.3	1.5
Analysis for S. aureus bacteraemias	100%	100%
MRSA colonisation acquisition	0	9
Hand hygiene audits	95%	85%,
with negative scoring for non-completion		68%
CVL care bundle audits	90%	86%
For substantive staff:		
IPC level 1 induction	95%	89%
IPC level 2 update	95%	82%

12. Training activities

Basic IPC training and update is provided for all staff through either e-learning, face to face teaching from the IPC team or both. Update is now only through e-learning, including assessment questions. Attendance is monitored.

New training modules:

The online level 2 update training package is due to be updated.

IPC training days: A popular training day programme continues.

Hand hygiene training for staff on wards is provided locally, and by the IPC team for staff without a ward. All episodes should be recorded by the training department.

IV and aseptic non-touch technique training an update is provided for nursing staff locally but currently there is no assurance that this is provided to all medical staff.

Training and competency assessment for intravascular catheter insertion is provided locally and all divisions should be working towards a standard policy. This is not yet completed. Vessel health programme will help this.

Attachment R

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 25 July 2018	
Annual Complaints Report 2017/18 **Submitted by:** Claire Williams, Interim Complaints Manager	**Paper No: Attachment R**
Aims / summary To provide an overview of formal complaints received during 2017/8. Key points: • 87 complaints received a 13% reduction to 2016/7 • Main themes of complaints were about communication, staff attitude and care and treatment (delays/outcomes and management of expectations). • 97% of complaints were closed within timeframes agreed with complainants but responses times were too long (average response time was 46.9 days). The Complaints team are working closely with services to underway to reduce response times.	
Action required from the meeting For information only	
Contribution to the delivery of NHS Foundation Trust strategies and plan Offering assurance of effective management of complaints to ensure the safest, most effective and efficient care.	
Financial implications N/a	
Who needs to be told about any decision? N/a	
Who is responsible for implementing the proposals / project and anticipated timescales? N/a	
Who is accountable for the implementation of the proposal / project? N/a	

Complaints Annual Report

2017/2018

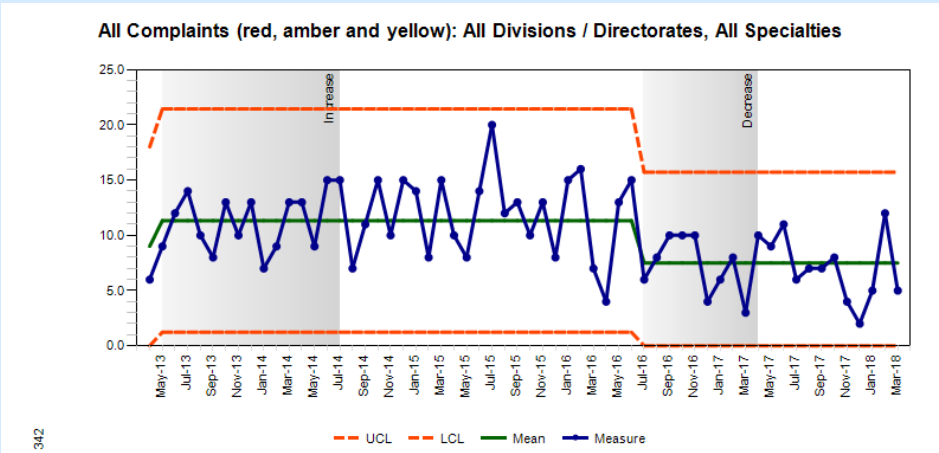
Complaints Summary

Great Ormond Street Hospital for Children NHS Foundation Trust

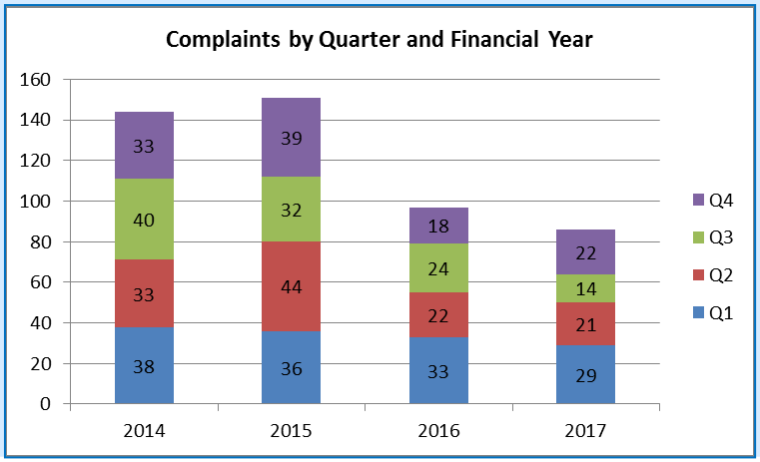
Summary of Key Points:

- The Trust received 87 formal complaints and 86 of these were investigated in line with the NHS Complaint Regulations, with one complaint withdrawn. This is a 13% reduction on 2016/2017.
- 8 complaints were graded as red (high risk) compared to 5 red complaints last year (2016/17).
- 97% of closed complaints were sent out within the timescale agreed with complainants . This is in comparison to 72% in 2016/7.
- 55% of draft responses were received from the lead investigator on time by the Complaints Team.
- 4 complaints were referred to the Ombudsman, one of which had been previously investigated by the Ombudsman and not upheld.
- Key themes in complaints this year were communication with parents, staff attitude (rudeness/disinterest) and concerns about delays in treatment.

Number of formal complaints received by the Trust:



Trends for the number of formal complaints received since April 2012



Complaints per quarter per financial year

Commentary: The Trust received 87 formal complaints this year, with one subsequently being withdrawn. This represents an overall 13% decrease on 2016/2017. There was an increase in red (high) level complaints from five to eight this year. Two of these were in the Charles West division, five in JM Barrie and one in International and Private Patients.
Consistent with 2016/7 the complaints team also received 63 informal complaints.

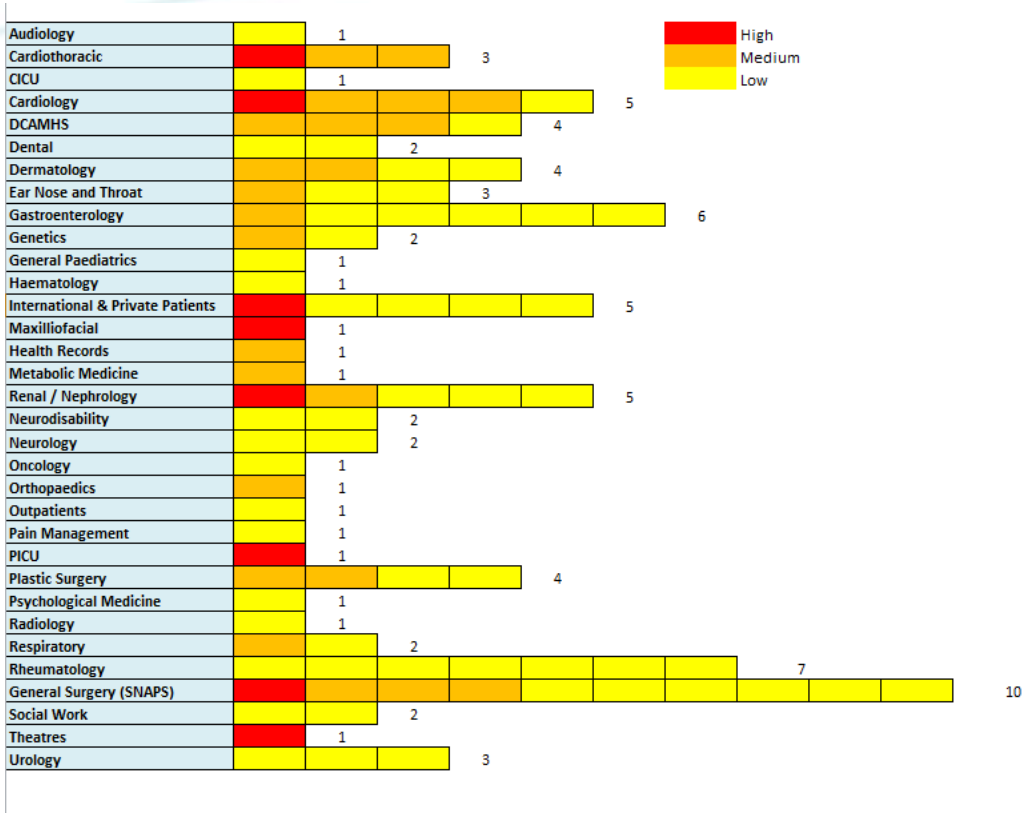
Commentary:
There were 22 complaints in the final quarter of 2017/18, including one red and five amber complaints.

Complaints by Grading & Speciality

Great Ormond Street Hospital for Children NHS Foundation Trust

Complaint grading definitions:

Red (high)	severe harm to patient or family or reputation threat to the Trust.
Amber (medium)	lesser than severe but still (a reported) poor service, communication or quality evident.
Yellow (low)	minor issues or difference of opinion rather than deficient service.



Commentary:
Since 2016/17 the number of Gastroenterology complaints has dropped from 15 to 6. However, we have seen a rise in complaints for SNAPS from 3 to 10 (the majority of concerns related to cancelled surgery) and Rheumatology from 4 to 7.

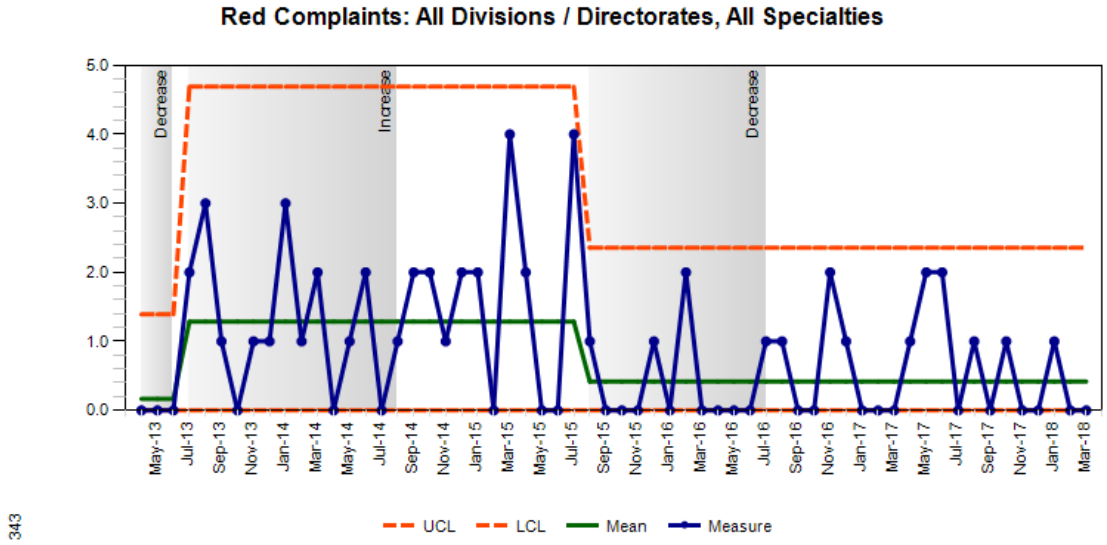
Comparison of complaints grading by year

	2017/18		2016/17	
	Number of complaints	% of complaints	Number of complaints	% of complaints
Red	8	9%	5	5%
Amber	23	26%	28	28%
Yellow	55	64%	66	67%
TOTAL	**86**	**100%**	**99**	**100%**

Red Complaints

Great Ormond Street Hospital for Children NHS Foundation Trust

Red Complaints



No of new red complaints in 2017/18:	8
No of re-opened red complaints in 2017/18:	1
Total no of open red complaints at the end of the reporting period (31/03/2018):	2
No of closed red complaints in 2017/18:	6

Number of new red complaints per quarter (17/18):

Q1	Q2	Q3	Q4
5	1	1	1

Subject themes from red complaints (17/18)

While communication is at the heart of most complaints received, a review of red complaints highlighted inadequate/ poor communication before and after patients had died. This has been fed back to the respective teams who are looking at their communication and training for staff to avoid exacerbating distress to families at such a difficult time.

Those complaints closed in 17/18 have appropriate actions and these are shared with the division to be completed once the complaint is closed. Some examples of this are shared later in this report.

On the whole, each of the red complaints raised this year covered different specialties and different areas of concern and there were no clear trends.

Complaints by Patient Activity

Great Ormond Street Hospital for Children NHS Foundation Trust

"Combined Patient Activity" is a very simple measure of all patient activity at Great Ormond Street Hospital. It combines inpatient (finished consultant episodes) and outpatient (attended appointments and ward attenders) activity so that it can be used as a denominator for comparable measures across the Trust such as complaints, harm and incident rates. It is useful for measures with numerators (such as the number of formal complaints etc.) that are applicable across multiple patient groupings (e.g. not only inpatients).

combined patient activity = outpatient attendances + inpatient episodes

This combined activity measure has advantages over other such measures of overall patient activity in that it is simple to understand and calculate, is easy to combine or separate NHS and private activity and it can be applied across a number of hospitals. It also produces patient numbers that are realistic, without applying complex weightings to different patient groupings.

Percentage of complaints received compared to patient activity for each Division:

Directorate	Total number of Complaints	Adjusted patient activity	Amount of Complaints per 1000 Adjusted Patient Days	% of Complaints per 1000 Adjusted Patient Days
Charles West	29	130623	0.22	29%
JM Barrie	52	163806	0.32	41%
IPP	5	21603	0.23	30%
Totals:	86	316032	0.27	100%

Percentage of complaints received compared to patient activity for the specialties with the highest amount of complaints:

Specialty	Total number of Complaints	Adjusted patient activity	Amount of Complaints per 1000 Adjusted Patient Days	% of Complaints per 1000 Adjusted Patient Days
Cardiothoracic Surgery	3	999	3.00	17.1%
General Paediatrics	1	404	2.48	14.1%
General Surgery (SNAPS)	10	5191	1.93	10.9%
CICU	1	738	1.36	7.7%
Gastroenterology	6	4944	1.21	6.9%
DCAMHS	4	5741	0.70	4.0%
Plastic Surgery	4	6130	0.65	3.7%
Pain Management	1	1545	0.65	3.7%
Rheumatology	7	11210	0.62	3.5%
Others (combined)	43	190340	N/A	28.5%

Complaints Timescale

Great Ormond Street Hospital for Children NHS Foundation Trust

Complaints closed within the agreed timescales:

Total number of complaints investigated in the year:	86	Total number of complaints closed in the year:	86
Percentage of draft reports received from investigation staff on time:	55%	Percentage of responses completed and sent to complainant within the agreed timescale:	97%

Yearly comparison of complaints closed within the agreed timescales:

48% of draft reports were received from the investigating staff on time last year (15/16). This year this has improved slightly to 55%. The percentage of responses completed and sent to complainant within the agreed timescale has increased this year to 97% from 72% last year. This reflects a change in our measure to reflect NHS standards where a complaint is not considered late so long as the family is properly informed of any delay, and the complaint is completed within 6 months.

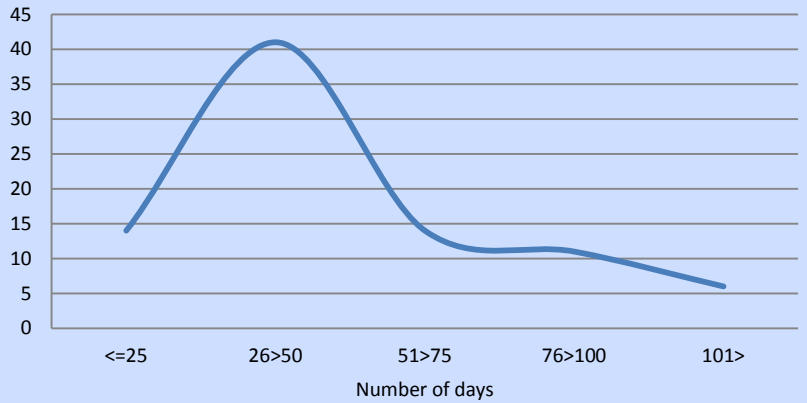
Complaints timescale monitoring

Since April 2016, the timescales for all new complaints (which have since been closed) are being monitored at each stage of the process in order to further understand the delays and therefore what additional support may be required.

	JM Barrie	Charles West	IPP	Corporate Departments 0
Number of complaints	55	27	4	0
Drafts received on time	60%	41%	75%	N/A
Responses sent on time	96.4%	96.3%	0%	N/A

Stage of the formal Complaints sign off process	Average number of days
Average working days for the complaints team to review draft	6
Average working days for the division to finalise the report following the draft review	23
Average working days for Chief Nurse sign-off	2
Average working days CEO sign-off	2

Complaint response times 2017/8



Disability and Ethnicity Data

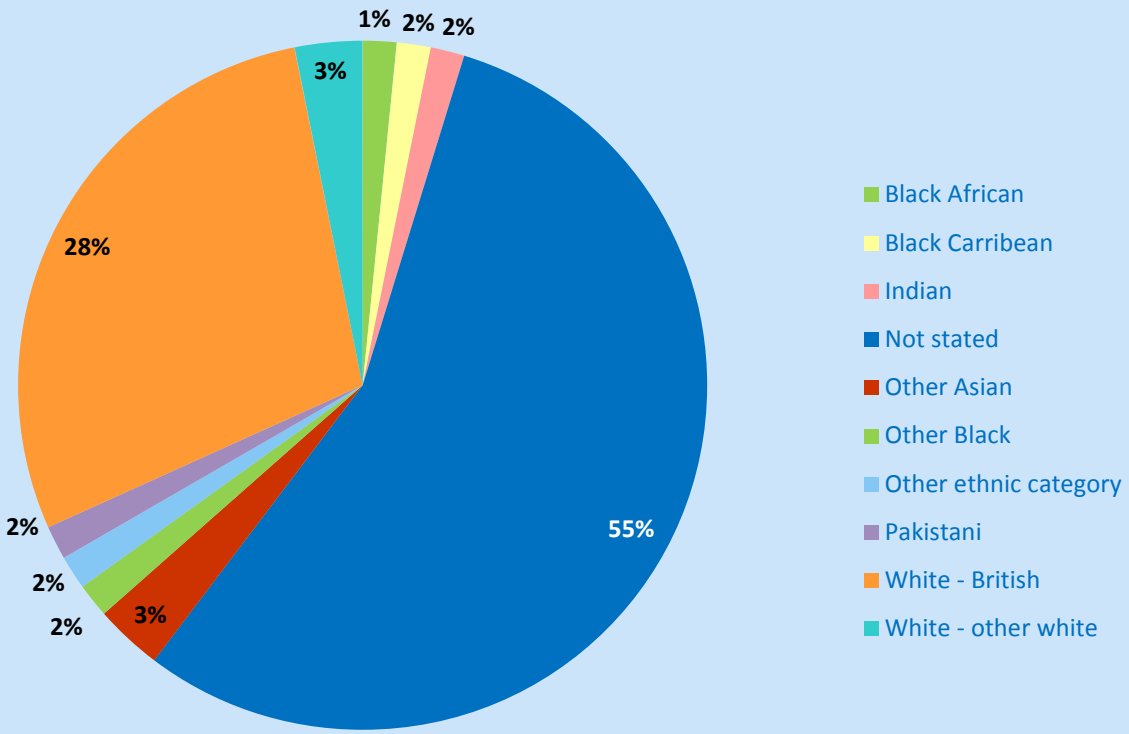
Great Ormond Street Hospital for Children NHS Foundation Trust

Disability data:

8.1% of complaints received during the 2017/18 financial year related to a patient recorded as having a disability; this is the same amount as last year. This is based on either the family informing us of the patient having a disability, or this being listed on PIMs as an alert. One patient had a hearing impairment and six had learning disabilities. One parent also informed us they had a disability (dyslexia) and additional support was offered during the complaints process and when responding to the concerns raised.

Complaint Ethnicity Data (16/17)

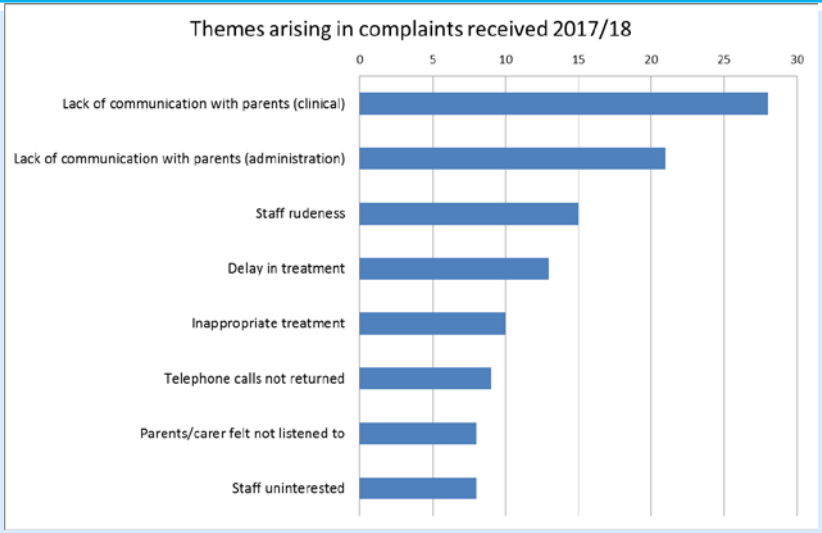
In order to understand who is and is not accessing the complaints service, the Trust records the ethnicity of the patient when complaints are received. This is done using either the Patient Information Management System (PIMS) or information within the complaint. In 55% of cases the complaints team were unable to log this information as the information was not recorded on PIMs.



Complaint Trend Analysis

Great Ormond Street Hospital for Children NHS Foundation Trust

Subjects arising in complaints received 2016/17



Some complaints raise multiple issues regarding a number of services and specialities. This chart shows the 10 most common issues raised in complaints received this financial year.

Communication

- As with previous years, communication remains the most significant issue complained about by families. This year clinical and administrative communication have been logged separately. This has shown that concerns about clinical communication are higher than administrative communication. This category primarily covers clinic letters, test result feedback, and communication in clinics.

Staff rude/ disinterested

- Concerns that staff acted rudely, or with disinterest, were raised on 23 occasions. Defensive or negative language was a frequently raised concern, as well as parents feeling that their own views were ignored or dismissed during consultations.
- Complainants also raised concerns that clinical reports were written in a misleading way. This is a theme which has been raised previously, usually relating to specific types of assessment which can involve questions about lifestyle and activities.

Delay in treatment

- Concerns were also raised that mistakes made by staff led to delays in clinical treatment. There were no major themes connecting these complaints.

Complaint Trend Analysis

Great Ormond Street NHS Hospital for Children
NHS Foundation Trust

35% of the subjects raised this financial year were linked to the 'One Team- Communicate' value. A further breakdown of complaints in relation to the Trust Always values and themes from these can be found below:

Complaints and the Trust Always Values 2016/2017:

Always Welcoming- Respect	14	Always Welcoming- Friendly	10	Always Helpful- Understanding	0	Always Helpful- Help others	1
Always Welcoming- Smiles	0	Always Welcoming-Reduce Waits	15	Always Helpful- Patient	0	Always Helpful- Reliable	21
Always Expert- Professional	3	Always Expert- Excellence	41	One Team- Listen	13	One Team- Involve	1
Always Expert- Safe	24	Always Expert- Improving	0	One Team- Communicate	77	One Team- Open	2

Themes

- Reflecting concerns about staff rudeness and disinterest, **Always Respect** had 14 subjects associated with it this year. Some families felt that the language/behaviour used by staff was disrespectful to them.
- **Reducing waits** was associated with 15 subjects this year. Concerns were raised by families about waiting times for appointments and admissions. Often this was due to their expectations not being appropriately managed by staff.

- **Always reliable** was a top value this year. 21 concerns were raised that the Trust was not reliable. This was mostly relating to cancelled appointments or admissions.
- Where cancellations were the fault of the Trust, reimbursement for train tickets or travel costs was offered to families.
- There is an issue in Cardiology especially where all patients are cancelled once or twice before their surgery. This is a known issue but does come up frequently in complaints.

- **Always safe** was raised as a concern this year. This mainly linked to concerns about clinical practice, and that it had a negative outcome for the patient.
- **Always Excellent** had 41 subjects associated with it, the second highest number of any value. This was mostly linked to criticism of the practice of individual members of staff and concerns they did not match the expectation of the family.

- Communication remains the most associated value. Good, clear communication with families remains the most important thing to improve upon. This includes ensuring families are aware of who to contact if they have any questions or concerns, and ensuring that these are responded to in a timely manner.
- 13 complainants also raised concerns that they were not listened to, which ties in with the concerns about respect.

Learning from Complaints

Examples of learning from Complaints:

Details of complaint:	What we said we would do/Action taken:	
Patient's procedure was cancelled at the last minute because of her infectious status. It was later found that the patient's infectious status was known to the team, but this information was not available to the consultant at the time he finalised the theatre lists.	We said we would ensure that the Consultant had available to them information about the infectious status of every child due for surgery at the time that the theatre list was finalised.	Clinical Audit have reviewed theatre lists since the complaint and have found that the team are compliant with this change in practice.
Patient's dental procedure was cancelled as the Dentist did not have the correct information about what blood materials the patient might need during the procedure (they had haemophilia). The complaint showed that there were not adequate lines of communication between the Dental and Haemophilia teams, and that discussions and outcomes were not fully documented.	As an outcome of this complaint, the Head of Clinical Service for Dental undertook a review of communication. The conclusion of the review was that all future requests for information from Haemophilia would be made in writing and documented on EDM (the electronic record management system), along with any advice given in return.	Clinical Audit will be meeting with Dental to make a plan to audit the EDM records of Dental Patients with Haemophilia to ensure that this practice is embedded. Expected in 6-12 months.
There were concerns raised by the family that the process of discussing clinical care plans (in Multi Disciplinary Team meetings) and feeding this back to the family was not clear.	As an action from this it was agreed that all clinical care changes for gastroenterology patients would be discussed as part of an MDT, and that this discussion would be documented in the letter sent to families. The MDT would decide amongst themselves who would be responsible for sending the letter.	Two audits were made of clinic letters. The first in October 2016 showed 62% compliance with the new standard, and the second in January 2018 showed 94% compliance. The audit was led by Dr Osvaldo Borelli, supported by Andrew Pearson.

Complaints

Great Ormond Street Hospital for Children NHS Foundation Trust

Re-opened Complaints: (8) –		
Ref	**Reason for dissatisfaction:**	**Action taken:**
16/089	Complainant raised concerns the initial response did not fully address her concerns.	General manager called complainant and discussed her concerns, and a letter was written outlining the actions that would be taken.
16/068	Complainant raises concerns regarding the accuracy of the original report and raises one additional new concern.	Written response sent clarifying the points which complainant raised, and responding to the new point raised.
16-076	Complainant raises concerns with the report and asks for a number of amendments to be made to a clinic letter.	Response sent addressing questions, and which amendments are appropriate to make.
16-039	Complainant raised concerns that some parts of the original response were not fully investigated.	Report written by Divisional Director responding to complainant's points.
16-095	Complainant raises additional questions after receiving the initial complaint investigation report	Investigator looked into the additional points and responded in writing.
17-010	Complainant felt the initial complaint response did not appropriately link treatment with deterioration of patient's sight.	Letter sent explaining that, following an expert review, there is no evidence that the two are linked.
17-028	Complainant raises concerns about some parts of the original response, and clarification on whether patient has been discharged from GOSH.	Letter sent clarifying the concerns raised by the complainant and confirming the patient is not under GOSH and has not been since 2012.
17/054	Mother raises concerns about inaccuracies in the original response.	Clarification of points raised sent by email.

