GOSH Foundation Trust Licence self-certification 22 May 2019

Great Ormond Street Hospital for Children NHS Foundation Trust

Licence condition	Description	Confirmed or Not Confirmed	Assurance

G6 – Systems for compliance with licence conditions and related obligations (scope = past financial year 2018/19)	The Licensee shall take all reasonable precautions against the risk of failure to comply with the Conditions of this Licence, any requirements imposed on it under the NHS Acts, and the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.
	
	The steps that the Licensee must take ….shall include:
	(a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and
	(b) regular review of whether those processes and systems have been implemented and of their effectiveness.
	
	A statement shall be provided for Monitor to certify compliance with this condition no later than 2 months from the end of the financial year.
		Confirmed taking into account the views of the governors	The Trust has systems and processes to monitor risks of failure through lack of compliance or adverse variances in performance:
			• There is clear accountability at Board level for safety and clinical quality objectives and structured reporting of performance against these objectives. (see Annual Governance Statement in annual report)
			• The Trust's Assurance and Escalation framework sets out how the organisation identifies, monitors, escalates and manages concerns and risks in a timely fashion and at an appropriate level (under review for completion by June 2019). This covers the following areas:
			  ○ Performance Management framework
			  ○ Risk Management framework
			  ○ Policy framework
			  ○ Compliance framework
			  ○ Accountability framework
			  ○ Escalation framework
			  ○ Assurance framework
			• Other key frameworks and policies in place include:
			  ○ Information Governance framework
			  ○ Safeguarding policy
			  ○ Health and Safety Policy
			  ○ Infection Control Assurance Framework
			• The Trust's risk management strategy, which sets out how risk is systematically managed, extends across the organisation from the front-line service through to the Board, to promote the reduction of clinical and non-clinical risks associated with healthcare and research,

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			and to ensure the business continuity of the Trust. The strategy identifies the organisational risk management structure, the roles and responsibilities of committees and groups that have some responsibility for risk, and the duties and authority of key individuals and managers with regard to risk management activities. It describes the process to provide assurance for the Trust Board review of the strategic organisational risks, and the local structures to manage risk in support of this policy. The strategy has recently been refreshed in light changes to the clinical operations structure. • The Trust's Board Assurance Framework is used to provide the Board with assurance that there is a sound system of internal control in place to manage the key risks to the Trust of not achieving its strategic objectives. The BAF records the controls in place to manage the key risks, and highlights how the control is operating. The BAF includes cross-references to assurance obtained from internal and external audits, and self-assessments of compliance with other regulatory standards. It has been monitored by the assurance committees and updated throughout the year. In February 2019 a revised BAF was approved by the Trust Board incorporating 6 new strategic risks. The Risk Assurance and Compliance Group monitors progress with the BAF. This includes a 'stress test' of an individual BAF risk at every meeting to check (using key performance indicators and external assurance information) whether the controls and assonances cited are working and appropriate. The internal auditors conducted a Risk Management audit looking at the processes in place for the recording and management of operational risks. The report allocated a rating of 'Significant assurance with four minor improvement opportunities'. • Directorate performance reviews take place on a monthly basis, attended by directorate management and Trust executives. These reviews are designed to facilitate a triangulated and risk-focused

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			discussion across a number of key domains: Caring, Safe, Responsive, Well-Led (people, management and culture), Effective, Finance, Productivity. The review packs contain an integrated dashboard which provides a one page summary of key metrics across the domains, allowing rapid identification of linked risks and issues. The packs also contain more in-depth dashboards for each domain. An integrated performance report is then scrutinised at each Board meeting. This provides a summary of the key issues in each domain and actions planned to resolve, as well as an integrated dashboard – this provides trust level data using the same format as the divisional integrated dashboard reviewed in the monthly performance reviews. • The Trust has identified an executive director and a manager who are respectively accountable and responsible for ensuring compliance with each element of the CQC registration standards and for monitoring compliance against other requirements across the Trust. The Trust has developed an action plan in response to the recent CQC inspection and actively monitors progress with this at operational level and provides assurance to the Board. All remaining outstanding actions from the Well led Review in October 2016 and any negative commentary from the CQC inspection I 2018 have been closed or consolidated with the Well Led action plan 2019 (reported at Board and Council in February 2019). • The Trust has commenced a programme of work in order to ensure CQC readiness and to maintain compliance for the Trust. This work has been rolled out with a view to ensuring that compliance and governance are interlinked with quality, safety and experience and embedded in day to day working within the Trust. The work being undertaken includes: • Weekly Steering Groups with Deputy Chiefs of Service ○ Mock inspection framework (CQC Quality Rounds) in clinical directorates