Parliamentary and Health Service Ombudsman (PHSO) activity:		
Ref	**Case Details:**	**Current status:**
New cases received in 17/18: 4		
15/112	Patient raises concerns regarding errors on a genetics report, and in particular the way her complaint was managed.	With the Ombudsman for consideration.
17/038	Mother raises concerns that she stepped on a needle on the ward.	With the Ombudsman for consideration.
16/027	Parents feel their son's cardiac condition was not adequately explained to them before his death.	Ombudsman is investigating and a report is due.
14/110	Parents raise concerns regarding patient's care prior to death. Raised previously by the Ombudsman and not upheld. They reopened due to concerns raised about their own investigative practices.	Awaiting response from the Ombudsman following GOSH letter. Ombudsman have stated they intend to reinvestigate.
Existing cases carried over to 17/18: None		

Complaints

Great Ormond Street Hospital for Children NHS Foundation Trust

Clinical Records Audit

Complaints and complaint responses are confidential, and are always kept separate from patients' clinical notes.

Compliance with this is monitored in a yearly audit of 10 clinical records selected at random. The audit found that there were that no complaint correspondence in any of the records checked.

Care Quality Commission Report

In January and February 2018 the CQC carried out an inspection at GOSH. As part of this, they spoke to members of the Complaints team, as well as the Head of Quality and Safety, about the Complaints process.

In their report the CQC highlighted complaint response times as a key area for improvement. In most cases families are given an initial timescale of 25 working days, and it is explained that this may change depending on the investigation. Families are then kept up to date with the progress of the investigation and the reason for any delay.

The CQC identified that between August 2016 and September 2017, the Trust took an average of 59 calendar days to close complaints. It is clear from monitoring that a significant portion of this is time taken to finalise complaints following review of the first draft response. After discussion with a number of complaint investigators it is apparent that many feel they would benefit from additional training and support, in order for initial drafts to require less revision. The Complaints team are aiming to produce a training strategy in Q1/Q2 2018/19 with a view to implement this by early 2019.

'Well Founded' Complaints:

In accordance with the NHS Complaints Regulations 2009, the Trust is required to comment on the complaints it considers to be "well-founded". This Trust feels that every complaint received is of value and is an opportunity to learn. Any family who have felt the need to raise concerns with us has experienced what they have perceived to be an unsatisfactory service. A complaint investigation may conclude that the care and treatment provided to a child has been appropriate, however this often highlights failures in communication which have led the family to have concerns.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 25 July 2018	
Annual PALS report 2017/18 **Submitted by:** Herdip Sidhu-Bevan Assistant Chief Nurse – Patient Experience and Quality	**Paper No: Attachment S**
Aims / summary Key points from the PALS annual report: 1. Most common themes of PALS contact across the divisions were cancellations (some with no prior notice), lack of communication and accommodation 2. Divisions to present to PFEEC the issues around cancellations within their areas picked up from this PALS data 3. To link PALS data more effectively with divisional performance meetings and for divisions to share this data with their staff 4. PALS contacts have increased each year 5. Last year showed a marked increase due to the NICU case however these contacts were separated when documented	
Action required from the meeting To receive and note the report	
Contribution to the delivery of NHS Foundation Trust strategies and plans To engage and listen to the experience of patients and families	
Financial implications N/A	
Who needs to be told about any decision? N/A	
Who is responsible for implementing the proposals / project and anticipated timescales? N/A	
Who is accountable for the implementation of the proposal / project? N/A	

PALS Report Annual 2017/18

Luke Murphy Pals Manager

Pan-Trust
Charles West
JM Barrie
IPP (International and Private patients) & DPS (Development and Property Services)
Key initiatives
Always values
Social media feedback
Always Values

Comparison of PALS cases received by the Trust during financial year 2017/18

Great Ormond Street Hospital for Children NHS Foundation Trust

Cases	15/16	16/17	17/18
*Promptly resolved cases (-48h)	1269	1322	1435
*Complex Cases (48h+)	279	321	275
*Escalated to Formal Complaints	37	21	38
*Compliments about specialities	53	25	12
*Special cases	5	248	3379
Total activity	1643	1937	5139

*See Appendix at the end for definitions

Commentary:

The promptly resolved cases have been gradually increasing since 2015/16 to the present financial year. The number of complex cases has decreased. The number of cases that families want escalated to formal complaints has increased and the number of compliments shared with Pals have decreased as well since the previous two financial years.

*Special Cases: These are cases that have generated work are not related to the normal Pals caseload but are supported by the Pals team.

There have been three episodes of special cases-

1. Q1 16/17 and Q3 and Q4 16/17 the second stage gastroenterology review took place and this discussed above. There were 43 contacts. Q3 16/17 we had 208 contacts following an episode of Question time, this was associated with the Speech and Language therapy Team. Each respondent received a verbal or written response.
2. There were two cases involving social medial interest during 17/18.

PALS Cases by Speciality Pan Trust 2017/18

Great Ormond Street Hospital for Children NHS Foundation Trust

Top 5 Specialties arising in PALS cases received in 2017/18

Theme	15/16	16/17	17/18
NICU	0	2	8 (normal cases) 3357 *(special cases)
Cardiology	72	63	105
SNAPS	67	83	93
Neurology	Was not a speciality in this financial year	11	84
Gastroenterology	206 (normal cases) 5 (special cases)	181 (normal cases) 38 (special cases)	84

*see appendix

NICU: There were 8 Pals cases for NICU. However, there were 3357 contacts following social media interest in activity at GOSH

Cardiology: There has been an increase in Pals cases this year compared to 16/17, when the numbers had decreased compared to 15/16. Pals is working with the service. Themes are communication, cancellations and waiting times

SNAPS: There has been a gradual increases in cases coming to Pals. Themes are cancellations, waiting times

Neurology: The number of cases coming to Pals for this service have not been previously recorded, as this speciality was created in Q4 of 16/17. The top themes are lack of communication with families; queries relating to outpatient appointments and parents wanting information about referrals to the service.

Gastroenterology: There has been a reduction in the cases for Gastroenterology compared to previous years. The themes are lack of communication; ward facilities and accommodation for second parent when a patient is admitted.

PALS Thematic Analysis

Great Ormond Street Hospital for Children NHS Foundation Trust

Top 5 themes arising in PALS cases received in 2017/18

Theme	15/16	16/17	17/18
Support/Listening	0	29	36 (normal cases) 3371 (*special cases)
Communication/letters	559	495	609
Cancellation	79	78	99
Waiting times	79	78	99
Failure to arrange appointment	37	63	70

Support and Listening: There has been an increase in cases under this theme following public interest in a social media case.

Communication: The specialities are Cardiology; Gastroenterology; Neurology; Epilepsy and Neurosurgery

Cancellations: The specialities are Cardiothoracic; Cardiology; Orthopaedics; General surgery and Spinal surgery.

Waiting times: The specialities are: Neurosurgery; General surgery; Spinal surgery; Cardiology and ENT

Failure to arrange appointment: The specialities are: Orthopaedics; Neurology; Neuromuscular; Opthalmology and Dental

PALS Cases by Division

Great Ormond Street Hospital for Children NHS Foundation Trust

Charles West (A1)

Top 5 Specialties	15/16	16/17	17/18
Health records	14	16	35
Outpatients	26	21	35
Respiratory	22	25	31
CICU	Not a speciality alone in this year	1	18
General Paediatrics	9	13	12

Commentary :

Health records: Support with accessing medical records/leaving completed forms; contacting the team; understanding how to access encrypted files

Outpatients: Lack of communication with family's about cancelled appointments; experience whilst in outpatients; transport arrangements not being made

Respiratory: Outpatient appointments arrangements/Cancellations; communication about admissions; lack of communication

CICU: Experiences as inpatients in relation to additional support; information about services at GOSH; query about discharge

General Paediatrics: Lack of communication with families; support with outpatient appointment bookings, information

PALS Cases by Division

Great Ormond Street Hospital for Children NHS Foundation Trust

Charles West (A2)

Top 5 Specialties	15/16	16/17	17/18
Cardiology	72	63	105
Rheumatology	73	63	66
Cardiothoracic	Not a speciality in this year	Created midway	34
Dermatology	19	31	33
Oncology	18	16	28

Commentary :
Cardiology: Lack of communication with family's; Cancellations of appointments / procedures; Waiting times
Rheumatology: Lack of communication; waiting times for appointments to be arranged; cancellation of appointments with no prior notice
Cardiothoracic: Lack of communication with family's; cancellation of admission with no prior notice; waiting times
Dermatology: Lack of communication with families; Cancellations; waiting times
Oncology: Lack of communication; transport arrangements following discharge; accommodation for family's during admissions

PALS Cases by Division

Great Ormond Street Hospital for Children NHS Foundation Trust

JM Barrie Portfolio 1

Top 5 Specialties	15/16	16/17	17/18
NICU	0	2	8 (normal cases) 3357 *(special cases)
Orthopaedics	0	1	76
Neurosurgery	28	35	76
Spinal Surgery	0	0	56
Endocrinology	52	37	48

Commentary :
NICU: Cases related to interest by media and public regarding care at GOSH
Orthopaedics: Lack of communication with families; cancellations; failure to arrange admission;
Neurosurgery: Lack of communication; waiting time for surgery; cancellation of procedures with no prior notice
Spinal Surgery: Cancellation of admission with no prior notice to family; Lack of communication with families; waiting times for admission arrangements;
Endocrinology Lack of communication with families, cancellations of appointments/procedures with no prior notice; parents concerns following appointment
*see Appendix

PALS Cases by Division

JM Barrie Portfolio 2

Top 5 Specialties	15/16	16/17	17/18
General Surgery	67	83	93
Ophthalmology	69	50	67
ENT	46	45	48
Urology	79	72	46
Dental	25	33	41

Commentary :

General surgery: Lack of communication with families; cancellations; waiting times; ward cleanliness and facilities

Ophthalmology: Lack of communication with families; cancellation of appointment with no prior notice; lack of information about waiting times

ENT: Lack of communication with families; waiting times for procedures; accommodation eligibility

Urology: Lack of communication with families; waiting times for appointments; cancellations with no prior notice

Dental: Cancellations; Lack of communication with families; Advice about referral to service.

PALS Cases by Division

JM Barrie Portfolio 3

Top 5 Specialties	15/16	16/17	17/18
Neurology	0	11	84
Gastroenterology	211	219	84
Epilepsy	Not a speciality in this quarter	3	49
Neuromuscular	9	25	39
Radiology	11	17	38

Commentary :
Neurology: Lack of communication with families; failure to arrange appointment; waiting times for tests/appointments
Gastroenterology: Lack of communication with families; ward environment; accommodation for 2nd parent during admission
Epilepsy: Lack of communication with families; waiting times for appointments; cancellations with no prior information
Neuromuscular: Lack of communication with families; failure to arrange appointment; error in appointment booking
Radiology: Lack of communication; cancellation with no prior notice and waiting times to hear about dates.

PALS Cases by Division

Great Ormond Street Hospital for Children NHS Foundation Trust

IPP

Top 5 Specialties	15/16	16/17	17/18
International and Private Patients	20	23	22

Commentary :

Pals works closely with IPP to support family's with their concerns. IPP have a strong management structure to liaise with families.

Development and Property Services

Top 5 Specialties	15/16	16/17	17/18
Facilities	Not a speciality in this financial year	Not a speciality in this financial year	57
Estates	Not a speciality in this financial year	Not a speciality in this financial year	18
Redevelopment	3	1	2

Commentary :
Facilities: Feedback about the lagoon; feedback about transport vehicles and feedback regarding ward facilities.
Estates: Family's being charged due to mail not being franked; concerns with patient hotel
Redevelopment: responds promptly to concerns raised and all cases have been resolved within 48 hours.

Key Initiatives 2017/2018

Pals Outreach Project (Popping)

Commentary: POP stands for Patient Outreach Project-

Pals new administrator and Pals manager started the POP programme with a team of volunteers. Currently there are visits to wards twice a week. The aim is to share information with family's and to hear any concerns.

Promoting Patient and Family Information

Commentary:

The projected lead by the Pals administrator has increased to four trolley's during this financial year. There has been a significant update in different information, which has included.

Financial support following GOSH error

Commentary:

Family's are sent to Pals when their procedures or appointments are cancelled after they arrived in the Trust. Pals has a budget provided by the charity to offer a reimbursement to the family's who have paid to attend the Trust.

PALS and the Always Values

Great Ormond Street Hospital for Children NHS Foundation Trust

Pals and the Trust Values: Pals allocates cases against the values that were lacking.

Always Welcoming- Respect	34	Always Welcoming- Friendly	26	Always Helpful- Understanding	178	Always Helpful- Help others	218
Always Welcoming- Smiles	2	Always Welcoming-Reduce Waits	91	Always Helpful- Patient	127	Always Helpful- Reliable	243
Always Expert- Professional	98	Always Expert- Excellence	42	One Team- Listen	3406	One Team- Involve	47
Always Expert- Safe	63	Always Expert- Improving	45	One Team- Communicate	492	One Team- Open	28

Themes

The top three themes that the values relate to are

- **Waiting times:** Cancellation of treatments; waiting times; failure to arrange appointment
- **Friendly:** Lack of communication with families; environment on wards; praise for care
- **Respect:** Lack of communication with families; Gosh information; staff attitude
- **Smiles:** lack of communication with families and staff attitude

The top three themes that the values relate to are

- **Understanding:** Lack of communication with families; accommodation; cancellations
- **Help Others:** Lack of communication with families; cancellation; accommodation
- **Reliable:** Cancellations; lack of communication with families; waiting times
- **Patient:** Lack of communication with families; waiting times, delay in arrangement admission

The top three themes that the values relate to are

- **Excellence :** Lack of communication with families; cancellation; praise for standard of care
- **Professional:** Lack of communication with families; Praise for staff; cancellations
- **Safe:** Lack of communication with families; Care advice; Incorrect treatment
- **Improving:** Cancellations; Lack of communication with families
- ; Staff attitudes

The top three themes that the values relate to are

- **Listen:** Support; lack of communication with families; dissatisfied
- **Communicate:** Lack of communication with families; cancellation; failure to arrange appointment
- **Open:** Lack of communication with families; accommodation; referral information
- **Involve:** Lack of communication with families; waiting times; cancellations

Other Feedback

Great Ormond Street Hospital for Children NHS Foundation Trust

Social Media and NHS Choices:

Postings on Social Media and on NHS Choices are shared with the clinical team that the posting relates to. NHS Choices has a public reply posted from the Pals Team encouraging direct contact with us to help support the concerns raised by the family. The postings are however anonymous and each of the postings this quarter had to be shared with the relevant teams without patient details to act upon.

16/09/2017 Fantastic dedicated staff My grandson had a planned operation last month, the care could not have been better. Although everything did not go to plan and there were some very anxious moments the 24/7 care by the ICU nurses and the brilliant Consultant gave us a fantastic outcome. We all could not thank everyone enough and all involved gave 100%. The hospital and staff are amazing.

19/02/2018 Best Hospital I have ever been to My daughter suffers from severe Eczema from when she was 3 months old until when she was referred to GOSH at age of 3 years old. Now she is almost 6 and she is doing much better. I can't describe how hopeless we were before coming to GOSH. I have seen many doctors in number of hospitals in 3 countries. The dermatology department did a great job I can't thank the staff enough. We are very happy to have one particular doctor, she is the best. I know I should not use names but I can't help it. She is caring and one of the best in here field. Please, GOSH keep up the good work! my family and I thank you from the bottom of our hearts.

12/10/2017 Felt disappointed I have visited this hospital last week. After promises and hope they promised they will get communication aid for my son. On second visit they discharged us they didn't offer any help and I have felt intimidated by doctor saying "your child was made this way". All is fake promises and my child is still suffering. They didn't listen my concerns they didn't take reports and findings from professionals seriously. These people have bombarded us with filling questionnaires for hours and hours and for nothing! This hospital needs Ofsted inspection.

21/04/2017 Children's & Adolescent Services Disgusting My son was due to have life changing surgery on his bowel next week. Someone decided to cancel it 4 days before and couldn't give a valid reason for it. Absolutely disgusting. My little boy has been suffering the day he was born and they want to post pone for god knows how much longer! Absolutely disgusted with certain people at this place!

Compliments:

Parent wanted to thank the clinical team for treating her daughter whilst she was an inpatient	**Anaesthetics & Theatres**
Family sent an email to Pals asking for letter praising team to be sent to relevant team members	Plastic Surgery
Father was to send his thanks to the staff that looked after his daughter when she was an inpatient at GOSH during a recent admission.	Urology
mother wants to compliment the team that supported her son during pre-admission	Craniofacial
Praise for porters nursing staff and play specialists	Facilities
mother emailed a compliment to appreciate the way the security manager	Facilities
Compliment for staff for supporting mother	Quality & Safety Team

Welcoming Helpful Expert One Team

Appendix

PALS grading definitions:

- **Complex Cases**

  Cases that involve multiple questions / longer than 48 hours to resolve

- **Promptly Resolved**

  These cases are resolved promptly (24-48hr)

- **Escalated to Formal complaint**

  Families who want a formal escalation to their concerns

- ***Special cases**

  During the financial year 17/18 there were two separate large contacts following interest by media and public regarding GOSH

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
25 July 2018

Results of the Care Quality Commission National Inpatient and Day Case Experience Survey 2016 **Submitted on behalf of** Alison Robertson, Chief Nurse	**Paper No: Attachment T**

Aims / summary

The 2016 National Care Quality Commission Paediatric Inpatient and Day Case Survey measures and compares the experiences of children, young people and their parents in paediatric inpatient settings across the country. In 2016 34,708 people took part from 132 acute and specialist NHS Trusts. GOSH received 372 surveys and a response rate of 30%. Data from this survey was received by Great Ormond Street Hospital (GOSH) on 28 November 2017.

4 key messages to take away from this report are:

1) Out of 63 questions, the CQC said that GOSH scored "better than average" for 20 questions and "about the same" for 43 questions
2) GOSH was praised for performing "better than expected" for the 0-7 age group
3) Areas where GOSH did well: communication about operations/procedures, responding to questions
4) Areas where GOSH could improve: communication with patients, catering, and providing activities for teenagers. Parents wanted more staff to have knowledge of their child's medical history

Action required from the meeting

Review and comment

Contribution to the delivery of NHS / Trust strategies and plans

- 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 Behaviors work
- Trust PPIEC strategy
- Quality Strategy

Financial implications

None

Who needs to be told about any decision

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

Emma James – Patient Experience and Engagement Officer

Who is accountable for the implementation of the proposal / project

Herdip Sidhu-Bevan– Assistant Chief Nurse Quality and Patient Experience

Author and date

Emma James – Patient Experience and Engagement Officer – January 2018

CQC National Children's Inpatient Survey Results 2016

Background

- **Run by the CQC**
- **First paediatric survey in 2014**
- **Second in 2016**

The survey

- **Questions were based on topics related to coming into hospital e.g. the ward**
- **Sample - October, November and December 2016**
- **Administered by paper during Feb - April 2017**
- **Scoring of questions ranged from 0 poor to 10 excellent**

Results

- **30% response rate (5% above national average) 1238 sent 372 returned**
- **66% of returned questionnaires were young patients' questionnaire**
- **In 2016, patients rated care experience as 9.3 out of 10. In 2014 it was 8.5**
- **In 2016 parents also gave the score of 9.30 out of 10. In 2014 it was 8.7**

GOSH results

	From Patients	From parents
In the top three performing questions	96% felt they were able to ask questions	95% of parents felt they were given enough information on how to use medicines
	95% felt staff answered their questions	95% of parents felt they were given an explanation of what would be done in operations/procedures
	92% felt they were given explanations of what was to happen in operations/procedures	95% of parents felt that prior to an operation/procedure they received answers to their questions in a way that they could understand
In the bottom three performing questions	Only 56% felt there was enough things for them to do whilst in hospital	Only 64% of parents felt there was enough things for their child to do whilst in hospital
	Only 55% felt they were involved in decisions about their care and treatment	Only 59% of staff were aware of their child's medical history
	Only 50% liked the hospital food	Only 38% of parents reported that they were given a choice of admission dates

National comparisons

20/63 questions - GOSH scored "better than average"

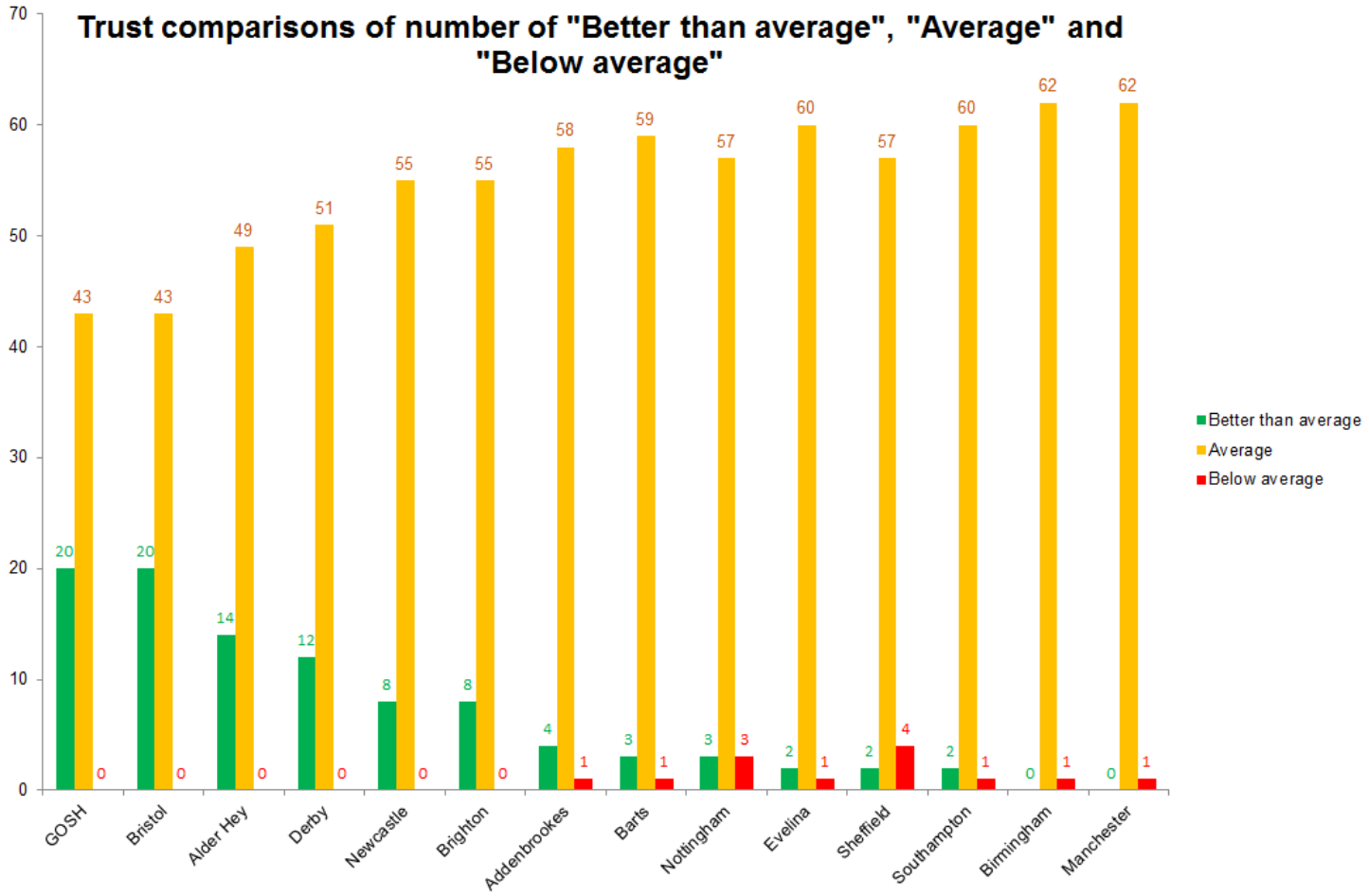
43/63 questions - GOSH scored "about the same"

GOSH identified as performing "better than expected" for the 0-7 age group compared to other Trusts within the survey

"Better than average" in the topics below :

- **Hospital wards**
- **Hospital staff**
- **Leaving hospital**

National comparisons 2016



Always Values Consideration

Positives

Clear communication with health professionals shows the Trust can be *one team, helpful and expert* with our patients and parents.

Negatives

- **Ensuring parents have a choice of admission dates, where possible (*one team, welcoming, helpful)***
- **Improving the hospital food *(expert, helpful, welcoming*)**
- **Ensuing children and young people feel involved in decisions about their care and treatment *(expert, helpful, welcoming, one team)***
- **Having enough things for children and young people to do whilst in hospital *(expert, helpful, welcoming, one team)***
- **Ensuring staff are aware of patients medical history *(expert, helpful, one team)***

Limitations of this data

- **It was collected in early 2017, from patients who stayed in GOSH during October-November 2016 – results received on 28 November 2017**
- **16+ and above were not eligible for this survey, as dictated by the CQC**

Next steps

- **Present at PFEEC and other relevant committees**
- **Share results with all staff via communications such as Roundabout**
- **Review existing work streams to identify whether any additional actions related to survey feedback can be incorporated. An action plan will be developed for all other areas not covered by existing work streams**

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
25th July 2018

Learning from Deaths **Mortality Review Group - Report of deaths in Q4 2017/2018** **Submitted by:** Mr Matthew Shaw, Medical Director Andrew Pearson, Clinical Audit Manager Dr Isabeau Walker, Consultant Anaesthesia and co-chair of the MRG	**Paper No: Attachment U**

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.

"*From April 2017, Trusts will be required to collect and publish on a quarterly basis specified information on deaths. This should be through a paper and an agenda item to a public Board meeting in each quarter to set out the Trust's policy and approach (by the end of Q2) and publication of the data and learning points (from Q3 onwards). This data should include the total number of the Trust's in-patient deaths (including Emergency Department deaths for acute Trusts) and those deaths that the Trust has subjected to case record review. Of these deaths subjected to review, Trusts will need to provide estimates of how many deaths were judged more likely than not to have been due to problems in care."*[1]

The Mortality Review Group (MRG) was established in 2012 to review the deaths that occur at Great Ormond Street Hospital (GOSH). The purpose of the MRG is to provide a Trust level overview of all deaths to identify themes and risks, and take action as appropriate to address those risks.

This report meets the requirements of the National Quality Board by

- Outlining the Trusts approach to undertaking case reviews
- Including data and learning points from case reviews.

The National Guidance on Learning from Deaths requires trusts to have a policy for reviewing and learning from deaths and for this to available on the trust website. The Trust published an interim policy in March 2018 and is awaiting publication of HM Government Child Death Review Statutory Guidance Once this is published, the Trust will review the interim policy and make any changes required. This is an executive summary of a report that will be reviewed at the Patient Safety and Outcomes Committee on the 3rd August 2018.

Action required from the meeting

The board is asked to note the content of the paper.

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.

Financial implications

None.

[1] National Guidance on Learning from Deaths, National Quality Board, published March 2017

Who needs to be told about any decision? N/a
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
Who is accountable for the implementation of the proposal / project?

Mortality Review Group: Report of deaths in Q4 2017/2018

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 available on the trust website. The Trust published an interim policy in March 2018 and is awaiting publication of HM Government Child Death Review Statutory Guidance. Once the Child Death Review guidance is published, further work will be required to assess any changes required, and develop a plan to meet any additional requirements.

Aim of report

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

This report describes the findings from MRG reviews of inpatient deaths at GOSH between 1st January and 31st March 2018.

This is an executive summary of a report which will be provided to the Patient Safety and Outcomes Committee on the 3rd August 2018

Headlines

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

Between 1st January and 31st March 2018 17 children died at GOSH. Case notes have been reviewed for 16 patients. One case could not be reviewed until police investigations had been completed and notes were available, the case will be reviewed in August 2018.

Of the 16 cases reviewed:

- There was one case where the review team felt that there had been a modifiable factor in the child's care both at GOSH and the referring hospital that may have contributed to vulnerability, ill health or death (influence score[1]two).
  The MRG Co-Chair has discussed this case with relevant GOSH teams. The case has learning about initial investigations including a plasma ammonia level as per the Royal College of Paediatrics and Child Health guideline 'Management of Children and Young People with an Acute Decrease in Conscious Level". It will be recommended to the Patient Safety and Outcome Committee on the 3rd August, that this is taken forward as a Trust wide learning event.

[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

- There were no deaths where modifiable factors at GOSH provided a complete and sufficient explanation for the death (influence score 3).

The table below provides a summary of the deaths that occurred during the quarter using NHS England reporting guidance and guidance included in the draft HM Government Child Death Review Statutory Guidance.

Total number of inpatient deaths at GOSH between 1st January and 31st March 2018	17
Number of those deaths subject to case record review by the MRG	16[2]
Number of those deaths investigated under the serious incident framework and declared as serious incidents	0
Number of deaths where a modifiable factor was identified at GOSH with an influence score of 2	1
Number of deaths where a modifiable factor was identified at GOSH with an influence score of 3	0
Number of deaths of people with learning disabilities	0
Number of people with learning disabilities that have been reviewed	N/A
Number of deaths of people with learning disabilities with where a modifiable factor was identified at GOSH with an influence score of 2 or more	N/A

Learning points for deaths occurring in Q4 17/18

The following general learning points have been derived from the case note reviews. This does not imply that any factors were directly linked to the death of the child, rather that an awareness of these points will help continuously improve the care provided in the Trust. A learning summary will be presented to the members of the Patient Safety and Outcomes committee to share with appropriate specialty, team, and local governance meetings.
Please note that these are learning points from case reviews and do not replace Trust policies and guidelines.

Clinical case management:

- High dose steroids may mask clinical symptoms.
- The UK Resuscitation Council recommended IV/IO dose of adrenaline in paediatric advanced life support in children is 10 micrograms kg^{-1}(https://www.resus.org.uk/resuscitation-guidelines/paediatric-advanced-life-support/). Subsequent doses of adrenaline are given every 3–5 min. Do not use higher doses of intravascular adrenaline in children because this may worsen outcome.
- The differential diagnosis in a child or young person with acute decrease in conscious level includes shock (hypovolaemic, distributive and cardiogenic), sepsis, metabolic diseases, intracranial infection, raised intracranial pressure, convulsions, intoxication / poisoning, trauma, hypertension, stroke, acute hydrocephalus, recovering from a previous convulsion (post-convulsion/'post-ictal' state), as per the Royal College of Paediatrics and Child Health 2015 Guideline. Initial investigations at all ages should include a plasma ammonia level.
- Frequency of observations should be increased for children at risk of deterioration. Concerns about children at risk of deterioration should be shared between nursing and medical staff at the safety huddle, irrespective of the PEWS score.

Communication:

- Parallel planning and early referral to palliative care is important for children with long term illnesses who are referred to ICU. Early involvement of the palliative care team is particularly helpful for families where the child has a life-limiting congenital disease.
- It is important to ascertain whether families are eligible for NHS care; however, these discussions should be handled sensitively and in the presence of an interpreter if the family is non-English speaking.

[2] 1 case is pending review by the MRG, as it is presently subject to the availability of notes following a police investigation . It is on the agenda for the August 2018 MRG meeting.

Equipment

- Octopus line extensions do not always have an anti-reflux valve and should not be used with drugs such as morphine where there is a risk of back-tracking (see MHRA medical device alert 2010 'Intravenous extension sets with multiple ports (all brands) (https://assets.publishing.service.gov.uk/media/5485ac2eed915d4c1000029b/con094007.pdf) A line extension with an anti-reflux valve must be used in this situation.

Training:

- The Clinical Emergency Team must always be summoned upon recognition of actual or imminent life-threatening collapse; it is not a 'cardiac arrest' team, but a 'clinical emergency team' unless there is a valid, current Resuscitation Care Pathway in place.'

Documentation

- It is very important to complete the Medical Certificate of Cause of Death (MCCD) accurately, to include your full name, GMC registration and date, and to record the MCCD in the clinical record.

31st May 2018
Dr Isabeau Walker, Consultant Anaesthetist & Co-Chair of MRG
Andrew Pearson, Clinical Audit Manager

Attachment V

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 25 July 2018	
Integrated Performance Report: July 2018 (Reporting Month 3 2018/19) **Submitted by:** Nicola Grinstead, Deputy Chief Executive Peter Hyland, Director of Operational Performance and Information	**Paper No: Attachment V**
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

Nicola Grinstead, Deputy CEO

July 2018

(Month 3 2018/19)

The child first and always

Index

Great Ormond Street Hospital for Children NHS Foundation Trust

Executive Summary

Great Ormond Street Hospital for Children NHS Foundation Trust

July 2018 (Month 3 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 3 (June 2018) data was available, with key national submission deadlines being met and data reviewed in time for inclusion.

Caring

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

Great Ormond Street Hospital for Children NHS Foundation Trust

Friends & Family Test (FFT)

Headlines via the Performance Report for these measures are:

- Continued positive recommendation responses for those undertaking the Inpatient FFT (97.11% in June compared to 98.19% in May)
- The rate (%) of those responding (for Inpatients) has seen fluctuation over the last six months with average response rate of 23.87%, however, June performance has seen significant deterioration at 13.01%, there are a number of contributing factors. June saw the go-live of the new electronic FFT data collection system where business cards to advertise that feedback can be left online were distributed but no explicate explanation that families can use the new technology or the existing paper cards. It was noted post go-live that the there was no report to monitor on a daily basis the number of responses received. In addition annual leave of ward administrators has also resulted in insufficient cover to support FFT. This has resulted in a significant drop in the responses received, 450 responses in June and 830 in May. Contextually based on data submitted in May the Trust is an outlier in the FFT response rate nationally which stands at 25%, with the Trust's peers having an average of 30% response rate.

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

Access to Healthcare for people with Learning Disabilities

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

Safe

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

Great Ormond Street Hospital for Children NHS Foundation Trust

Serious Incidents and Never Events

As confirmed in the Performance Dashboard and in the Quality & Safety Report, there were two serious incidents and zero never events reported in June. At the end of quarter one we have reported 5 Serious Incidents and zero never events.
Further detail is provided in the Quality and Safety report.

Healthcare Associated Infections (HCAIs)

Incidents of C. Difficile
The Trust did not report any cases of C Diff in June for the third consecutive month. The Trust's total allowance for 2018/19 is 14 cases, as set nationally.

Incidents of MRSA
The Trust did not report any incidents of MRSA in June for the third consecutive month.

CV Line Infections
At the point of submitting this paper June's CV Line data was being validated. May performance was 1.39 against 1.6 per 1000 line days compared to April when the Trust reported 1.11 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 June the Trust achieved 92.13% for the data collected on PIMs. This a slight deterioration from May when the Trust reported 93.29%.
However, as part of the NatSSIPs project a week-long trust-wide observational audit of 89 operating lists was undertaken in April 2018 which measured Team Brief, Sign In, Time Out, Sign Out and Debrief. This indicated that compliance with Team Brief and Sign-in is excellent across the Trust at 100%, Time out and Sign Out had positive data collection at 95% and 92% respectively but has room for improvement. The weak point is Debrief at 57% and work continues within divisions to improve this. A further audit will take place in August 2018.

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

The Trust reported no patients with a grade 3 pressure ulcer in June. Further details are provided in Quality & Safety report.

Responsive

Great Ormond Street Hospital for Children NHS Foundation Trust

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

In June, the Trust underachieved against the standard of 99% for patients accessing the 15 diagnostic modalities within 6 weeks of referral / request at 98.43%, this is an improvement from May (97.45%). The Trust has underachieved against this standard since February 2018, this is illustrates the volatility in the denominator and breach numbers. However the Trust has reduced the number of breaches, reporting ten in June, compared to seventeen in May.

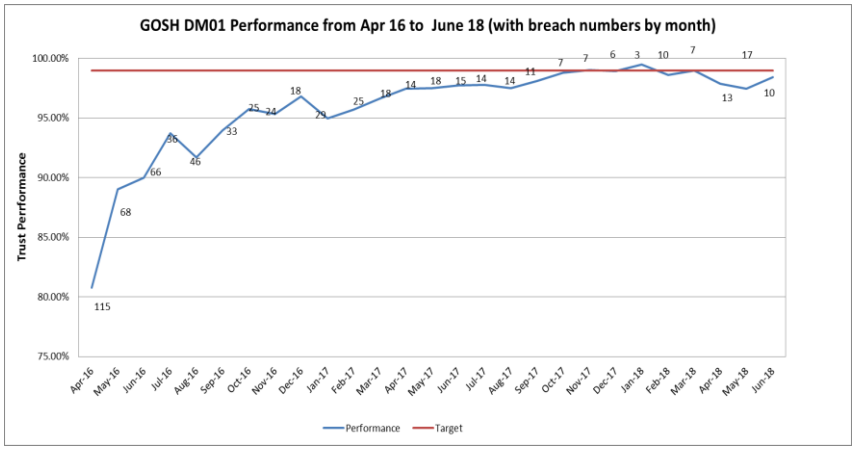
As shown in the table opposite, the overall number of breaches for June was ten (decrease of seven from May). Breaches occurred in MRI (2), Non Obstetric Ultrasound (4), Cardiac MRI (4)

Seven of the ten breaches could potentially have been prevented: 5 breaches were due to process / booking issues and three breaches occurred due to delay in request form being received. One breach occurred due to failed sedation and the remaining breach was due the patient being unwell.

There has been considerable work undertaken with administrative teams to improve the capturing of appointments offered to patients. In May twelve patients breached due to process/booking issues.

It should be noted that Cardiac MRI is included within the report as per work undertaken to ensure patients are being recorded accurately inline with national guidance.

Contextually when comparing GOSH nationally, out of 364 providers reporting against the standard (NHS and Independent sector) 248 in May were delivering 99% or better (it must be noted that 118 of these trusts reported a waiting list of less than 100 and a number are also providers just offering certain specific diagnostics, rather than a full range). 39 providers reported 98-99%, 23 at 97-98%) and 54 reported <97%.



Row Labels	Breach	No Breach	Grand Total	Performance
Barrie	6	538	544	98.90%
Audiology - Audiology Assessments		33	33	100.00%
Barium Enema		12	12	100.00%
Colonoscopy		2	2	100.00%
Computed Tomography		45	45	100.00%
Cystoscopy		10	10	100.00%
DEXA Scan		6	6	100.00%
Gastroscopy		24	24	100.00%
Magnetic Resonance Imaging	2	173	175	98.86%
Neurophysiology - peripheral neurophysiology		21	21	100.00%
Non-obstetric ultrasound	4	196	200	98.00%
Urodynamics - pressures & flows		16	16	100.00%
West	4	90	94	95.74%
Magnetic Resonance Imaging	4	13	17	76.47%
Respiratory physiology - sleep studies		77	77	100.00%
Grand Total	**10**	**628**	**638**	**98.43%**

Cancer Wait Times

At the time of writing the report for May 2018 based on national submissions reported against the Cancer Wait time standards applicable to the Trust performance is 100%. However, during post submission data quality validation processes a breach of the 31 day decision to treat and 62 day referral to treatment standard has been identified. In line with national guidance this breach will be shared with the original referring organisation and a refreshed position will be submitted and the Trust Dashboard updated to reflect this.

Responsive

Great Ormond Street Hospital for Children NHS Foundation Trust

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

For the month of June the Trust achieved the RTT 92% standard, submitting performance of 92.59%, this is the sixth consecutive month since returning to reporting that the Trust has met the standard. Significant improvements have been made across a number of specialties with Orthopaedics, Neurology and Endocrinology meeting 92% standard. Spinal Surgery reported 87.% in June, a sustained improvement in performance compared to previous months. Specialties which continue not to meet the standard are Plastic Surgery (sub-specialisation within the service), SNAPS (bed capacity) and Urology (complex patients and capacity).

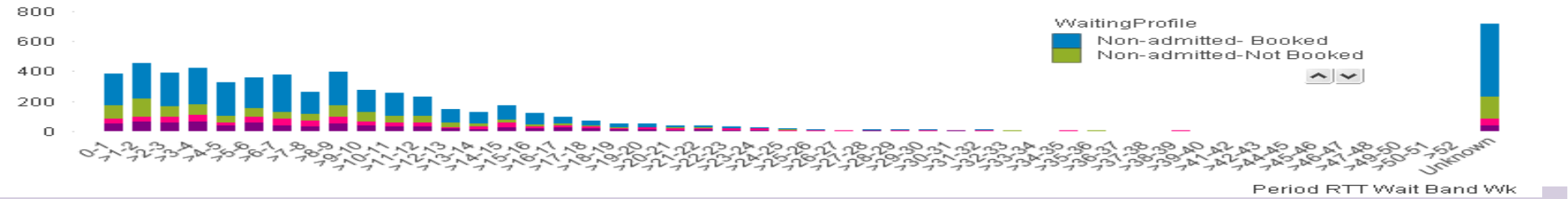
Revised improvement trajectories for the above specialties have been agreed and indicate compliance will be achieved by 31st October 2018.

The number of patients waiting 40 weeks+ has remained at circa 10 patients. We reported 43 patients waiting over 40 weeks in April 2017 and in June 2018, there were 10 patients waiting over 40 weeks.

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 151 providers reporting against the standard (NHS Trusts only) 52 in March were delivering 92% or better. 20 providers reported 90-92%, 65 at 80-90% and 9 reported <80%. 5 providers did not report.

Nationally, GOSH is ranked as the 21st best performing Trust out of 151 providers. In London, GOSH is the 6th best performing Trust out of 23 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). As is evident the number of long waiters >18 weeks continues to improve.



52 week waits:

The Trust reported 2 patients waiting over 52 weeks in June. One was related to a child who breached a number of months ago but wanted to wait until after their GCSE exams for treatment, and as such were treated in early July. The second relates to a child referred to us from St Georges Hospital who had waited in excess of 52 weeks prior to receipt at GOSH. We are currently in discussion with St Georges about this specific case. All children who wait over 52 weeks are clinically reviewed by our Medical Director.

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 slight decrease in June in comparison to what the Trust reported in May. Divisions have been asked to further push in engaging with referring Trusts and escalate where necessary.

Responsive

Great Ormond Street Hospital for Children NHS Foundation Trust

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 May 2018, the Trust reported an improvement in performance the number of patient cancelled. There were 34 last minute non-clinical hospital cancelled operations, compared to 42 in April 2018. The areas contributing most to these were Cardiology/Cardiac Surgery (16), Radiology (7) and Dermatology (4). Some of the reasons for cancellations were theatre lists overrunning (10), cancellations due to emergency patients (8) and consultant/theatre staff unavailable (8).

The Trust reported seven last minute cancelled operations within 28 days of the cancellation in May, (compared to 7 April). There are plans to set up a joint working group for both divisions on cancelled operations where processes around cancelling and rebooking operations will be reviewed.

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 a second time

Data Completeness

Great Ormond Street Hospital for Children NHS Foundation Trust

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 99.13% of patients having valid data in June.

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.
It highlights that the Trust requires significant work in collating ethnicity, with only 40.85% of patients accessing Mental Health services in June having a valid ethnic code. This is being addressed with operational teams via weekly monitoring, refreshed training and focused Data Assurance work.

Patients with a valid NHS Number

% of patients with a valid NHS Number Inpatients and Outpatients

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

Well-Led

Great Ormond Street Hospital for Children NHS Foundation Trust

Workforce Headlines

- **Contractual staff in post:** Substantive staff in post reduced slightly to 4459 FTE (full-time equivalent) in June. This is 330.9 FTE (8%) higher than the same month last year.
- **Unfilled vacancy rate:** The Trust vacancy rate for June was 3.90% (180.8 FTE), well below the Trust target of 10% and the 12 month average rate (5.8%)
- **Turnover** is reported as voluntary turnover. Voluntary turnover currently stands below target at 13.96%, and below the same month last year (15.8%). The most common reason this reported value excludes non-voluntary forms of leavers. Relocation and promotion were the most common reported leaving reason.
- **Agency usage** for 2018/19 (year to date) stands at 1.37% of total paybill, which is below the local stretch target, and is also well below the same month last year (2.23%). 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 June the compliance across the Trust was 91%. Divisions with below average compliance are being offered targeted support. The target for 2018/19 remains 90%.
- **Sickness absence** remains below target at 2.4% and below the London average figure of 2.8%. During 2018, the Trust will implement an integrated rostering system. The system will support improvements in the accuracy of absence reporting, which may lead to fluctuations in reported rates. The 2018/19 target remains 3%
- **Appraisal/PDR completion** The non-medical appraisal rate has reduced to 84% which is below the Trust target, however the Trust continues to benchmark well. Consultant appraisal rates have increased in recent months and now stands at 88%. Targets this year remain at 90%.

Well-Led

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust KPI performance June 2018

Metric	Plan	June 2018	3m average	12m average
Voluntary Turnover	14%	14%	13.9%	14.4%
Sickness (12m)	3%	2.4%	2.4%	2.3%
Vacancy	10%	3.9%	3.9%	4.7%
Agency spend	2%	1.1%	1.0%	1.8%
PDR %	90%	84%	84%	87%
Consultant Appraisals	90%	84%	86%	82%
Statutory & Mandatory training	90%	91%	90%	90%

*Month 01 budgets not available yet.

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

Well-Led

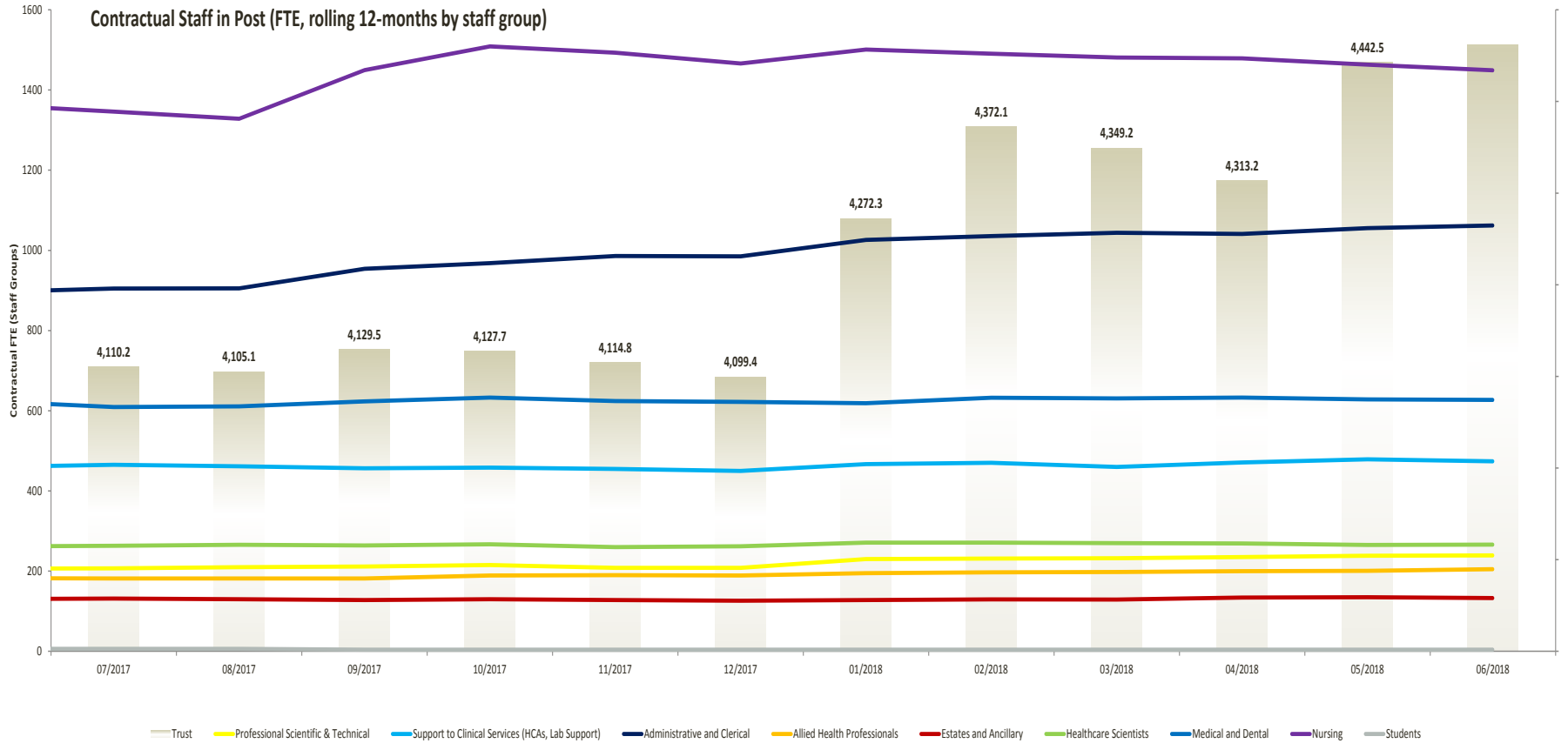
Great Ormond Street Hospital for Children NHS Foundation Trust

Divisional KPI performance June 2018

Metric	Plan	Trust	Barrie	West	IPP	Clinical Ops	Corp Affairs	Dev & Property Services	Finance	HR&OD	Medical Director	Nursing & Patient Exp	Research & Innov.
Voluntary Turnover	14%	14%	11.8%	14.8%	21.8%	10.7%	30.0%	14%	14.3%	25.8%	12.5%	10.8%	24.2%
Sickness (12m)	3%	2.4%	2.3%	2.5%	3.1%	2.7%	0.6%	1.6%	1.7%	3.7%	1.5%	1.6%	2.2%
Vacancy	10%	3.9%	2.9%	-1%	15.9%	-66%	36%	5.9%	22%	1.4%	-4.9%	-22%	-64%
Agency spend	2%	1.1%	0.5%	1.4%	0.0%	5.1%	-0.8%	2%	4.0%	9.4%	0.0%	0.2%	0.0%
PDR %	90%	84%	85%	86%	93%	62%	60%	89%	79%	84%	63%	71%	81%
Stat/Mand Training	90%	91%	91%	98%	98%	97%	88%	96%	99%	96%	94%	91%	94%

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. Nutrition and Hydration week at GOSH took place in March 2018;
- HRBP working with management teams in Finance and ICT to ensure sickness absence is being logged using the correct system so reporting can be accurate.

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 Programme Board.
- Developing B5s into vacant B6 roles helps to decrease turnover of B5s
- All Nurses within R&I on fixed term contracts have been transitioned over to permanent contracts to support retention of Nurses

Workforce: Highlights & Actions

Agency Spend

- HRBPs continue to work within the Divisions 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 rates now regularly reported and accessible via the intranet with continued reminders to individuals and line managers
- 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 Divisions / Directorates.

Statutory & Mandatory Training Compliance

- 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
- Simplicity in reporting process to improve compliance
- StatMan rates are a rolling agenda item for Performance Meetings within the Divisions / Directorates.

Effective

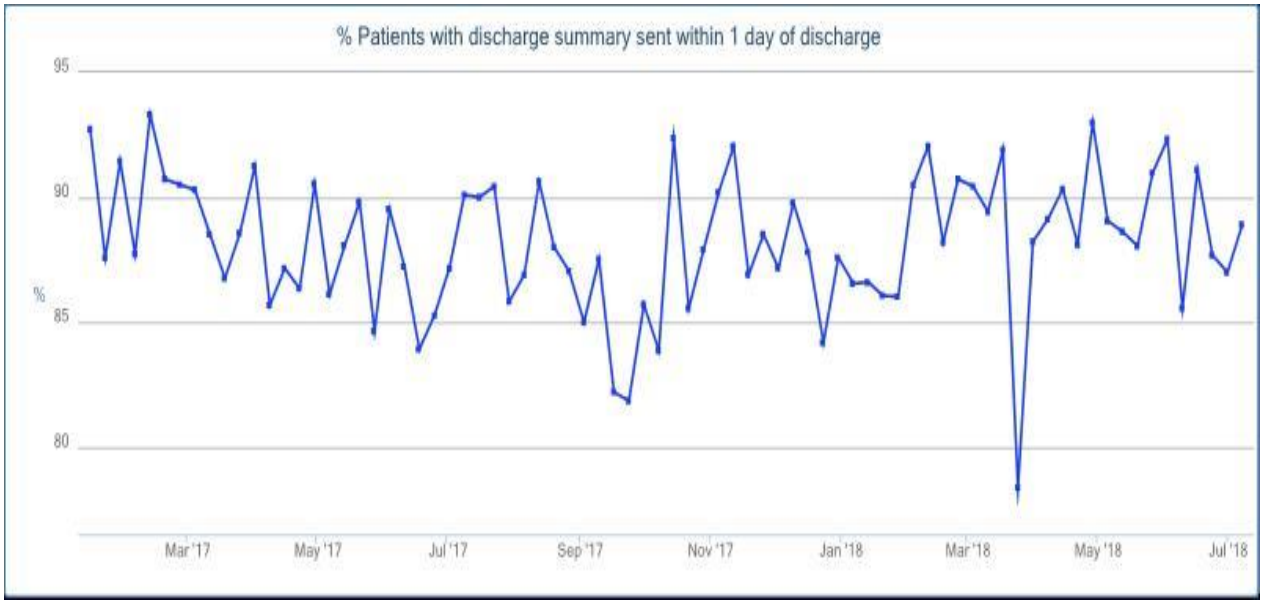
Great Ormond Street Hospital for Children NHS Foundation Trust

Discharge Summaries

As is evident from the SPC chart and the dashboard, performance in this area continues to fluctuate. For June 2018, the position was 89.08% sent within 24hrs of discharge, which is a slight deterioration from May's performance. As per definitions of this metrics, the expectation for the Trust is to send all discharge summaries within 24 hours.