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			○ Gap analysis of information for RPIR undertaken ○ Reviews of potential areas/sources of learning e.g. review of themes from other CQC reports, evaluation of insight reports • The Trust has systems and processes in place to support staff and patients in escalating concerns in provision of care or management of systems. These include the complaints process, PALS, Freedom to Speak Up Guardian, Guardian of Safe Working, Raising Concerns Policy, Counterfraud service etc. The Trust is one of the first UK hospitals to partner with the Cognitive Institute in their Safety and Reliability Improvement Programme. Signing up to this partnership recognises our commitment to achieving zero preventable harm and delivering the best possible outcomes through providing the safest, most effective and efficient care. Safety Champions from across the hospital have been appointed and a pilot is in the process of being run in one of the directorates. • The Trust assesses compliance with the FT licence annually.
CoS7 – Availability of resources (scope = next financial year 2019/20)	The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources. The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee. The Licensee, not later than two months from the end of each Financial	**Confirmed** taking into account the views of governors: "*After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it*	The Trust sets its budget on an annual basis and actively manages and monitors its financial position and resource levels on a regular basis throughout the year through routine performance reporting to the Board and its Committees. The Executive Team actively monitors the finance position at every meeting to ensure that the mitigations in place are effective and appropriate. Both External and Internal Audit services provide assurance that reporting is accurate and there is no material mis-statement. No material agreements which might create a material risk have been entered into. The Trust Audit Committee and Board approved the 2018/19 annual report and accounts (22 May 2012), on a going concern basis, confirming that the

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	Year, shall submit to Monitor a certificate as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate.	*after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate*."	Directors have a reasonable expectation that the organisation has the required resources available for the next 12 month licence (a). The Trust is implementing a robust savings plan for 2019/20. The Trust is holding discussions with other NHS trusts on managing implications of tariff changes. The external auditors issued a clean financial audit opinion for 2018/19.
FT4- NHS foundation trust governance arrangements (scope = next financial year 2019/20)	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.	**Confirmed** taking into account the views of governors	The Trust has a range of governance and assurance structures and systems in place including a Trust wide strategy, scheme of delegation, risk management framework, accountability framework, compliance framework, escalation framework, policy framework and assurance framework and a financial management framework. Directors and governors are asked to sign a code of conduct (both documents were refreshed in 2018) and declare any interest for publication on a Register of Interests. Directors complete a self-assessment for the Fit and Proper Person Test (and are reviewed against the criteria annually) and are required to declare any interests annually. Governors sign an eligibility form which includes reference to the Fit and Proper Person's Process. A self-assessment is prepared annually against the Monitor code of Governance and will be reported to the Board in May 2019. The Trust Board considers that from 1 April 2018 to 31 March 2019 it was compliant with the