The Clinical Divisions continue to keep this as an areas of focus, and reported into their monthly performance meetings. It should also be noted that 94% of patients and referrers receive a discharge summary within 48 hours of discharge

Some of the on going actions in place in divisions include daily reminders to HoCS/SM/fellows to complete the DS within 24 hours, a training refresher course for Junior Doctors, 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 clinical cover between all specialties and recruitment is ongoing with support of HR.



Clinic Letter Turnaround times

For May (as this indicator is reported a month in arrears), there has been some deterioration in performance in relation to 14 day turnaround, 69.33% from 72.16% in April. For those sent within 7 working days, performance has improved, 42.99% from 39.88% in April. As with the above, specific specialties are being targeted by the service management teams to ensure turnaround is improved. Some of the actions in place in divisions include weekly reminders for clinical teams to sign of letters, 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, and extra admin time to work through the backlog of letters in specific areas.

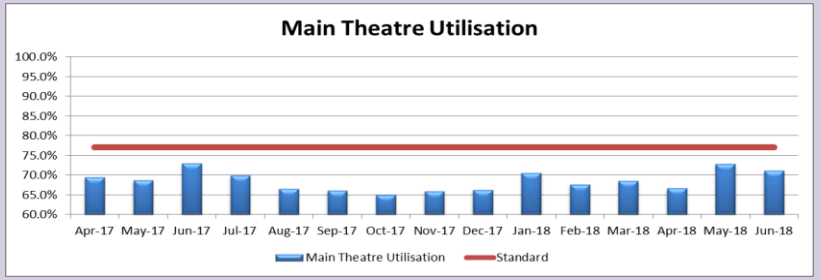
Productivity

Great Ormond Street Hospital for Children NHS Foundation Trust

Theatres

Utilisation of main theatres has slightly decreased in June to 71.1% from 72.8% (May), however, it should be noted that this is the second consecutive month since July 2016 where utilisation above 70% has been maintained. JM Barrie division saw a dip in utilisation in June 72.08% from 74.70%, Charles West division have seen no change in utilisation at 66%. Particularly affected specialties are Spinal Surgery (61%), Ophthalmology (63%), Nephrology (53%), Haematology (43%), Rheumatology (54%) and Dental (68%).

The main drivers for non compliance include delays with consenting and clerking of patients, poor theatre booking management in some specialties not utilising complete capacity or booking to over 100% and in some areas data quality is impacting utilisation. These are being addressed by weekly targeted theatre planning sessions attended by the theatres Service Manager and General Manager.
Over the last 12 months the average theatre utilisation for the Trust is 68.1%



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 June, occupancy has increased from previous levels to 82.6%. This indicator and methodology is currently under-review as part of the statutory returns review, and as such the metrics should be used as a guide at this time, pending completion of this exercise.

Bed closures: There has been a increase in the average number of beds closed in June (24) compared to 20 in May. This was mainly due to staffing shortages. Sky, Fox, Bumblebee and Hedgehog wards have had bed closures for more than 75% of the month.

Activity

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

Long stay patients: This looks at any patient discharged that month with a length of stay (LOS) greater than 100 days, and the combined number of days in the hospital. For June, the Trust had six patients discharges that had amassed a combined LOS of 856 days of which 627 are attributable to critical care. The longest stay patients were Respiratory, BMT, Cardiac and CAMHS. As reported previously, the West division looked at a sample of patients who had an excess stay of > 100 days, and found the reasons for their stay were clinically appropriate due to many having complex conditions and comorbidities warranting that LOS.

PICU Metrics

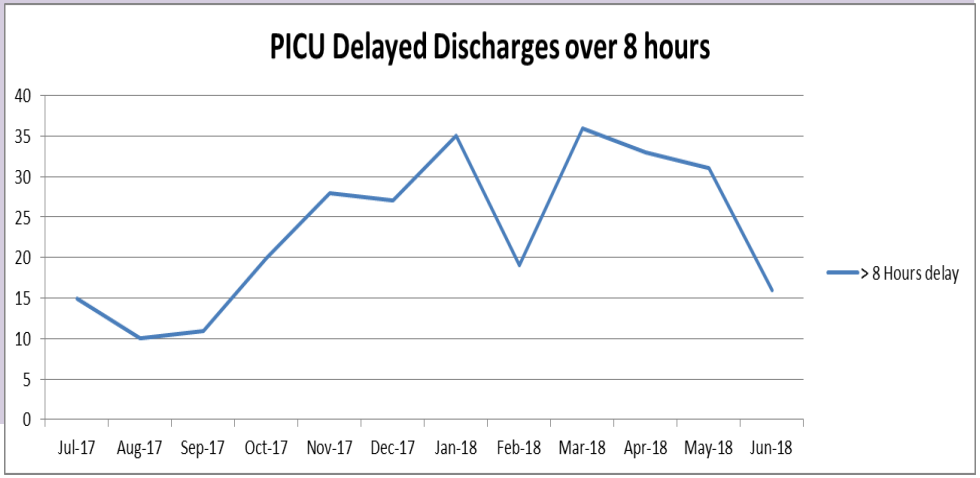
As previously reported the metrics supporting PICU shared in this month's IPR are the first iteration of KPIs. The KPIs have been agreed collaboratively with the Trusts PICU consultants and are designed to provide a triangulated picture of the service. Further analysis and intelligence will be added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

CATS PICU/NICU Refusals: The number of CATS referral refusals into PICU/NICU from other providers during June has increased to nine from a May position of 4. Compared to the first quarter of 17/18 (26 refusals) the number of refusals has reduced by two to 24 in 18/19. During April – June 2018 the Trust received 86 patients via the CATs retrieval service.
It should be noted that although The Trust has seen an improvement in the number of refusals, the Trust remains a national outlier. As part of the specialised services Quality Dashboard, a KPI is monitored on emergency admission refusals. It clearly shows the Trust refuses a higher percentage of patients than the national average, as demonstrated in the table below.

Quarter	GOSH PICU/NICU/ CICU refusals	GOSH admission requests	GOSH % refused	National % refused
Q3 17/18	99	226	43.8	19.8
Q2 17/18	32	148	21.6	7.14
Q1 17/18	28	164	17.1	7.12
Q4 16/17	66	163	40.5	9.45

PICU Emergency Readmissions: Readmissions back into PICU within 48 hours is zero for both the months of May and June. This indicator illustrates patients being safely discharged from unit by the clinical teams.

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. June has seen a significant improvement in the total number of delays with 16 reported compared to 31 in May. Over the last 7 months, 42% of patients have been delayed due to accessing another Provider, and 58% accessing a bed internally within the hospital.



Our Money

Great Ormond Street Hospital for Children NHS Foundation Trust

Summary

This section of the IPR includes a year to date position up to and including June 2018 (Month 3). In line with the figures presented, the Trust has a YTD Control Total Surplus of £1.1m which is £0.3m ahead of plan. The Trust is generating a YTD deficit of £1.6m which is £0.3m better than plan.

- Clinical Income (exc. International Private Patients and Pass through Income) is £2.1m higher than plan
- Non Clinical revenue is £1.5m lower than plan
- Private Patients income is £0.8m lower than plan
- Staff costs are £0.3m lower than plan
- Non-pay costs (excluding pass-through costs) are £0.1m lower than plan

Appendices

Appendix I – Integrated Performance Dashboard

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

Appendix II – Data Quality Kite-Marking

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

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

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

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

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

Appendix III – Definitions

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

Trust Board Dashboard - June 2018

Great Ormond Street Hospital for Children NHS Foundation Trust

Caring

	Apr	May	Jun	Trend	Plan	NHS Standard
Access to Healthcare for people with Learning Disability				→		
% Positive Response Friends & Family Test: Inpatients	96.73%	98.19%	97.11%	↓		95%
Response Rate Friends & Family Test: Inpatients	24.54%	24.34%	13.01%	↓	40%	
% Positive Response Friends & Family Test: Outpatients	94.03%	95.38%	94.58%	↓		95%

Safe

		Apr	May	Jun	Trend	Plan	NHS Standard
Serious Patient Safety Incidents	In-month	2	1	2			
	YTD	2	3	5			
Never Events	In-month	0	0	0	→		0
	YTD	0	0	0	→		0
Incidents of C. Difficile	In-month	0	0	0	→		
	YTD	0	0	0	-		
C.Difficile due to Lapses of Care	In-month	0	0	0	→		
	YTD	0	0	0	→		14
Incidents of MRSA	In-month	0	0	0	→		0
	YTD	0	0	0	→		0
CV Line Infection Rate (per 1,000 line days)		1.11	1.39			1.6	
WHO Checklist Completion		93.99%	93.29%	92.13%	↓	98%	
Arrests Outside of ICU	Cardiac Arrests	0	0	2	↓	5	
	Respiratory Arrests	4	2	3	↓		
Total hospital acquired pressure / device related ulcer rates grade 3 & above		1	0	0	→	0	

Responsive

		Apr	May	Jun	Trend	Plan	NHS Standard
Diagnostics: Patients Waiting <6 Weeks		97.87%	97.45%	98.43%	↑		99%
Cancer 31 Day: Referral to First Treatment		No Pts	100%				85%
Cancer 31 Day: Decision to Treat to First Treatment		100%	100%		→		96%
Cancer 31 Day: Decision to Treat to Subsequent Treatment - Surgery		100%	100%		→		94%
Cancer 31 Day: Decision to Treat to Subsequent Treatment - Drugs		100%	100%		→		98%
Cancer 62 day: Consultant Upgrade of Urgency of a referral to first treatment		100%	100%		→		
Last Minute Non-Clinical Hospital Cancelled Operations		42	34		↑		
Last Minute Non-Clinical Hospital Cancelled Operations: Breach of 28 Day Standard		7	7		→		0
Urgent Operations Cancelled for a 2nd Time		0	0	0	→		0
Same day / day before hospital cancelled outpatient appointments		1.20%	1.28%	1.49%	↓		
RTT: Incomplete Pathways (National Reporting)		93.62%	93.64%	92.59%	↓		92%
RTT: Number of Incomplete Pathways (National Reporting)	<18wks	4840	5021	4850	↓		-
	>18wks	330	341	388	↓		-
RTT: Incomplete Pathways >52 Weeks - Validated		1	3	2	↑		0
RTT: Incomplete Pathways >40 Weeks - Validated		10	9	10	↓		0
Number of unknown RTT clock starts	Internal Referrals	0	3	1	↑		-
	External Referrals	894	799	710	↑		-
RTT: Total Number of Incomplete Pathways Known/Unknown	<18 weeks	5711	5813	5550	↓		-
	>18 weeks	352	353	399	↓		-

Data Completeness

		Apr	May	Jun	Trend	Plan	NHS Standard
Mental Health Identifiers: Data Completeness		99.08%	99.23%	99.13%	↓		97%
Mental Health Ethnicity Completion - %		43.01%	41.51%	40.85%	↓		90%
% of Patients with a valid NHS number	Inpatients	92.1%	92.3%	TBC	↓		99%
	Outpatients	94.0%	94.0%	TBC			

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

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

People, Management & Culture: Well-Led

		Apr	May	Jun	Trend	Plan	NHS Standard
Sickness Rate		2.37%	2.34%	2.40%	↓	3%	
Turnover	Total	17.3%	17.2%	17.1%	↑	18%	
	Voluntary	14.0%	13.9%	14.0%	↓	14%	
Appraisal Rate		84%	85%	84%	↓	90%	
	Consultant	88%	86%	84%	↓		
Mandatory Training		88%	92%	91%	↓	90%	
% Staff Recommending the Trust as a Place to Work: Friends & Family Test						61%	
Vacancy Rate	Contractual		3.9%	3.9%	↑	10%	
	Nursing	1.1%	1.1%	5.2%	↓		
Bank Spend		6.0%	5.8%	6.1%	↓		
Agency Spend		0.75%	1.18%	1.14%	↑	2%	

Effective

		Apr	May	Jun	Trend	Plan	NHS Standard
Discharge Summary Turnaround within 24hrs		89.12%	89.85%	89.08%	↓		100%
Clinic Letter Turnaround within	7 working days	39.88%	42.99%				
	14 working days	72.16%	69.33%		↓	100%	
Was Not Brought (DNA) Rate NHS (exc Telephone Contacts)		8.26%	8.04%	8.68%	↓	7.73%	

Productivity

		Apr	May	Jun	Trend	Plan	NHS Standard
Main Theatres	Theatre Utilisation	66.7%	72.8%	71.1%	↓		77%
	No. of theatres	14	14	14			
Outside Theatres	Theatre Utilisation	56.8%	53.3%	52.0%	↓		77%
	No. of theatres	7	7	7			
Trust Beds	Bed Occupancy	80.4%	80.4%	82.6%	↑		
	No of available beds	408	405	401	↓		
Average number of trust beds closed	Wards	18.0	20.0	24.1	↓		
	ICU	1.0	2.0	2.8	↓		
Refused Admissions	Cardiac refusals	2	1	6	↓		
	PICU / NICU refusals	8	4	9	↓		
Number of PICU Delayed Discharges	Internal 8 - 24 hours	2	1	0	↑		
	Internal 24 hours+	19	16	15	↑		
	External 8 - 24 hours	2	3	0	↑		
	External 24 hours+	10	11	1	↑		
	Total 8 - 24 hours	4	4	0	↑		
	Total 24 hours+	29	27	16	↑		
PICU Emergency Readmissions < 48 hours		2	0	0			

Activity

		Apr	May	Jun	Trend	Plan	NHS Standard
Daycase Discharges (YOY comparison)	In-month	2,318	2,432	2,405	↓	2,156	
	YTD	2,318	4,750	7,155		6,658	
Overnight Discharges (YOY comparison)	In-month	1,380	1,495	1,493	↓	1,495	
	YTD	1,380	2,875	4,368		4,247	
Critical Care Beddays (YOY comparison)	In-month	1,192	1,140	945	↓	1,083	
	YTD	1,192	2,332	3,277		3,464	
Bed Days >=100 Days	No. of patients	6	13	6	↑		
	No. of beddays	986	2,575	856	↑		
Outpatient Attendances (All) (YOY comparison)	In-month	20,558	20,805	21,097	↑	22,353	
	YTD	20,558	42,533	65,658		62,929	

Our Money

	Apr	May	Jun	Trend		
Net Surplus/(Deficit) v Plan	0.2	0.7		↑		TBC
Forecast Outturn v Plan	12.1	12.1		→		TBC
Better value	TBC	TBC				TBC
Debtor Days (IPP)	202	195		↑		TBC
Quick Ratio (Liquidity)	1.80	1.80		→		
NHS KPI Metrics	1.0	1.0		→		TBC

Activity: YTD Feb 16/17 figures have been updated on 28/03/2018- these will be different to the ones which went to the March board as March board report figures were full year 2016/17 rather than YTD Feb 16/17.

KITE MARKING SUMMARY SEPTEMBER 2017*

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

*To be reviewed December 2017

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

TRUST BOARD PERFORMANCE DASHBOARD: KPI DEFINITIONS

	Measure	Definition	Standard	Calculation formulae	Reporting Frequency
Caring	Access to Healthcare for people with Learning Disability	Covers the NHSI 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
	% Positive Response Friends & Family Test: Inpatients	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.	>95%	**Numerator:** respondents who would be extremely likely or likely to recommend the service **Denominator:** total respondents	Monthly
	Response Rate Friends & Family Test: Inpatients	This is an indicator of the percentage volume of patients responding to the Friends and Family Test Questionnaire	>40%	**Numerator:** Total number of patients that have completed the FFT Questionnaire. **Denominator:** Total number of patients eligible to respond.	Monthly
	% Positive Response Friends & Family Test: Outpatients	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.	>95%	**Numerator:** respondents who would be extremely likely or likely to recommend the service **Denominator:** total respondents	Monthly
	Mental Health Identifiers: Data Completeness	Measurement of data completeness for Mental Health patients covering NHS Number, Date of Birth, Postcode, Gender, Registered GP Practice and Commissioner Code	>97%	**Denominator for NHS number, DOB, postcode, gender, GP practice:** count of distinct patients in that submission **Numerator:** does the patient have a valid NHS number, DOB, postcode, gender, GP practice **Denominator for Commissioner Code:** Count of referrals in submission **Numerator:** Does each referral have a valid commissioner code. All denominators and numerators are added up to create the overall Monitor measure	Monthly
Effective	Discharge Summary Turnaround within 24hrs	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)	This based on the number of NHS Patient Attendances and DNA's for all specialties covering Clinic and Ward Attenders but excludes Telephone Consultations	8.36%	**Numerator:** number of non-attendances **Denominator:** total number of expected attendances	Monthly
	Clinic Letter Turnaround within 7 Working Days	The percentage of patients with a completed Clinic Letter within 7 working days of attendance	100%	**Numerator:** number of clinical letters sent for eligible patients within 7 working days **Denominator:** total number of matching clinical letters for eligible patients on Clinical Documents Database	Monthly

	Measure		Definition	Standard	Calculation formulae	Reporting Frequency
Responsive	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 verfied		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 verfied		Total number unknown clock starts from an external referral	Monthly
	RTT: Total Number of Incomplete Pathways	Under 18 Weeks	Patients waiting below 18 Weeks on an Incomplete RTT Pathway at month end with a known and unknown clock date (i.e. clock start and no stop)		Total number of patients waiting below 18 weeks	Monthly
		Over 18 Weeks	Patients waiting above 18 Weeks on an Incomplete RTT Pathway at month end with a known and unknown clock date (i.e. clock start and no stop)		Total number of patients waiting above 18 weeks	Monthly
	Serious Patient Safety Incidents		Serious Incidents include acts or omissions in care that result in; unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm - including those where the injury required treatment to prevent death or serious harm, abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services.	N/A	Total number of Serious Patient Safety Incidents reported in month.	Monthly
	Never Events		Never Events are serious incidents that are wholly preventable Never Events include incidents such as wrong site surgery, retained instrument post operation or wrong route administration of chemotherapy	0	Total number of Never Events reported in month.	Monthly
	Incidents of C. Difficile		This is the number of C.Difficile infections that have been reported in the Trust, regardless of whether they are hospital acquired and/or categorised as infection due to lapses of care.	0	Total number of C. Difficile infections that have been reported in month, in the Trust.	Monthly

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

	Measure	Definition	Standard	Calculation formulae	Reporting Frequency
Our Money	Net Surplus/(Deficit) v Plan	Variance between YTD Net Surplus/(Deficit) - Excluding Capital Donations and Impairments compared to YTD Plan Surplus/(Deficit) - Excluding Capital Donations and Impairments			Monthly
	Forecast Outturn v Plan	Variance between Forecast month 12 Net Surplus/(Deficit) - Excluding Capital Donations and Impairments compared to Annual Plan as at month 12 Surplus/(Deficit) - Excluding Capital Donations and Impairments			Monthly
	P&E Delivery	Actual YTD recurrent savings delivered v YTD Planned Savings			Monthly
	Pay Worked WTE Variance to Plan	Variance between worked WTE in period and plan WTE in period			Monthly
	Debtor Days (IPP)	IPP Debtors / Total Sales x365			Monthly
	Qucik 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: • 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 elecetive 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

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 25th July 2018	
Better Value Update **Submitted by: Nicola Grinstead, Deputy Chief Executive**	**Paper No: Attachment W**

Aims / summary

This paper provides an update on Better Value programme delivery over the first quarter (Q1) and summarises the current position and actions under way related to finalising the 2018-19 full-year programme. It notes that after mitigation, the programme is reporting on-track delivery of £2.4m at the end of Q1 and is currently forecast to deliver the total programme value of £15m by year end. Considerable progress has been made in firming up the specification of the programme; over £13m has now been identified and the remaining gap subject to final work-up has reduced to £1.9m. This work is overseen by the Better Value Programme Board and subject to oversight by the Finance and Investment Committee and the Quality and Safety Assurance Committee.

Action required from the meeting

The Board is asked to note the Q1 position against the 2018-19 Better Value programme and receive assurance that arrangements are in place to oversee the finalisation and delivery of a robust 2018/19 Better Value programme.

Contribution to the delivery of NHS Foundation Trust strategies and plans

The Better Value Programme is a significant contributor to the Trust's overall financial strategy and plans. Delivery of the £15m Better Value target this year is important in the context of the Trust's overall control total and requirement to move towards delivering a robust ongoing financial surplus. For this reason, the actions described in this report are important and their successful delivery is being closely managed by the Programme Office and Executive team.

Financial implications

Included within the overall Trust financial position.

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

Deputy Chief Executive and individual project / programme leads with support of Programme Office.

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

Deputy Chief Executive.

Better Value Programme Update Report
June 2018

Section 1 - summary of Q1 Better Value programme delivery

2018-19 BETTER VALUE PROGRAMME Q1 UPDATE				
Delivery against plan	Before mitigation: £1.4m	A	After mitigation: £2.4m	G
Programme Delivery	After mitigation, the Better Value programme is reporting delivery of £2.4m as at the end of Q1. This is in line with the initial phased plan for the programme, as a number of schemes were planned to begin from Q2. Based upon current run-rates, the Trust is projecting that the full £15m target will be achieved at year-end although it is anticipated that – as for previous years – some slippage of schemes likely to take longer to become fully-established will be mitigated by other actions over the course of the year. During Q1, non-recurrent expenditure reductions and increased patient care activities have contributed c£1m towards the Better Value target. Delivery over the first quarter has included a combination of: • local schemes led within clinical and corporate divisions and directorates, with many of the associated savings resulting from the detailed line by line budget review process led by the Deputy CEO with divisional leadership and finance colleagues; • a range of cross-organisational schemes including, for example, c£250k associated with flow programmes to improve theatre utilisation and bed management. These benefits have come from additional activity within existing capacity related to initiatives targeting: ○ reduced cancellations; ○ reduced emergency admission refusals; ○ reduced operating list over-runs by starting the first case faster; ○ improvements in the use of pre-operative assessment clinics. A range of other initiatives related to workforce, ICT enabled savings and procurement are anticipated to come on-line from Q2 – with a particular focus on non-pay opportunities following the move to a new procurement shared services partner from the start of August.			
Recommendation	The Board is asked to note the Q1 position against the 2018-19 Better Value programme.			

Section 2 – progress towards sign-off of the 2018-19 Better Value programme

PROGRESS DURING PERIOD				
Programme RAG Status	This Reporting Period:	A	Last Reporting Period:	R
RAG Reason	▪ Opportunities of £13.1m (before risk adjustment) have been found although a complete Better Value programme has not yet been specified to meet the total £15m requirement. There remains a gap of £1.9m in the plan, mitigated to-date by non-recurrent savings and higher than planned income levels in other areas, leading the Trust to forecast overall that it will achieve its control total for the year. ▪ This gap is largely focused in cross-organisational areas; following the line by line budget review exercise led by the Deputy CEO, there is only a small (£26k) overall gap in identifying schemes to meet the local 2.5% savings target (£8.1m, the largest part within the clinical divisions). ▪ Ongoing work over the past couple of months to confirm final budgets has delayed programme documentation (POD) sign-off and schemes that have yet to have PODs developed have also yet to be subject to risk assessment, with the potential that the remaining ask could increase further.			
RAG Recovery Action Plan	▪ Work continues with divisions, finance and scheme leads to finalise PODs for all schemes, including Quality Impact Assessments (QIAs) where required. This will enable risk adjustments to be applied to ensure robustness of the programme and identify priority/exception areas for focussed attention in-year. ▪ PMO and finance colleagues continue to work with cross-organisational scheme SROs to finalise proposals for these work streams, so they can be identified at budget level and implementation against agreed targets tracked. ▪ Progress is managed at business planning meetings chaired by the Deputy CEO, schemes are discussed where necessary at the Operational Performance & Delivery Group, and the programme is overseen by the Better Value Programme Board chaired by the Chief Executive.			
Progress Summary	▪ Significant progress has been made in developing a substantial programme for the current year, with final schemes being confirmed at a rate approaching £1m/month since the start of the year; the value of the identified live schemes within the programme has increased to over £13m. ▪ All corporate directorates have identified their 2.5% target in full, and the vast majority of clinical divisions' local scheme proposals have been accepted through the relevant QIA processes. Work continues to ensure other schemes planned to go live from the pipeline have full PODs and QIAs completed where applicable, to ensure they are properly-specified and do not have the potential for adverse impact on the quality of care we provide to our patients. ▪ A number of cross-organisational programmes are close to final sign off i.e. coding, ICT enabled, nursing workforce and patient placement; these are awaiting account and budget code validation. There has been good initial progress made to begin developing a robust procurement programme following the agreement to proceed with the new GSTT service. ▪ There remain significant gaps for the cross-organisational commercial, medical workforce, and medicines management schemes, which are being escalated for targeted attention to be overseen by the Better Value Programme Board.			

SECTION 2 – FINANCIAL OVERVIEW – PROGRAMME IDENTIFICATION		
2.5% **local scheme plans** which are identified at budget code level	£5.923m	
Additional 2.5% local schemes being worked up (not yet got budget codes)	£2.132m	
Total 2.5% **local scheme identified**	**£8.056m**	
Remaining gap against 2.5% local target	**£0.026m**	
Cross organisational plans now identified at budget code level	£0.613m	
Additional cross organisational plans still being worked up	£4.422m	
Total cross organisational scheme identified	**£5.035m**	
Remaining gap against cross organisational schemes target	**£1.883m**	
Total programme identified to-date	**£13.091**	
Schemes valued at c£13.1m have been identified. The remaining gap in the scoping of the cross-organisational schemes is further discussed in section 4.		

SECTION 3 – FINANCIAL OVERVIEW – RISK ADJUSTMENT		
Total 2.5% local scheme identified		**£8.056m**
2.5% **local scheme plans** included in the risk adjustment to date		**£6.423m**
Risk Adjustment		**- £0.226m**
Remaining 2.5% identified schemes still to be risk adjusted	**£1.632m**	
Total cross organisational scheme identified		**£5.035m**
cross organisational schemes included in the risk adjustment to date		**£1.363m**
Risk Adjustment		**- £0.364m**
Remaining cross organisational identified schemes still to be risk adj	**£3.672m**	
Total Risk Adjusted Value		**£7.197m**
Total still to be risk adjusted	**£5.304m**	
Total programme inclusive of risk adjustments to-date	**£12.501m**	
Not all of the identified value of £13.1m has been risk rated as not all PODs have been worked up for each of the identified schemes. Therefore, the table above displays risk adjustments applied where PODs have been completed and the scheme has been approved to go in to the live programme. After risk adjustment applied to £7.8m schemes we have seen a net reduction in the programme value of £0.6m or approx. 7.5**%.** If we applied this % of risk adjustment on average to the complete programme as it stands it would value the programme at £12.1m (after risk adjustment applied).		

SECTION 4 – GAP ANALYSIS – 2.5% LOCAL SCHEMES		
Local 2.5% Better Value Programme 2018/19	**Remaining Gap**	**£0.026m**
Divisions/Directorates that have fully identified their 2.5% targets • Clinical operations (incl ICT) • Development and Property Services • Finance • Human Resources & Organisational Development • Corporate Affairs and Communications • Medical Directorate • Nursing Directorate • JM Barrie Division • International & Private Patients	**+£0.473m**	
Divisions/Directorates with gaps still to fill: • Charles West Division	**£0.499m**	
All corporate directorates have fully identified schemes to meet their 2.5% targets, with plans at cost centre and account code level. The largest remaining gap is in the Charles West Division which is c£500k below their target, although this figure is expected to reduce substantially once work to validate carry forward impacts from the 2017/18 programme is concluded. JM Barrie division have exceeded their target identification by £426k.		

SECTION 5 – GAP ANALYSIS – CROSS ORGANISATIONAL SCHEMES		
	Identified	**Gap**
Cross organisation schemes – FLOW **XC Outpatients** Improving clinic utilisation **XC Theatres** Various incl reducing list overruns, increased use of APOA, starting first case on time, scrubs dispensing machine **XC Patient Placement** Reduce number of elective surgical admissions cancelled due to bed unavailability Reduce number of non elective admissions refused due to bed unavailability Increase utilisation of Nightingale ward.	Outpatients **£0.159m** Theatres **£0.600m** P Placement **£0.800m**	Outpatients **£0.016m** Theatres **£0.200m** P Placement **£0.000m**
Cross organisational schemes – WORKFORCE **XC NURSING** Review of bank rates New ROI recruitment campaign arrangements **XC OTHER WORKFORCE** Review of study leave and Mandatory Training Temporary staffing Staff overpayments	Nursing **£0.392m** Medical **£0.000m** Other workforce **£0.225m**	Nursing **+£0.042m** Medical **£0.350m** Other workforce **£0.125m**

Cross organisational schemes – PROCUREMENT, NON PAY, WASTE **XC Procurement** Procurement savings from PPIB and AdviseInc dashboard	**Procurement** **£1.000m**	**Procurement** **£0.218m** **Diagnostics** **£0.300m**
Cross organisational schemes – PHARMACY & MEDICINES MGT **XC Medicines Management** Nitrofurantoin switch from oral suspension to tablets	**Medicines Management** **£0.058m**	**£0.342m**
Cross organisational schemes – COMMERCIAL **XC IPP** Overseas opportunities from Saudi Arabia, Kuwait, Egypt Additional craniofacial, spinal and urology activity **Other commercial (R&D, Education & Training)** HEE paediatric dementia project Orchard Therapeutics data agreement phases 1 & 2	**IPP** **£0.450m** **Other** **£0.180m**	**IPP** **£0.550m** **Other** **£0.170m**
Cross organisational schemes – ICT ENABLED (NON EPR) **XC ICT** Video interpreting service Dr Doctor SMS messaging service Insourced network services Single transcription service Contribution from DRIVE Reduce computer hardware budgets pan trust	**£0.371m**	**+£0.046m**
Cross organisational schemes – CODING **XC Coding** Ensuring accurate and complete coding	**£0.500m**	**£0.000m**

Commentary:

The cross-organisational schemes pose a significant risk to identification of the full £15m programme. Five cross-organisational scheme areas have identified opportunities at their full value – ICT enabled, coding, nursing workforce and patient placement, although these are not yet at budget code level; the next step is to complete that process. There is significant work to be done against the other cross organisational scheme to ensure they meet their full allocated target. Taking each of the main cross-organisational areas and progress against target is set out below:

Flow

A wide range of projects is under way, led by a revitalised **theatres** steering group. Attention is being focussed on reasons for cancellation on the day, on planned versus actual theatre session utilisation (by clinician and by specialty), improving the use of pre-assessment and on improving future planning and booking performance. Early indications are that utilisation is starting to increase again following the introduction of these initiatives, with additional cases being undertaken within existing sessions.

The **patient placement** programme continues its work to: roll out systematic use of expected discharge dates; develop a central planning tool and booking system; enable more intelligent scheduling, and; focus on ensuring all patients suitable for treatment in the new Nightingale day case unit are treated there (freeing up more expensive inpatient capacity in other parts of the hospital). These ideas mean the programme has now identified opportunities to meet its £800k target.

Outpatients have made significant progress since the last FIC update. A thorough review of clinic utilisation was completed which found numerous clinics not fully utilised; as a result of this they have identified £159k of their target by way of improving clinic utilisation, leaving a small £16k gap.

Workforce

The **nursing workforce** group has identified its full £350k target for 2018/19, mainly through a scheme aimed at reducing an enhancement paid to specific bank nursing staff; the remainder being covered through a reduction in recruitment agency spend. Work has commenced with the new medical director on **medical workforce** plans, which are to focus in the first instance on revamping the approach to job planning and using this to identify potential opportunities. It is unlikely that this process will be completed until the latter part of 2018/19 thereby leaving this as an area of high risk this year. The **HR&OD** team is continuing work to finalise its proposals to meet its target including initiatives to address issues raised through the CQC process around improving statutory and mandatory training. These schemes are now being finalised with PMO and finance colleagues.

Procurement

Good progress has been made with the new procurement partner (GSTT) who have already undertaken much ground work to identify potential big wins to help deliver the £1.2m target in the lead up to the formal shared service agreement starting (Aug 2018). Further refinement of the identified opportunity areas is taking place through use of the PPIB Dashboard in conjunction with the national PPIB benchmarking, which the Trust will be pursuing as soon as new shared service arrangements are in place. A target for reduced unnecessary ordering of diagnostic investigations is considered to pose a higher risk, especially in advance of EPIC implementation, and is subject to further discussion with the medical director. However, a small contribution may be possible from a new joint QI and PMO supported project to reduce pre-analytical errors.

Pharmacy/Medicines Management

One scheme has been identified that the team is confident of delivery against as noted above. Other ideas for potential incorporation are being developed, including consideration of how the Trust can continue, evidence and count its performance on reducing average medication costs per patient.

Commercial/IPP

The commercial cross-organisation target remains an area of high risk. Against the context that significant additional growth is already built into the planning expectations for IPP, and that one of the larger cross-organisational proposals (international fellowships) has now been built into the division's baseline, the main areas for further work relate to continuing to develop new opportunities abroad, and increasing the amount of cardiac private practice done at GOSH. These schemes will continue to be overseen by the Commercial Oversight Group and it is likely that additional schemes or mitigating actions will also need to be found.

SECTION 6 – KEY ACTIVE RISKS AND ISSUES (Risk Score =>12 prior to mitigation)

ID	Title and Description	Priority / Score	Likely Consequence if Left Unaddressed	Mitigation Plans	Priority / score after Mitigation applied
BV01	Programme not yet fully specified and signed off	20	If final plans are not implemented rapidly, the risk of failure to meet the financial control total will increase, unless more drastic actions are taken which could have higher potential likelihood to have quality and or reputational impact (e.g. freezes on spend)	Line by line budget review process has identified further savings opportunities. Progress is being made to close the gap, overseen by the CEO-chaired Better Value Programme Board which includes EMT, SROs and key divisional/PMO representatives	12

BV02	Slippage on implementation of agreed schemes due to poor planning or lack of capacity to implement	20	This would have similar consequences to risk BV01 above, with failure to meet the Better Value target, risk of failure to meet the control total, and need for mitigating actions to be rapidly implemented	All schemes require clear documents and sign off processes, and are risk-rated (in addition to QIA) for likelihood of implementation with values adjusted accordingly before incorporation into the programme.	9
BV03	Further gap in the programme as a result of the agreed risk ratings being applied to the identified values	20	There could be a substantial gap in the better value programme meaning the trust may not be able to fully meet its control total if additional schemes are not identified to close the gap	Further scoping work will need to continue in order to identify schemes to close the gap. Existing schemes that were risk rated down will need to be reviewed on an ongoing basis to ascertain if the risk rating can be improved to contribute more to the delivery.	9

NEXT STEPS AND RECOMMENDATION

The Board is asked to note the Q1 position against the 2018-19 Better Value programme and receive assurance that arrangements are in place to oversee the finalisation and delivery of a robust 2018/19 Better Value programme.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
25th July 2018

2018/19 Month 3 Finance report **Submitted by:** Helen Jameson, Chief Finance Officer	**Paper No: Attachment X**

Key Points to take away

1. The Trust finished Month 3 with a £0.3m favourable control total variance against a target of £0.08m. The Trust is currently forecasting to meet its control total.

2. The Trust's financial position is underpinned by over-performance of NHS contracts and finished the month £2.1m ahead of plan (excluding pass through). This is a mixture of additional activity to plan and more complex case mix. IPP income is behind plan by £0.8m due to under delivery against the plan. Other Income is £1.5 m behind plan (ytd) and the majority of this relates to R&I; this is offset by reduced expenditure.

3. Pay was underspent in month by £0.3m due to vacancies within the establishment not yet recruited to. Non pay was underspent by £0.3m, driven by changes in casemix and a number of cost efficiencies identified in year including in the provision of haemophilia drugs.

Purpose
The purpose of this paper is to report the Trust's financial position at Month 3 2018/19.

Financial Position – Summary points
The Trust finished Month 3 with a £0.3m favourable control total variance against a target of £0.08m. Income overall is £0.5m behind plan due to NHS Activity being ahead of plan by £2.1m (excluding pass through), offset by underperformance within IPP activity (£0.8m) and non-clinical revenue being behind plan by £1.5m. This is offset by pay underspends of £0.3m mainly due to vacancies within the establishment. Non pay is on plan (excluding pass through).

Income
NHS income for the month was broadly in line with the trend from prior months and is up against the overall plan. An analysis is provided within the report that seeks to identify what of the performance within income is driven by price variances (the level of price per case received is more than was anticipated within the plan) and what is driven by activity (activity is greater than was assumed within the plan).

Initial analysis shows that the position is underpinned by favourable price variances with a £0.4m benefit arising from the casemix with significant gains within highly specialised services and elective care. This is offset by £0.1m of adverse activity variances driven by lower than planned ITU bed days and lower than anticipated demand for some highly specialised services. Private Patient revenue overall was £3.4m behind plan.

Non clinical revenue was behind plan by £1.4m due to the timing of a number of research grants, education income not matching the timing assumed within the plan and the non-achievement of some commercial better value schemes.

Pay
Pay expenditure was underspent year to date by £0.3m. This is predominantly due to a number of vacancies held within the divisions which are not offset by equivalent bank or agency usage. Slippage within R&I against the plan is also contributing to the overall underspend (though this is offset with income).

The Trust has provided for costs for the inflationary 1% pay award (excluding the recent announcement on pay for AfC staff for which the funding settlement was not released until Month 4) and for the impact of the CEA awards has not yet been agreed in year.

Non pay
Non-Pay was on plan at Month 3 (excluding pass through). There were overspends within areas that were activity related e.g. cardiac services and theatres where activity has been above plan, however there have been a number of areas of under spend including within Bone Marrow Transplants, SNAPS and theatres which are principally activity related.

Better value
The Better Value programme is reporting delivery of £2.4m of better value savings as at Month 3. This is made up of a mixture of recurrent and non-recurrent schemes. £13m of the £15m programme has been identified as outline schemes which are being developed; the Trust is still forecasting full delivery of the programme in 2018/19.

Other
Capital donations remain behind plan in line with prior years; this is predominantly due to slippage against major capital projects against plan including completion of CICU and SPECT. Overall the capital programme remains behind plan by £3.7m but is forecasting full delivery of the plan by year end.

Financial Indicators – Month 3

Indicator	Comment
NHSI Financial Rating	All KPI ratings are Green.
Cash	The closing cash balance was £60.1m, £7.8m higher than plan. • EBITDA is higher than plan by £0.1m. This is as a result of higher levels of increased activity. • Inventories is higher than plan by £0.3m. This mainly relates to the increase in Cardiac respiratory stock and Pharmacy drugs held in M03. • Trade and other receivables including capital debtors (lower than plan by £1.0m). • Trade and other payables are higher than plan by £5.1m. This includes accruals for maintenance contracts (£1.5m); Pass through expenditure (£3.8m); Pharmacy drugs (£1.5m) which will be settled on receipt of invoices. • Trust funded capital expenditure is lower than plan by £1.9m, including the effect of rephasing supplier contracts for VNA (£0.3m) and Onbase (£0.2m), and slippage of estates projects (£0.3m).
NHS Debtor Days	NHS Debtor days decreased in month to 7 days from 8 days which remains within target.

IPP Debtor Days	IPP debtor days fell from 195 days to 191 days. Receipts are just over £5m and invoices raised in month 3 were £4.8m. Over £3m was received Kuwait Health Office for both current and older invoices which has contributed to the reduction in debtor days.
Creditor Days	Creditor days decreased in month from 31 days to 30 days. The Trust has increased the speed in which it pays invoices.
Inventory Days	Drug inventory days increased in month from 7 to 8 days. Non-Drug inventory days decreased in month to 67 days. The methodology for calculating inventory days is based upon stock level and stock usage in month. Non drugs stock usage in June 18 was £0.1m which was higher than the average usage per month which resulted in the reduction in inventory days.

Action required from the meeting

- To **note** the financial position as at 30th June 2018

Contribution to the delivery of NHS / Trust strategies and plans

This paper details the Trusts delivery against its agreed Financial Plan for 2018/19

Financial implications

Not delivering the Control Total would have led to the Trust losing the PSF Fund. Other affects include the NHSI ratings of the Single Oversight Framework.

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

Great Ormond Street Hospital for Children NHS Foundation Trust

Finance and Workforce Performance Report Month 3 2018/19

Contents

Trust Performance Summary for the 3 months ending 30 Jun 2018

KEY PERFORMANCE DASHBOARD

Great Ormond Street Hospital for Children NHS Foundation Trust

FINANCIAL PERFORMANCE

	In month			Year to date			Full Year Forecast	
	Plan	Actual	RAG	Plan	Actual	RAG	F'cst	RAG
INCOME incl. passthrough	£38.1m	£37.8m		£113.8m	£113.4m		£470.6m	
PAY	£21.7m	£21.4m		£64.7m	£64.4m		£262.7m	
NON-PAY incl. passthrough	£14.9m	£14.7m		£44.2m	£43.9m		£179.0m	
CONTROL TOTAL	£0.2m	£0.3m		£0.8m	£1.1m		£12.1m	

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

AREAS OF NOTE:

NHS and other clinical income is favourable to plan by £2.1m YTD, but this is offset by underperformance within Private Patient revenue (£0.8m adverse YTD) and Other non-clinical income (£1.5m adverse YTD).

INCOME BREAKDOWN RELATED TO ACTIVITY

Income breakdown	Plan (£m)	Actual (£m)	Var (£m)	RAG
NHS & Other Clinical Revenue	£68.4m	£70.5m	£2.1m	
Pass Through	£15.6m	£15.2m	(£0.3m)	
Private Patient Revenue	£15.2m	£14.4m	(£0.8m)	
Non-Clinical Revenue	£14.8m	£13.3m	(£1.5m)	
Total Operating Revenue	£113.8m	£113.4m	(£0.5m)	

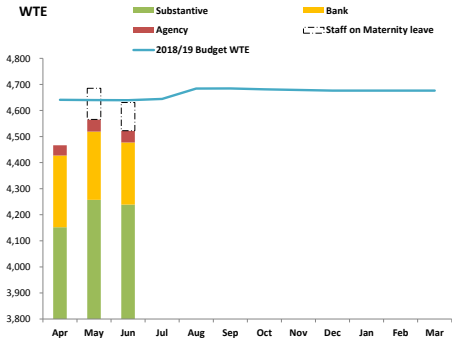
RAG: on or favourable to plan = green, 0-5% adverse to plan = amber, 5%+ adverse to plan = red

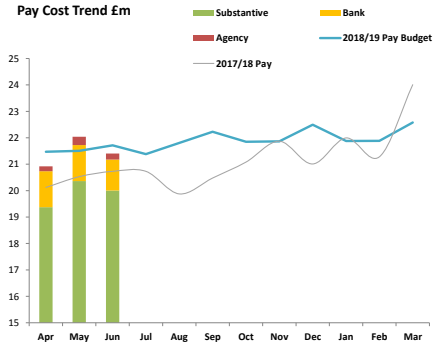
PEOPLE

	M3 Plan WTE	2018/19 M3 WTE	Variance
PERMANENT	4,610.1	4,243.1	367.1
BANK	21.2	238.1	(216.9)
AGENCY	8.1	45.6	(37.5)
TOTAL	**4,639.5**	**4,526.7**	**112.7**

AREAS OF NOTE:

The Trust hold a number of vacancies for permanent positions which are being recruited to, but in the meantime are fulfilling staff needs to meet demand through bank and agency staffing. In addition, the Trust has a number of staff on maternity leave which do not show as WTEs but will contribute to the pay cost of the Trust.



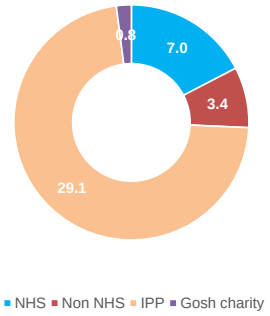


CASH, CAPITAL AND OTHER KPI's

Key metrics	Plan	Actual
CASH	£52.3m	£60.1m
NET RECEIVABLES	n/a	£40.3m
IPP OVERDUE DEBT	n/a	£26.6m

Capital Programme	YTD Plan M3	YTD Actual M3	Full Year Plan & F'cst
Total Trust-funded	£4.7m	£2.8m	£28.0m
Total Donated	£8.8m	£7.0m	£45.0m
Grand Total	£13.5m	£9.8m	£73.0m

Net receivables breakdown



NHSI metrics	Plan M3	Actual M3
CAPITAL SERVICE COVER	1	1
LIQUIDITY	1	1
I&E MARGIN	2	1
VAR. FROM CONTROL TOTAL	1	1
AGENCY	1	1
TOTAL	1	1

AREAS OF NOTE:

Cash held by the Trust is higher than plan by £7.8m.
IPP debt continues to make up the majority of net receivables held (c.72%), and the majority of IPP debt is held beyond terms due to being owed by foreign governments.
The Trust capital programme is currently £3.7m behind plan given slippage in some capital projects. Forecast continues to be the same as plan.
NHSI metrics are all on or above plan.

Trust Income and Expenditure Performance Summary for the 3 months ending 30 Jun 2018

Great Ormond Street Hospital for Children NHS Foundation Trust

2018/19											Notes	2017/18	CY vs PY	
Annual Budget	Income & Expenditure	Month 3				Year to Date				Rating		YTD Actual	Variance	
		Budget	Actual	Variance		Budget	Actual	Variance		Current Year				
(£m)		(£m)	(£m)	(£m)	%	(£m)	(£m)	(£m)	%			(£m)	(£m)	%
280.59	NHS & Other Clinical Revenue	22.86	23.29	0.43	1.88%	68.37	70.46	2.09	3.06%	G	1	70.50	(0.04)	(0.06%)
63.49	Pass Through	5.27	5.27	0.00	0.00%	15.56	15.22	(0.34)	(2.19%)			15.80	(0.58)	(3.67%)
63.55	Private Patient Revenue	5.03	4.75	(0.28)	(5.57%)	15.16	14.40	(0.76)	(5.01%)	R	2	14.10	0.30	2.13%
62.93	Non-Clinical Revenue	4.98	4.44	(0.54)	(10.84%)	14.75	13.28	(1.47)	(9.97%)	R		12.20	1.08	8.85%
470.56	**Total Operating Revenue**	**38.14**	**37.75**	**(0.39)**	**(1.02%)**	**113.84**	**113.36**	**(0.48)**	**(0.42%)**			**112.60**	**0.76**	**0.67%**
(260.28)	Permanent Staff	(21.48)	(20.03)	1.45	6.75%	(64.11)	(59.77)	4.34	6.77%			(56.00)	(3.77)	(6.73%)
(0.50)	Agency Staff	(0.04)	(0.23)	(0.19)		(0.12)	(0.72)	(0.60)				(1.40)	0.68	48.57%
(1.87)	Bank Staff	(0.19)	(1.17)	(0.98)		(0.46)	(3.90)	(3.44)				(4.00)		0%
(262.65)	**Total Employee Expenses**	**(21.71)**	**(21.43)**	**0.28**	**1.29%**	**(64.69)**	**(64.39)**	**0.30**	**0.46%**	G	3	**(61.40)**	**(2.99)**	**(4.87%)**
(13.48)	Drugs and Blood	(1.10)	(1.17)	(0.07)	(6.36%)	(3.24)	(3.20)	0.04	1.23%	G		(3.30)	0.10	3.03%
(41.45)	Other Clinical Supplies	(3.34)	(2.24)	1.10	32.93%	(10.67)	(9.57)	1.10	10.31%	G		(11.80)	2.23	18.90%
(60.62)	Other Expenses	(5.18)	(6.06)	(0.88)	(16.99%)	(14.76)	(15.89)	(1.13)	(7.66%)	R		(14.90)	(0.99)	(6.64%)
(63.49)	Pass Through	(5.27)	(5.27)	0.00	0.00%	(15.56)	(15.22)	0.34	2.19%			(15.60)	0.38	2.44%
(179.04)	**Total Non-Pay Expenses**	**(14.89)**	**(14.74)**	**0.15**	**1.01%**	**(44.23)**	**(43.88)**	**0.35**	**0.79%**	G	4	**(45.60)**	**1.72**	**3.77%**
(441.69)	**Total Expenses**	**(36.60)**	**(36.17)**	**0.43**	**1.17%**	**(108.92)**	**(108.27)**	**0.65**	**0.60%**	G		**(107.00)**	**(1.27)**	**(1.19%)**
28.87	**EBITDA (exc Capital Donations)**	**1.54**	**1.58**	**0.04**	**2.60%**	**4.92**	**5.09**	**0.17**	**3.46%**	G		**5.60**	**(0.51)**	**(9.11%)**
(16.79)	Owned depreciation, Interest and PDC	(1.35)	(1.31)	0.03	2.38%	(4.04)	(3.95)	0.10	2.42%		6	(3.60)	(0.34)	(9.58%)
12.08	**Control total**	**0.19**	**0.27**	**0.07**	**37.11%**	**0.88**	**1.14**	**0.27**	**30.56%**	G		**2.00**	**(0.86)**	**(42.75%)**
(11.60)	Donated depreciation	(0.89)	(0.91)	(0.01)	(1.34%)	(2.71)	(2.73)	(0.02)	(0.66%)			(2.30)	(0.43)	(18.48%)
0.48	**Net (Deficit)/Surplus (exc Cap. Don. & Impairments)**	**(0.70)**	**(0.64)**	**0.06**	**8.57%**	**(1.83)**	**(1.58)**	**0.25**	**13.66%**			**(0.30)**	**(1.28)**	**(426.67%)**
(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	3.82	3.57	(0.25)	(6.54%)	8.78	6.99	(1.79)	(20.39%)		5	6.00	0.99	16.50%
42.93	**Adjusted Net Result**	**3.12**	**2.93**	**(0.19)**	**(6.09%)**	**6.95**	**5.41**	**(1.54)**	**(22.16%)**			**5.70**	**(0.29)**	**(5.09%)**

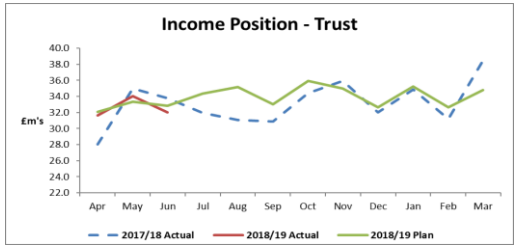
Summary

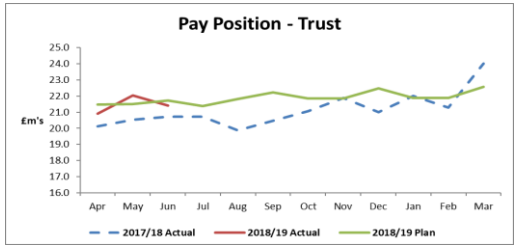
- The Trust is reporting a YTD £0.3m control total surplus position against plan (£1.1m against plan of £0.8m).

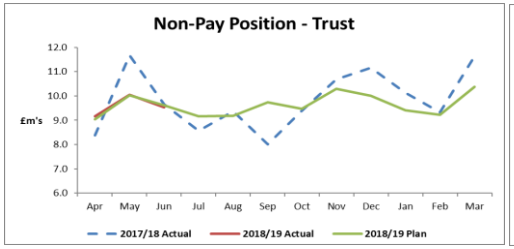
Notes

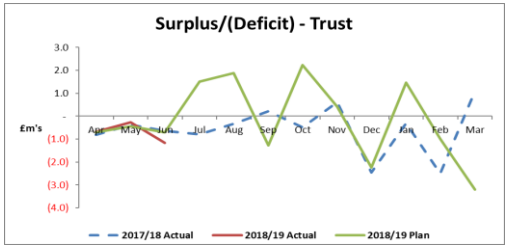
1. NHS & other clinical revenue (excluding pass through) is favourable to plan by £2.1m YTD and £0.4m in month.
2. Private Patient income is £0.8m adverse to plan YTD and £0.3m adverse in month. Though overall private patient activity is down against plan, there has been a significant increase in PICU / NICU activity in the period that is supporting the overall position (£0.5m ahead of plan).
3. Pay is favourable to plan YTD and in month by £0.3m. The clinical divisions continue to hold vacancies which they are attempting to recruit to and are utilising bank and agency staff to fulfil current demand, especially prevalent within nursing staff.
4. Non pay (excluding pass through) is £0.3m favourable to plan YTD and favourable to plan in month by £0.1m. Better value targets within other expenses are being offset by cost management across the rest of the non-pay spend.
5. Income from capital donations was £1.8m less than plan due to slippage of some capital expenditure on donated assets into M3: CICU equipment (£0.3m), SPECT (£0.9m), Squirrel (£0.5m).
6. Depreciation YTD is on plan.