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<tr><th>Licence condition</th><th>Description</th><th>Confirmed or Not Confirmed</th><th>Assurance</th></tr>
<tr><td></td><td></td><td></td><td>provisions of The NHS foundation trust Code of Governance and explains its compliance (on a comply or explain basis) for the following criteria in the annual report:
<table>
<tr><td>B.1.2</td><td>The Board is normally comprised of a Chair, Deputy Chair, Senior Independent Director (SID), three additional independent Non-Executive Directors, and six Executive Directors. One of the Non-Executive Directors is appointed by University College London.
Mr Chris Kennedy joined the Board as a non-–executive director on 1 April 2018 and Ms Kathryn Ludlow joined as a non-–executive director from 6 September 2018. From 31 May 2018 until the appointment of Ms Kathryn Ludlow, the Board comprised a chair and five non-–executive directors, including one appointed by University College London.</td></tr>
<tr><td>B.2.2</td><td>The directors on the Board have all been required to sign a statement declaring that they meet the criteria of a ‘fit and proper person’.
Governors are asked to make a declaration about their fitness to hold the role of Governor and are subject to a DBS check every three years (and on appointment/ election). Further checks are underway with regards director disqualifications and bankruptcy and on an annual basis.</td></tr>
<tr><td>B.6.5</td><td>An evaluation of Council was due in 2018. A decision has been taken to delay this to Q2 2019/20, allowing time for new governors to be inducted and become familiar with their roles.</td></tr>
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Further information about corporate governance systems and standards at GOSH is detailed below.</td></tr>
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	The Licensee shall: (a) have regard to such guidance on good corporate governance as may be issued by Monitor from time to time; (b) comply with the following paragraphs of this Condition.	**Confirmed** taking into account the views of governors	The Trust has regard to guidance on good corporate governance as issued by NHS Improvement.
	The Licensee shall establish and implement: (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.	**Confirmed** taking into account the views of governors	The Board has a formal schedule of matters reserved for its decision, and delegates certain matters to committees. The Board has a work programme, which includes all matters the Board is required to consider by statutory, regulatory and other forms of guidance. It also has a range of strategic and operational performance information, which enables it to scrutinise the effectiveness of the Trust's operations, and deliver focused strategic leadership through its decisions and actions. The Board maintains its commitment that discussion of patient safety will always be high on its agenda. There are two Board assurance committees - the Audit Committee and the Quality, Safety and Experience Assurance Committee. These committees assess the assurance available to the Board in relation to risk management, review the Trust's non-clinical and clinical and quality risk management processes and raise issues that require the attention of the Board. In addition to the two assurance committees, the Finance and Investment Committee considers financial performance, productivity and use of resources. The chairs of these committees report to the Board following every committee meeting. Each committee is charged with reviewing its effectiveness annually. In February 2019 the Board agreed to establish (for one year in the first instance from June 2019), a new assurance subcommittee of the Board – the People and Education Assurance Committee. The remit of the committee is to

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			provide assurance to the Board and that the necessary structures and processes are in place to deliver the Trust's vision for a supported and innovative workforce, an excellent learning environment for clinical and non-clinical staff and a culture that aligns with the Trust's strategy and always values. The committee was established to scrutinise the new strategic risks on the Board Assurance Framework on culture, service innovation and provide additional scrutiny to the risk around recruitment and retention of staff. The Trust has terms of reference and work plans in place for the Board, Council and relevant committees. The Board committees conduct annual effectiveness reviews (surveys) on the delivery of their terms of reference and running of the committees. Findings are reviewed and where appropriate, changes to the terms of reference and workplans of the committees are made. The assurance committees receive minutes from other assurance committees to prevent matters from falling between the governance framework. Summaries of assurance committee meetings are reported at the Board and the Council. At the Council, the chairs of the assurance committees present the summary reports and are held directly to account by the governors at the Council meeting. Governors are also invited to attend assurance committees and Board meetings throughout the year. The Board and Council receive regular updates on findings from CQC Well led reviews and progress with the Well Led action plan. The Trust's Assurance and Escalation Framework presents a single, comprehensive picture of the governance and assurance structures and systems through which the Trust Board and other stakeholders receive assurance. The Trust routinely reviews and reports this assurance through the following key governance processes and frameworks including:

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			• Performance Management: The Trust has a range of frameworks and policies in place that outline how the Trust's performance objectives and standards will be met, reviewed and managed; most significantly, the Performance Management Framework. • The Trust's Risk Management Strategy (see above) sets out how the organisation identifies, monitors, escalates and manages risks in a timely fashion and at an appropriate level. Further detail on the identification and evaluation of strategic and local risks is provided below. • The Trust has in place a comprehensive and integrated Compliance Framework that seeks to ensure on-going compliance with statutory and regulatory requirements through integrated, rigorous and proactive structures, policies and practices. It ensures appropriate controls are in place to maintain compliance with statutory and regulatory requirements and that external guidance and alerts are considered in a fulsome and responsive way. • Policy Framework: This provides for clear and accessible policies, procedures and guidelines which support staff in undertaking their duties in a safe and effective way that takes account of all relevant legislation, regulation and guidance. The Trust's policy framework, which is administered by the Policy Approval Group (PAG) • Committee structure: The Trust's committee structure, developed from the Trust Board down, is currently under review to ensure each committee or group has a clear purpose, scope and authority. Some committees have statutory functions, others have authority to make decisions and direct actions, and others provide advice, support and oversee specific functions. The clinical operations structure was consulted on in 2018, reviewed and revised. There are no eight directorates, each with a Chief of Service, Deputy Chief of Service, Head of Nursing and General Manager. The Senior Leadership