Trust summary graphs









2018/19 NHS Clinical Income for the 3 months ending 30 Jun 2018

Great Ormond Street Hospital for Children NHS Foundation Trust

Summary by Point of Delivery excluding CQUIN

	Current month			Year to date							
Point of Delivery	**Plan £000's**	**Actual £000's**	**Variance £000's**	**Plan £000's**	**Actual £000's**	**Variance £000's**	**Current forecast £000's**	**Previous forecast £000's**	**Forecast variance £000's**	**Annual plan £000's**	**Plan v forecast variance £000's**
Day Case	£2,088	£2,118	£30	£6,165	£6,419	£254	£25,004	£25,004	0%	£25,004	£0
Elective	£5,218	£5,509	£291	£15,392	£15,898	£506	£64,688	£64,688	0%	£64,688	£0
Hdu Bed Days	£277	£301	£25	£841	£848	£7	£3,372	£3,372	0%	£3,372	£0
Highly Specialised Services	£2,444	£2,194	(£250)	£7,382	£7,129	(£253)	£29,681	£29,681	0%	£29,681	£0
Inpatient excess bed days	£401	£252	(£149)	£1,201	£1,010	(£191)	£4,860	£4,860	0%	£4,860	£0
Itu Bed Days	£3,330	£2,887	(£442)	£9,113	£7,993	(£1,120)	£36,552	£36,552	0%	£36,552	£0
Non Nhs Clinical Income	£363	£267	(£96)	£1,081	£1,138	£57	£3,573	£3,573	0%	£3,573	£0
Non-Elective	£1,474	£1,559	£84	£4,471	£5,182	£711	£17,932	£17,932	0%	£17,932	£0
Other Nhs Clinical	£3,961	£5,258	£1,297	£12,804	£13,218	£414	£53,607	£53,607	0%	£53,607	£0
Outpatients	£3,302	£2,943	(£359)	£9,751	£9,956	£205	£39,884	£39,884	0%	£39,884	£0
Total excluding pass through	**£22,857**	**£23,287**	**£430**	**£68,201**	**£68,791**	**£590**	**£279,153**	**£279,153**	**£0**	**£279,153**	**£0**
Pass-Through Income	£5,270	£5,274	£4	£15,558	£15,218	(£340)	£63,014	£63,014	0%	£63,014	£0
Total clinical income	**£28,127**	**£28,561**	**£434**	**£83,759**	**£84,009**	**£250**	**£342,167**	**£342,167**	**0%**	**£342,167**	**£0**

Summary

The year to date income is £250k ahead of plan including pass-through income and £590k above plan excluding pass-through.

The main areas of favourable variance are elective and non-elective activity at £506k and £711k respectively. The elective variance is driven by both activity and casemix whereas for non-elective it is due to increased activity.

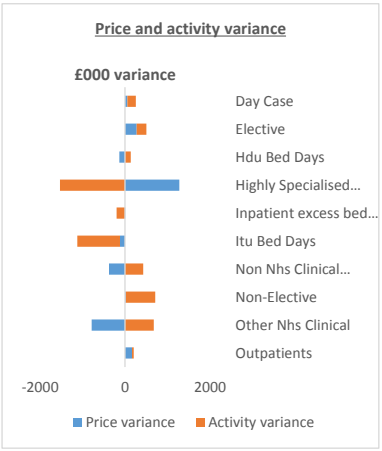
ITU beddays is an adverse variance of £1,120k against year to date plan that is driven by activity under-performance for PICU.

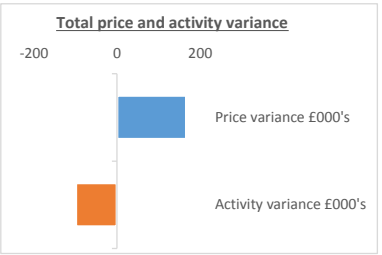
2018/19 NHS Income & Activity for the 3 months ending 30 Jun 2018

Great Ormond Street Hospital for Children NHS Foundation Trust

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	Ave price per plan	Ave price received	Ave price var %	Price variance £000's	Activity variance £000's
Day Case	5,247	5,415	168	£6,165	£6,419	£254	£1,175	£1,185	1%	£57	£197
Elective	3,428	3,480	52	£15,392	£15,898	£506	£4,490	£4,568	2%	£273	£233
Hdu Bed Days	864	1,005	141	£841	£848	£7	£973	£844	-13%	(£130)	£137
Highly Specialised Services	4,547	3,605	(942)	£7,382	£7,129	(£253)	£1,623	£1,978	22%	£1,276	(£1,529)
Inpatient excess bed days	2,116	1,767	(349)	£1,201	£1,010	(£191)	£568	£572	1%	£7	(£198)
Itu Bed Days	3,119	2,776	(343)	£9,113	£7,993	(£1,120)	£2,922	£2,879	-1%	(£118)	(£1,002)
Non Nhs Clinical Income	415	580	165	£1,081	£1,138	£57	£2,605	£1,962	-25%	(£373)	£430
Non-Elective	407	470	63	£4,471	£5,182	£711	£10,985	£11,026	0%	£19	£692
Other Nhs Clinical	15,509	16,294	785	£13,327	£13,218	(£109)	£859	£811	-6%	(£784)	£675
Outpatients	39,492	39,644	152	£9,751	£9,957	£206	£247	£251	2%	£168	£38
Total	**75,144**	**75,036**	**(108)**	**£68,724**	**£68,792**	**£68**	**£915**	**£917**	**0%**	**£167**	**(£99)**





Summary

- The variance of £68k is driven by a small adverse activity variance of £99k that is offset by the price variance of £167k.

- The impact of the adverse activity variance for highly specialised services is £1.5m; this is due to lower than expected levels of non-elective and complex respiratory elective activity and dermatology packages of care however this is largely offset by the favourable price variance from elective and non-elective activity in month 1. Highly specialised activity is largely based on estimates for the current month therefore there is the potential for movements when based on actual activity.

- The adverse variance for ITU bed days is due to lower than planned activity for paediatric intensive care.

Key variances by specialty

Specialty	Ytd plan	Ytd Actuals	Variance
Spinal Surgery	£11,029	£643,507	£632,478
Neurosurgery	£3,608,359	£4,068,368	£460,009
Cardiac Surgery	£3,972,950	£4,432,053	£459,103
Ear, Nose & Throat	£1,105,258	£1,488,910	£383,652
BMT	£1,504,285	£1,122,529	(£381,757)
ECMO	£1,880,223	£1,488,312	(£391,912)
PICU/NICU	£6,099,467	£4,980,820	(£1,118,648)
Haemophilia	£3,714,023	£2,089,595	(£1,624,427)

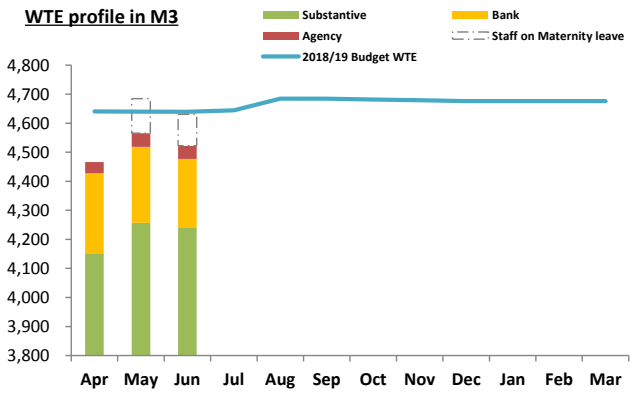
Workforce Summary for the month - June 2018

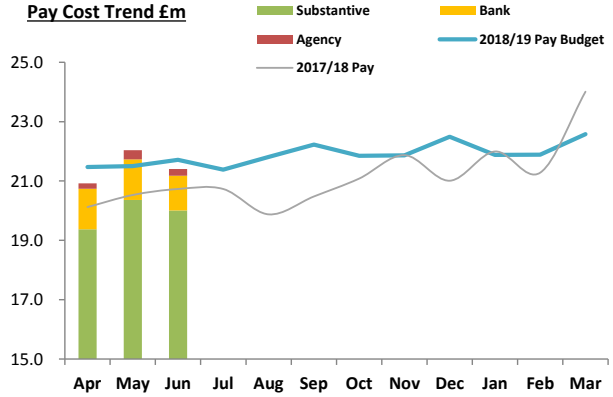
*WTE = **Worked WTE**, Worked hours of staff represented as WTE

Great Ormond Street Hospital for Children NHS Foundation Trust

£m including Perm, Bank and Agency	2018/19 plan			2018/19 actual			Variance			
Staff Group	M3 (£m)	M3 WTE	£000 / WTE	M3 (£m)	M3 WTE	£000 / WTE	M3 (£m)	M3 WTE	Volume Var (£m)	Price Var (£m)
Admin (inc Director & Senior Managers)	4.1	1,131.4	43.3	3.6	1,067.2	40.2	0.5	64.2	0.2	0.3
Consultants	4.3	354.7	146.3	4.3	320.6	161.8	0.0	34.1	0.4	(0.4)
Estates & Ancillary Staff	0.3	129.3	30.8	0.3	113.7	33.7	0.0	15.5	0.0	(0.0)
Healthcare Assist & Supp	0.8	314.7	30.6	0.7	272.8	30.3	0.1	41.9	0.1	0.0
Junior Doctors	2.1	351.2	71.3	2.2	320.6	80.9	(0.1)	30.6	0.2	(0.3)
Nursing Staff	6.5	1,586.5	49.3	6.3	1,526.9	49.2	0.3	59.6	0.2	0.0
Other Staff	0.0	8.7	53.9	0.0	4.6	48.2	0.0	4.1	0.0	0.0
Scientific Therap Tech	4.0	911.5	52.3	3.6	854.8	50.9	0.3	56.7	0.2	0.1
Total substantive and bank staff costs	**22.2**	**4,787.9**	**55.5**	**21.0**	**4,481.2**	**56.2**	**1.2**	**306.7**	**1.4**	**(0.2)**
Agency	0.0	8.1	60.6	0.2	45.6	59.5	(0.2)	(37.5)	(0.2)	0.0
Total substantive, bank and agency cost	**22.2**	**4,796.0**	**55.5**	**21.2**	**4,526.7**	**56.2**	**1.0**	**269.3**	**1.2**	**(0.2)**
Reserve*	(0.5)	(156.6)	0.0	0.2	0.0	0.0	(0.7)	(156.6)	(0.5)	(0.2)
Total pay cost	**21.7**	**4,639.5**	**56.2**	**21.4**	**4,526.7**	**56.7**	**0.3**	**112.7**	**0.5**	**(0.2)**
Remove Maternity leave cost				0.3						
Total excluding Maternity Costs	**21.7**	**4,639.5**	**56.2**	**21.1**	**4,526.7**	**55.9**	**0.6**	**112.7**	**0.5**	**0.1**

Plan reserve includes WTEs relating to the better value programme





Summary

- In Month 3 pay spend is £21.4m (including Maternity) which is £0.3m favourable to plan.
- £0.2m has been accrued for the inflationary pay rise which will be paid once formally approved.
- The Trust continue to focus on recruitment of permanent nursing staff to reduce use of bank and the additional costs associated. M3 18/19 nursing cost continues to be of a similar level to 17/18 given the continuing challenge with recruiting to the posts.
- There are 108 WTEs on maternity leave which are not recorded within the actual WTE's (given not working). This is the key driver between the favourable WTE and the on-plan YTD spend.

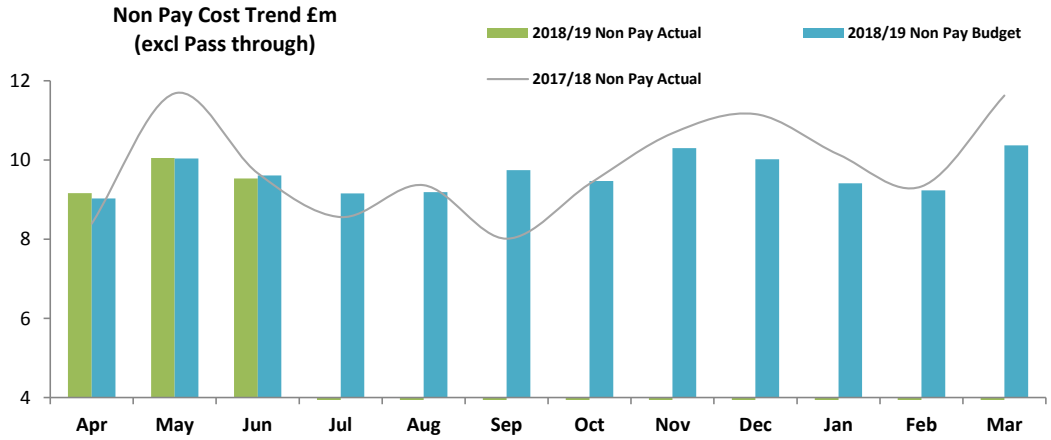
Non-Pay Summary for the 3 months ending 30 Jun 2018

Great Ormond Street Hospital for Children NHS Foundation Trust

NON PAY COSTS (excl Pass through) YTD and in-month						
£m	2017/18		2018/19		Change from prior year	
	Budget (£m)	Actual (£m)	Budget (£m)	Actual (£m)	Budget (£m)	Actual (£m)
Non Pay (In month)	(8.6)	(9.7)	(9.6)	(9.5)	(1.0)	0.2
Non pay (YTD)	(26.7)	(30.0)	(28.7)	(28.7)	(2.0)	1.3

Top 5 YTD Clinical* Non Pay overspends by Speciality (£m)			
	In-month 2018/19 Budget (£k)	In-month 2018/19 Actual (£k)	Variance (£k)
Pathology	(465)	(658)	(193)
Cardiac Serv	(317)	(461)	(144)
Theatre	(631)	(755)	(125)
Medical Gastroenterology	(35)	(137)	(102)
Genetics	(245)	(294)	(49)

Top 5 YTD Clinical* Non Pay underspends by Speciality (£m)			
	In-month 2018/19 Budget (£k)	In-month 2018/19 Actual (£k)	Variance (£k)
Bone Marrow Transplant	(156)	167	323
Snaps	(23)	99	121
Pharmacy	(78)	34	112
Radiology	(217)	(119)	98
Cardiac Critical Care	(91)	(4)	87



Summary

- YTD non-pay excluding passthrough in 2018/19 is broadly on plan which is also in line with YTD total income.
- There has been an overspend in selected clinical non-pay areas including:
  - Pathology - due to reagent costs due to associated activity levels
  - Cardiac Serv - increased purchases of consumables for current and prospective activity
  - Theatres - continued spend on general supplies and consumables
  - Med Gastro - income is higher and therefore non-pay spend is higher than budget to meet demand
  - Genetics - associated with increased activity levels within the specialty
- There has also been a number of underspends within clinical non-pay areas including:
  - BMT - as costs were over accrued in the previous month due to an overestimate in work-in-progress income
  - Snaps/Pharmacy - due to correction of miscoding in previous months
  - Radiology - favourable to plan due to adjustments made to maintenance contracts within the service

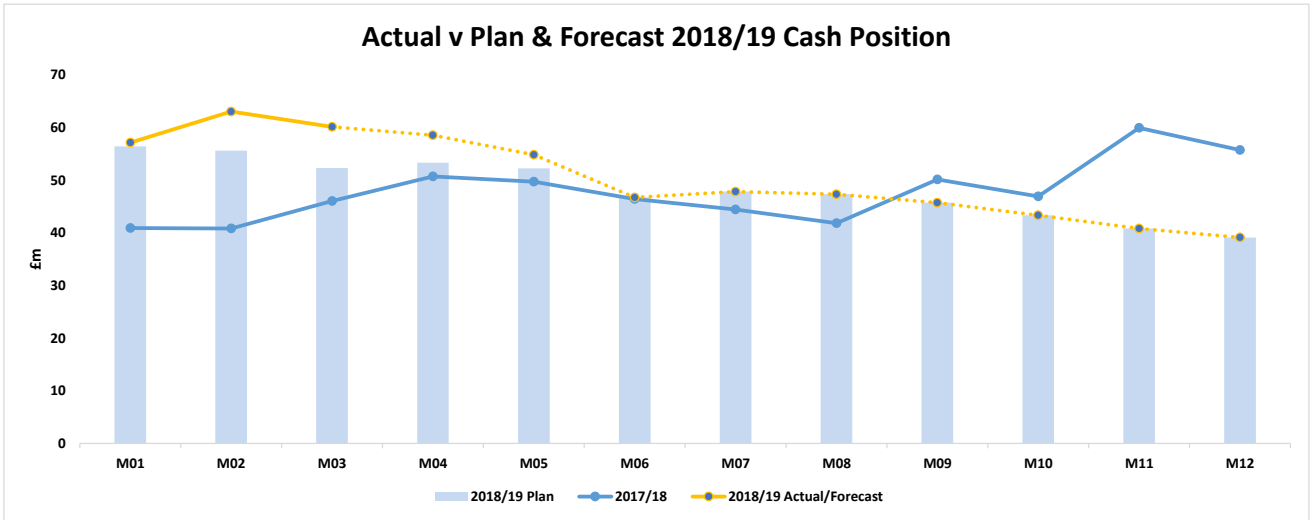
**Clinical non-pay includes blood costs, drugs costs, healthcare from non-NHS bodies, services from NHS organisations, supplies & services clinical and excludes passthrough*

31 Mar 2018 Audited Accounts £m	Statement of Financial Position	YTD Plan 30 Jun 2018 £m	YTD Actual 30 Jun 2018 £m	*YTD Variance £m*	*Forecast Outturn 31 Mar 2019 £m*	YTD Actual 30 Apr 2018 £m	*In month Movement £m*
463.29	Non-Current Assets	471.75	468.10	(3.65)	512.30	464.99	*3.11*
85.92	Current Assets (exc Cash)	89.29	87.40	(1.89)	86.80	90.28	*(2.88)*
55.69	Cash & Cash Equivalents	52.27	60.07	7.80	39.10	57.05	*3.02*
(69.95)	Current Liabilities	(71.58)	(75.33)	(3.76)	(60.97)	(76.45)	*1.12*
(5.51)	Non-Current Liabilities	(5.34)	(5.38)	(0.04)	(4.87)	(5.47)	*0.09*
529.44	**Total Assets Employed**	**536.39**	**534.86**	**(1.53)**	**572.36**	**530.40**	**4.46**

31 Mar 2018 YTD actual £m	Capital Expenditure	YTD Plan 30 Jun 2018 £m	YTD Actual 30 Jun 2018 £m	YTD Variance £m	Forecast Outturn 31 Mar 2019 £m
5.81	Redevelopment - Donated	3.17	2.70	0.47	16.30
9.06	Medical Equipment - Donated	1.89	1.46	0.43	12.63
9.78	ICT - Donated	3.73	2.83	0.90	16.03
24.65	**Total Donated**	**8.79**	**6.99**	**1.80**	**44.96**
6.99	Redevelopment & equipment - Trust Funded	1.78	1.51	0.27	9.35
1.61	Estates & Facilities - Trust Funded	0.62	0.28	0.34	3.30
4.73	ICT - Trust Funded	2.28	1.01	1.27	15.35
13.33	**Total Trust Funded**	**4.68**	**2.80**	1.88	**28.00**
37.98	**Total Expenditure**	**13.47**	**9.79**	**3.68**	**72.96**

31-Mar-18	Working Capital	31-May-18	30-Jun-18	RAG	KPI
19.00	NHS Debtor Days (YTD)	8.0	7.0	G	< 30.0
189.00	IPP Debtor Days	195.0	191.0	R	< 120.0
27.70	IPP Overdue Debt (£m)	27.3	26.6	R	0.0
5.00	Inventory Days - Drugs	7.0	8.0	G	7.0
70.00	Inventory Days - Non Drugs	69.0	67.0	R	30.0
35.00	Creditor Days	31.0	30.0	A	< 30.0
70.3%	BPPC - NHS (YTD) (number)	47.8%	42.4%	R	> 95.0%
43.3%	BPPC - NHS (YTD) (£)	73.6%	71.3%	R	> 95.0%
89.3%	BPPC - Non-NHS (YTD) (number)	82.3%	82.6%	R	> 95.0%
85.0%	BPPC - Non-NHS (YTD) (£)	86.0%	85.8%	A	> 95.0%

RAG Criteria:
NHS Debtor and Creditor Days: Green (under 30); Amber (30-40); Red (over 40)
BPPC Number and £: Green (over 90%); Amber (85-90%); Red (under 85%)
IPP debtor days: Green (under 120 days); Amber (120-150 days); Red (over 150 days)
Inventory days: Green (under 21 days); Amber (22-30 days); Red (over 30 days)



Appendices

Statement of Financial Position as at 30 Jun 2018

Great Ormond Street Hospital for Children NHS Foundation Trust

Audited Actual as at 31 Mar 2018		Plan as at 30 Jun 2018	Actual as at 30 Jun 2018	*YTD Variance*	Forecast Outturn 31 Mar 2019	Actual as at 31 May 2018	*Change in month*
£000		£000	£000	£000	£000	£000	*£000*
	Non Current Assets						
200,068	Property, plant and equipment - purchased	443,265	441,082	*(2,183)*	221,727	438,771	*(2,311)*
18,429	Intangible assets - purchased	22,413	20,947	*(1,466)*	13,655	20,453	*(494)*
6,188	Trade and other receivables	6,069	6,070	*1*	5,713	6,109	*39*
463,289	**Total Non Current Assets**	**471,747**	**468,099**	***(3,648)***	**512,297**	**465,332**	***(2,766)***
	Current Assets						
8,853	Inventories	9,050	9,383	*333*	9,500	9,142	*(241)*
54,512	Invoiced Debtors	46,750	40,302	*(6,448)*	55,103	42,181	*1,879*
12,471	Accrued income	15,983	20,470	*4,487*	12,597	19,121	*(1,349)*
54	PDC dividend receivable	0	0	*0*	0	0	*0*
1,329	Other receivables - revenue	2,383	2,208	*(175)*	1,333	2,545	*337*
4,338	Receivables due from NHS charities - capital	8,775	8,260	*(515)*	4,353	5,317	*(2,943)*
3,382	Prepayments	5,520	5,469	*(51)*	3,394	5,055	*(414)*
985	VAT receivable	825	1,102	*277*	488	990	*(112)*
0	Investments	50,000	55,000	*5,000*	30,000	51,000	*(4,000)*
55,695	Cash and cash equivalents	2,272	5,067	*2,795*	9,137	11,986	*6,919*
141,619	**Total Current Assets**	**141,558**	**147,261**	***5,703***	**125,905**	**147,337**	***76***
604,908	**Total Assets**	**613,305**	**615,360**	***2,055***	**638,202**	**612,669**	***(2,690)***
	Current Liabilities						
(6,380)	Other trade payables - capital	(8,051)	(6,810)	*1,241*	(7,498)	(6,201)	*609*
(6,599)	NHS payables - revenue	(6,082)	(6,827)	*(745)*	(5,490)	(6,731)	*96*
(5,076)	Other trade payables - revenue	(4,678)	(1,940)	*2,738*	(4,223)	(4,174)	*(2,234)*
(3,001)	Social Security costs	(2,766)	(3,057)	*(291)*	(3,096)	(3,059)	*(2)*
(2,506)	Other taxes payable	(2,309)	(2,559)	*(250)*	(2,546)	(2,554)	*5*
(8,700)	Other payables	(8,019)	(10,129)	*(2,110)*	(7,179)	(8,938)	*1,191*
(4,926)	Private Patient Cash on Account	(4,540)	(4,564)	*(24)*	(4,098)	(5,003)	*(439)*
0	Other payables - PDC	(1,825)	(1,825)	*0*	0	(1,199)	*626*
(25,171)	Expenditure accruals	(25,518)	(29,356)	*(3,838)*	(19,929)	(29,147)	*209*
(6,329)	Other liabilities	(6,523)	(6,791)	*(268)*	(6,681)	(7,051)	*(260)*
(1,264)	Provisions for liabilites and charges	(1,264)	(1,264)	*0*	(227)	(1,264)	*0*
(69,952)	**Total Current Liabilities**	**(71,575)**	**(75,122)**	***(3,547)***	**(60,967)**	**(75,321)**	***(199)***
71,667	**Net Current Assets**	**213,133**	**72,139**	***9,250***	**64,938**	**72,016**	***(123)***
534,956	**Total Assets Less Current Liabilities**	**541,730**	**540,238**	***(1,492)***	**577,235**	**537,348**	**(2,889)**
	Non Current Liabilities						
(4,543)	Lease incentives	(4,426)	(4,442)	*(16)*	(4,111)	(4,475)	*(34)*
(968)	Provisions for liabilites and charges nca	(917)	(942)	*(25)*	(764)	(951)	*(9)*
(5,511)	**Total Non Current Liabilities**	**(5,343)**	**(5,384)**	***(41)***	**(4,875)**	**(5,426)**	***(43)***
529,445	**Total Assets Employed**	**536,387**	**534,854**	***(1,533)***	**572,360**	**531,922**	***(2,932)***
	Financed by Taxpayers' Equity						
127,280	Public dividend capital	127,280	127,280	*0*	127,280	127,280	*0*
306,494	Retained earnings	312,048	311,903	*(145)*	349,409	308,971	*(2,932)*
92,557	Revaluation reserve	93,945	92,557	*(1,388)*	92,557	92,557	*0*
3,114	Other reserves	3,114	3,114	*0*	3,114	3,114	*0*
529,445	**Total Taxpayers' Equity**	**536,387**	**534,854**	***(1,533)***	**572,360**	**531,922**	***(2,932)***

Notes

1. Current assets excluding cash at 30th June totals £87.2m, which is £2.1m lower than plan. The variance is largely due to the movement in the following:
   - Invoiced Debtors (lower than plan by £6.4m, of which £2.4m was received from Camden CCG which mainly related to Overseas reciprocal income;
   - Accrued Income (higher than plan by £4.5m which includes International Private Patients work in progress (£7.2m); LCRN (£0.5m), NHS Patient treatment income (£1.8m)
   - Other receivables (£0.5m lower than plan and includes VAT, Capital debtors and prepayments) and
   - Inventories (£0.3m higher than plan)
2. Current Liabilities at 30th June totals £75.1m, which is £3.5m higher than plan. The variance in month mainly relates to the increase in expenditure accruals (£3.8m higher than plan) Capital creditors (£1.2m lower than plan) and other creditors (£0.9m higher than plan).
3. The Property, Plant and Equipment (PPE) and Intangibles balance increased by £2.8m in June due to capital expenditure of £4.4m less depreciation of £1.6m. The closing balance of PPE/Intangibles at 30 June was £3.6m less than plan. This is because:
   - Trust funded capital expenditure was £1.9m less than plan due to project slippage. Two IT projects were delayed due to extended time to agree Statements of Works: VNA (£0.3m) and Onbase (£0.2m). In aggregate, Estates projects were £0.3m behind plan pending approval of individual projects.
   - Donated capital expenditure was £1.8m less than plan. Significant projects where expenditure was less than plan are: EPR (£0.9m) due to contingency reserve not being allocated; Echocardiogram machines delivered July (£0.6m); intra-operative neuro-scanning due to extended procurement/selection under OJEU rules (£0.3m); Squirrel Ward refurbishment (£0.7m) due to delays in contractor certification of works.
   - Depreciation for the month is on-plan.
4. NHS Debtor days decreased in month to 7 days which remains within target.
5. IPP debtor days fell from 195 days to 191 days. Receipts are just over £5m and invoices raised in month 3 were £4.8m. Over £3m was received Kuwait Health Office for both current and older invoices which has contributed to the reduction in debtor days.
6. Creditor days decreased in month from 31 days from 30 days. The Trust has increased the speed in which it pays invoices.
7. Drug inventory days increased in month from 7 to 8 days. Non-Drug inventory days decreased in month to 67 days. The methodology for calculating inventory days is based upon stock level and stock usage in month. Non drugs stock usage in June 18 was £0.1m which was higher than the average usage per month which resulted in the reduction in inventory days.

Great Ormond Street Hospital for Children NHS Foundation Trust

Statement of Cash Flows for the 3 months ending 30 Jun 2018

Audited Actual For YTD Ending 31 Mar 2018 £000		Plan For YTD Ending 30 Jun 2018 £000	Actual For YTD Ending 30 Jun 2018 £000	Actual For Month Ending 30 Jun 2018 £000	Forecast Outturn 31 Mar 2019 £000
	Cash flows from operating activities				
6,061	Operating surplus - excluding charitable capital expenditure contributions	17	222	(38)	2,858
2,939	Impairment and Reversals	0	0	0	2,519
24,653	Charitable capital expenditure contributions	8,782	6,992	3,568	44,965
33,653	**Operating surplus**	**8,799**	**7,214**	**3,530**	**50,342**
	Non-cash income and expense				
17,582	Depreciation and amortisation	4,891	4,861	1,621	20,963
2,939	Impairments and Reversals	0	0	0	2,519
15	Proceeds on disposal	0	6	5	6
(8,884)	Increase in trade and other receivables	(3,046)	(676)	(2,563)	277
(627)	(Increase)/decrease in inventories	(197)	(530)	(241)	(647)
12,287	(Decrease)/increase in trade and other payables	(2,120)	2,450	(1,174)	(9,423)
311	Decrease in other current liabilities	78	361	(293)	(79)
1,246	Decrease in provisions	(51)	(24)	(9)	(1,241)
24,869	**Net cash inflow/(outflow)from operating activities**	**(445)**	**6,448**	**(2,654)**	**12,375**
	Cash flows from investing activities				
138	Interest received	21	69	23	84
(38,610)	Purchase of property, plant and equipment and Intangibles	(11,798)	(9,359)	(3,818)	(71,847)
(38,472)	**Net cash used in investing activities**	**(11,777)**	**(9,290)**	**(3,795)**	**(71,763)**
	Cash flows from financing activities				
562	Public Dividend Capital received	0	0	0	0
(7,411)	PDC dividend paid	0	0	0	(7,512)
(6,849)	**Net cash outflows from financing activities**	**0**	**0**	**0**	**(7,512)**
13,201	**Increase/(decrease) in cash and cash equivalents**	**(3,423)**	**4,372**	**(2,919)**	**(16,558)**
42,494	**Cash and cash equivalents at period start**	**55,695**	**55,695**	**62,986**	**55,695**
55,695	**Cash and cash equivalents at period end**	**52,272**	**60,067**	**60,067**	**39,137**

Notes

1. The closing cash balance was £60.1m, £7.8m higher than the plan. The variance is largely due to the following:
   - EBITDA is higher than plan by £0.1m. This is as a result of higher levels of increased activity
   - Inventories is higher than plan by £0.3m. This mainly relates to the increase in Cardiac respiratory stock and Pharmacy drugs held in M03.
   - Trade and other receivables including capital debtors (lower than plan by £1.0m).
   - Trade and other payables are higher than plan by £5.1m. This includes accruals for maintenance contracts (£1.5m); Pass through expenditure (£3.8m); Pharmacy drugs (£1.5m) which will be settled on receipt of invoices.
   - Trust funded capital expenditure is lower than plan by £1.9m, including the effect of rephasing supplier contracts for VNA (£0.3m) and Onbase (£0.2m), and slippage of estates projects (£0.3m).

2. In June 18, 42.4% of the total value of NHS creditor invoices were settled within 30 days of receipt (47.8% in May 18); this value relates to 71.3% of the total number of invoices paid in month (73.6% in May 18). The majority of invoices which remain unpaid outside of terms relate to non contracted activity and are under query with the suppliers. The total value of Non-NHS creditor invoices settled within 30 days of receipt was 82.6% (82.3% in May 18); this value relates to 85.8% of the total number of Non-NHS invoices paid in month (86.0% in May 18).

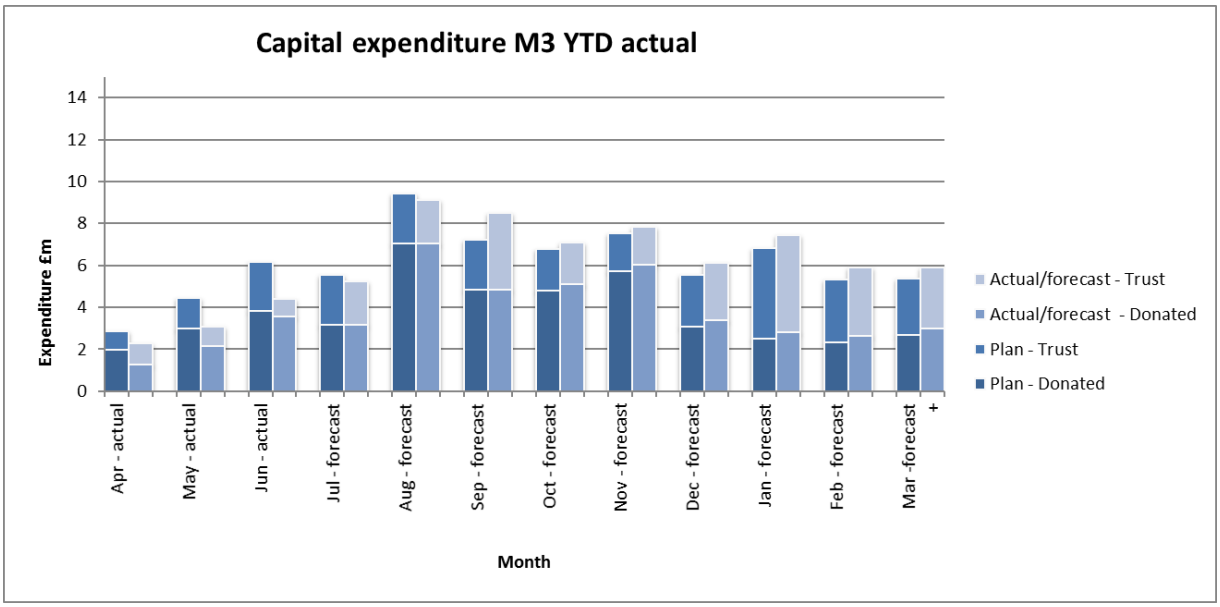
Capital for the 3 months ending 30 Jun 2018

Great Ormond Street Hospital for Children NHS Foundation Trust

		YTD June 2018			Full year 2018/19		
		Plan £000	Actual £000	Variance £000	Plan £000	Forecast £000	Variance £000
Estates and Facilities	Trust-funded	622	283	339	3,300	3,300	0
	Total Estates & Facilities	**622**	**283**	**339**	**3,300**	**3,300**	**0**
EPR	Trust-funded	261	(26)	287	7,625	7,625	0
	Donated	3,730	2,827	903	16,034	16,034	0
	Total IM&T	**3,991**	**2,801**	**1,190**	**23,659**	**23,659**	**0**
Information Technology	Trust-funded	2,019	1,033	986	7,786	7,726	60
	Donated	0	0	0	0	0	0
	Total IM&T	**2,019**	**1,033**	**986**	**7,786**	**7,726**	**60**
Medical Equipment	Trust-funded	0	0	0	0	0	0
	Donated	1,887	1,463	424	5,287	12,631	(7,344)
	Total Medical Equipment	**1,887**	**1,463**	**424**	**5,287**	**12,631**	**(7,344)**
Phase 4	Trust-funded	531	312	219	2,116	2,116	0
	Donated	0	0	0	0	0	0
	Total Redevelopment	**531**	**312**	**219**	**2,116**	**2,116**	**0**
Redevelopment	Trust-funded	1,253	1,193	60	7,173	7,233	(60)
	Donated	3,165	2,703	462	23,644	16,300	7,344
	Total Redevelopment	**4,418**	**3,896**	**522**	**30,817**	**23,533**	**7,284**
Total Trust	**Total Trust-funded**	**4,686**	**2,795**	**1,891**	**28,000**	**28,000**	**0**
	Total Donated	**8,782**	**6,993**	**1,789**	**44,965**	**44,965**	**0**
	Grand Total	**13,468**	**9,788**	**3,680**	**72,965**	**72,965**	**0**

Notes on YTD variance

YTD slippage is £3.7m of which £1.9m is Trust funded. This is due to slippage in project timing including VNA and Onbase rephased to later in the year in accordance with contracts with suppliers £0.4m; network LAN switches rephased to mid-year £0.3m; endpoint rephased to meet EPR requirements £0.2m. Other equipment procurement delays to later in year for the ECHO/Intraoperative neuro scanners £0.8m and CICU equipment. A detailed forecast outturn is currently being developed; at present key movements have been highlighted above where the sight & sound hospital programme and iMRI projects costs have slipped into 2019/20 which has been offset by ZCR equipment costs.



Attachment Y

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
25 July 2018

Safe Nurse Staffing Report for May/June 2018 **Submitted by:** Alison Robertson, Chief Nurse.	**Paper No: Attachment Y**

Aims / summary

1. Receive developing format of safe staffing report.
2. Unify v Actual CHPPD data that provides the actual number of nursing and HCA hours available for each patient for the month.
3. Assurance of Safe Staffing Levels include patient acuity, staff sickness and appropriate measures are undertaken to ensure patient safety.
4. Recognition of vacancies and prospective staff numbers.

Action required from the meeting
To note the information in the report on safe staffing, the continued improvement in retention and the progress of the recruited newly qualified nurses and the impact on the staffing numbers.

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.

Compliance with *How to ensure the right people, with the right skills, are in the right place at the right time – A guide to nursing, midwifery and care staffing and capability'* (NHS England, Nov 2013) and the *'Hard Truths Commitments Regarding the Publishing of Staffing Data'* issued by the Care Quality Commission in March 2014. In July 2016 there was further guidance – '*Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time' (National Quality Board, July 2016).* This guidance provides an updated set of NQB expectations for nurse staffing to help Trust boards make local decisions that will deliver high quality care for patients within the available staffing resource.

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 Heads 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

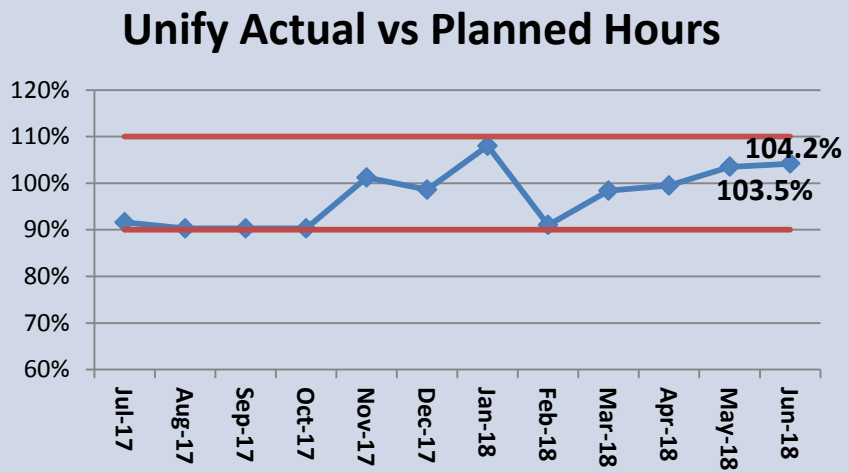
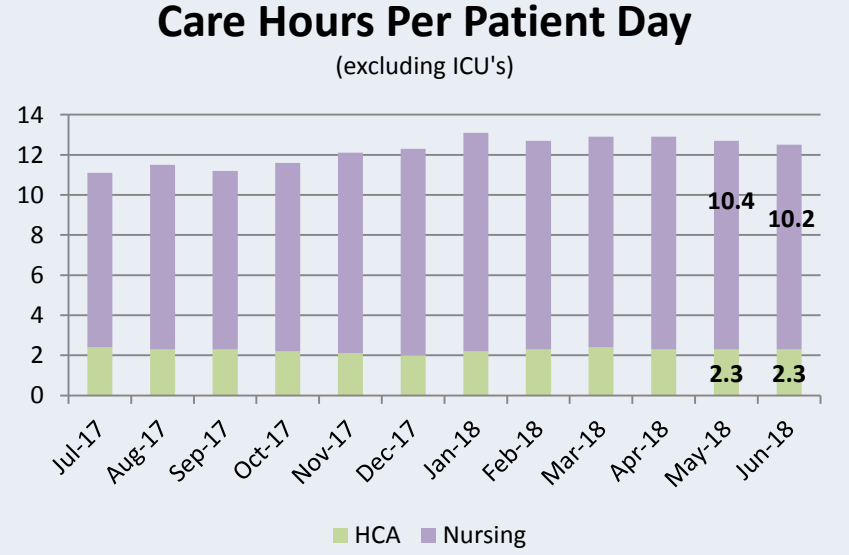
Safer Staffing Report May/June 2018

The child first and always

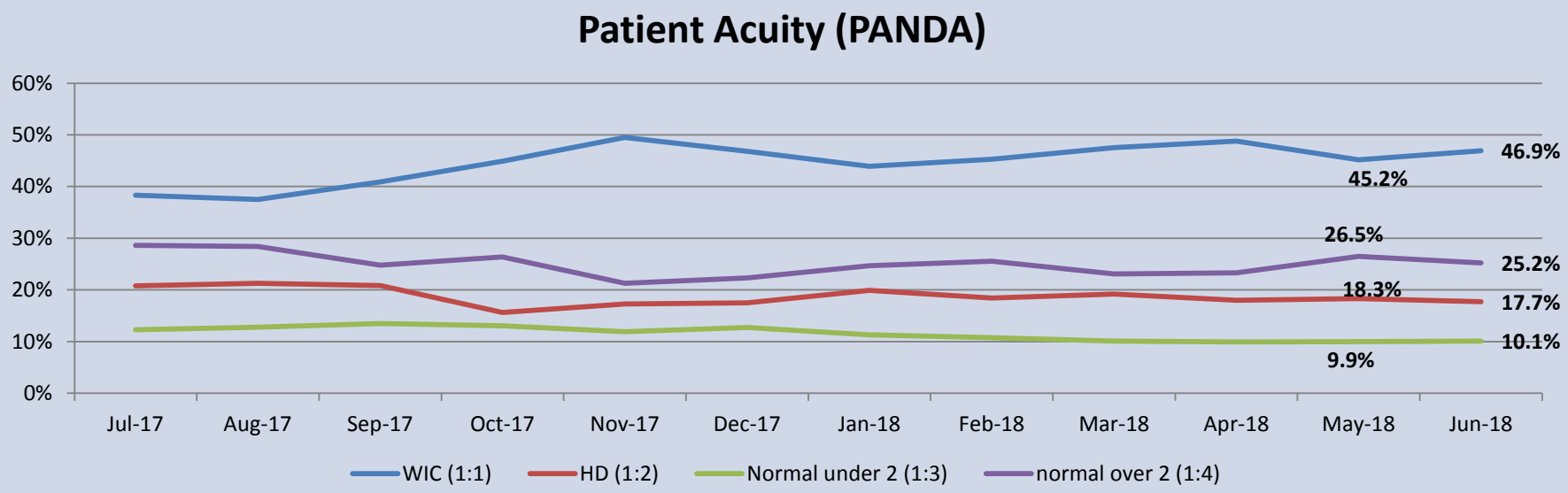
Always

Welcoming Helpful Expert Team

Nursing & HCA Safe Staffing- May/June 2018

Definition	Trend	Comments
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%.		Actual vs Planned has increased from 103.2% in May to 104.2% in June. Nursing hours during the day were 116.2% against plan and 99.4% at Night. The trend for May was 103.5% and June was 104.2% therefore within safe staffing parameters.
Care Hours Per Patient Day (CHPPD) - CHPPD is calculated by adding the hours of registered nurses and healthcare support workers available in a 24 hour period and dividing the total by the number of patients at midnight. CHPPD is reported as a total and split by registered nurses and HCAs to provide a complete picture of care and skill mix. CHPPD data is uploaded onto the national Unify system and published on NHS Choices on a monthly basis.		CHPPD for June was 12.5. This is slightly lower than in May but compares favourably to the same month last year (11.8). 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 June indicate that patients received, on average 1:2 nursing. This is used to reflect the activity on each ward and the staffing levels required. These results cannot be taken in isolation but is compared to the Unify results to ensure that safe staffing was achieved. Recorded patient numbers increased in May from 7,731 to 8,042, this is a positive trend, showing an increase in patient numbers but still having 1:2 nursing.

Nursing & HCA Safe Staffing- May/June 2018



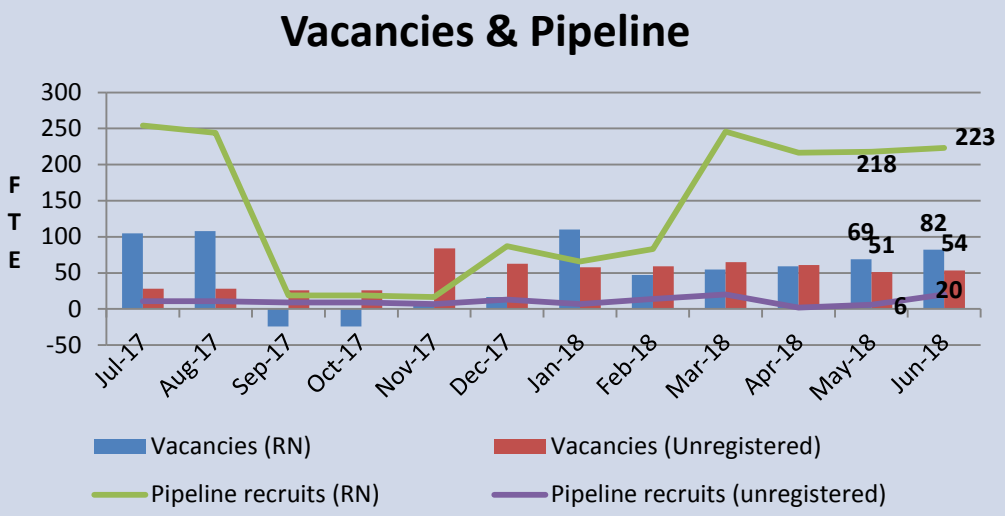
PANDA acuity data measures patient dependency based on the actual acuity and dependency of children. These are the following categories that are evaluated:

- 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 1:1or 1:2 level of care has been consistent over the last few months and is currently reporting at 64.6%, which is higher than the same month last year (59%). Patients with normal dependency of 1:3 and 1:4 were 35.3% of the total reported in June. This is a trend that is continually reviewed and discussed to ensure that correct numbers and skill mix of staff are available for the needs of the wards and departments.

Nursing & HCA Safe Staffing- May/June 2018

Recruitment & Retention

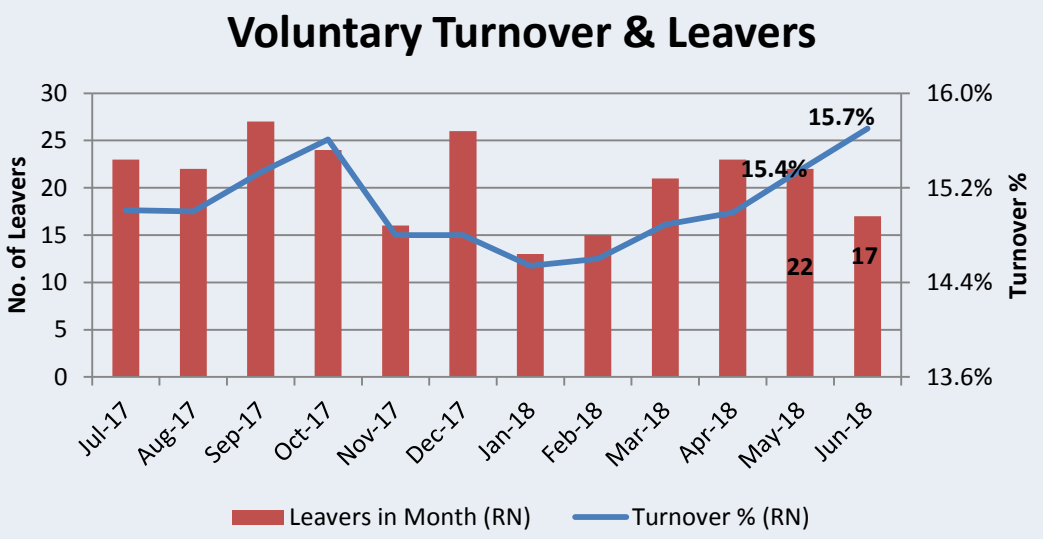


Comments

The RN Vacancy rate for June was 5.2%, which was a slight increase from the previous month (4.4%), but is well below the set Trust target of 10% target and the same month last year (6.1%).

Unregistered Vacancies are currently 17% (54 WTE). There are ongoing plans including local and central recruitment and the recruitment pipeline includes 154 Newly Qualified Nurses who will join the Trust in September.

The new Recruitment and Retention Action Plan has been finalised and the highlights was presented at the Operational, Development and Performance Group for their information in June.



Turnover has been increasing over the last few months, which is an expected seasonal trend, and the figure shows the trend over the last year, where as the number of leavers is on a downward trend.

Of the leavers in the last twelve months identified reasons for leaving include: -

relocation (39%) and work life balance (24%). The Workforce Advisory Board (WAB) format has been modified to a new interactive format. A monthly update showing the highlights and the next month Action plan is attached to this report and is now sent to all staff as an update. (Appendix 1)

The WAB is currently focusing on retention strategies as part of a wider workforce strategy. There is a review of the Clinical Nurse Specialists and Advanced/Nurse and Trainee Practitioners to understand the role and the current skill resource available to the Trust workforce.

Nursing & HCA Safe Staffing- May/ June 2018

Division	Actual vs Planned %	CHPPD (exc ICUs)	RN Vacancies %	RN Vacancies (FTE)	Pipeline (No.)	Turnover %	Sickness %	Maternity %
JM Barrie								
May.	102%	13.1	5.2%	41.75	n/a	13.7%	3.1%	3.8%
June	105.4%	12.3	4.7%	37.6	n/a	12.6%	3.1%	4.6%
Charles West								
May.	108.4%	13.4	0.3%	1.5	n/a	19.7%	3.0%	3.3%
June.	106.1%	12.9	2.9%	17.2	n/a	19.0%	3.0%	3.4%
IPP								
May	97.8%	14.2	16.4%	18.1	n/a	13.5%	2.8%	4.3%
June	89.4%	11.4	21%	23.1		14.9%	2.5%	2.3%
Trust								
May	103.6%	12.7	3.5%	51	218	16.6%	3.0%	3.8%
June	104.2%	12.7	5.2%	82.0	223	15.7%	3.0%	4.1%

IPP and Sky Ward will be the focus of any initiative for recruitment. In the pipeline already are adverts and offers of workplace experience to HM Forces. This is collaborative work stream developed to encourage personnel leaving the Services to consider Great Ormond Street as a career opportunity. Also the Pick 'n' Mix initiative and new style adverts especially targeting Sky Ward are being used and developed.

Appendix 1

Claims: May 2018

Recruitment:

- Offered **155** Junior Band 5's to start Sept 2018.
- 28 additional Junior Band 5 candidates shortlisted & invited to interview 5th June.
- Recruited the Nursing Times Awards *Student Nurse of the Year*.
- **HPMA finalists**, shortlisted for HSJ Strategic Recruitment Award. Final June 7th 2018
- New Head of Nursing has been appointed in IPP, due to start in July.

Retention

- Retention is the main focus for nursing in 2018, to review and implement new and innovative ideas especially for Band 6's
- Retained 218 out of 225 Junior Band 5 nurses from Sept 2017 cohort.
- Successful **Matrons** update at Nursing Trust Board.
- Careers Clinic started incorporating Realtime vacancies and Internal Transfers Windows
- Innovation introduced to attract new nurse's to the Nurses League including a donation for future nursing celebrations.

Education:

- Excellent feedback from elective students.
- New format of **Visible Leadership**, without the old agenda is working better; has been well received.
- Success of **International Nurses Day** on 11th May, boosted morale.

GOSH Staff Awards:

- increased number of nurse nominations.
- Winners include-

Liam Southern- Leader of the year,

Liesje Andre- Colleague of the year,

NICU- Team of the year

FOCUS FOR NEXT MONTH:

- Allocations for Junior Band 5 Staff nurses, September 2018 cohort.
- Establishment Review.
- Junior Band Sister role.
- Changing Rooms
- Combination Loan from Charitable Funds
- Encourage more nursing staff at all levels to attend WAB Meetings
- Invite AHP's to attend future WAB Meetings. Nominated Representative to be decided.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **25th July 2017**	
Guardian of Safe Working report **Submitted by:** Dr Renée McCulloch, Guardian of Safe Working	**Paper No: Attachment Z**
Aims / summary This report is the third report to the Board regarding Junior Doctor working practice at GOSH. This report covers the period May to June 2018 inclusive.	
Action required from the meeting The board is asked to note the report and the issues influencing junior doctor's working and the challenges in monitoring compliance with the TCS 2016.	
Contribution to the delivery of NHS Foundation Trust strategies and plans The Guardian of Safe Working supports and enables a safe and positive working and learning environment for junior doctors. This contributes to the Trusts strategic objective relating to providing safe patient care and an excellent place to work and learn.	
Financial implications Continuing payment for overtime hours documented through the exception reporting practice.	
Who needs to be told about any decision? n/a	
Who is responsible for implementing the proposals / project and anticipated timescales? Dr Renee McCulloch, Guardian of Safe Working Dr Sanjiv Sharma, Deputy Medical Director for Medical & Dental Education Sarah Ottaway, Head of Medical HR & PGME Services	
Who is accountable for the implementation of the proposal / project? Matthew Shaw, Medical Director	

Trust Board Report
Guardian of Safe Working
July 2018

1. Purpose

1.2. To inform the board on issues arising relating to the junior doctors working at GOSH and the work of the Guardian of Safe Working (GOSW).

1.3. The GOSW is directly accountable to the Trust Board.

1.4. The role of 'Guardian of Safe Working' (GOSW) includes;

- overseeing the safeguards outlined in the 2016 contract
- ensuring that issues of compliance with safe working are addressed by the doctors and/or the employer
- facilitating the reporting structures
- supporting the wellbeing of the junior doctors.

2. Background

2.2. From 2nd October 2017, all junior doctors in training posts have transferred to the 2016 Terms & Conditions (TCS).

2.3. The 2016 TCS clearly indicate the importance of appropriate working hours and attendance at training and education as having a direct effect on the quality and safety of patient care. **The GOSW champions the application of both these principles to ALL junior doctors at GOSH.**

2.4. Exception reporting is the contractually mandated mechanism used by doctors to inform the Trust when their day-to-day work varies significantly and/or regularly from the agreed work schedule of their post.

2.5. From June 2018 ALL GOSH junior doctors (training doctors on the 2016 contract and Trust doctors on local TCS) can exception report and financial compensation when necessary for extra hours worked. GOSH is the only Trust in the country to have extended the implementation of exception reporting to all junior doctors.

- Number of Trust Doctors as of 30 June 2018 = 148
- Number of Training Doctors as of 30 June 2018 = 181

3. GOSH Junior Doctor Rotas

3.2. Rotas

3.3. There are 45 different rota patterns currently in place within the Trust. All GOSH rotas are compliant with the 2016 TCS.