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			Team meets weekly (around 100 senior managers from across the clinical and corporate areas of the Trust). An Operations Board has been established which meets fortnightly. The purpose of the Board is to bring together clinical and corporate senior leadership members to ensure the robust, effective and efficient operational management of the Trust. The Trust's risk management strategy sets out how risk is systematically managed. This extends across the organisation, from the front-line service through to the Board, to promote the reduction of clinical and non-clinical risks associated with healthcare and research, and to ensure the business continuity of the Trust.
	The Licensee shall establish and effectively implement 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 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;	**Confirmed** taking into account the views of governors	The Board has agreed standing orders and standing financial instructions, which provide the framework for ensuring appropriate authorisation of expenditure commitments in the Trust. The Board's processes for managing its resources include approval of annual budgets for both revenue and capital, reviewing financial performance against these budgets, and assessing the results of the Trust's cost improvement programme on a monthly basis. In addition, the Trust has a prescribed process for the development of business cases for both capital and revenue expenditure and, where significant, these are reviewed by the Trust Board. The Trust's performance management framework is aligned to the revised directorate management structure. Each specialty and clinical directorate has an internal monitoring structure so teams regularly review their progress and identify areas where improvements may be required. Each directorate's performance is considered at monthly performance review meetings. The Finance and Investment committee reviews the operational, productivity and financial performance and use of resources both at Trust and divisional level.

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			The Board has a work programme (aligned with the Well Led Assessment Key Lines of Enquiry), which includes all matters the Board is required to consider by statutory, regulatory and other forms of guidance. It also has a range of strategic and operational performance information, which enables it to scrutinise the effectiveness of the Trust's operations, and deliver focused strategic leadership through its decisions and actions. The Board maintains its commitment that discussion of patient safety will always be high on its agenda. The Board assurance committees scrutinise the strategic risks facing the trust on a rotational basis every year, with committee members reviewing the effectiveness of controls and seeking assurances that any gaps in controls will be closed in a timely manner. Key performance indicators are presented on a monthly basis to the Trust Board. The report, which has recently been refreshed and integrates quality and performance data includes progress against external targets, internal safety measures, operational efficiency/process measures, well-led and other clinical quality measures such as complaints, incidents and reports from specific quality functions within the Trust such as the Patient Advice and Liaison Service (PALS). It also includes the external indicators assessed and reported monthly by the CQC. The report is aligned to the CQC key lines of enquiry: Safe, Effective, Caring, Responsive and Well Led. It asks the question: are our patients receiving high quality care? The external auditors issued a clean financial audit opinion for 2018/19 In January 2018, the Trust was inspected by the CQC and achieved an overall rating of GOOD. An action plan was developed and rolled out across the Trust. The Trust has developed an action plan in response to the recent CQC inspection and actively monitors progress with this at operational level and provides assurance to the Board. All remaining outstanding actions from the

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			Well led Review in October 2016 and any negative commentary from the CQC inspection in 2018 have been either closed or consolidated with the Well Led action plan 2019 (progress reported at Board and Council in February 2019). The Trust has commenced a programme of work in order to ensure CQC readiness and to maintain compliance for the Trust. This work will be rolled out with a view to ensuring that compliance and governance are interlinked with quality, safety and experience and embedded in day to day working within the Trust. The initial work being undertaken will include: • Weekly Steering Groups with Deputy Chiefs of Service • Mock inspection framework (CQC Quality Rounds) being drafted and implemented • Service line meetings with Directorates and Medical Director established and on-going • Communication plan being drafted • CQC action plan routinely monitored and scrutinised • Work to review potential areas/sources of learning being undertaken e.g. review of themes from other CQC reports, evaluation of insight reports. Whilst the CQC made no formal recommendations to the Trust in relation to the findings in its Well Led Assessment published in April 2018, the Trust took it upon itself to review any negative commentary in the report and ensure that relevant actions were taken to mitigate the issues raised. The executive team have reviewed evidence against the Well Led Key Lines of Enquires and developed an action plan in preparation for the next CQC Well Led assessment. Themes arising from an assessment of the evidence and identified gaps mapped to the KLOEs include:

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			• Ensuring that strategies and associated plans are developed, consulted on, communicated across the Trust, monitored and implemented. • Ensuring that governance frameworks, procedures and policies are in place and up to date. • Ensuring staff (all groups) and director appraisals and mandatory training targets are met. • Reviewing how strategy, decisions, changes to practice, learning from risks are communicated across the Trust to all staff groups. • Ensuring that directors and senior managers are visible to staff. • Being deliberate about documenting: • Progress with strategic and local partnerships. • Responding to external benchmarked data such as the staff survey results etc. • Progress with actions against internal and external reviews of GOSH services. The Trust received a qualified opinion for its Quality report on the basis of the results of an audit of the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period. During the year, the Trust continued work to improve the quality and robustness of its waiting list data, building on the work that had been completed over previous years. The principle focus for 2018/19 was maintaining compliance against the RTT standard as an organisation and focusing on speciality level compliance. In addition a significant focus was placed on the build of the EPIC system to ensure we are able to robustly track and manage patients who are awaiting treatment, both within the EPIC system, as well as utilising Qlikview reporting to provide a patient targeting list (PTL) and booking reports for the operational teams. Throughout 2018/19, the Trust successfully delivered the 92% incomplete standard every month.

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			This was a testament to the work completed by the clinical and operational teams. The majority of the errors identified in the audit related to documentation management and late receipt / processing of referral information and thus were not material to the Trust's reported RTT position and as such this led to a modified opinion by the auditor, Deloitte. The review highlighted a reduced quality of data across those pathways below 18 weeks, compared to those who have waited over 18 weeks as all of these pathways are validated as part of our RTT reporting processes in-line with processes completed. Those pathways under 18 weeks are randomly sample audited as part of our waiting times and data assurance processes on a weekly basis. The previous patient administration system was not capable of tracking patients against an RTT pathway, so this had to be constructed and calculated outside of the system in a data warehouse environment. While much work has been completed to compensate for this, it allowed the user to enter pathway data and an outcome code regardless of the status of the pathway. The functionality provided by Epic EPR will go some way to mitigate this, although this is unlikely to address all the issues identified as part of the audit. In addition, the initial concept of RTT was developed around the clinical model of simple surgical care, rather the complex tertiary and quaternary care that we offer at GOSH. As such, it remains a challenge to our clinicians and operational teams to apply the rules to the clinical pathways we have at GOSH. This is further compounded by the fact that 93% of the patients we receive at GOSH have been referred from another hospital setting and hence will have already waited for care at another organisation. This means that for each we have to source a minimum dataset, informing us of the current status of the patient together with their current waiting time. This vital information is often hard to source. However the Trust has completed a significant

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			amount of work to reduce the volume of unknown clock starts from 894 in April 2018 to 231 in March 2019. Finally, although the number of errors was higher than the organisation expected, GOSH notes the context of other Foundation Trusts and their performance against this indicator. It is clear this is a significant challenge to the wider NHS.

s.151(5) of the Health and Social Care Act (not a licence condition) (scope = past financial year 2018/19)	NHS Improvement require the Board to state whether it is satisfied that during the financial year most recently ended the Trust has provided the necessary training to Governors, to ensure that they are equipped with the skills and knowledge they need to undertake their role.	**Confirmed** taking into account the views of governors	**Governor Induction and training and development:** During 2018/19, governors received mandatory Trust training and were provided with access to the Trust's internal on line training portal (GOLD) to update their training during their tenure. This is actively monitored by the Deputy Company Secretary and governors reminded and supported to complete the training during the year. Governors attended three induction sessions between April and August 2018. The sessions prepared and supported Governors to discharge their duties and complete the mandatory training. Prior to each Council of Governors' meeting, the Chair meets with all governors in a private session. This gives the Governors an opportunity to discuss any issues directly with the Chair and to gather information about the Trust and its activities and processes. The Trust established a buddying programme between Non-Executive Directors (NEDs) and governors from September 2018. The buddying programme provides governors with direct contact with a NED to support their role and share information on matters of interest or concern. The programme will be evaluated after 12 months. The Governor Induction programme concluded in August 2018 and transitioned into a series of Governor Development sessions. These sessions were developed in partnership with Governors to provide them with the skills and knowledge needed to deliver their key duties over their tenure. Representative Governors attended NHS Providers events. Information was provided to governors appointed to the Constitution Working Group from an external legal/governance provider. In April 2019 Governors were provided with access to an online library of resources, 24/7. Since February 2019, governors receive a monthly newsletter from the Corporate Affairs team containing key dates, developments and training and development opportunities.