3.4. Rota Gaps (due to unfilled positions and sickness) put significant pressure on the system and result in junior doctors working over hours and not accessing training and education opportunities.

3.5. As of the 30 June 2018 the following junior doctor posts were vacant:

Specialty	Rota grade	Rota establishment	Vacant posts	Vacancy rate %
Neurology	SHO	4	1	25
Orthopaedic Surgery	SHO	3	2	66.6
Urology	SHO	4	1	25
Plastic Surgery	SHO	3	2	66.6
ENT	SHO	2	1	50
Gastroenterology	SpR	5	1.4	28
Gastroenterology	SHO	3	3	100
Metabolic	SpR	3	1	33.3
Metabolic	SHO	2	1	50
Megga 2 Metabolics	SpR	7	1	14
ICON	SpR	8	4	50
ECMO	SpR	7	2	29
Cardiothoracic Surgery	SpR	8	2	25
International Private Patients	SpR	14	5	35.5

3.5.1. The overall vacancy rate across junior doctor rotas is 9.6% with 27.4 FTE vacant out of a total of 284 rota slots

3.6. Understanding how rota gaps impact on work flow is essential. For example:

3.6.1. Gastroenterology are currently working with 4.6/ 7 middle grade doctors and no SHOs (so 4.6 doctors out of 10 junior doctor posts filled in department). Day time work intensity is affected by no SHOs; hours are increased; leave cannot be taken; middle grade doctors are not accessing training and education opportunities; this affects patient safety, job satisfaction and morale.

3.6.2. Surgical SHO rota is combined across units and is considerably down (6/18) putting strain on junior doctors- again this affects working hours; opportunities for training and education; leave and results in low morale.

3.7. There is no assessment of risk relating to patient safety when there are significant, on-going rota gaps and reduced junior doctor numbers.

4. **Exception Reports**

4.2. The purpose of exception reports (ERs) is to ensure prompt resolution and / or remedial action to ensure that safe working hours are maintained.

4.3. The first quarterly Guardian reports with anonymised data re ER were sent to Divisional Directors/ Heads of Clinical Service in June.

4.4. **Numbers of ERs May & June 2018**

Date:	Number of Exception reports:	Number of Episodes:	No closed / completed
May & June 2018	19	35	7

4.5. Exception Report Outcomes:

Exception Report Outcomes (Per Episode- some have >1 outcome) May to June incl. 18					
Compensation with payment	TOIL	Work Schedule review	Further information	Pending ES meeting	Level 1 review
5	12	1	1	25	1

Response times from ER to closure are slow. We need to improve on this.

4.6. **Exception Report by Specialty and Grade**

Exception reports May to June 2018 Details by specialty; grade and reason for ER					
Specialty	**Rota grade**		**Exceptions relating to hours of work**	**Exceptions relating to educational opportunities**	**Exceptions relating to missed breaks**
	SHO	SpR / Fellow			
Cardiothoracic		1	1		
Gastro		7	7	(2 mentioned with hours)	
Imm/ID					
IPP		10	10		
PICU/ NICU					
Respiratory					
Rheumatology		14	12		4
Neurosurgery					
Surgery	3		3		
Total	**3**	**32**	**33**		**4**

4.7. Exception Report Themes

The predominant themes behind the extra hours being worked are:

4.7.1.

- Staying late to complete clinical duties
- Rota gaps putting pressure on time to complete daily workload
- Work volume

5. Speciality Focus

5.2. GOSW has identified specific specialities that require further support and is working alongside the teams to improve rotas, examine work flow systems and processes and facilitate access to learning opportunities.

6. Locums - Bank and Agency use

6.2. Below is a breakdown of locum (Bank and agency) usage across junior doctor rotas, for the period 1 May to 30 June 2018.

Specialty	Number of Shifts	Cost
CAMHS Juniors	2	£593.18
Cardiology SHOs	12	£5,989.80
Cardiothoracic SpRs	9	£9,746.50
CATS	19	£12,110.48
CICU	57	£38,138.12
Cleft Service	1	£382.38
Haematology/Oncology	101	£51,562.39
MEGGA	108	£43,610.22
Neurology	73	£27,246.36
NeuroResp Nights	1	£656.50
Neurosurgery	42	£13,916.71
NICU PICU ICON	77	£63,852.02
Ortho Spinal SpRs	4	£1,208.00
Private Divisional Medical	74	£33,885.50
Respiratory Medicine	11	£3,762.29
Rheumatology	52	£20,688.25
Spinal	20	£1,969.60
Surgery SHOs	228	£85,082.99
Surgery SpRs	1	£353.50
Urology SpRs	5	£2,371.50
Total	**897**	**£417,126.29**

7. Compliance with 2016 TCS

7.2. The existing reporting system and software makes it impossible to determine whether doctors are working beyond the limits set out in schedule 3 of the 2016 TCS.

7.3. Many GOSH doctors are actively encouraged to work on bank shifts. **Recording and assimilation of these extra bank hours in conjunction with scheduled working hours is not undertaken.**

7.4. Analysis of data is extremely cumbersome. The existing Allocate software does not support longitudinal data collection comparison against individual doctor's working rotas. This has been fed back to the software designers.

8. Fines and Payments

8.2. GOSW along with HR has ensured payment process for overtime compensation is streamlined.

8.3. No 'Higher' fines have been levied by GOSW against non-compliant departments. **This is not to say that all GOSH departments are compliant.** Unless the doctors report all their hours (including bank duties) on every shift across several weeks the GOSW cannot determine these breaches.

9. **Junior Doctors' Forum**

9.2. The JDF and DocsReps Committee have merged to form one representative group. This is working well but attendance numbers at JDF is generally low. Quality of discussion and actions however is constructive.

10. Externality

- GOSH experience of ER presented at the HEE DMD and GOSW meeting in June and was well received.
- BMA hosting a Pan London GoSW networking meeting in September chaired by GOSH Guardian
- GOSH involved with the NHS improvement national ER working group.

11. **Summary**

11.2. Unfortunately with current reporting systems and practices GoSW cannot offer any assurance of compliance with the 2016 JD contract.

11.3. Rotas are theoretically compliant but rota gaps directly affect compliance and safety in addition to education and training opportunities, affecting junior doctor morale.

11.4. Despite the above exception reporting is being used appropriately and constructively. When used proactively it can provide a constructive conduit to supporting junior doctor working.

11.5. There is no measure to assess 'safe doctor numbers' and control work flow systems. GoSW and MD have discussed implementing some form of risk management for this.

11.6. Review of work flow when rota numbers are down, with attention to the junior doctor 'job plan' and content of role, enables positive suggestions by junior doctors to improve working conditions and establish a sense of agency. This improves morale and highlights safety issues.

11.7. Processes and systems that support Junior Doctors working are slow and cumbersome. We do not act on concerns fast enough.

11.8. The GOSH experience regarding ER will continue to be communicated to external organisations raising awareness of issues and influencing national policy.

11.9. GOSW is continuing to work to support the junior doctors at GOSH.

Attachment 1

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 25th July 2018	
Medical Revalidation Annual Board report and statement of compliance **Submitted by:** **Dr Andrew Long, Interim Medical Director and Responsible Officer**	**Paper No: Attachment 1**
Aims / summary This report is presented to the Board to provide assurance that the statutory functions of the Responsible Officer are being appropriately fulfilled; to report on performance in relation to those functions; to update the Board on progress since the 2017 annual report; to highlight current and future issues; and to present action plans to mitigate potential risks.	
Action required from the meeting The Board is asked to note the contents of the update	
Contribution to the delivery of NHS Foundation Trust strategies and plans Revalidation is an essential part of clinical governance.	
Financial implications There are no further financial implications consequent upon this update.	
Who needs to be told about any decision? Higher Level Responsible Officer	
Who is responsible for implementing the required statutory role. Interim Medical Director/Responsible Officer	
Who is accountable for the implementation of the proposal / project? Dr Andrew Long, Interim Medical Director/ Responsible Officer	

Annual Board Report and Statement of Compliance: Revalidation of Doctors
(Based on NHS England Revalidation Team Template)

1. Purpose

This report is presented to the Board to provide assurance that the statutory functions of the Responsible Officer are being appropriately fulfilled; to report on performance in relation to those functions; to update the Board on progress since the 2017 annual report; to highlight current and future issues; and to present action plans to mitigate potential risks.

2. Background

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system. It is based on all doctors undertaking an annual appraisal that includes information defined by the GMC.

The purpose of medical revalidation is to assure patients and the public that doctors are up to date and fit to practice.

Each doctor must have a Responsible Officer who must oversee a range of processes including annual appraisal, and who makes, at five yearly intervals, a recommendation to the GMC in respect of the doctor's revalidation.

The Responsible Officer is appointed by the Board of an organisation termed a Designated Body, to which the doctor is linked by a Prescribed Connection. This link is created when a contract of employment, substantive, locum or honorary, is agreed between the doctor and the Designated Body.

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations[1] and it is expected that executive teams will oversee compliance by:

- Monitoring the frequency and quality of medical appraisals in their organisations
- Checking there are effective systems in place for monitoring the conduct and performance of their doctors
- Confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation for doctors; and
- Ensuring that appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that medical practitioners have qualifications, experience and language skills appropriate to the work performed

It should be noted that compliance with these regulations also forms part of the Care Quality Commission's surveillance model.

The last report to the Trust Board was submitted in November 2017 for the year 2015 – 2017 (no Annual Report in 2016). Since this date there have been significant changes in both the way in which revalidation is managed internally and externally and the types of challenges faced. The most important of these is that the implementation phase of revalidation has been completed, with a recommendation made in respect of the revalidation of every doctor who held a licence to practice as of 4th December 2012. Hence the majority of doctors in the UK are now in their second cycle of revalidation.

[1] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012'

3. Governance Arrangements

The current Responsible Officer (Andrew Long, Deputy Medical Director) was appointed on 1st January 2017 in line with statutory requirements. He works closely with the Medical Director and the Deputy Director for HR and OD, meeting weekly to discuss current and new activity and meeting monthly with the Divisional Directors and the Director of HR and OD. Outside these regular meetings, supported by the Deputy Medical Director for Postgraduate Education and other Associate Medical Directors, there is an effective Decision Making Group (DMG) to identify early concerns with clinician performance and ensure that potential problems are identified early and action taken where appropriate. Several individuals within the organisation, including those identified above, have undertaken training in the procedures involved in Maintaining High Professional Standards (MHPS) to ensure that experienced individuals are involved at an early stage when concerns are raised. There is a clear and transparent link to the Executive Incident Review Meeting (EIRM) where potential Serious Incidents (SI's) are reviewed by the Medical Directors team to identify where there are concerns about individual clinical practice.

The organisation is subject to external quality control processes in two ways:

1) There is regular organisation audit conducted through NHS England requiring quarterly returns of audit activity which contribute to an Annual Organisation Audit (AoA – Appendix 2) where organisational activity for appraisal and revalidation are benchmarked against similar organisations.
2) There is an Independent Verification Visit carried out by NHS England which examines the internal governance arrangements and offers external advice on systems and processes which support appraisal and revalidation.

As a designated body, GOSH submitted an annual organisational audit to NHS England in June 2018 (Appendix 2). We responded "no" to 3 questions:

2.2. Every doctor with a prescribed connection to the designated body with a missed or incomplete medical appraisal has an explanation recorded
This is addressed in the action plan at the end of this paper.

2.7 Medical appraisers are supported in their role to calibrate and quality assure their appraisal
This is addressed in the action plan at the end of the paper.

3.7 The designated body has arrangements in place to access sufficient trained case investigators and case managers.
This is addressed in the action plan at the end of the paper.

The last Independent Verification Visit (IVV) took place in February 2015. An Action Plan was resubmitted to NHS England in May 2017 (submitted as part of the Report in 2017) as there was no evidence that this had been submitted in 2015. NHS England have accepted the Action Plan as evidence of good practice and have indicated that they do not intend to visit GOSH again in the near future.

4. Policy and Guidance

The Trust has had appropriate policies in place for Medical Appraisal and Revalidation for Consultant staff as well as for non-consultant medical staff. They were reviewed in 2016, approved by the LNC and some changes have been requested by the Policy Advisory Group

in early 2017. They have now been approved by PAG and externally reviewed as part of the External Quality Assurance visit (Appendix 3). The Trust Policy for Maintaining High Professional Standards (MHPS) has been reviewed and is currently awaiting further discussion with the Trust Local Negotiating Committee (LNC).

The Responsible Officer actively contributes to London Region Responsible Officer Network meetings and seeks advice and support from other RO's as well as taking advice internally from the Medical Director and DMG supported by Human Resources.

5. Process of Medical Appraisal and Revalidation

a. Appraisal Performance Data

For 390 consultants (including honorary consultants) appraisal rates for 2017-18 were 87% and almost meets the national target (90%). This is similar to 2016-17 (88%) and better than 2015-16 (74.3%) but not as good as 2014-15 (90%). For the 46 consultants in 2017-18 where an appraisal was not completed there was a reported, justified reason (eg maternity leave, long term sickness) in 5 individuals. There is a persisting issue for consultants with honorary contracts which we are actively seeking to resolve by reviewing all requests for honorary contract status. A small number of consultants are still not engaging with their responsibilities under the current system and one 'Non-engagement' warning letter (GMC REV06) has been issued to a consultant during the past year with positive effect. The RO is in the process of contacting all consultants who have not had an appraisal during the past 18 months to understand the reasons and take action as appropriate.

For SAS grades appraisal rates were 55% which compares badly with 2016-17 (100%). There are only 9 doctors in this grade and the RO is in the process of contacting them.

This is the first year where accurate figures are available for the 241 non-consultant grade doctors (Trust Fellows). The current ePortfolio system (PReP) was only extended to all Trust Fellows in October 2017. They had previously been using paper systems and there has been a gradual move to the electronic recording however this explains the current rate of 77% of which only 2 missed appraisals were due to approved reasons. From April 2018 it has been made clear that appraisals can only be undertaken using the PReP system.

The overall appraisal rate for all medical staff on GOSH contracts for 2017-2018 is 82.6%.

Compliance by Division (July 2018)

Count of Employee	Column Labels			
Row Labels	No	Yes	Grand Total	
271 4AIPP - International		3	3	100%
271 4CDIV1 - West Division	29	124	153	81%
271 4CDIV2 - Barrie Division	26	206	232	89%
271 4DMED - Medical Directorate		5	5	100%
271 4DRAD - Research & Innovation		1	1	100%
271 Bank	1	2	3	67%
Grand Total	**57**	**340**	**397**	85.5%

Nationally the appraisal rate has risen from 85% in 2015-16 to 91%. For London the average appraisal rate across all organisations was 88% and for 40 NHS Trusts is 89% in 2016-17. There were 9 Trusts in London that had an appraisal rate below 85% and the reported figure of 82.6% in the AoA would place GOSH in the bottom quartile for similar organisations if rates are similar for 2017-18 (data not available from NHSE).

b. Appraisers

For 2017-18 the Trust had 123 trained appraisers. Most of these had been trained over three years ago and it is the expectation that appraiser training update takes place every two years. 55 appraisers have updated their appraisal training during the last two years using an eLearning module, and enough user licences are now available for all those needing training updates. Of the 123 appraisers, 25 had not appraised anyone within the previous year's cycle (4 of these had undertaken refresher training). 13 appraisers had only appraised one individual (4 of these doctors have recently retired) and 6 individuals had appraised 10 or more appraisees. The recommendation is that every trained appraiser should appraise at least 3 and no more than 6 doctors within each cycle. The same appraiser/appraisee relationship is only permitted for a maximum of three cycles. Some clinical services have a disproportionate appraiser-appraisee ratio (ie too few appraisers leading to excessive workload for a few individuals)

c. Quality Assurance

External assessment of appraisal policies and procedures is a recommendation and informs NHS England's Annual Organisational Audit.

Formal quality assurance of the content and output of appraisals was planned to start in 2014-15 but was not undertaken due to lack of capacity in the appraisal team although it was hoped that this would start in the following year. There was a high quality external review of the appraisal service undertaken in December 2017 (Appendix 3).

The External Quality Assurance (EQA) Review found that there was a general high standard of appraisal output with a reasonable standard of supportive documentation but there was a need for appraisees to increase detail with greater evidence of reflective practice to add true value. There was also a requirement for appraisers to provide the RO with comment on appraisee progress to support the revalidation recommendation. **It was identified that more appraiser training was required and systems needed to be put in place to make sure that appraisers had time allocated in job plans and due notice was given to appraisees who failed to have their appraisal completed within the allocated appraisal year.**

The greatest challenges from the EQA were on organisational changes recommended. There was a suggestion that there should be a centralised process to ensure a standardised approach across the whole Trust including centralisation of appraisers with the appointment of Appraisal Lead(s). **The reviewers noted that there was insufficient resource currently allocated for the size of Trust and the expected workload. There was a clear recommendation that a fulltime Revalidation Manager should be appointed with appropriate administrative support.**

d. Revalidation and Appraisal Resources

Currently the appraisal and revalidation support team consists of the Deputy Medical Director/RO (1 PA until May 2018) and 0.5 WTE Band 6 Medical HR Services Team Leader/Revalidation Support Assistant. There is still a need for a specific budget identified for training appraisers (for new appraisers and updates) and to ensure there are adequate numbers of licences for the ePortfolio (PReP) system and for Edgecumbe 360 degree feedback (patients and colleagues).

6. Revalidation Recommendations

For 2017-18 16 revalidation recommendations were made on 26 doctors, with 10 deferral recommendations. This gives a deferral rate of 38% which is higher than the national average, however only 2 of the 10 deferrals were for staff with permanent contracts; 4 had joined the Trust during the previous 12 months without a good appraisal record and these have all moved on to new organisations; 2 have since been revalidated after good appraisal

processes; 1 is due to be revalidated shortly and 1 is on maternity leave. The number of doctors requiring revalidation recommendations is set to increase steeply (86 in 2018; 149 in 2019; 200 in 2020). This will require considerable committed RO time, the services of an experienced Revalidation Manager and good administrative support and is discussed in the action plan.

7. Recruitment and engagement background checks

Robust pre-employment checks are conducted on all candidates as per national guidance. A great deal of work is being undertaken by HR to strengthen the process around honorary contract holders and ensure full checks are made. There are still challenges experienced by doctors from overseas with achieving the expected standard of English language assessment (IELTS) required by the GMC. This is likely to continue to be a problem as we experience staff shortages related to Brexit. Although we are using 'in house' assessments of communication skills they are not always recognised by the GMC and we have had to delay some doctors taking up post until they had satisfied GMC requirements.

8. Monitoring Performance

The hospital has appropriate mechanisms in place for monitoring the professional performance of doctors. As required by the GMC, never events involving doctors are reported to them and also to NHS England.

9. Review of previous Action Plan (2017-18)

Issue	Action	Responsible	By	Achieved
Inadequate administrative support	Review admin support (amount and line management) for short and long term	Dep Dir HR/DMD/RO	31 08 17	In process
Ensure DMD/RO has sufficient time in job plan	Review with MD	DMD/RO/MD	31 08 17	Yes
Ensure that there are adequate numbers of trained appraisers	Work with Senior Management Team to ensure that appraisers are appropriately trained and given time within job plans	DMD/RO/MD	31 12 17	Yes
Ensure that appraisee/appraiser relationships are consistent	Work with Senior Management Team to review process of facilitating appraisee/appraiser matching	DMD/RO/MD	31 12 17	In process
Process to ensure key items of information are available to be included in the appraisal portfolio	Work with CG team to implement a system of proactive uploading of information by appraisal administrator into appraisal portfolio	DMD/RO	31 10 17	No
Recording of non-training grade doctor appraisals	Develop more robust system to prompt appraisals and capture revalidation information	Head of Medical HR & PGME Serv./AMD/RO	31 12 17	Yes
Quality Assurance of appraisal content and output	DMD/RO to develop and undertake quality assurance process	DMD/RO	30 11 17	Yes
External Quality Assurance	DMD/RO to commission an independent review of its processes relating to appraisal	DMD/RO/MD	30 11 17	Yes

	and revalidation			
Identifying movement of doctors in non-training grade posts	Work with PremierIT to develop more robust system for transferring appraisal information between organisations	DMD/RO/ Dep Dir HR	31 12 17	No
Identify role and purpose of secondary appraiser and map accordingly	Work with PremierIT to develop rules for secondary appraiser and refine Trust appraisal policy to meet these needs/	DMD/RO	31 12 17	Yes
Clarify responsibility for appraisal for doctors with honorary contracts	Work with Senior Management Team and HR to review process of issuing and maintaining honorary contracts	DMD/RO/MD/ Dep Dir HR	31 12 17	In process

10. Monitoring Performance, Responding to Concerns and Remediation

Concerns about a doctor's performance are managed under the Trust's 'Conduct Capability, III Health and Appeals Policies and Procedures for Medical Practitioners'. Minor issues should be dealt with by the Head of Clinical Service, supported, where appropriate, by the Divisional Director and/or Divisional Chair. Escalation to the Medical Director and/or DMD for Professional Accountability/RO takes place after discussion and where a more formal process is deemed necessary.

Weekly review meetings take place between the Medical Director, DMD/RO, and Deputy Director of HR/OD supported by the Employment Relations Manager to manage the more serious cases. Where appropriate a Non-Executive Director is assigned to each case to monitor compliance with process and ensure a timely resolution. A report on exclusions and involvement in such processes is presented periodically to the Trust Board for information.

The Medical Director, DMD/RO, Deputy Director for HR and OD meet with the GMC Employment Liaison Advisor every four months to discuss cases which have been escalated or referred to the GMC. Other GMC related matters are also discussed at these meetings.

The DMD/RO meets regularly with the Head of Medical HR & PGME Services and the Medical Workforce Business Partner for Medical HR & PGME Services to discuss Revalidation recommendations and issues related to appraisal.

11. Risks and Issues

The Board was informed last year of the risks associated with an ineffective system for appraisal and revalidation. The GMC have recently recirculated their handbook for Boards (Appendix 4) which identifies a number of governance questions (Handbook Appendix 1). As previously outlined the current appraisal and revalidation support team at GOSH is very lean and requires more resources to be identified (ref EQA Report). The amount of clinician time available and administrative support (and expertise) in using the ePortfolio system, supporting the appraisal process, recruiting and training appraisers is currently inadequate. It compares poorly with other Trust of a similar size and complexity and is likely to become unsustainable when the revalidation cycle returns to its expected level in 2018-19.

At the current time, the appraisal system within Great Ormond Street still relies on individual doctors choosing their own appraisers. Since there is a paucity of trained appraisers within some specialty areas this results in an unequal burden of time spent undertaking appraisal by a small number of clinicians. There is still no specific time commitment made available within job plans for clinicians to undertake this important process. The EQA suggests that there is a variety of commitment to the appraisal process by both appraisers and appraisees. Because the internal quality assurance is not robust there is the risk that some appraisees

might choose their appraisers for expedience rather than to ensure a high-quality appraisal experience. Many neighbouring Trusts choose to have a system where appraisers are appointed, rather than chosen, which leads to an improvement in appraisal quality and commitment.

Many consultants maintain honorary contracts with GOSH after retirement. It is an expectation from the GMC that annual appraisal should continue to take place as long as a clinician holds a License to Practice. Doctors on honorary contracts are extremely difficult to manage even though they retain a connection with GOSH as their designated body. It is the view of the DMD/RO that this should be managed at a Divisional level.

Those in joint academic/clinical roles are required to undertake a joint appraisal between their clinical (NHS) representative and their academic representative under the Follett principles. This adds complexity to the appraisal process however it enables their academic commitment to be appropriately recognised. Historically those in senior management roles have requested a joint appraisal with representatives from the Executive Management Team. This has been more difficult to implement recognising the balance between clinical and managerial commitments and informing the individual Personal Development Plan to meet Trust strategic objectives.

12. Corrective Actions, Improvement Plan and Next Steps

Issue	Action	Responsible	By
Inadequate administrative support	Review admin support (amount and line management) for short and long term	MD/HR Dir/Dep Dir HR/DMD/RO	31 08 18
Ensure that appraisee/appraiser relationships are consistent	Work with Senior Management Team to review process of facilitating appraisee/appraiser matching and ensure sufficient time in appraiser job-plans	DMD/RO/MD	31 08 18
Ensure that high quality appraisal is taking place in a timely fashion to support revalidation	Create systems to remind appraisees to complete appraisal and ensure that the appraisal process is adequately supported and regularly quality assured	DMD/RO/MD	31 12 18
Process to ensure information is available to be included in the appraisal portfolio	Work with CG team to implement a system of proactive uploading of information by appraisal administrator into appraisal portfolio.	DMD/RO	31 12 18
Identifying movement of doctors in non-training grade posts	Work with PremierIT to develop more robust system for transferring appraisal information between organisations	DMD/RO	31 12 18
Clarify responsibility for appraisal for doctors with honorary contracts	Work with Senior Management Team to review process of issuing and maintaining honorary contracts	DMD/RO/MD	31 12 18
Ensure that there is access to trained Case Investigators	Work with HR and Senior Management Team to identify and train individual capable of undertaking Investigation	DMD/RO/MD	31 12 18

13. Recommendation

The Board is asked to receive the contents of the report, noting that it will be shared with the Tier 2 Senior Responsible Officer at NHS England. The Board is also asked to note the Statement of Compliance attached at appendix 1.

Report Prepared by:

Dr Andrew Long, Deputy Medical Director and Responsible Officer

Shared with Mr Matthew Shaw, Medical Director

Appendices

1. **Statement of Compliance**
2. **Annual Organisational Audit**
3. **External Quality Assurance Report**
4. **Effective governance to support medical revalidation (Handbook for Boards)**

Appendix 1

Designated Body Statement of Compliance

The board of Great Ormond Street Hospital for Children NHS foundation Trust has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   Comments: Dr Andrew Long, Deputy Medical Director was appointed as Responsible Officer in January 2017

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   Comments: This is undertaken through GMC Connect and supported by HR.

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   Comments: Although there are enough trained appraisers they are inequally distributed meaning that there is too much workload for some appraisers with some doing too little. There also needs to be time allocated within consultant job-plans.

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

   Comments: There is need for greater resource to support this at the current time

5. All licensed medical practitioners[2] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   Comments: All licensed medical practitioners are expected to participate in the appraisal process. It is intended that new systems are introduced to ensure that appraisal takes place within the required timeframe.

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

   Comments: There is a system in place which meets most of these requirements however there is often difficulty in ensuring that information is available for doctors to include in their appraisal documentation. This is being addressed.

[1,2] Doctors with a prescribed connection to the designated body on the date of reporting

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

   Comments: The system in place is now more robust than in previous years.

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

   Comments: This has been implemented during 2017

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners[3] have qualifications and experience appropriate to the work performed; and

   Comments: This is largely fulfilled but needs regular quality assurance in place.

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

    Comments: An action plan has been recommended to the Trust Board for implementation.

Signed on behalf of the designated body

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Dr Peter Steer, CEO

Date: _ _ _ _ _ _ _ _ _ _

[3] Doctors with a prescribed connection to the designated body on the date of reporting